Health and Wellbeing Board

Agenda

BRISTOL CITY COUNCIL

NHS
BRISTOL CCG

Date: Wednesday, 22 June 2016

Time: 3.00 pm

Venue: Committee Room - Brunel House, St George's Road, Bristol, BS1 5UY

Issued by: Ian Hird, Democratic Services
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Date: Tuesday, 14 June 2016

Agenda

1. Welcome, apologies and introductions 3.00 pm

2. Public forum

Petitions and statements (must be about matters on the agenda):
Members of the public and members of the Council may present a petition or submit a statement to the Health and Wellbeing Board. One statement per member of the public and one statement per member of Council is permitted. A maximum of one minute shall be allowed to present each petition and statement. The deadline for receipt of petitions and statements for the 22 June Health and Wellbeing Board is **12.00 noon on Tuesday 21 June.** These should be emailed to democratic.services@bristol.gov.uk or sent to Democratic Services, City Hall, P.O. Box 3176, Bristol, BS3 9FS by the above deadline.

Questions (must be about matters on the agenda):
Questions may be asked by a member of the public or a member of Council. A maximum of 2 written questions per person can be asked. At the meeting, a maximum of 2 supplementary questions may be asked. A supplementary question must arise directly out of the original question or reply. Replies to questions will be given verbally at the meeting. If a reply cannot be given at the meeting (including due to lack of time) or if written confirmation of the verbal reply is requested by the questioner, a written reply will be provided within 10 working days of the meeting. The deadline for receipt of questions for the 22 June Health and Wellbeing Board is **5.00 pm on Thursday 16 June.** These should be emailed to democratic.services@bristol.gov.uk or sent to Democratic Services, City Hall, P.O. Box 3176, Bristol, BS3 9FS by the above deadline.

3. Declarations of interest

To note any declarations of interest from the Mayor and councillors. They are asked to indicate the relevant agenda item, the nature of the interest and in particular whether it is a **disclosable pecuniary interest**.

Any declarations of interest made at the meeting which is not on the register of interests should be notified to the Monitoring Officer for inclusion.

4. Minutes of previous meeting

To agree the minutes of the previous meeting held on 20 April 2016 as a correct record. **(Pages 4 - 11)**

5. Key decision - Commissioning of out of hours home care services **3.10 pm**

To be presented by Leon Goddard, Service Manager – Joint Commissioning (Adults) **(Pages 12 - 34)**

6. Key decision - Commissioning Home Improvement Agency and community equipment services **3.30 pm**

To be presented by Rob Logan, Service Manager – Contracts and Quality **(Pages 35 - 42)**

7. Sustainability and Transformation Plan - Bristol, North Somerset and South Gloucestershire **3.45 pm**

To be presented by Jill Shepherd, Chief Officer – Bristol Clinical Commissioning Group **(Page 43)**

8. Better Care Bristol - 2016/17 plan and Section 75 agreement **4.00 pm**

To be presented by Mike Hennessey, Service Director – Care and Support (Adults) **(Pages 44 - 94)**

9. Health and Wellbeing Board - next steps 2016 and beyond **4.15 pm**

To be presented by Kathy Eastwood, Service Manager – Health Strategy and Becky Pollard, Director of Public Health **(Pages 95 - 106)**

10. Any other business **4.55 pm**

11. Information item - Report of the People Scrutiny Mental Health Working Group

For information only. **(Pages 107 - 111)**

Bristol City Council
Minutes of the Health and Wellbeing Board

Wednesday 20 April 2016 at 2.30 p.m.

Health and Wellbeing Board members present:
George Ferguson, Bristol Mayor and Co-Chair of the Board
Dr Martin Jones, Chair, Bristol Clinical Commissioning Group (CCG) and Co-Chair of the Board (Chair for this meeting)
Alison Comley, Strategic Director - Neighbourhoods, BCC
John Readman, Strategic Director - People, BCC
Jill Shepherd, Chief Officer, Bristol CCG
Dr Jo Copping, Public Health Consultant for Becky Pollard, Director of Public Health
Councillor Fi Hance, BCC
Councillor Brenda Massey, BCC
Councillor Glenise Morgan, BCC
Elaine Flint, Voluntary and Community Sector representative
Ellen Devine, Service Co-ordinator - HealthWatch Bristol
Keith Sinclair, HealthWatch - Carers Support Centre
Dr Pippa Stables, Inner city & east Bristol locality group
Justine Mansfield, North & west Bristol locality group
Steve Davies, South Bristol locality group

