Bristol Clinical Commissioning Group

Bristol Health and Wellbeing Board

Better Care Funding Submission	
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Date of meeting	11th February 2014
Report for Discussion and Decision	

1. Purpose of this Paper

The purpose of this report is to set out the Better Care Fund (BCF) approach that has been taken by the Bristol Clinical Commissioning Group (CCG) and Bristol City Council to determine how the BCF best supports the integration of social care and NHS delivery in Bristol.

The draft template will be tabled at the meeting.

2. Context

Background

2.1 The HWB on 28th November 2013 received a report on The Better Care Fund (previously referred to as the Integration Transformation Fund).

2.2 The £3.8 billion Better Care Fund was announced by the Government in the June 2013 Spending Round, to ensure a transformation in integrated health and social care.

2.3 The BCF is a single pooled budget to support health and social care services to work more closely together in local areas in order to deliver better services to older people and those with Long Term Conditions, keeping them out of hospital and avoiding long hospital delays.

2.4 The Better Care Fund is not “new” money, but a reallocation of money that is currently within the health services budget. It is estimated by NHS England (NHSE) that the impact will be to reduce spending directly controlled by the CCG by 3%.

2.5 The fund is to be used to significantly transform the delivery of local services, shifting resources and demand away from the acute sector towards more community-based services and focus on prevention.

2.6 The national funding will come from £1.9 billion that is already allocated to joint arrangements between health and local authorities, with the additional £1.9 billion being released from other current NHS allocations. The existing joint funding is made of:

- £130 million Carers' Break Funding
- £300m CCG Re-ablement Funding
- £350m Capital Grant Funding (Including £220m Disabled Facilities Grant (DFG))
- £1.1 billion existing transfer from Health to Social Care (The existing Section 256 transfer).

2.7 A further £200m of new money in 2014/15 nationally has been allocated and will transfer from the NHS to adult social care, where councils have jointly agreed 2-year action plan for the implementation of pooled budgets from April 2015.

3. Local Context and Implications

3.1 In Bristol, in 2014/15 an additional £1.7m of funding will be allocated directly by NHSE to the Council in addition to the £7.6 million already funded for social care services. This additional funding is to be used to help pump prime investment and to enable implementation of the agreed action plan for the transformation of Health and Social Care Services for Older People and those with long-term conditions.

3.2 In 2015/16 – the Section 256 funding of £9.3m will be allocated to the CCG with the requirement that is placed in a pooled budget as part of the Better Care Fund creation. The Better Care Fund in Bristol will be a minimum of £30.4m annually of recurring funding that can only be spent on the purposes agreed for the Better Care Fund and on the agreed action plans, which will have been formally agreed by the CCG, Council, and HWB, in consultation with providers, stakeholders and users. It is intended that funding will be released in two phases, which are based on achieving performance outcomes. Where outcomes are not met, if there continues to be pressure in the system some of the funding may need to be used to alleviate the pressure on other services.

3.3 Local funding in 2015/16 will come from a number of sources:

• Existing Section 256 Funding	£9.3m
• Carers Breaks	£1.0m
• Re-ablement	£2.4m
• Disabled Facility Grants	£1.3m
• Social Care Capital Grant	£1.1m
• **Sub Total**	**£15.1**
• **Funding identified via CCG allocation**	**£15.3**
• **Better Care Fund Total**	**£30.4**

3.4 Total funding in 2015/16 will come from a range of sources and will assist transformation through new ways of working across our partnerships and pathways including the acute sector.

3.5 The existing budgets set out above provide £15.1m towards the total £30.4m fund, with an additional £15.3m to be released from service transformation working with all partners.

3.6 Release of funding is conditional on meeting seven national conditions. These are:-

- Protection for adult social care services
- Plans to be jointly agreed with health partners and the outcomes expected from this investment (2 Year and 5 Year Plan)
- 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes in the acute sector.

3.7 To enable the Better Care Funding to be accessed, the CCG and the Council are required to have a jointly agreed action plan for implementation, which has been consulted on with stakeholders (health providers, statutory and independent sector, service users, carers and the public) and agreed by the HWB.

3.8 The plan should focus on expanding community services that maximise independence and prevent unnecessary admissions to hospital and

permanent residential / nursing care and reduce time in hospital. Funding will be awarded based on performance in 2014/15 and 2015/16, across the following areas:

- Delayed Transfers of Care
- Reduced Emergency Admissions
- Effectiveness of Re-ablement
- Admissions to Residential and Nursing Care
- Patient & Service User Experience.

3.9 The timetable for having an agreed action plan in place is very tight. The BCF submission to NHSE must be submitted by 14th February for approval, and then the final draft by 4th April.

3.10 In June, a further revised detailed 5 year plan must be submitted. In this final draft, the first two years, which had previously agreed should not be amended.

