AGENDA ITEM 5 b

Bristol Health & Wellbeing Board

Performance Report from Better Care Bristol Joint Commissioning Board	
Author, including organisation	Bevleigh Evans – Programme Director Better Care (Joint appointment Bristol City Council and Clinical Commissioning Group)
Accountable Officers	Jill Shepherd and John Readman
Date of meeting	21 October 2015
Report for Information	

Better Care Bristol

Table of Contents

Summary

The Better Care Fund (BCF) has been established by Government to provide funds to local areas to support the integration of health and social care. Section 75 of the National Health Service 2006 Act gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service (NHS) functions.

The purpose of this report is to provide the Health and Wellbeing Board with assurance from the Commissioning Board in relation to:

- Better Care Bristol Section 75 spend and variance report
- Performance against the six national metrics (65+ years)
- Performance against Better Care metrics
- Progress against the national standards
- National Quarter 1 reporting (April-June 2015/16)

The report also contains

- Risks and opportunities
- Financial implications

There are circa forty projects that help us achieve our aims. This report contains updates on three of those projects.

- Wellbeing Partners
- Social prescribing
- Design Team

Health and Wellbeing Board should note:

- HWB to note the delay in reporting planned, variance and actual spend against the section 75 but to be assured that a Fund Manager has been appointed and this will be reported in next bi-monthly report.
- HWB to note that out of seven national metrics we are assessed on we are currently failing to deliver on four of the five monthly KPIs, delivering against one and the remaining two KPIs are completed annually, and we have no monitoring in year to indicate the likely outcome of these at year end
- HWB to note two of the six national conditions are still not achieved and condition 3 has only been partly achieved. We will need to develop project plans and dates for achievement to work towards meeting these.
- HWB to note pay for performance has not been awarded to the Local Authority for Q4 (Jan-March 2015) and Q1 (April-June) and this will be used by the CCG to offset additional unplanned costs against emergency

admissions as set out in the Better Care Fund Guidance. This means that Better Care Bristol is not achieving its aims of reducing emergency admissions to enable additional investment into the community.

Better Care Bristol Section 75 spend and variance report

The Better Care Bristol Joint Commissioning Board are unable to provide assurances on spend and variance against the Section 75.

In July 2015 Adult Social Care moved to a new financial system (Liquid Logic / Controcc). This means it has not been possible to validate data and the LA has not been able to confirm the accuracy and completeness of the information generated.

The first reliable information will be available from 1st of September and this will be reflected in the next report to the Commissioning Board in December 2015.

Due to this we have submitted a nil return to NHSE on forecast, spend and variance against Section 75 in our Q2 national submission to NHSE.

The LA appointed a Fund Manager on the 30th September to start week commencing 5th October 2015. We are confident that the next bi-monthly report will give assurances on the profile, spend and variances against the budget lines within the Section 75.

Performance against the six national metrics (65+ years)

This table sets out the metrics that need to be achieved in 2015/16. Six of the metrics have been nationally mandated and the seventh metric releases funding from the acute hospital back into the fund to be spent on care in the community. Appendix Two specifies the submitted targets that need to be achieved.

Metric	Achievement
To reduce the number of people that are admitted into hospital as an emergency	**RED**
To reduce the number of people that are admitted into hospital as an emergency after a fall	**RED**
To ensure that people stay at home as long as possible after reablement service	**GREEN**
To ensure that people leave hospital as soon they are well and no longer need acute medical care (Delayed Transfers of Care)	**RED**
To reduce extra number of days that people stay in hospital then expected (excess bed days)	**RED**

To reduce the amount of people being admitted into residential and nursing home	Measured Annually
To improve the quality of life of users of care and support	Measured Annually

We are achieving the metric relating to the proportion of older people >65 who are still at home 91 days after discharge from hospital into reablement / rehabilitation services. This is a good indicator to demonstrate that of those receiving reablement independence is maintained and these individuals stay in their own homes. Two of the metrics are measured on an annual basis and therefore we cannot give assurances on progress throughout the year and there is a risk at year end these may also not be achieved. These are:

- People being admitted into care homes on a permanent basis
- Quality of life of users of care and support

There are four national metrics agreed by the HWB that are not delivering as planned. These are;

a) Reduction of emergency admissions,
b) Reduction of emergency admissions relating to falls
c) Ensuring that people don't stay in hospital any longer than they have to (Delayed Transfers of Care)
d) Reduction of excess bed days

Issues impacting on delivery of agreed planned reductions

a) Reducing Emergency Admissions

We are continuing to see an increase in emergency admissions for Over 65s in both UHB and NBT which cumulatively shows we are continuing to fail to delivery against our overall HWB planned emergency admission reductions.. Overall, we have 762 additional emergency admissions by month five over plan. This equates to 203 over plan at UHB and 554 over plan at NBT in over 65s

We have not been able to make a reduction in emergency admissions, although many of the current projects across health and social care has been to ensure that people are discharged as quickly as possible, which supports reduction in DTOCs and Excess Bed Days.