Support officers present:
Kathy Eastwood, Service Manager, Health Strategy, BCC (supporting the Board)
Ian Hird, Democratic Services, BCC

Others present:
Leonie Roberts, Consultant in Public Health, BCC
Rob Logan, Service Manager – Contacts & Quality, BCC
Mike Hennessey, Service Director - Care, Support & Provision - Adults, BCC
Frances Tippett, Programme Director - South West Integrated Personal Commissioning Programme, NHS England
Jessica Harris, Secretary - South West Integrated Personal Commissioning Programme, NHS England
Chief Superintendent Jon Reilly, Avon & Somerset Police – Bristol Area Commander

1. PUBLIC FORUM

(agenda item 1)

Public forum questions – Health and Wellbeing strategy / dementia services – questions from Tony Hall, Bristol Dementia Action Alliance:

It was noted that questions had been received in relation to dementia services, asking for details:

a. on the achievements and challenges over the last 3 years, and the future plans for these services.
b. about which BCC/CCG officers would be leading on this, and about the plans being made for future dementia support in Bristol and the wider area.

The Chair responded verbally to the questions, commenting that dementia was a priority within the current Joint Health & Wellbeing Strategy, and that these questions were helpful in terms of highlighting the ongoing importance of dementia services. In Bristol, there was evidence of good practice in relation to dementia diagnosis.

In discussion, it was noted that there was an ongoing challenge to ensure appropriate care packages for patients with dementia, on leaving hospital.

It was noted that a follow-up written reply would be sent to the questioner.

2. DECLARATIONS OF INTEREST

(agenda item 2)

It was noted that no Board members had any declarations of interest with regard to the matters to be discussed at this meeting.

3. WELCOME AND APOLOGIES FOR ABSENCE

(agenda item 3)

The Chair welcomed attendees to the meeting.

Apologies were received from Linda Prosser, Becky Pollard, Nicola Yates, and Councillor Claire Hiscott.

4. MINUTES - HEALTH AND WELLBEING BOARD - 17 FEBRUARY 2016

(agenda item 4)

RESOLVED:
That the minutes of the meeting of the Board held on 17 February 2016 be confirmed as a correct record and signed by the Chair.

5. REFRESH OF THE JOINT HEALTH AND WELLBEING STRATEGY - UPDATE

(agenda item 5)

The Board considered a report providing an update on the work of the strategy development group, and seeking agreement on the proposed approach and criteria for prioritisation.

Kathy Eastwood presented the report.

Key points highlighted included:

a. The strategy development group was recommending the draft criteria set out at Appendix A in relation to agreeing the strategy priorities.
b. The recent Joint Strategic Needs Assessment (JSNA) refresh had identified that within the current strategy, there was insufficient focus on "healthy weight", including tackling obesity and promoting physical activity. It was proposed that this should now be considered as a priority as part of the refresh.

Main points raised/noted in discussion:

a. The Chair stressed the importance of taking into account the JSNA refresh - the Board needed to identify and focus on the "must do" priorities, to maximise its impact and influence the channelling of resources to meet the areas of greatest need. The refresh allowed an opportunity for the Board to re-focus its core purpose.
b. In terms of the criteria, the "evidence of need" criterion should be made more explicit. It would be important to assess the impact of/scale of problems being experienced in relation to each proposed priority.
c. It would be important to ensure there was no duplication of activity in taking forward the priorities, once identified. The Board needed to focus on the unique difference(s) that it could make/influence.
d. A number of key city strategies were due to be refreshed by other strategic partnerships over the next few months, including the community safety strategy, and the children and young people's strategy. It would be important to ensure appropriate links and alignment between these refreshed strategies. It would also be desirable for the refreshed strategies to be launched within a co-ordinated timeline.
e. A specific action plan should be developed, identifying key tasks against each priority, including specific early, achievable actions.
f. A workshop should be arranged during the summer to enable Board members to discuss and shape the refreshed priorities.