3.11 To enable a co-ordinated approach to be taken to manage the implications of these proposals, the Council has been working with the CCG, health providers and HealthWatch to set up a Joint Better Care Programme Board, which will manage and oversee creation of the action plan, agree priorities for implementation and monitor delivery on behalf of our respective organisations, reporting to the HWB on a regular basis.

3.12 Part of our planning has involved working closely with stakeholders to gain their input to the Vision for Bristol. We held a consultation event at City Hall on 24th January and the collated high level responses are attached at Appendix A for information.

4. Key Risks and Opportunities

4.1 Integration of health and social care services is an opportunity to improve the quality of experience and the outcomes for service users.

Risk	Assessment	Mitigation
Finance and performance	There are risks to finance and performance that are yet to be fully quantified but encompass: financial penalties or opportunities; Clinical - adverse impact upon current health and social care provision; negative impact upon performance arising from transformation activities.	Better Care Programme Board to work closely with NHSE to ensure that financial implications are worked into any planning assumptions. Performance will be closely managed in relation to any changes to services to ensure that there is no negative impact. A risk assessment will

Risk	Assessment	Mitigation
	Risks associated with the transformation of services not releasing sufficient funding from the acute sector to reinvest in community care.	be completed before implementation and actions identified to mitigate any risk as part of the process. Schemes will be managed closely to monitor the impact off changes to pathways to ensure that it is having the required outcomes. Where this is not the case, schemes will be reviewed accordingly. A risk sharing agreement will be put in place between the CCG and the Council. The Better Care Programme Board is currently developing a comprehensive risk assessment across the project and will monitor this regular and agree any mitigation needed.
Equality Impact	No adverse impact upon patients is anticipated.	An EQIA will be completed to mitigate any identified risks.
Reputation	Any reputational issues are likely to be more of a risk in relation to any negative impact upon acute health care services and statutory social care provision.	The Better Care Programme Board will jointly manage impacts on their respective organisations.
Legal	Policy requirement on implementation from NHSE and Local Government Association.	The Better Care Programme Board will follow the national guidance and is consulting with colleagues in NHSE at various stages of development to ensure compliance with the national guidance.
Resources required	Commissioning, Finance, Performance, Transformation, Quality, Communication and Engagement within the Council and CCG. NHS & LGA Guidance on Better Care Fund	The Better Care Programme Board will agree the resources required to deliver the aspirations set out within the agreed priorities and outcomes

5. Recommendations

The HWB is asked to:

5.1 Comment on the draft BCF Vision and summary of initiatives set out in Appendix B and propose any amendments.

5.2 Receive an update on the stakeholder engagement event held on 24th January which informs BCF Bristol vision and initiatives.

5.3 Approve a pooled budget for 2015/116 under a Section 75 agreement to be hosted by the Council as set out in paragraph 3.3.

5.4 Give delegated authority to the Chair of the HWB to agree the final BCF Plan following the Health and Wellbeing Board meeting. The Plan has already been endorsed by the Chief Officer of Bristol CCG.

6. Appendices

Appendix A – Responses to Consultation
Appendix B – BCF draft Vision and Summary of Initiatives

APPENDIX (5) A

Better Care Fund Bristol – Planning Event 24 January 2013

Case Study 1 - Irene and Bob

Irene is 85 years old and lives in Bristol with her husband Bob, aged 87, in their home of 58 years. They have 3 children – Bill, Margaret and Carol. Margaret and Carol live in Bristol.

- Bob has had dementia for 5 years and he can no longer be left on his own
- Irene is Bob's carer
- Irene has Type 2 diabetes, and angina, which is worsening
- Irene has lost touch with many of her friends as she has spent more of her time looking after Bob
- Some of their friends have drifted off as Bob's dementia has worsened
- They do attend a monthly group of 'Singing for the Brain'
- Their house is not very accessible - Irene struggles to get in and out of the bath and she struggles to help Bob in and out of the bath
- For the last 18 months Bob has gone to a Day Centre once a week but this is becoming more difficult
- When Bob is at the day centre Irene spends the day trying to catch up with chores around the house
- They tend to go the GP once a week, for either Irene's needs or Bob's needs

Discuss

1. What support is there already in Bristol to help Irene and Bob?
2. What could be in place to help Irene and Bob?
   - What would make it better?
   - How can integration make a difference?

Task

1. In your groups, please record your ideas for helping Irene and Bob on the flipchart paper on the tables

Better Care Fund Bristol – Planning event 24 January 2013

Case Study 2 - Irene

Irene is 85 years old and lives in Bristol with her husband Bob, aged 87, in their home of 58 years. They have 3 children – Bill, Margaret and Carol. Margaret and Carol live in Bristol.