'Better Care Other' is a number of small schemes that contribute to an overall saving of £1.8million that is the pay for performance element for Better Care to local authorities, split into four quarterly payments if planned reductions in each quarter is achieved. Better Care Bristol invested additional funding as part of its invest to safe schemes to provide additional resources/capacity to reductions in emergency admissions, but these schemes are not making the necessary impact on reducing emergency admissions to reductions agreed by the HWB.

The details of these schemes are included in appendix three.

- Additional Resource REACT / Social Care Practitioner working with REACT in ED
- Resource to the Independent Living Team
- Dementia Support at Home
- Reablement (Discharge to Assess – pathway one)
- Bristol Primary Care Agreement (BPCAg)
- Nurse practitioner pilot (Extra Care Housing)
- Joint Front door
- Single Point of Access

'Better Care Other' projects will be the subject of an NHSE 'deep-dive' to understand the barriers to delivery of our plans. This is deep-dive is driven by the activity not shifting from the acute sector into the community. As stated earlier in the report this resources has also been used to focus on getting people discharged, but we may need to focus more at the front door to prevent emergency admissions.

We are undertaking a piece of work to understand the large increase in emergency admissions at North Bristol Trust and what has caused this. The increase has coincided with the introduction of a frailty ward and although the patients are being discharged very quickly, this will still be counted (coded) as an emergency admission.

Therefore it is paramount that we are able to evidence and demonstrate that schemes that we have are making the difference they need to and are value for money. The HWB will receive a December update in this area.

b) Emergency admissions relating to falls

Falls were reducing as per plan in the first two months. It is not clear why emergency admissions for falls has increased and this may need a further piece of work to ensure that coding is correct, particular characteristics of those admitted (i.e. care homes, extra care housing, age profile, geographical). It should also be noted that falls for South Gloucestershire CCG and LA has been increasing.

The Transformation Board will undertake a min-deep dive to understand possible factors and report to the Commissioning Board in December 2015 on appropriate actions.

Bristol City Council has commissioned Brunel Care to deliver a service specification relating to falls within care homes. The programme is funded (£23,000) 2014/15 and is half way through. Brunel Care is using Safety Cross and Measles mapping approach. This will clearly alert care home providers to who is falling and where, hence preventive measures can be put in to minimise further falls.

The Public Health (Bristol) budget is enabling 600 social workers to be trained to screen for vulnerability to falls. Where high risk people are identified gait and balance assessment and potentially full multi multi-factorial assessment will form part of care

and support planning processes. Interventions may include Strength and Balance Classes already commissioned by the CCG.

We will report back to HWB in December 2015 on the outcomes of factors impacting on the higher rates of admissions for falls.

c) Ensuring that people don't stay in hospital any longer than they have to (Delayed Transfers of Care)

We are not currently achieving the reduction that we profiled in December 2014. A lot of focus has been to drive down the 'green to go list' and implementing a new model - Discharge to Assess. Appendix Four gives some definitions relating to 'excess bed days', 'delayed transfers of care' and 'green to go' The aims of this project are to improve flow across the acute care system, reduce length of stay in acute and community beds and reduce excess bed days.

The multi-agency Integrated Hospital Discharge Hub facilitates the transfer of patients on the day they are medically optimised to the most suitable step-down option so that assessments and onward care planning can be completed form the community. There will be three broad pathways:

- Pathway 1 – Home with Support (care and / or rehab / reablement)
- Pathway 2 – Community Rehab Bed (including inpatient rehab)
- Pathway 3 – Complex Assessment Beds (social care or full CHC assessments)

Home will be the default care setting for patients with or without rehabilitation needs, unless considered and deemed unsafe or unsuitable. BCC's new model for the delivery of homecare launched on August 2015 and underpins all of the discharge to assess work by supporting flow through the urgent care system. It is anticipated that once fully staffed, the four providers will pick up all package of care requests, as per the "no refusal" clause in the contract. This will in turn deliver a zero wait for homecare, and consequent reduction in excess bed days. However, for now there are significant staffing and capacity issues which mean that the new providers are only picking up approximately half of all work offered to them.