RESOLVED:

That, taking into account the above comments, the prioritisation criteria and overall approach, as outlined in the report be approved; and that a workshop be arranged during the summer to enable Board members to discuss and shape the refreshed strategy priorities.

6. ALCOHOL MISUSE STRATEGY - UPDATE

(agenda item 6)

The Board considered a report providing an update on the work of the alcohol misuse strategy sub-group, established following the alcohol misuse summit in July 2015.

Leonie Roberts presented the report, with reference to an accompanying presentation.

Key points highlighted included:

a. The key aim of the strategy was to prevent and reduce the harm caused by alcohol to individuals, families and communities in Bristol; and to achieve this through partnership work, using the best available evidence of what works best.
b. 3 workstreams had been identified:
    - Alcohol prevention workstream - aiming to increase individual and collective knowledge about alcohol, and change attitudes about alcohol consumption. Key actions were focused on prevention and campaigns.
    - Alcohol intervention workstream - providing early help, intervention and support for people affected by harmful drinking. Key actions were around access to services and pathways for liver disease.
    - Alcohol environment workstream - creating and maintaining a safe environment. Key issues included the reduction of alcohol availability and accessibility, and ensuring a safe night-time economy.
c. The first draft of the strategy was currently the subject of consultation with the Bristol alcohol short-life working group. The final draft of the strategy would be discussed with wider stakeholders at the Bristol alcohol summit in July 2016.

Main points raised/noted in discussion:

a. It was acknowledged that this action-orientated work on alcohol misuse represented a good example of where effective work was taking place, and key actions were being put in place, following a decision by the Board that this needed to be taken forward as a priority.
b. A wide range of relevant organisations/interests were represented on the short-life working group, including BCC public health, the CCG, the police, the ambulance trust and licensee representatives.
c. It would be important for organisations to collaborate in terms of organising and funding campaigns on alcohol misuse.
d. The final version of the strategy should maintain the focus on key actions to take forward. It would also be important to assess the impact as actions were implemented.
e. In relation to enforcement issues, there should be appropriate linkage and liaison with the Safer Bristol Partnership, as this was a shared agenda.

RESOLVED:

That the update report, setting out progress on this priority be noted, together with the above information/comments, and that further assurance on progress be sought/reported at future meetings.

7. HOME IMPROVEMENT AGENCY COMMISSIONING
(agenda item 7)

The Board considered a report setting out the background to a key decision (to be scheduled for the 22 June Board meeting) on commissioning Home Improvement Agency (HIA) services in Bristol.

Rob Logan presented the report.

Key points highlighted included:

a. The framework for commissioning HIA services was originally procured in 2012. Any decision to extend the current services under this framework must be taken before 24 July 2016. Accordingly, it was proposed that a formal, key decision report be submitted to the Board on 22 June seeking authorisation to call-off of a further HIA service under the current HIA framework, to end on 30 September 2018.
b. In terms of future commissioning, the aim was to take the opportunity to align and co-ordinate the procurement of HIA and community equipment services, ready for implementation from 1 October 2018. This approach was supported by commissioning partners.
c. No assumptions had been made on the outcome of the future commissioning process. Services in future could be procured from one or more organisations.

Main points raised/noted in discussion:

a. It was felt that this more “system wide” approach would bring benefits in terms of facilitating hospital discharge work.
b. The Council and CCG derived strong benefits from commissioning jointly with partners; it was important that these partnerships were maintained with a view to maximising economies of scale (in terms of purchasing) under this approach.
c. The community equipment model was very much a “recycling” model, ensuring that equipment was used for as long it was serviceable.
d. The opportunity should be taken to link this work with other relevant services, e.g. linking with the fire service around fire blanket provision where appropriate; and linking in with warm homes initiatives.

RESOLVED:

1. **That, as per the proposal set out in the report, a formal, key decision report be submitted to the Board on 22 June 2016 seeking authorisation to call-off of a further HIA service under the current HIA framework, to end on 30 September 2018.**

2. **That the benefits of starting work on a co-ordinated procurement of HIA and community equipment services, for implementation on 1 October 2018 be noted and supported.**

8. BETTER CARE BRISTOL: 2016/17 FUND PLAN

(agenda item 8)

The Board considered a report

a. providing an overview of Better Care Bristol and an understanding of the opportunities it presents.
b. on the Better Care Fund Plan for 2016/17.