- Bob has had dementia for 5 years and he can no longer be left on his own
- Irene is Bob's carer
- Irene has Type 2 diabetes, and angina, which is worsening
- Irene has lost touch with many of her friends as she has spent more of her time looking after Bob
- Some of their friends have drifted off as Bob's dementia has worsened
- They do attend a monthly group of Singing for the Brain
- Their house is not very accessible - Irene struggles to get in and out of the bath and she struggles to help Bob in and out of the bath
- For the last 18 months Bob has gone to a Day Centre once a week but this is becoming more difficult
- When Bob is at the day centre Irene spends the day trying to catch up with chores around the house
- They tend to go the GP once a week, for either Irene's needs or Bob's needs

Six months later

- Bob died 3 months ago
- Irene is no longer in contact with any of the dementia support groups that she had at some time had contact with
- Irene is increasingly isolated and depressed
- Irene falls trying to get upstairs and she attends Accident & Emergency. She has a badly sprained ankle and returns home

Eight months later

- Irene falls while out shopping and breaks her hip; she is admitted to hospital
- Irene's confidence is shattered but she is really keen to go home

Discuss

1. After Bob's death, what support is there already in Bristol to help Irene?
2. What could be in place to help Irene? What would make it better – how can integration make a difference?

Task & Feedback

1. In your groups, please record your ideas for helping Irene on the flipchart paper
2. **Additionally, what are your personal top 3 ideas for helping Irene & Bob? (**these may be different to those recorded by the group). Please make a note of these on the sticky notes and place them on the flip charts around the room, where you think they best fit under the following four categories:
   - Community/Neighbourhoods - Health Services & Social Care – Hospitals - Other

Bristol Clinical Commissioning Group

Better Care Fund:

Case Study Exercise - What is already available for Bob and Irene?

Health

- Community Nurse for Older People
- Link Worker
- GP
- District Nurses
- Admiral Nurses
- Carers Leads
- Community Matrons
- Network of Champions (new)
- Long wait for assessment in Hospital
- Weekly GP visit seems like 'waiting for something to go wrong'

Social Care

- Social Work Teams – Assessment for Bob and Irene
- Day Service
- Meals on wheels
- Care Direct advice/information
- Care Direct – better branding required
- Homecare (subject to assessment)
- End of life care
- Care Planning
- Supporting People
- Personal Care Budget
- Single point of entry/exit

Respite

(at home & in community)

- Day Care in Care Home
- Day Centre
- Sitting Service
- Family Support
- Befriending
- Carers Breaks
- Carers Support

Bob & Irene

What is available?

Housing

- Move to ECH
- Homeshare Scheme
- OT adaptations in own home
- Care & Repair
- DFG

Technology

- Telehealth for Irene
- Telecare
- Bristol CareLine
- Assistive Technology (included LA provided adaptations)
- Advice on Internet/Libraries
- WellAware (with better promotion)
- LinkAge

Community

- Church & Faith Groups
- Neighbourhood social networks

Activities groups

- "Singing for the Brain"
- Arts for the Elderly

Third Sector Orgs

- Alzheimer's Society
- Leg Ulcer Network (Support Network)
- Age UK/S Gloucs Pilot – appointment of volunteer post within surgery. Overview by GP – some early success
- Carers Centre – GP 'link' volunteers

Bristol Clinical Commissioning Group

Better Care Fund:

Case Study Exercise - What is already available for Irene?

Health

- Community Nurse for Older People
- Link Worker
- GPs
- Admiral Nurses
- Carers Leads
- Falls Pathway
- Diabetes Services

Social Care

- Social Work Teams
- Meals on wheels
- Homecare (subject to assessment)
- Home assessment following hospital visit
- Intermediate Care
- Dom Care Service
- Community Outreach
- Integrated Carers Team

Respite **(at home & in community)**

- Day Care in Care Home
- Day Centre
- Sitting Service
- Family Support
- Befriending Service (Lottery-funded, Age UK led)
- Carers Breaks
- Carers Support Centre

Irene

What is available?

Housing

- Move to ECH
- Homeshare Scheme
- OT adaptations in own home
- Care & Repair
- DFG

Technology

- Telehealth for Irene
- Telecare
- Bristol CareLine
- Access to Assistive Technology (included LA provided adaptations)
- Advice on Internet/Libraries
- WellAware
- Lifeline Alarm

Community

- Church & Faith Groups
- Neighbourhood social networks

Activities groups

- “Singing for the Brain”
- Arts for the Elderly

Third Sector Orgs

- Alzheimer’s Society –
- ‘Graduates Group’ for bereaved carers/partners
- Age UK – Shopping Service Counselling

Bristol Clinical Commissioning Group

Better Care Fund:

Case Study Exercise - What ***could be*** available for Bob and Irene?