Significant delays attributable to homecare remain in both acute Trusts, with resulting excess bed-days, which is also impacting our ability to delivery our agreed DTOCs target. Although home care is one of the reasons that excess bed days are charged to the CCG this means it is unlikely that we will achieve the excess bed day target in the next quarter, which contributes towards the additional savings for investment in Better Care through Excess Bed Day reductions.

To support the model an additional piece of work has also been developed around the codes used to report nationally, this project starts in October 2015.

The new model of discharge to assess combined with the newly developed codes should reduce the number of people waiting in hospital.

d) Reduction of excess bed days

Excess Bed Days are accrued when patients remain in hospital in excess of the treatment spell defined as appropriate or "average" for their particular treatment / condition. The patient's spell in hospital is coded retrospectively, and is worked out depending on the HRG (Healthcare Resource Group) which is applied. Once a patient starts attracting excess bed days the CCG responsible is billed at a daily rate depending on what type of bed the person is using. A typical figure would be in the region of £250 per day per patient, which is causing a significant financial cost pressure and financial impact on Bristol CCG. To release funding from the acute hospital, which can be invested into community services, we must reduce the amount of excess bed days that the CCG are being charged. This money would be routed into the Better Care Fund for use in the community to support care closer to home.

The scorecard used to track performance and details performance year-to-date is at appendix Five, which is monitored monthly by Bristol CCG Finance Planning and Performance meeting and the Better Care Transformation Board.

Pay for Performance

Pay for performance is nationally mandated and requires the CCG and BCC to work together using the 'preparing for Better Care Fund' additional monies to develop schemes that reduce emergency admissions.

The value of the payment for performance to the local authority is £1.8m, payable in four quarterly payments in arrears based on the delivery of the planned emergency admission reductions in the previous quarter.

We have currently failed to deliver our planned emergency admission reductions in the first three quarters of reporting. The quarterly payments of £450,000 for each of these quarters will be used by the CCG to fund the increased unplanned emergency admission activity within the acute hospitals, as set out within the National Guidance.

Quarter	Q4 (Jan-Mar)	Q1 (Apr-June)	Q2 (July-Sept)	Q3 (Oct-Dec)
Achievement	RED	RED		

As stated elsewhere in this paper the focus is reducing length of stay and little focus has been given to avoiding emergency admissions, which is where the payment for performance achievement is attributable. The 'Better Care Other' schemes are not making the required impact of reducing emergency admissions reductions. It is important to note that January-March was nationally set figures of all non-elective admissions over all adults. April-Dec has been locally set for emergency admissions 65+ years, agreed by the HWB.

The majority of the work carried out to date has been focused on discharge and unless we focus more on preventing emergency admissions, it is highly likely we will fail to delivery our planned reductions in Q2 and Q3.

The new models of care and new ways of working with primary and acute care provide an opportunity for us to consider services that will assist with admission avoidance (such as community based ambulatory platforms with limited access to beds in the community setting). Understanding and testing this model will be the focus of work during 2015/16.

The main driver for 2016/17 to reduce emergency admissions will be the introduction of the joint primary care model that will be supported by an Urgent Care Centre in University Hospitals Bristol. There is not a front door model planned for North Bristol Trust in this period, so we will need to look at how we continue to support reductions in emergency admissions at the front door of the hospital.

Progress against the national conditions.

The achievement of the national standards is one of the conditions of NHSE transfer into the Better Care Fund 2015/16. We are required to report on a quarterly basis the progress against delivery of the conditions.

Quarter one submission is detail below with the submitted summary commentary detailed at appendix six. We are currently achieving three of the national conditions fully, one partially and two are still to be delivered. These are set out below, along with some additional supporting information.

Condition	Please Select (Yes, No or No - In Progress)
1) Are the plans still jointly agreed?	Yes
2) Are Social Care Services (not spending) being protected?	Yes
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes – limited services
4) Data Sharing - Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes

Condition 3 - Relates to seven day services and although we have reported that we have limited services in place (such as a REACT team which includes social care) for preventing unnecessary admissions and supporting discharges, there remains more work to do to ensure that services are able to support people through extended

hours and services that cover seven days. This is why this is amber rather than green.

Condition 4 - Bristol City Council implemented their system Liquid Logic in July 2015. The Liquid Logic system gives Connecting Care the ability to use the NHS number. Plans are being developed to use the NHS number as one of the primary identifiers. This means that we now have the technical capability to use the NHS number to identify individuals across health and social care for read purposes.

The postponement of the Care Act duties from 2016 to 2020 means that there is a re-planning exercise internally to the LA regarding the Care Record upgrade to enable the 'read function' of connecting care. Nationally we have not been able to report when we will achieve this national condition.