Mike Hennessey presented the report, with reference to an accompanying presentation.

Key points highlighted included:

a. In taking forward Better Care Bristol, there now needed to be a clear move away from “doing things better” to ensure a focus on “doing better things”.
b. The Better Care Fund Plan 2016/17 final submission was now being prepared, for submission by 3 May 2016. The Board was asked to delegate authority to lead officers to approve the final submission. The section 75 agreement would be brought to the 22 June meeting of the Board, for approval.
c. Building on the “vision” event held on 12 April, in refreshing the vision for Better Care, the mandate for system leaders was to develop a vision that:
    - was forward looking and compelling, representing a step-change in ambition.
    - demanded a step-change in patient/service user experience.
    - focused on self-help and prevention.
    - delivered sustainability, for patients/service users and stakeholders. This was likely to involve cross-organisation changes.
    - ensured the best use of resources.

Main points raised/noted in discussion:

a. In relation to the “test and learn” pilots to be run in 2016/17, there was strong support for being ambitious about taking forward social prescribing, which could have a real impact in terms of addressing social isolation and loneliness experienced by many people. The importance of this should be made more explicit within the plan.
b. It would be important to encourage further and improved working across organisations, including more joint training and co-learning.
c. It would be important to consider the specific areas where the Board itself could “add value” and emphasis, over and above the action and activities to be taken forward by the respective organisations under the plan. This could potentially include championing social prescribing.
d. It would be important to learn from, and compare progress with other comparators in taking forward the plan. Moving forwards, in terms of performance data/metrics, meaningful and comprehensible monitoring information should be presented to the Board.

RESOLVED:

1. **That the Board notes and supports the progress in developing a refreshed vision for Better Care.**

2. **That, noting the 3 May deadline for submission of the Better Care Fund Plan and template 2016-17, authority be delegated to the Chief Officer, Bristol CCG and to the Strategic Director - People, BCC to approve the final submission to NHS England.**

3. **That the updated version of the final plan be submitted to the Board for their information at their 22 June 2016 meeting**

4. **That the proposed Section 75 agreement be received at the 22 June 2016 meeting of the Board, for final approval prior to submission to NHS England by 30 June 2016.**

9. INTEGRATED PERSONAL COMMISSIONING – SOUTH WEST PROGRAMME

(agenda item 9)

The Board considered a report providing an update on the Integrated Personal Commissioning (IPC) programme, to enable the Board to understand the aims of the programme and how this aligned with local IPC plans.

The Board viewed a short "case study" film showing the impact of a personal health budget on an individual.

Frances Tippett presented the report, with reference to an accompanying presentation.

Key points highlighted included:

a. The overriding aim of the programme was to give people choice and control over their care, and make this more widespread.
b. The IPC model aimed to be a delivery vehicle for personalisation and comprised:
    - a care model: person-led integrated care planning, with an optional personal health or integrated budget.
    - a financial model: an integrated "year of care" capitated payment model.
c. The South West IPC programme was one of 9 demonstrator sites nationally, bringing together local government, NHS, and the voluntary and community sector to work differently to support people with complex care needs. IPC aimed to use person led approaches, with the option of a personal budget to integrate support for people.

d. The programme was starting with small scale implementation across the region, testing and learning in different settings. 51 local implementation sites had been identified, and 11 had already started.
e. A governance framework, and 3 workstreams (right skills; person led care and support; finance and commissioning) were in place.
f. In terms of the Bristol perspective, a strong partnership was in place across the CCG, Council, and voluntary and community sector organisations, with bi-monthly meetings involving IPC partners. There was an opportunity to build on this, aiming for further integration across organisations.
g. Challenges and barriers regarding the programme included:
    - Moving personal health budgets and integrated budgets beyond Continuing Healthcare (adults) and Continuing Care (children and young people).
    - Getting the money to follow the individual (much of the relevant NHS money was tied into "block" contracting arrangements).
    - Developing a broader culture of personalisation and integration across all organisations, including providers.