Health

- Named Link Worker/Keyworker– single point of contact (or multidisciplinary team of – ensuring quality of support, and direct links with GP)
- Hospital – missed opportunities to identify discharge needs at an earlier stage
- Information at GP surgeries and hospitals – not just posters!
- Better accessible information about what is available
- Better use of Community Matrons and more of them to manage health conditions
- Multi-purpose community GP services with social prescribing
- Not to have to visit GP weekly
- Advanced planning rather than crisis management
- Creating significant care relationships
- Low waiting times
- Map of medicine and connecting care – need 'helicopter view' of care – circles of support
- Earlier intervention
- Dedicated phone line for health concerns
- High quality experiences maintains trust relationship between provider and service user
- Diabetes service
- Community profiling for services

Social Care

- Services joined up and joint-funded
- Health & Social Care coordinator with checklist so that everyone gets the right information
- Review access points – not just assessment – needs to be friendly and in the community (GP-based?)
- Single assessment for physical and emotional needs with appropriate signposting (holistic assessment) Individualised support planning (person centred health and social care)
- Ensuring all benefits available are claimed
- Better forward planning – End of Life care
- Better dementia education – lack of carers long-term, real need for work with schools and colleges now
- Closing the gap between quality of care between LA-funded and self-funders
- More prevention, less firefighting requires commitment of resources
- Coordination of Care Plan is vital
- Overcome gap/disconnect between CCG objects/agenda and Public Health/BCC
- Joining health with Community Hubs
- Joined up Transport with Health

Respite (at home & in community)

- Irene is a carer but needs her independence and support – support to Bob at home enables Irene to maintain and develop independence
- Family Support – enabling creative ideas around family involvement (up-skill children to provide informal care, with childcare funding to enable this)

Bob & Irene

What ***could be*** available?

Housing

- Risk assessment of the home Discuss move to Supported Living / ECH
- Capital investment around the person's home
- Increased links to Housing – who is prepared to Invest in modern adaptable housing? How is that stock allocated?

Technology

- Telehealth for Irene
- Advice on Internet/Libraries
- What connects the parts? (e.g. IT systems talking to each other – shared data via Connected Care – feedback from CCG required on this IT Programme)
- Challenges of sharing data
- Resilient IT systems
- Bristol & Me social network
- Computers for older people

Community

- Neighbourhood social networks
- Intergenerational work, including enabling family link
- Social network improvements
- Encourage Irene to invest in support
- Better transport access and use of buildings
- Services to reflect the needs of the community

Activities group

- Meaningful activities for Bob based on his life experience – person centred
- Activities more than 'once a month'

Third Sector Orgs

- Alzheimer's Society – Information Pack such as 'This Is Me' to be shared with all associated with both Bob and Irene's support and care.
- Voluntary sector involvement Advice and access to 'discretionary services' and activities
- Knowing your 'patch' and local groups

Bristol Clinical Commissioning Group

Better Care Fund:

Case Study Exercise - What ***could be*** available for Irene?

Health

- Link Worker (continued beyond Bob's passing), links with family/immediate circle of support
- Single point of contact to address physical and emotional needs Consultants needing Support Plans or GP Info so they can offer best care
- Information going with people if they change wards
- Information accessible to all professionals involved
- Advocacy services in hospitals
- Avoid hospital admission wherever possible by good community intervention
- MC Advocate – Health should know and promote this
- Contact point for falls – assessment @ hospital (why did she fall, what could prevent this – adaptations, environment)
- Identifying Risk at Hospital visit – re-assessment of Care Package
- Self-referral into falls pathway
- Social Prescription (arts, trips outside, etc) link with befriending service
- Joined up Transport with Social Care

Social Care

- Low-level homecare
- Assessment includes other medical conditions
- Care coordinators to facilitate
- Reablement service – confidence building and increased independence
- Reablement bed if needed
- Intermediate services to assess health need and decide if hospital admission is not necessary
- Holistic health and social care plan for hospital discharge
- Bristol Ageing Better – better access to what is already available
- Better publicity of positive living – Celebrating Age.
- Stimulate user demand with good examples of alternative ways of living
- More flexible reablement beyond 6 weeks post-fall

Joining health with Community Hubs

Respite **(at home & in community)**

- Family Support – linked through Link Worker
- Family breaks – links needed to enable childcare to ensure Irene's children are able to provide respite and support
- Befriending
- Carers Breaks

Irene

What ***could be*** available?

