AGENDA ITEM 7

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Performance Report from Better Care Bristol Joint Commissioning Board February 2016	
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Date of meeting	**17th February 2016**
Report for: Assurance and Information	

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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 second performance 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 conditions
- National Quarterly reporting

The circa forty projects have been rationalised to nineteen projects (appendix one) that help us achieve our three aims

- We will help you to help yourself be well
- We will provide care in the right place
- We will support you to be independent for longer

This report contains updates on three of those projects.

- First Contact checklist (Aim 1)
- Discharge to Assess (Aim 2)
- Integrated Personal Commissioning (Aim 3)

There is a schedule of projects that will be reported to HWB via Better Care performance reports (appendix two).

Key Items to Note:

- Financial reporting for Q3 is included. There is a projected underspend within the 'Preparing for Better Care – invest to save' projects agreed in June 2014.
- There is an improving picture in performance across the metrics even if we are not meeting the targets. Bristol is not achieving four of the seven KPIs; the remaining three KPIs are completed annually. There is no in-year monitoring to indicate the likely outcome of these at year end.
- Health and Wellbeing Board (HWB) to note four of the six national conditions have been achieved and working towards two conditions. There is a 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), Q1 (April-June) Q2, (July-September)

and Q3 (October-December). The pay for performance funding will used by the CCG to offset additional unplanned costs against emergency admissions as set out in the Better Care Fund Guidance.

Better Care Policy Framework 2016/17

The Better Care Policy Framework sets the direction of travel for 2016/17. The priorities are:

1) To continue to reduce emergency admissions
2) To continue to work to reduce delayed transfers of care with the new additional of having a risk sharing agreement on DToC with the health and care community
3) To achieve the Better Care metrics
4) To achieve and be working towards the National Conditions

These priorities will ensure that Better Care contributes to the achievement of the triple aim, better health, transformed quality of care delivery and sustainable finances.

Key Points

- The pay for performance element for reducing emergency admissions has been removed
- Two new national conditions (risk sharing arrangement for delayed transfers of care (DToC) and investing in community services)
- Requirement to have a Better Care Plan 2016/17 signed off by HWB
- Requirement to have pooled fund (Section 75) 2016/17 signed off by HWB
- Must have integration plan for March 2017

Better Care Bristol Section 75 spend and variance report

The Commissioning Board has been receiving regular bi-monthly financial reports since November 2015. Appendix three sets out the financial position of the Better Care Bristol pooled budget at month nine (December 2015).

The total value of the Better Care pooled budget is £30.392m. Of this total £3.618m is released on pay-for-performance measures and efficiency savings. To date no funding has been released into the pooled budget for these elements

Expenditure against the remaining £26.774m is forecast to underspend by £0.760million, there are ongoing discussions relating to the underspend that will be reported to the next HWB meeting.

Long term care, including mental illness and Learning Disabilities budget of £4.100m is set to overspend by £1.073m. On this pooled budget Bristol CCG hold a

90% risk share of overspend and 10% with Bristol City Council as per the section 75 agreement.

Better Care Metrics

The table on page five sets out the metrics that need to be achieved in 2015/16. Six of the metrics are nationally reported and the seventh metric releases funding from the acute hospital back into the fund to be spent on care in the community. Appendix Four specifies the submitted targets that need to be achieved. The HWB need to be aware that there is no reliable data from NBT this quarter due to the Lorenzo Project (new patient IT system being implemented in NBT) and data validation is still ongoing. The first projection of validated data is March 2016.

This means that the data within the table on page 5 relates to UHB and we are unable to track the performance, report nationally for Q3 and provide assurances to HWB on the following metrics for NBT:

- emergency admissions,
- emergency admissions relating to falls
- delayed transfers of care
- excess beds days

There is a risk that the metrics could be off expected target.