Main points raised/noted in discussion:
a. It was noted that housing costs could form a very practical issue for some individuals, although there was nothing to prevent an element of a personal health budget being used to help meet housing costs.
b. Each person's plan was developed on an individual basis, and might sometimes involve the "employment" of close family members. In all cases, a contingency plan and budget also needed to be in place. Carers would also be closely involved in the development of plans.
c. It would be important to scale up the ambition for this agenda in Bristol, recognising that this approach has already been developed locally in health and social care. It would be important to make linkages with the work that had already taken place and avoid two separate systems being in place.

RESOLVED:
That the report and the above information/comments be noted.

10. OTHER BUSINESS
(agenda item 10)

a. LGA innovation award - most effective Health and Wellbeing Board: Bristol had received a "highly commended" rating.
b. It was noted that a vision document: "Working together – a joint vision for health and social care in Bristol, North Somerset and South Gloucestershire" had been emailed for information to all Board members.
c. Callington Road bus link – officers would check the position in relation to whether this bus service had been re-instated.

The meeting finished at 4.03 p.m.

Chair

BRISTOL CITY COUNCIL
HEALTH AND WELLBEING BOARD
22ND JUNE 2016

REPORT TITLE: Commissioning of Out of Hours Home Care Services

Ward(s) affected by this report: Citywide

Strategic Director: **John Readman / Strategic Director – People**

Report author: (Adults) **Leon Goddard / Service Manager – Joint Commissioning**

Contact telephone no. & e-mail address: **0117 9036158**
leon.goddard@bristol.gov.uk

Purpose of the report:

To seek approval to change the way Bristol City Council commissions 'Out of Hours' Home Care Services.

Please note: Out of hours home care relates to any home care that is delivered to a person from 22.00 – 07.00. These services need to be arranged and delivered in a different way from home care services during the day, which is why the Council commissions a specific out of hours service.

RECOMMENDATION for the Mayor's approval:

1. Approve the re-commissioning of out of hours home care provision, on the basis of the model and approach set out in this report.

2. Approve the inclusion of the planned long term out of hours care currently delivered by BCC staff, within the scope of the new contracts and commissioning model

3. Delegate authority to Strategic Director – People to agree the detailed commissioning model

4. Delegate authority to Strategic Director – People and Section 151 Officer to award contracts to the home care providers who are successful in this tender process

The proposal:

1. Current Situation

1.1 'Out of hours home care service' describes the provision of care and support services to people over 18 years old in their home between 22.00 – 07.00. This service operates every night of the year.

1.2 On May 1st 2016, the council commissioned a total of 48.25 hours of care for 112 people. These figures fluctuate from week to week, but are relatively constant and so the snapshot taken on this date provides an accurate indication of the level of provision.

1.3 The type and level of care a person will receive varies as it is specific to their needs and situation. Here are two typical examples that illustrate the lower and higher end of provision.

1.3.1 Low – A person leaves hospital and receives a single visit each night to check on their health and wellbeing. This may occur a few nights per week, or for a few consecutive nights and then end as the person no longer requires this check.

1.3.2 High – A person has a long term condition that means they are unable to meet their own medication, personal care or personal hygiene needs. They could receive 2 visits per night (e.g. midnight and 04.00) to help them go to the toilet, ensure they are hydrated and administer medication. This person is very likely to also receive a significant level of care during the day.

1.4 The council currently commissions out of hours home care services in Bristol from:

1.4.1 Kumari – An independent home care organisation

1.4.2 BCC in house team – A team of staff employed directly by the council

1.5 Table 1: Current level and costs of service provision

	Kumari	**BCC***	**Total**
Daily number of SUs	98	14	112
Daily number of hours	44	4.25	48.25
Annual cost of service	£446,468	£65,229	£511,697
Unit cost per hour of service	£27.80	£42.05	£29.06

*Specifically relates to planned, long term care

2. Scope of this report and recommendations

2.1 The new commissioning arrangements cover the provision of all planned, long term out of hours home care that is commissioned by the council.

2.2 This includes all of the service provided by Kumari. This service is covered by a short term contract, which included the provision for this arrangement to continue past the official end date on the same terms. This date has passed and either party can now bring the arrangement to an end by giving the other party 3 months' notice.