Housing

- Alternative accommodation if Irene is isolated and depressed (ECH)

Technology

- Telehealth for Irene
- Telecare
- Bristol CareLine
- Assistive Technology (included LA provided adaptations) – all connections and solutions not workable if the person's actual home is not suitable
- Advice on Internet/Libraries
- Quality and consistent IT systems
- University of Bristol developing technology that collects data within a person's home
- Training befrienders in technology (Skype)
- iPad use / reminiscence therapies (Alive! Charity)

Community / Social Inclusion

- Church & Faith Groups
- Neighbourhood social networks
- Library Services
- Friends (if we have done our work)
- Volunteering opportunities – sense of purpose
- Mobility – accessing community
- Social network improvements

Activities groups

- "Singing for the Brain"
- Arts for the Elderly
- Non-dementia-based singing group Exercise groups - chairobics

Third Sector Orgs

- Alzheimer's Society
- Talking Therapies – need to ensure awareness of what is available
- Alive! Charity
- Connecting services dependent on availability and signposting
- Counselling - emotional support for depression
- Access to volunteering (LinkAge)
- Support for people after caring to help with change in role
- Funding for local groups

Bristol Clinical Commissioning Group

Better Care Fund

APPENDIX (5) B

Our Vision

A city where people live happier and healthier lives and their care and support needs are met at the right time, to the right quality and in the right place for them

Delivery of our shared vision will be challenging and will require a significant shift from current service delivery models to more integrated models of care and a joint approach to building resilient individuals and communities through prevention and self-care . This will require commissioners and providers to transform the way we currently work, plan and commission, which is essential if we are to manage the increasing demand for services, whilst continuing to improve our productivity and the efficient use of diminishing resources. We will achieve this by pooling funding across our organisations, sharing resources and working together with our communities as we can't achieve this transformation on our own.

The key priorities in Bristol's Health & Wellbeing Strategy are based on the things that people said mattered to them most:-

- Building social capital
- Developing community assets and voluntary action
- Improving community cohesion and perceptions of safety
- Addressing poverty and social isolation, particularly in older age.

These priorities are reflected in our operational plans. In recognition of our shared agenda for change, we want to ensure that Bristol is a **healthy and caring** city – a place where the cared for and the caring, young and old, are respected and valued and where living healthy, happy and safe lives is the shared aspiration for everyone. We want to see **better health and sustainable health care** for all citizens.

We recognise that increasing demand for services and reducing resources require us to work differently in order to be:-

- Enabling and supportive, putting people at the centre of services and giving them more choice and control;
- Listening to what people say they need and improving our services in response.

Our vision and aims have been informed by consultation with local people and organisations. Initially, we will work on transformation of services for the benefit of people with long term conditions and older people. We will roll out this approach for all adults, children and young people over the coming years. The Mayor has already outlined a vision for older people in which he wants Bristol to be a city:

- Where older people are well informed about, and get, good quality services;
- Where older people are treated equally and respected;
- Supports and maximises older people's economic and social contribution to society;
- Which is easy for older people to get out and about in.

We will make changes across the whole spectrum of health and social care activity over a 5 year period. Our ambition will require a change in culture and more effective working and joint commissioning of services. We don't have all the answers and we will continue to work with the community and voluntary sector, providers, users, carers and the wider public to help shape and influence services for the future to provide more sustainable solutions. The framework for our transformation programme has been split into four key areas:

- Community Support;
- Joint Health and Social Care Services
- Hospital Services
- Enablers for Integration.

We have set out the work we intend to undertake beneath each of these areas below.

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
Community Support	1.1	City of Service bid by BCC	Building community capacity, building resilient communities could be driven forwards by City of Service work. Needs to be **aligned** but not led by BCF.	• Discharge / Length of Stay • Readmission Prevention • Admission Avoidance • Long Term Conditions Management • Social care related quality of life • Reduced GP attendance	B, C, D, L	High (1-2 years) - I
	1.2	Community and Patient Transport	Look at opportunities to improve co-ordination of transport services	• Discharge/Length of Stay	C	High (1-2 years) - D
	1.3		Bereavement Support	• Admission Avoidance	B, D	Medium (1-2 years) - I
	1.4	Falls Prevention	Improve falls prevention services by early identification of people at risk and provide services to support them	• Admission avoidance • Social related quality of life • Reduced GP attendance	B, D, L	High (1 – 2 years) - D
	1.5	Peer Support for Older People and Mental Health	Increase peer support for people with: • Mental health problems • Sensory Impairment • Becoming a carer • Long term condition avoidance, awareness • Retiring	• Discharge/Length of Stay • Readmission Prevention • Admission Avoidance • Long Term Conditions Management • Improved support to carers • Overall satisfaction of carers with social services • Proportion of people who use services and carers who find it easy to find information about services	B, D, H, I ,J	Medium (1 – 2 years) - I
	1.6	Individual Organisational Checklists	First Contact Checklist to be used by all those who first making contact with Health or Social Care to share	• Long Term Conditions Management • Discharge / Length of Stay	B	Medium (1-2