Condition 5 - We are working towards a single assessment across Health and Social Care that is being led by BCC and is closely linked to the on-line assessment that they are developing for care and support planning. Better Care Bristol is keen not to duplicate work and when the online assessment work has been completed the next phase of integrated / single assessments will be taken forward across Health and Social Care. Nationally we have not been able to report when we will achieve this national condition.

Quarter 1 Reporting

In Q2 reporting Bristol reported

- Achievement against one of the seven metrics
- Nil pay for performance – Quarterly Reductions in Emergency Admissions not achieved
- Nil financial return – No Data Available
- Achievement against three fully, one partially of the six national conditions

Project dashboard development

The Transformation Board is exploring how to gain assurances over the circa 40+ projects that deliver the outcomes. This will be used to give assurance to the Commissioning Board and in turn provide assurances to the HWB.

There are three programmes of work, which sit under the Transformation Board, which have multiple projects that support the delivery of the Better Care aims.

Please see Appendix Seven for work in progress. This work will be completed by the next HWB December report.

Risks and Opportunities

The Bristol system is currently under considerable pressure and scrutiny for 'Better Care Other' not delivering the agreed reductions in emergency admissions or DTOCs. The NHSE 'deep dive' of 'Better Care Other' will highlight that there is a need to focus on the schemes that will reduce emergency admissions at the front door in addition to the work we are doing to support DTOCs.

NHSE will also want to understand as a system what we are doing to address key issues and our agreed mitigations, which are impacting on the delivery of our planned reductions in emergency admissions, DTOCS and XBD and how these will be monitored along with organisational accountability.

The increase in emergency admissions that relate to falls also needs closer examination and understanding of if there is an underlying issue for more people to be admitted after a fall, or if there is a coding issue.

There is a risk that the benefits of the discharge to assess model and the re-calibrating of the codes for recording delays in hospitals will not realise the reduction in delayed transfer of care, we need as a system, if there isn't sufficient capacity within the health and social care community to support this.

We are failing to deliver the two of the six national conditions required under Better Care and most therefore develop plans with agreed timescales when we can deliver against these. In particular the single assessment and using the NHS number as one of the primary identifiers for sharing information across Health and Social Care.

There are a number of opportunities that present themselves over the next year including the development of the multi-speciality community providers, primary and acute care systems and enhanced health in care homes. These models should help to achieve the activity shift from the acute into the community.

Project Update 1 - Successful Wellbeing Partner bid

Better Care Bristol has been successful in securing some funding from the Health Education South West Membership Council Innovation Fund. The funds have been acquired to support a pilot to employ and train up young apprentices as 'Wellbeing Partners'. The pilot seeks to be innovative in a number of areas:

- Value based recruitment of young care leavers
- Ability to have conversations that prevent illness and can refer to non-medical services (social prescribing)
- Placement approach to this group of staff to ensure training programme that encourages generic skill-mix across acute, community and independent sector

In Bristol, Health, Social Care and the independent sector have all expressed the challenges they face with recruiting and retaining the traditional role of the health care worker / care support workers / nursing home assistants. As a result the sector if consistently understaffed creating problems across the whole healthcare system.

A Wellbeing Partner's role will be to support prevention, promote independence and support people to stay well for longer. This will support Better Care Bristol outcomes to reduce avoidable admissions and promote prevention opportunities.

The training will run over a 12 month period and be rotational, meaning the apprentices will have an opportunity to work in hospitals, care homes and in domiciliary care. They will be trained by public health as health champions. This training will allow the apprentices to refer individuals with social, emotional or practical needs to a range of local, non-clinical services (social prescribing). They will also be trained by Centre for Sustainable Energy to prevent illness by tackling cold homes. This will enable them to have conversations with people about their home environment and possible risk factors.

The pilot has been designed to train, develop and support a section of Bristol's young population who would not normally have the opportunity to enter the Health and Social Care workforce. We will use Bristol Learning City to ensure that these young people are supported in gaining their Care Certificate so lack of qualifications is not a barrier to applying for the role. The pilot is also an opportunity to develop a new model that will enable the provision of a more flexible and responsive service.

Project Update 2 - Social prescribing primary care framework

Update on Social Prescribing in Bristol.

"Social prescribing provides a pathway to refer clients to non-clinical services, linking clients to support from within the community to promote their wellbeing, to encourage social inclusion, to promote self-care where appropriate and to build resilience within the community and for the individual".