Three 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 that stay at home as long as possible after reablement services
- People being admitted into care homes on a permanent basis
- Quality of life of users of care and support

There are four reported national metrics agreed by the HWB that are not delivering against the Better Care targets 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

The table on the following page demonstrates the achievement against the metrics and the progress within each quarter to-date against the 2014/15 baseline. The arrows pointing up signify performance is worse than baseline, arrows pointing down signify that performance is better than baseline.

It can be seen in many areas the performance is improved against the 2014/15 baseline. DToC are increased from the 2014/15 baseline but the monthly reporting demonstrates a reduction between October – November 2015.

Metric	Achievement @ Q3	Quarters			
		Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
To reduce the number of people that are admitted into hospital as an emergency as compared to Better care baselines, same Quarter age 65+	RED	↓	↓	↓	↓
To reduce the number of people that are admitted into hospital as an emergency after a fall age 65+ compared to 2014/15 activity	RED	↓	↓	↓	↓
To ensure that people stay at home as long as possible after reablement service	UNKNOWN	Measured on annual basis			
To ensure that people leave hospital as soon they are well and no longer need acute medical care (Delayed Transfers of Care) Compared to Better care baselines, same Quarter	RED	↑	↑	↑	↑
To reduce extra number of days that people stay in hospital then expected (excess bed days) compared to 2014/15	RED	↓	↓	↓	↓
To reduce the amount of people being admitted into residential and nursing home	UNKNOWN	Measured on annual basis			
To improve the quality of life of users of care and support	UNKNOWN	Measured on annual basis			

The detailed Better Care score card is at appendix five

Issues impacting on delivery of agreed planned reductions at UHB

a) Reducing Emergency Admissions

The data demonstrates that in comparison to baseline 2014/15 emergency admission have been reducing. They have not reduced to target in the +65 years population. This means that no pay for performance funding has been released into the Better Care Fund in 2015/16.

There are a number of different pieces of work that will take place over the next quarter that have the potential to reduce emergency admissions.

1) Continue GP Support Unit at UHB and GP Support Team at NBT
2) Extra Care Housing model of admission prevention
3) Expansion of Care Home project to reduce emergency admissions from care homes
4) GP to work at the front door prior to admission
5) Single Point of Access to coordinate and streamline access points into acute and community services
6) Review of emergency surgical admissions
7) Scoping a model of step-up beds that are community run and link into the Rapid Access Clinic for Older People (RACOP) that is already functioning in South Bristol Hospital.

b) Emergency admissions relating to falls

Reduction of emergency admissions from falls is a locally determine metric and is measured against 2014/15 month on month data. . The last data-set from NBT in October 2015 demonstrated that falls were increasing (noting that 70% of the care home population lives in the NBT geographical area) we have not had further data to substantiate if the increase is a trend.

The falls presenting to UHB are decreasing but not to target hence the metric has not been achieved.

The previous HWB Better Care Performance Report highlighted that falls in June 2015 increased but within the quarter the falls were below 2014/15 by 2 falls.

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

The official national data for Delayed Transfers of Care (DToC) has a two ½ months month time-lag. DToC is increased from the baseline 2014/15.

The last official data for November 2015 was a promising picture for UHB as DToC had reduced from the October 2015, although not against November 2014 (baseline).

The discharge to assess model and the re-coding exercise across BNSG has the potential to have a positive impact on the reported DToC's.

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 work being carried out under discharge to assess model and the reducing DToC picture will have a positive impact on the excess bed days that the CCG currently fund

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	**Not achieved**	**Not achieved**	**Not achieved**	**Not achieved**

It is unlikely that the planned schemes for 2015/16 will have a significant impact in the final quarter (January-March) of 2015/16 as neither model is operational as of February 2016.

However, it should be noted that Bristol is achieving a reduction in emergency admissions compared to the previous year.

To build on 'ORLA Virtual Ward' and 'Community Ward', 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.

Since last report to the HWB we have achieved another national condition. The software NextGate on Connecting Care achieves this use of NHS number across health and social care. We have had to adjust 7 day services to 'no in progress' as although Bristol does have 7-day services they are not delivering reduction in emergency admissions at the weekends.