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
			information across appropriate agencies to remove duplication.	• Readmission Prevention • Admission Avoidance • In Hospital Care		years) - D
	1.7	Care Home Visiting Schemes – pilot (shift to Quality & Safeguarding Theme)	Extend scheme using volunteers (currently use RSVP), explore role of HealthWatch and other user-led orgs. Consider potential links with personalisation and community empowerment (see under Health & Social Care below)	• Long Term Conditions Management • Admission Avoidance • Discharge / Length of Stay • Readmission Prevention	A, B, D	High (1-2 years) - D
	1.8	Social prescribing Pilots – various but also Social Return on Investment Evaluation by UWE	CCG have committed £100k and are looking for match funding into pooled budget for range social prescribing from complex needs for people with mental health problems (CCG funding) to low-level 'wellbeing prescriptions' for older people run by volunteers (eg RSVP, Social Mirror)	• Social related quality of life • Reduced GP attendance • Admission Avoidance • Discharge/Length of Stay • Readmission Prevention	A, B, D, L	High (1 – 2 years) - I
	1.9	Tackling social isolation, 'Bristol Ageing Better'	Wide strategic approach that BCF must **align** with, but does not need to lead. CCG and BCC reps on Bristol Ageing Better Board will link all in	• Social related quality of life • Reduced GP attendance • Reduced levels of diagnosed depression • Reduced home care packages (if linked via community empowerment/ personalisation)	L, M, N, O	High (1-2 years) - I
	1.10	Dementia-friendly City & Age-friendly City work	**Aligned** work that does not need to be led by BCF, but does show we are addressing the whole system	• Social related quality of life • Reduced GP attendance • Admission avoidance • Support to Carers • Readmission Prevention • Discharge / Length of Stay		High (1-2 years) - I

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
	1.11	BCC Housing policy/strategy – "My home is my springboard for life"	**Aligned** areas of work that does not need to be led by BCF, but which shows we are addressing the whole system	• Social related quality of life • Reduced GP attendance • Admission avoidance • Support to Carers • Readmission Prevention • Discharge / Length of Stay		High (1-2 years) – I/D
Health & Social Care	2.1	Mixture of Care Co-ordination options between Health & Social Care	Single point of contact to access services across all agencies (Care Direct, Reablement SPA, South Gloucs)	• Long Term Conditions Management • Admission Avoidance • Readmission Avoidance • Overall satisfaction of carers with Social Services	A	High (1-2 years) - D
	2.2	Care Co-ordinators	Ensure a joint approach to assessments and care planning providing more effective use of staffing and resources including key workers to coordinated care operating across all providers to enable a seamless transition from one service to another (single key worker)	• Long Term Conditions Management • Admission Avoidance • Discharge / Length of Stay • Readmission Prevention		High
	2.3	Disabled Facilities Grants and providing adaptions to homes of disabled people, including those 17 years and younger	Provision of adaptations will be incorporated in the strategic consideration and planning of investment to improve outcomes for service users, whilst maintaining the statutory duty for adaption to home of disabled people, including those 17 years and younger.	• Discharge / Length of Stay • Readmission Prevention • Admission Avoidance	B, C, D	High (1 – 2 years) - I
	2.4	Carers Breaks	Roll out of pilot integrated carers team approach and carers personal budgets. Increased focus on carers of people at end of life, mutual caring and young carers. Improved access to emergency carers relief, including	• Discharge / Length of Stay • Readmission Prevention • Admission Avoidance • Long Term Conditions Management	B, C, D, H, I, J	High (1 – 2 years) - I

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
			direct access for health professionals	• Improved support to carers • Overall satisfaction of carers with social services • Proportion of people who use services and carers who find it easy to find information about services		
	2.5	Information, Advice – WellAware jointly funded service provided by The Care Forum	There is an identified need for better information, support, advice, advocacy, safeguarding and other measures. This could be delivered through an e-market (see Enablers below), or through improved WellAware functionality.	• Admission Avoidance • Long Term Conditions Management • Improved support to carers • Overall satisfaction of carers with social services • Proportion of people who use services and carers who find • it easy to find information about services	B, D, H, I J	High (1 – 2 years) - D
	2.6	Telehealth, Telecare, Assistive Technology	Greater use of Assistive Technology to help users manage their conditions more effectively such as Long Term Conditions, (Stroke, Dementia, Diabetes, Cancer, Asthma, COPD). Further advice from CCG and BCC officers required.	• Discharge / Length of Stay • Readmission Prevention • Admission Avoidance • Long Term Conditions Management • Proportion of people who use services who have control over their daily life	B, C, D, P	High (1-2 years) - D
	2.7	Personal Budgets in Social Care	Introduce the use of personal health budgets where suitable and joint personal budgets with social care where appropriate. Ongoing work via People Directorate to increase numbers of older people taking a Direct Payment	• Admission Avoidance • Long Term Conditions Management • Proportion of people who use services who have control over their daily life • Proportion of people using social care who receive self-directed support	B, D, P, Q, R	Medium