Social Prescribing in Bristol Working Group, 2012

In November 2013, the Bristol Health and Wellbeing Board agreed to the development of a citywide approach to social prescribing. Further to this, Public Health funded a 6 month 'Social Prescribing Commissioner' secondment (1st April 2015 to 30th September 2015) to the Better Care Bristol Team, with the aim of developing a social prescribing pathway for primary care. The work was overseen by the Social Prescribing Steering Group made up of representatives from the Voluntary Sector, Primary Care, Bristol CCG, Bristol City Council Adult Social Care, Public Health and Bristol Health Partners.

The Social Prescribing Commissioner has developed an extensive report (final report available November 2015), outlining the importance of social prescribing, the evidence base and potential level of need in Bristol, as well as mapping some of the current social prescribing services in Bristol. Surveys and interviews with primary care staff and service users were also undertaken. A draft social prescribing pathway for primary care was presented at Voscur's Social Prescribing Conference in September.. This pathway takes into account

- the findings from this work; and
- the proposed streamlining of access into public health lifestyle services though a new Health and Wellbeing 'Hub'

Further work with stakeholders is needed to refine this pathway to ensure city wide access to social prescribing and building upon existing mechanisms.

A number of key issues were identified though this work including:

a) The current and sustainable increase in long term condition and care and support needs and the radial upgrade in prevention and public health needed (five year forward view) means there is a need to consider expanding the role of social prescribing in the city of Bristol.
b) There is lack of clear leadership for developing social prescribing in Bristol. Although there are numerous interested stakeholders, no overall lead for this agenda has been agreed.
c) No additional funding from Better Care Bristol, Bristol City Council or the CCG has been allocated to commission new social prescribing interventions. The redesign of Public Health Bristol allocated staff resource to support this work but imminent anticipated budget cuts have already reduced the capacity of this support.
d) The Bristol voluntary sector is active and engaged and is a significant asset to the City and scope exists to further utilise this sector to support the expansion of the social prescribing approach in Bristol.

e) There was no clear and simple mechanism or pathway for knowing about and referring people into the wealth of existing social prescribing interventions. This limits primary care referrals into such services
f) There is a lack of monitoring and evaluation data for many of the social prescribing activities currently taking place hence the understanding of how many people are being reached and whether the interventions are effective or in the right place to address those with most need are incomplete.
g) Once social prescribing initiatives have been mapped, the challenge is to ensure that the database is kept up to date, as due to the nature of the sector changes are frequent and so our information would be out of date quickly. In Cornwall this issue has been addressed, here they have a system which enables community navigators to populate their database.
h) No consistent quality assurance process for interventions exists, and this acts as a barrier to primary care referrals.

Recommendations to Better Care Bristol

a) We need to harness the enthusiasm to develop social prescribing in Bristol agree a city wide vision through wide stakeholder engagement.
b) Social Prescribing now sits clearly within the Better Care Bristol Plan. Leadership for Social Prescribing should be identified by the new joint Commissioning Board and supported by key and senior stakeholders to take the agreed city wide vision forward
c) Since there is no new money, we need to maximise the efficiency of funded services as well as harness the enthusiasm and capacity of other community groups and services including the non-funded, self-sustaining voluntary sector, preferably further utilising the asset based community health development approaches already adopted within the council.
d) We need to develop clear pathways to ensure the right people are able to access appropriate social prescribing services. A draft pathway for primary care has been developed. This pathway needs should undergo further consultation with stakeholders and should ensure wider access to all social prescribing initiatives.
e) A monitoring and evaluation framework and a quality assurance process needs to be developed. This should dovetail with other key developments, such as the Prospectus for grant funded activities and Bristol Ageing Better.
f) Further work is needed to consider how best to map and keep updated the extensive number of social prescribing initiatives in Bristol.

Recommendations to the Health and Wellbeing Board

The Board are recommended to note the findings of the Social Prescribing Commissioner to date and to endorse the recommendations to be taken through the Better Care Bristol Commissioning Board.

Project Update 3 – Design Team

Better Care Bristol Design Team is a task and finish group, which will help develop the Bristol Care and Support model for Better Care Bristol at a local level.

The Design Team are looking at services models primarily around urgent care provision, working with professionals, patients, their carers and the public to test and learn from models, which underpin delivery of integrated Health and Social Care Services at a local level, in order to build a safe, more efficient and sustainable service for the future.

The Design Team are working on three potential areas to be discussed at Transformation Team in October 2015. The current areas that are being further developed are:

1. Healthy Neighbourhoods (Multi-speciality teams)
2. Community Ward (Primary care and acute working together)
3. Identifying people in Sheltered housing (social care and primary care)

All these areas are being approached in an integrated manner.