Condition	Please Select (Yes, No or No - In Progress)	Direction of Travel
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?	No - In Progress	↓
4) Data Sharing - Is the NHS Number being used as the primary identifier for health and care services?	Yes	↑
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. Bristol needs to ensure that the projects in place can evidence that they support discharge and avoid emergency admissions at the weekends.

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.

National Quarterly Reporting

We have completed three national returns the fourth to be submitted on 26th February 2016, this will be signed off by the co-chairs submission and reported to the Board in April 2016.

	Metrics Achievement	P4P	Financial Return	National Conditions Achieved	Integration Metrics
Q4 (Jan-March) 2014/15	0	£00.00	Nil return	4/6	No
Q1 (April-June) 2015/16	0	£00.00	Yes	4/6	No
Q2 (July-Sep) 2015/16	0	£00.00	Yes	4/6	Included
Q3 (Oct-Dec) 2015/16	0	£00.00	Yes	4/6	Included
Q4 (Jan-March) 2015/16					

Risks and Opportunities

There is a delay on the guidance being released by NHS England for Better Care 2016/17. This means that we do not have the

- Template for planning achievement of the metrics
- Technical guidance regarding what should be achieved during 2016/17
- The Section 75 mandated allocation

This means that Bristol City Council and the Clinical Commissioning Group are not aware of the allocations for the Section 75 2016/17; it may not be available until the beginning of March 2016. There is a risk that the Section 75 will not be signed by 1st April 2016.

Due to the lack of validated data from NBT (due to the Lorenzo Project) there is a risk that the metrics could be off expected target.

There is a real opportunity for Bristol City Council and the Clinical Commissioning Group to use the 'test and learns' during 2016/17 to determine what model of integration will work best for the people of Bristol. This will inform the required Integration Plan for March 2017 and clarify the recomissioning of community adult services.

Project Update 1 – First Contact Checklist (Aim 1)

The First Contact Checklist falls under Better Care Bristol's Aim 1 –'We will help you to help yourself be well' and currently consists of eight projects that establish an integrated approach to health and wellbeing. There is a mixture of different projects within Aim 1 with different providers delivering the outcomes. First Contact Checklist is being delivered by Bristol Aging Better.

Ensuring that people have access to information about services which would help them retain their independence and avoid loneliness and isolation can be very challenging. There is no single solution – a number of different initiatives need to be deployed. A "First Contact Checklist" does this in a very creative way. This 'Bristol Ageing Better' initiative takes as its starting point the potential to build upon the numerous contacts that practitioners from a range of agencies have with older people on a daily basis. It puts in place an infrastructure which allows a number of areas of an older person's life to be looked at quickly and for referrals to be easily made to follow up any needs that are identified.

The system is a very low cost way of extracting maximum value from joined up working by public agencies to ensure that older people have access to support and information to promote their independence. First Contact Checklists have been successfully implemented in other areas and now 'Bristol Ageing Better' is leading the development of this service in Bristol. The project is currently in its design stage; its project group has members from Bristol City Council, Better Care Bristol, Centre for Sustainable Energy, Voscur, amongst others.

First contact check and refer systems are an important part of the 'infrastructure' of a social care, health and the wider system of public services. They enable older people to access services through a single point of contact: One simple checklist of questions enables people to receive vital services to stay safe and well connected with others. They are able to match up those people 'in need', with the mainstream or open access services which are already available in the area. First contact check and refer systems provide a way for front line practitioners from a range of statutory and voluntary sector organisations to undertake opportunistic 'case finding'.

A simple checklist of questions is completed by the first organisation to make contact with the older person and a 'back office' facility ensures that referrals are automatically recorded and distributed to the appropriate organisation for action.

An example of checklist questions that may be used in Bristol:-

- Have you got a working smoke alarm on each floor of your house?
- Are you able to keep your home warm?
- Have you fallen and injured yourself in the last 12 months?
- Would you like advice on money you may be entitled to?
- Are you interested in information about community transport?