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
				• No. people helped to live independently at home		
	2.8	Care Home Pilot to extend nutrition awareness	Extend training to all care homes in nutrition and other support services	• Admission Avoidance • Discharge/Length of Stay	B, C, D	Medium (1 – 2 years) - I
	2.9	Extracare Housing (Bristol Retirement Living)	Include Community Nurse input into two major new ECH schemes at Coldharbour Lane and New Fosseway, Hengrove. Consider the potential for CCG/joint commissioning of other services e.g. rehabilitation and reablment. Consider potential for CCG/joint commissioning of nomination rights to flats for rehabilitation/reablement.	• Discharge/Length of Stay • Readmission Prevention • Admission Avoidance • Long Term Conditions Management • No. people helped to live independently at home	B, D, R	High (1-2 years) D (3-5 years)
	2.10	Key Workers	Accountable lead professional to coordinate care operating across all providers to enable a seamless transition from one service to another by a single joint assessment process (single key worker)	• Long Term Conditions Management • Admission Avoidance • Discharge / Length of Stay • Readmission PreventionProportion of older people (65+) offered reablement services following discharge from hospital (ASCOF) • Improved support to carers • Overall satisfaction of carers with social services • Proportion of people who use services and carers who find it easy to find information about services	A, B, C, D, G, H, I J	High
	2.11	Reablement Teams	Need to increase by 25% on current resource to meet existing demand. To increase offer more widely will require increased resource allocation.	• Admission Avoidance • Discharge / Length of Stay	A, B, C, D, E, G	High

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
				• Readmission Prevention • Proportion of older people (65+) offered reablement services following discharge from hospital (ASCOF)		
	2.12	Rehabilitation & Reablement • Rapid In-reach • St Monica • Increased Rehab Team Therapy Resources	Extension of service to 7 day working across Intermediate Care and Reablement. Links to 3.1.	• Admission Avoidance • Discharge / Length of Stay • Readmission Prevention • Proportion of older people (65+) offered reablement services following discharge from hospital (ASCOF)	A, B, C, D, E, G	High?
	2.13	Support Plans	Implement a single care/support plan with a named co-ordinator	• Long Term Conditions Management • Admission Avoidance • Discharge / Length of Stay • Readmission Prevention • Improved support to carers • Overall satisfaction of carers with social services • Proportion of people who use services and carers who find it easy to find information about services	A, B, C, D, H, I, J	High
	2.14	Individual Organisational assessments	Joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional. Dementia services will be a particularly priority	• Admission Avoidance • Discharge / Length of Stay • Readmission Prevention • Long Term Conditions Management	A, C, D, E	(1-2 years)

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
	2.15		Community Empowerment linked to Personalisation e.g. Community interest company to link low level preventative activities (eg social engagement / reduce social isolation) with support packages with view to reduction in support package over time and sharing of 'cost avoidance' between the CIC and local authority – could also potentially be extended to CCG	• Admission Avoidance • Readmission Prevention • Long Term Conditions Management • Reduction in size of home care package • Improve support to carers • Social care related quality of life	A,C,D, E,H,L, M	
Hospital	3.1	Joint Discharge Co-ordination in BRI and NBT	Joint out-of-hours teams working 7 days pw to support early discharge / reablement / rehabilitation	• Long Term Conditions Management • Admission Avoidance • Discharge / Length of StayReadmission Prevention • Proportion of older people (65+) offered reablement • Services following discharge from hospital (ASCOF) • Improved support to carers • Overall satisfaction of carers with social services • Proportion of people who use services and carers who find it easy to find information about services • Improve experience and outcomes for people leaving hospital	A, C, D, E, G, H, I J, K	High (1-2 years) - D
	3.2	Some admissions prevention work is in place, but tends to focus on the working	We will work with hospitals to reduce avoidable admissions by looking at current pathways and improving integration between GPs, hospitals and	• Long Term Conditions Management • Admission Avoidance • Readmission Prevention	B	High (1-2 years) - I

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
		week.	community services			
	3.3		We will work with hospitals to ensure appropriate services including diagnostics are available 7 days a week to facilitate early discharge and reduce length of stays.	• Discharge / Length of Stay • Readmission Prevention • Admission Avoidance • Proportion of older people (65+) offered reablement services following discharge from hospital (ASCOF)	B, C, G	High (1-2 years) - I
	3.4	Patient Records are currently not shared in real time with others but can take a few days to be shared with GPs/Others	We will work with hospitals and other providers to share data in real time to join up care across the system and enable early interventions, discharge and reduce the need for unnecessary diagnostics	• Long Term Conditions Management • Admission Avoidance • Discharge / Length of Stay • Readmission Prevention	A, C, D, E	(1-2 years) - I
Enablers	4.1	IT systems currently not based on a shared user identifier	We will put in place appropriate governance controls with information sharing in line with Caldicott 2, using open API system to improve data sharing by implementing NHS Number Identifier with Social Care to assist in sharing data in real time between providers	• Discharge / Length of Stay • Readmission Prevention • Admission Avoidance • Long Term Conditions Management	B	High (1-2 years) - I
	4.2	Mixed ability to book online appointments	Extend Online appointment bookings to all practices.	• Readmission Prevention • Admission Avoidance • Long Term Conditions Management • Improved support to carers • Overall satisfaction of carers with social services • Proportion of people who use services and carers who find it easy to find information about services	B, D, H, I J	High (1-2 years) - I