There is an expectation that these projects will need resourcing and support. Better Care Bristol has always has the ethos that transformation teams within each organisation can take the lead in implementing projects but the expectation is that Better Care Bristol would provide the project support. This would need to be further explored to understand if there is the capacity to project manage all of the design team out-puts or if additional support will be required from provider partners.

The Design Team have away day on the 30th September to develop the detail needed for the Transformation Board meeting in 27th October 2015.

The HWB is asked to note the contents of this update and request a detailed report in December 2015.

Appendix One – Metrics Table

Better Care Bristol Metric	Target	Reduction	Savings (£)	
Number of patients +65 who are permanently admissions to residential and nursing care homes	405	5	156,000	2015/16
Proportion of older people 65+ who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (Savings based on reduction in days - costed as XBD)	131	14	411,600	2015/16
Number of delayed transfers of care (DTOC) days from hospital (aged 18+)	17983	646	242,200	2015/16
Patient / Service User experience rating ASCOF 1a Social Care related Quality of Life (8 questions combined) Source: Adult Social Care Survey 2012-13	18.5	0.1		2015/16
Number of Emergency hospital admissions for falls injuries in persons aged 65+ (Rate calculated using European Age Standardised Population 2012)	1535	143		Jan 2015 to Dec 2015
Total non-elective admissions in to hospital (general & acute, all-age)	14012	1259	1,876,454	Jan 2015 to Dec 2015
Other Excess Bed Days	11161	3695	931,775	2015/16
Totals			3,618,029	

Appendix Two 'Better Care Other' schemes

Scheme	Commentary
Additional Resource REACT / Social Care Practitioner working with REACT in ED	REACT is a BCH service; this received additional resource from December 2014 and has had the support of a social care. Recent figures demonstrate that 60% of individuals seen are discharged within 4 hours. However, this is not being reflected in the number of people being admitted. The figures for UHB +65 years emergency admissions are reducing but NBT's figures are increasing which has had an adverse effect on Better Care Bristol achieving the overall reduction of emergency admissions for 65+ years required
Independent Living Team	This project relates to the £100k that was allocated in 2014/15 which helped fund the employment of occupational therapy (OT) agency staff, which have now completed their contracts. Currently a business case is being drawn by the Council to employ more OT staff. This impact was not realised at the front door
Dementia Support at Home	This service has been redesigned by integrating the Dementia Support Team into the broader reablement services. This will enhance the skills across the wider team and ensure more individuals are able to support people with dementia on their reablement journey. The service will still accept the same type of referrals and through skill mixing of the Teams during the amalgamation, the relevant skills in each part of the city will be retained, as well sharing those skills on to others within the teams across the City. The performance indicators that measure this service show that a high proportion of people that enter this service do not get re-admitted into hospital.
Reablement (Discharge to Assess – pathway 1)	Money has been identified from the preparing for Better Care Fund money. The investment was used to support the over-spend in homecare 2014/15. The Discharge to assess - pathway 1 is reliant on the £1.4 million investment that Better Care Bristol has identified. The plans to implement will be taken to the October 2015 Transformation Board.
Joint Front door	To remodel and implement a primary care led joint front door and urgent care centre at UHB. It is expected that phase 1 will start in January 2016; this will be a two year project that will need capital investment.
Single Point of Access	The aim of the Single Point of Access is to replace the current multiple single points of access to health and social care services across many providers to underpin the Urgent Care system to meet the aims, objectives, and outcomes outlined in the Urgent Care Service model. The Single Point of Access will provide triage / assessment / advice for Health Care Professionals and identified patients and arrange the most appropriate response from the appropriate service to support admissions avoidance, support within the community or facilitate discharge.
Bristol Primary Care Agreement (BPCAg)	The Bristol Primary Care Agreement (BPCAg) is the three year delivery vehicle through which the CCG brings together all CCG funding streams directed at commissioning list based services in primary care. We are now entering the 2nsd year of the agreement. The BPCAg aims to simplify the contracting process, maximise the benefit of the funding in order to support practices to deliver the primary care element of the CCGs 5 year plan and move toward outcomes based commissioning.
Nurse practitioner pilot (Extra Care Housing)	Pilot in two care homes to reduce to support admission avoidance from extra care housing facilities. This is currently subject to evaluation.

Appendix Three – Definitions

Green to Go List (G2G)

Patients on this list are medically fit for discharge, but are unable to leave hospital because they require services to be put in place which are discharge dependent, and which are being arranged within the operational standard for that type of service. Consequently, not all patients on this list will be DTOCs (see below). Often the services required are care and support, or rehab and reablement type services, and involve partner support from social care and community health teams. Patients on this list are often referred to as the "complex" (as opposed to "simple") discharges.