This initiative is particularly designed to target those people who are reticent to come forward and ask for help or seek out information. By creating simple mechanisms for individuals to access support, it will in turn promote independence and ability to self-care. It reduces a reliance on statutory services and acknowledges that unplanned care and urgent admissions can be a consequence of a deterioration in issues that are often not health related in the first instance. The checklist's promotion of addressing issues that may be detrimental to a person's wellbeing is aligned with many of the other projects within the Better Care Aim 1 and with the driver of helping people to help themselves.

The numbers of people likely to be helped by the checklist will clearly vary considerably depending on local circumstances. However, on the experience of a number of such services it is possible that it will reach around 4% of population over 75. Costs will vary according to the way in which the service is established. On average, the total cost of the service is likely to equate to about £0.80p per head of people over 75. Once development work is complete, Bristol Ageing Better will commission a delivery partner for the checklist. It is estimated that the date for Invitation to Tender will be May/June 2016.

Project Update 2 - Care Homes (Aim 2)

The Care Home Project falls under Better Care Bristol's Aim 2 –'We will provide care in the right place' and currently consists of two transformational work streams, these work streams are in the form of two pilots.

- The Care Home Support Team pilot (Focus on Care Homes With Nursing - CHwN)
- Extra Care Housing Nurse Pilot.

There is a significant requirement locally and nationally for improvement across the Care Homes, Home Care and Extra- care housing. Bristol has an aging population, and an increasing number of older people are suffering with complex and long term conditions. The demand for care given in these environments is on the rise, and therefore we need to address the system's capacity and quality issues to allow for a more pro-active and effective approach.

This project aims to support a reduction in avoidable admissions, reduce safeguarding issues, and help maintain bed capacity in the community to support patient flow, discharges and the overall patient experience.

Both pilots have been in place since Dec 2014 /Jan 2015 and although some excellent work has taken place, the pilots have not had the level of impact in supporting the reduction in avoidable emergency admissions we have hoped for.

Both pilots have taken the learning from their activity in the last 12 months and submitted new business cases with their revised plans. These business cases have been agreed in principal and await a final decision by the Health and Wellbeing Board before they can begin.

Care Home Support Team Pilot

The Care Home Support Team pilot provides selected Care Homes with nursing some additional support. The team consists of registered nurses, a team manager and a virtual team. The virtual team provides support from medicine management, dietetics, quality and safeguarding and will improve links with existing Bristol Community Services BCH services, ensuring residents have access to the care they require.

The team will have two main focuses, to support the immediate system issues of limited bed capacity and support and empower CHwN who are having problems to make sustainable changes to improve of the quality of the care given within the home.

The team will:

- signpost CHwN staff to services available to them by other providers
- identify, deliver and provide access to training
- offer clinical advice, support and supervision
- help build relationships between care home staff, GP's, and other providers
- develop champion roles within CHwN's to support the continuity of quality care.

- support and facilitate the End Of Life (EOL) care agenda, making improvements in end of life care, planning and to enable residents to die in their place of choice.

Due to the limited capacity of the team, it has been agreed that one of their main focuses will be on EOL care. EOL Care Planning is about supporting residents in CHwN to die with dignity in their current place of residence if that is their wish and helping to reduce avoidable admissions for those residents with end of life care plans.

Extra Care Housing Nurse Pilot

ECH enables individuals to have additional support in a suitable home environment but recognises that they often have complex needs and co-morbidity requiring additional healthcare input. It provides a cost effective alternative to lower level residential and nursing home placements.

Effective ECH schemes benefit the health and social care system in expanding capacity in residential level capacity, freeing up care home places to be available for those who need them. As currently residents of these ECH schemes are creating a local pressure on all aspects of the health system including GP call outs, community services, A&E attendances, ambulance call outs and hospital admissions.

The learning from the initial pilot demonstrated that providing nursing support within an Extra Care Housing (ECH) scheme supports improved self-management and enables ECH staff to identify signs and symptoms earlier, whilst also identifying similar issues with other tenants.