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
	4.3	Organisational Training and Induction Processes	Implement more joined up Induction and Training programmes to ensure consistency of care, awareness and understanding of available services	• Readmission Prevention • Admission Avoidance • Long Term Conditions Management • Proportion of older people (65+) offered reablement services following discharge from hospital (ASCOF)	B, D, G	Medium (2-3 years) - D
	4.4	Organisational Commissioning Plans	Improved collaborative working and planning between commissioners and providers to agree outcomes for patients	• Long Term Conditions Management • Admission Avoidance • Discharge / Length of Stay • Readmission Prevention	A, B, C, D	High/Medium (1-2 years) - I
	4.5	Mix of shared resources and roles	We will move towards more generic job roles and use of pooled budgets to enable the best use of resources across Health and Social Care	• Long Term Conditions Management • Admission Avoidance • Discharge / Length of Stay • Readmission Prevention	A, B, C, D,	Medium
	4.6	Governance - Variety of policies and procedures across systems	Governance - Integrate policies and procedures to ensure there are consistent across services and organisations so users are clear what to expect.	• Long Term Conditions Management Admission Avoidance • Discharge / Length of Stay • Readmission Prevention	A, B, C, D	Medium
	4.7	5 day access with limited 7 day working	7 days access to Health and Social Care to support users and improving reablement and rehabilitation to reduce length of stay in hospital, where there is no clinical need and improve weekend discharge and support	• Long Term Conditions Management Admission Avoidance • Discharge / Length of Stay • Readmission Prevention • Proportion of older people (65+) offered reablement services following discharge from hospital (ASCOF) • Improved support to carers	B, C, D, E, G, H I J	High (1-2 years) D

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
				• Overall satisfaction of carers with social services • Proportion of people who use services and carers who find it easy to find information about services		
	4.8		E-Market for use by people with a personal budget/Direct Payment (social care and health). Web portal provides information about available services and ability to purchase service direct with payment made direct. Can provide increased information (see above) and is an enabler for increasing Direct Payments which benefits adult social care and empowers service users. Nationally and locally much work has been done to scope available systems. If taken forwards, BCC would want to invest in a system that also meets the needs of citizens with or without social care needs (self-funders) and which lists volunteers (eg transport, gardening) and community based activities (eg lunch clubs, exercise sessions)	• Long Term Conditions Management Admission Avoidance • Improved support to carers • Overall satisfaction of carers with social services • Proportion of people who use services and carers who find it easy to find information about services	B, D, H I J	High
	4.9	Organisationally we consult on our individual operation plans with statutory and independent organisations, service users, carers and the wider public	We will jointly engage with statutory and independent organisations, service users, carers, and the wider public to help inform our future commissioning plans. We will use information contained within the JNSA and the emerging Joint Strategic Assets Assessment to help target our engagement. We will use existing Partnerships and Partnership Boards to maximise our collective capacity and ensure informed engagement with representatives of older people and people with long term conditions.	• Long Term Conditions Management Admission Avoidance • Discharge / Length of Stay • Readmission Prevention	A, B, C, D, E	High (1-5 years) D

Programme Workstream	Ref	Currently In Place or Underway	Potential Project or Initiative (Future)	• Outcome Area	KPIs	Priority (Time)
	4.10		Better Care Board members will explore potential initiatives for adding to the Better Care Fund	•		

Key National Performance Indicators

A) Combined measure of inpatient satisfaction and overall satisfaction with social care (index – Oct 2013 = 100)
B) *Avoidable Emergency Admissions per month per 1000 pop 65+*
C) *Delayed Transfers of Care from hospital per 100,000 population (average per month)*
D) *Reduction in number of permanent admissions to residential and nursing homes per month per 100,000 population*
E) Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Better Fund Local Performance Indicator

F) Yet to be agreed.

Local Performance Indicators

G) Proportion of older people (65+) offered reablement services following discharge from hospital (ASCOF)
H) Improved support to carers
I) Overall satisfaction of carers with social services
J) Proportion of people who use services and carers who find it easy to find information about services
K) Improve experience and outcomes for people leaving hospital
L) Social Care related quality of life
M) Reduction in size of home care package
N) Reduced GP attendance
O) Reduced levels of diagnosed depression
P) Proportion of people who use services who have control over their daily life
Q) Proportion of people using social care who receive self directed support
R) Number of people helped to live independently at home