DTOCs (Delayed Transfers of Care)

These are patients who are medically fit for discharge (so will already be on the G2G list), and require a service on discharge, which has not been put in place within the operational standard to that type of delay. For example, social care have five days within which to complete an assessment of need, and the teams have two days to progress patients via discharge to assess pathway one before they breach the standard. DTOCs are formally reported monthly to the Department of Health.

XBD (Excess Bed Days)

These are accrued when patients remain in hospital in excess of the treatment spell defined as appropriate or "average" for their particular treatment / condition. The patient's spell in hospital is coded retrospectively, and is worked out depending on the HRG (Healthcare Resource Group) which is applied. Once a patient starts attracting excess bed days the CCG responsible is billed at a daily rate depending on what type of bed the person is using. A typical figure would be in the region of £250 per day. A patient could be attracting excess bed day payments and be Green to Go or DTOC, but equally could attract excess bed day charges whilst still medically unwell; this will just depend on where the trim point / HRG code for their condition falls and how the individual patient is responding to treatment. Insert table from Better Care Board

Appendix Four - Better Care Bristol Scorecard

Section 3 Better Care Bristol Indicators			Target	13/14	14/15	Quarter 1				Quarter 2				Quarter 3				Quarter 4				YTD RAG
						Apr	May	Jun		Jul	Aug	Sep		Oct	Nov	Dec		Jan	Feb	Mar		
Better Care Fund Indicators	Delayed Transfer of Care from hospital per 100,000	Delayed Transfer of Care from hospital per 100,000	1,269.1 Average	1,388.4	1,330.5																	
		Number of days delayed	17,983	15,476	19,227	1,742	1,921	1,911	5,574	1,962												R
	Permanent admissions of older people >52 to residential and nursing care homes, per 100,00 population	Permanent admissions of older people >52 to residential and nursing care homes, per 100,00 population	678.5	725.7	696.6																	
		Numbers	405	415	410																	
	Proportion of older people >65 who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Proportion of older people >65 who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	81.9	73.1	73.1																	
		Numbers	131	115	117																	
	Avoidable emergency admissions per 100,000 population	Avoidable emergency admissions per 100,000 population	2,860.7	3,060.7	2,881.0																	
		Number of Falls	1,705	1,776	1,694	138	153	167	458	155	107											R
	Emergency Excess bed days	Excess bed days UHB	TBC	11,713	10,557	974	748	981	2703	264	513											R
		Excess bed days NBT	TBC	6,143	6,604	270	443	247	960	264	513											R
	Emergency Admissions for ages 65+	Emergency Admissions for ages 65+	13,976	14,460	15,135	1,321	1,312	1,264	3897	1,272	1,208											R
	Patient and Service User Experience		TBC																			

Appendix Five – Quarter 1 (April – June) national reporting

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" enter date when condition will be met if not already in place	Comment
1) Are the plans still jointly agreed?	Yes		We have recently amended our governance structure to support implementation of Better Care Bristol. The Joint Commissioning Board gives assurance to the Health and Wellbeing Board that plans are on track and how the totality of the fund is being spent. The Better Care Bristol Transformation Board is responsible for ensuring that transformation is in line with the vision that has been set by the Joint Commissioning Board. The Better Care Bristol Transformation Board has members from providers, commissioners, voluntary sector and Health Watch. To support the transformation and integrated working there is a system wide Workforce and Organisational Development Group, that has representation from all providers and commissioners (including the independent sector) which is working together to assess the future capacity and workforce requirements.
2) Are Social Care Services (not spending) being protected?	Yes		Funding (previously Section 256, now Better Care Fund) is being used to support adult social care services in in Bristol City Council that has a health benefit. The Better Care Board has agreed the 2015/16 spend and the additional £1.7 million, which will be spent on reablement. The expected outcomes from this spend are measured on a quarterly basis by the Better Care Bristol Commissioning Board.
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes		We have limited services in place such as a REACT team (including social care) for preventing unnecessary admissions and supporting discharges. We held a 7 day Services workshop on 8th June and the outputs from this are being reported to System Reliance. Social Workers routinely work at weekends in one acute trust as a test and learn exercise. 7- Day services are not just about front-line staff being available; it is also about support systems being available (such as brokerage for social care and easy access to diagnostics for community staff). All business cases within the CCG need to document that they have considered the need for 7-day services and what that impact is. The majority of the work carried out to date has been focused on discharge. The new models of care and new ways of working with primary and acute care provide an opportunity for us to consider services that will assist with admission avoidance (such as community based ambulatory platforms with limited access to beds in the community setting). Understanding and testing this model will be the focus of work during 2015/16. The main driver for 2015/16 to reduce emergency admissions will be the introduction of the joint primary care model that will be supported by an Urgent Care Centre in 2016/17.