The new business case proposes extending the current pilot for two years to provide continued nursing support to six Extra Care Housing schemes, taking in to account the lessons learnt. The pilot aims to reduce unnecessary hospital admissions particularly for those with long term conditions and supporting self-care at home.

Summary

Its felt that we are now better equipped to collate our intelligence and pull together the data available through GP LES and the Care Home Project's dashboard to build a more robust and effective support network for both CHwN and ECH.
It's hoped with these revised proposals the two works streams will make a notable impact on the quality of the care provided to residents within these environments and as a result this will have a positive impact on the wider system through increased admission avoidance and reduction in excess bed days.

Project Update 3 – Integrated Personal Commissioning (Aim 3)

The Integrated Personal Commissioning Pilot falls under Better Care Bristol's Aim 'We will support you to be independent for longer'. Ensuring, where necessary, people get the ongoing support they need to be safe and to live as independently as possible. Integrated Personal Commissioning enables individuals that opportunity.

The primary focus on the Integrated Personal Commissioning (IPC) pilot is to offer integrated health and social care packages of support for individuals with complex care needs. This will be achieved in two parts: firstly, individuals recruited to the pilot will be offered an integrated care plan that incorporates their health and their social care needs. Secondly, these individuals will be offered personal budgets that will be a merging of a Personal Health Budget and a social care Direct Payment. This new model has the potential to reduce health inequalities by facilitating commissioning on an individual basis whilst taking a personalised approach to care and support planning. The model is aimed at implementing incentives to providers to take a preventative, rather than a reactive, view towards health and social care.

The pilot is part of a wider consortium known as the South West IPC Programme under NHS England. It is one of eight demonstrator sites in England and is expected to run for 3 years. The Bristol IPC project team is made up of representatives from Bristol CCG, Bristol City Council and a number of local voluntary and community organisations and is led by the Better Care Bristol team. The Bristol plan aims to introduce 40 person centred care plans during the lifespan of the pilot. There are four discrete cohorts of individuals that the pilot will focus on: Children with complex needs, adults with Mental Health difficulties, adults with a diagnosis of multiple long term health conditions and adults with a diagnosis of a learning disability.

The goals of the IPC Programme are:

- To ensure that people with complex needs and their carers have better quality of life, allowing them to achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances.
- Prevention of crises in people's lives that lead to unplanned hospital and institutional care by keeping them well and supporting self-management.
- Better integration and quality of care, including better user and family experience of care.

To date, Bristol has successfully implemented four integrated packages for Children with complex needs. There are several more in the pipeline for the coming months. The team is also in the process of recruiting individuals with a diagnosis of a learning disability to the pilot. These will be service users who are under section 117 of the Mental Health Act and so are eligible for funded care packages. The

team will use the learning from the first two cohorts and from the wider South West region to help shape the roll out of the final care packages.

The IPC team is keen to make significant strides towards embedding the culture change required to truly deliver person centred and integrated care and support for service users. Being part of this demonstrator site will mean that Bristol will trial integrated budgets and test out the capitated budget financial model as recommended by the Five Year Forward View. This work sits within the Better Care Bristol Programme as it shares the key themes of personalisation and integration.

Appendix One: Better Care Programme Aims and associated projects

Aim 1 We will help you to help yourself be well Establishing an integrated approach to wellbeing and prevention that addresses healthcare inequalities and provision of appropriate advice and guidance for individuals to make informed decisions relating to care and support	
Project Name	**Project Summary**
Active self-care	
Healthy Living Pharmacies	A training programme to upskill community pharmacies to enable them to have a much more holistic role in managing people's health issues and working closer with local communities.
Wellbeing Partner Pilot	Pilot to train apprentices as Wellbeing Partners to support prevention and promote independence and support to stay well for longer. Ultimately the wellbeing partner will be able to refer individuals with social , emotional or practical needs to a range of local, non-clinical services , often provided by the voluntary and community sector known as social prescribing.
HG Wells LTC (Diabetes) Pilot	An integrated model of care that crosses institutional boundaries to support patients with diabetes. Seeing significant improvements in the management and treatment of diabetes, helps activate patient engagement in managing the disease through community based lifestyle interventions.
Signposting for information	
Information, Advice and Guidance & Self-Assessment	Jointly Commissioned Information, Advice and Guidance Service which will be in the form of an on-line platform. It aims to ensure that people can get the information and advice they need to make good decisions about their care and support
Public Health Wellbeing Hub	A central hub that offers advice and signposting to people wanting to improve their help. Health trainers will provide disease prevention support
First Contact Checklist	A series of simple questions that public and voluntary staff can ask in their day to day contact with older people, with simple referral mechanism. This is being developed by Bristol Aging Better
Making Every Contact Count (MECC)	Making every contact count (MECC) encourages conversations based on behaviour change methodologies (ranging from brief advice , to more advanced behaviour change techniques) empowering healthier lifestyle choices and exploring the wider social determines that influence all of our health.
Signposting for information	
Community Webs	A test and learn created by the Better Care Design Team. Several of the assets in a community (GP, voluntary sector, social care, family early help, etc.) to work together at a neighbourhood level to support adults. By working in this more co-ordinated system the needs of the whole individual living in that neighbourhood would be identified and met in a more timely way and we can get more out of our limited resources

Aim 2 We will provide care in the right place Ensuring that there is support available to keep people well at home and that when they require acute medical care in a hospital this is coordinated and managed to ensure people spend less time in hospital and are able to leave safely with appropriate support as soon as possible	
Project Name	**Project Summary**
Primary and Community Transformation	
Bristol Primary Care Agreement (BPCAG)	South Bristol Hospital development - This work is currently being scoped within the design team and is not yet an agreed project.
	Working with Primary Care to develop schemes to help support Emergency Admissions Avoidance
Care Homes Project	Work stream 1 : Care Home Support Team pilot Working with Care Homes to reduce admissions including nutrition, hydration and falls (Training)
	Work stream 2: Extra Care Housing Nurse pilot Working with schemes to reduce admissions including nutrition, hydration and falls (Training)
Empowering communities	
Joint Front Door Model	To implement a Primary Care Lead Joint Front Door Model and Urgent Care Centre at UHB
Single Point of Access	Establishing a joint SPA that replaces the current multiple access points that are currently seen in the urgent care system.
Single assessment – the care and support plan will be complimentary to this.	Develop a single, trusted assessment which evolves as the patient or service user moves along their care pathway. Reduce the bureaucracy, hand offs and inefficiencies of multiple assessments and improve the patient experience by making decisions quicker and without the need for repetition
Discharge to Access (D2A) Project includes Excess Bed Day Reductions and Delayed Transfers of Care (DTOCs)	Discharge to assess model Pathway 1 – Home with Support (package of care and / or rehab / reablement)
	Discharge to assess model Pathway 2 – Community Rehab Bed (including inpatient rehab at SBCH or Elgar 1)
	Discharge to assess model Pathway 3 – Complex Assessment Beds (social care and/or full CHC assessments)

Aim 3 **We will support you to be independent for longer** Ensuring, where necessary, people get the ongoing support they need to be safe and to live as independently as possible	
Project Name	**Project Summary**
Supporting Independence	
Extra Care Housing	Bristol Retirement Living is a project to deliver 200+ units of Extra Care Housing and a 60-bed high quality dementia-specialist care home on the New Fosseway site, Hengrove, including communal facilities and outdoor space within a central hub.
Home Care	Developing skills and capacity in the independent workforce in training around their roles as enablers and re-ablers, as opposed to doers and home carers.
Section 117 - Aftercare Services	Providing suitable and appropriate housing to maintain independence for those on aftercare services (section 117) A review in to the systems involved in delivering section 117 care packages
Integrated personal commissioning pilot	Study involving the integration of health and social care budgets for patients with complex needs.
Technology	
Connecting Care	Supporting integration care record IT enabler