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" enter date when condition will be met if not already in place	Comment
4) In respect of data sharing - confirm that:			
i) Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress		The City Council have implemented their system Liquid Logic in July. The Liquid Logic system gives Connecting Care the ability to use the NHS number using our matching engine NextGate. Plans are being developed to us this as one of the identifiers - not agreed if primary yet. This means that we now have the technical capacity to use the NHS number to identify individuals across health and social care for read purposes. The postponement of the Care Act duties from 2016 to 2020 means that there is a re-planning exercise therefore it is not currently possible to give an exact date when this will be achieved. Out of hours are already using systems to book individuals into routine practice appointments. The community provider has also recently changed to the system EMIS which will be the same system that Bristol primary care uses. This will enable read and write facility.
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes		All LA and CCG contracts are clear that all providers can only purchase software that have open APIs and we are currently working with the company that provides the GP's system to ensure that it is able to confirm to open APIs.
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes		Documents attached to the Better Care Submission in September 2014. We have also developed an information sharing agreement with Information Governance Department. This can be used on a project by project basis to ensure that the development of services is not hampered by lack of sharing data but it is shared in an appropriate way and conforms to data protection requirements.

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" enter date when condition will be met if not already in place	Comment
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	31/03/2016	Have recently filled a vacancy for Single Assessment Project Manager, this role will be supporting the City Council in developing the on-line assessment for the Care Act which will morph into Single Assessment. The GP's have recently identified the top2% of their population 75years + and all identified have a care plan with the GP responsible for patient centred care. To support this House of Care training is being rolled out to a number of identified practices as a pilot to enable evaluation of impact. We are also a pilot site for integrated personal commissioning and this means that we are aiming to have one care plan that is populated from the Single Assessment and then further populated by the patient in terms of what matters to them.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes		The acute Trust are in agreement with the Better Care Plans and sit on the Better Care Board. The acute providers plans reflect the reduction in emergency admissions and delayed transfers of care. We are working in partnership to reduce excess bed days.

Better Care Bristol
BCF Quarterly Submis

Appendix Six – Sample Dashboard Development

Transforming Care Programme report

Pillar	Details	Purpose	Status	Milestone review last month August	Key deliverables	Month	Benefits / Measures	Risks
Improving patient flow	**Project:** Operating Model - Unscheduled Care & Discharge **Exec lead:** Deb Lee **Project lead:** Rowena Green IDH: Integrated Discharge Hub D2A: Discharge to assess	To establish an unscheduled care pathway, supported by a fully integrated Health and Social care team which reduces occupied bed days whilst improving patient outcomes and experience.	G	• New care providers service contracts started (11/8)	• Impact of non weight bearing pathway reviewed	Sep	• Reduction in number of patients on green to go list to 30 patients • Reduction in LOS to achieve 90% bed occupancy • Closure of 17 beds by August 2016 • Achievement of the emergency access performance	• Divisional ability to resource project • Lack of capacity and staffing resources in the community to support the projects
			G	• Revised Operational policy to include KPI's and the lines of reporting for the Discharge Lounge in place	• New management structure in place for Discharge Lounge	Sep		
					• Extra capacity in community in place	Oct		
					• D2A roll out to Medicine completed for all three pathways	Oct		
					• Implementation of IDH rota to support weekday board rounds in BRI & BHI	Oct		
					• Internal processes to support D2A across all pathways in place	Oct		
					• Staff engagement event held for IDH and winter planning	Oct		
	Project: Ward Processes **Exec lead:** Deb Lee **Project lead:** Rowena Green Med: Medicine SpS: Specialised Services SHN: Surgery, Head & Neck W&C: Women's & Children's	Increase number of discharges between 7AM - 12 noon	A	• SpS, SHN and W&C: 1st ward workshops scheduled	• Med: 7 / 10 ward processes workshops completed	Sep	• Increase number of discharges between 7AM and 12 noon to 1100 a month by the end of March 2016	• Lack of capacity of ward staff / multi disciplinary team members to carry out project and embed ward processes • Culture and behaviours of clinical teams don't change
					• SpS, SHN and W&C: 1st ward workshops held	Sep		
					• SpS, SHN and W&C: all wards in scope prioritised	Sep		
					• Cross Divisional sharing event	Nov		

Updated: 03.09.2015

Milestone complete / Activities on track to achieve milestone

Milestone behind plan, with action to remedy

Milestone behind plan, project/programme risk