Appendix Two – Schedule of project reporting to HWB

Reported project				
	Aim 1	**Aim 2**	**Aim 3**	**Additional reports**
16th December 2015	Wellbeing Partner			Social Prescribing & Design Team
17th February 2016	First Contact Checklist	Care Homes	Integrated Personal Commissioning	
20th April 2016	Healthy Living Pharmacies	Discharge to assess	Connecting Care	
22nd June 2016	Public Health Wellbeing Hub	Single assessment	Extra Care Housing	
10th August 2016	HG Wells LTC (Diabetes) Pilot	Front Door	Home Care	
19th October 2016	Making Every Contact Count (MECC)	Single Point of Access	Section 117 - Aftercare Services	
14th December 2016	IAG & Self Assessment	Bristol Primary Care Agreement	Integrated Personal Commissioning	
15th February 2017	Community Webs	TBC	Connecting Care	
12th April 2017	BAB – Identifying and Informing	TBC	Extra Care Housing	

Appendix Three – Financial Report Summary – Month 9

Scheme Name	Source of Funding (as per DH Submission)	Plan Value 2015/16 (£'000)	Spend to Date (£'000)	Future Commitments (£'000)	Forecast Outturn (£'000)	Forecast Variance (£'000)	Risk Share Element	
							LA (£'000)	CCG (£'000)
Early & Preventative Interventions	NHS England Unplanned DES	1,410	1,175	235	1,410	0	-	0
Reduction in Hospital Admissions	Primary Care Funding	2,559	2,050	410	2,460	(99)	-	(99)
Frail & Complex, Falls Preventions	Falls Strength & Balance	70	58	12	70	0	-	0
Reablement	Bristol CCG	4,651	3,876	775	4,651	0	-	0
Adaptations	Disabled Facilities Grant	1,339	930	409	1,339	0	0	-
Personalisation Capital Spend	Social Care Capital Grant	1,129	940	189	1,129	0	0	-
Carers	Carers Break	1,036	638	367	1,005	(31)	(31)	-
Dementia Services	Section 256	1,000	365	24	389	(611)	(611)	-
Community Equipment / Telecare	Section 256	700	525	175	700	0	0	-
Domiciliary Prevention	Section 256	500	371	129	500	0	0	-
Adult Safeguarding and DoLs	Section 256	300	497	248	746	446	446	-
7 day working	Section 256	280	154	32	186	(94)	(94)	-
Reablement	Section 256	2,500	1,947	805	2,752	252	252	-
Intermediate Care	Section 256	2,000	1,316	487	1,803	(197)	(197)	-
Long Term Care, including mental illness & LD	Bristol CCG	4,100	4,229	944	5,173	1,073	107	966
Care Act Implementation	Bristol CCG	1,500	679	267	946	(549)	(549)	-
Preparing for Better Care	Bristol CCG	1,700	471	279	716	(950)	(226)	(725)
	Total	**26,774**	**20,221**	**5,787**	**26,009**	**(760)**	**(903)**	**142**

Appendix Four – 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 Five - 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	2,349	2,275	6,586	2,390	1,933							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	154	167	459	162	127	136	425	124								
	Emergency Excess bed days	Excess bed days UHB	TBC	11,713	10,557	950	706	964	2,620	962	1,090	1,183	3,235	1,224	1,000	756	2,980					R
		Excess bed days NBT	TBC	6,143	6,604	332	443	247	1,022	264	499	274	1037	325								R
	Emergency Admissions for ages 65+	Emergency Admissions for ages 65+	13,976	14,460	15,135	1,323	1,311	1,264	3,898	1,272	1,206	1,258	3,736	1,241								R
	Patient and Service User Experience		TBC																			

this is UHB and NBT only

** Data For NBT is not available for Novemeber so figures are not updated.

UHB data for November shows that the emergency admissions are above target but YTD there has been reduction compare to 2014/15, November 2015 did not show a decrease compared to Novemeber 2014