2.3 The situation with the BCC in house team is more complex as the team that deliver long term planned out of hours care also deliver other similar, but different, home care services. This is further complicated because many staff within the team deliver both planned long term out of hours and other types of services as part of their job.

2.4 The services that are delivered by the BCC in house that are deemed out of scope are those which are delivered to people in their own home in the following circumstances:

2.4.1 In an emergency and for a short period

2.4.2 As part of a reablement package. This is delivered by the Reablement Service and for a short period (maximum of 6 weeks)

2.4.3 Other scenarios where short term and / or unplanned care is required

2.5 Any reference to 'BCC in house service' specifically refers to the planned, long term care and excludes the services listed in 2.4.

2.6 Excluding the team leader, 20 people work in the team with a total of 13 FTE. The percentage of the team's time (excluding the team leader) that is spent delivering services that are in scope of this report is 17.4%. This equates to £65,229 of the total projected FY16/17 cost of the in-house team and in staff terms, equals 2.3 FTE.

2.7 The total percentage of team time (excluding the team leader) spent delivering service that are out of scope is 82.6%. This equates to 11.7 FTE.

2.8 If recommendation 1 and 2 are approved, the commissioning exercise and future contracts will include all services provided by Kumari and the in scope services provided by the BCC in house team.

2.9 If recommendation 1 is approved, but recommendation 2 is not, the commissioning exercise and future contracts will only include the services currently delivered by Kumari.

2.10 The council currently delivers or commissions various out of hours services, most of which have nothing to do with home care. Prior to the start of any tender process for out of hours home care services a review of these other out of hours services will be undertaken to see if there are any benefits of commissioning some of these services together.

3. Approach to commissioning adult care and support services

3.1 In recent years there have been significant changes in the area of adult social care services. These include, but are not limited to; the introduction of the Care Act 2014, demographic changes, budget pressures and difficulties recruiting and retaining care staff.

3.2 In many areas of social care service provision, the council has chosen to make changes to how it commissions these services to ensure we can secure the right type, level and quality of service provision for vulnerable people. The proposed changes to out of hours home care is just one example of this. Many of the challenges are the same, regardless of the specific service being re-commissioned and so the People Directorate has developed an approach to re-commissioning services that draws upon best practice and knowledge of the local care environment to create a clear, transparent and consistent approach. The key features of this approach are:

3.2.1 Transparent and robust tender process – This process follows best practice and all EU regulations. It ensures that for each area where services are re-commissioned, once the tender is completed, the council will only work with providers that have demonstrated they meet the standards the council, and the people that receive the services, require.

3.2.2 Outcomes Focus – In the past, social care services been commissioned in a way that requires providers to deliver a specific service at a specific time. This approach will continue, but in addition to this, providers will be required to deliver services in a way that supports people to achieve the outcomes that are most important to them. These outcomes are set by the service users and reflect what is achievable and best supports them to live the lifestyle they want. An outcome could be; being able to get themselves out of bed, being able to attend a local social group, or finding employment.

3.2.3 Contractual arrangements – Once a tender process is completed, the providers the council works with will have long term contracts that provide clarity and stability. Providers should incorporate this stability into their long term planning and service delivery

3.2.4 Value for money – All care services will be commissioned in a way that makes best use of scarce resources. This does not mean buying the cheapest, but buying the right services, in the right way at the right price. For instance, home care contracts have recently been commissioned in a way that means providers have volunteered to pay all of their staff at or above the living wage foundation wage of £7.85, whilst also reducing the amount they charge the council.

4. Proposed Commissioning Model

4.1 If this report is approved, the council will undertake a formal tender process for the award of two separate out of hours contracts:

4.1.1 South Bristol – Contract for the delivery of all home care in zones 1, 2, 3, 4, 5, 6
North Bristol – Contract for the delivery of all home care in zones 7, 8, 9, 10, 11

(See Appendix 1 for a map of the home care zones)

4.2 Key features of the proposed service deliver model are:

4.2.1 A provider will only be awarded one contract – either the South or the North.

4.2.2 No provider will be awarded both contracts.

4.2.3 The council will set price parameters. Bids will only be accepted if the rate offered by the provider sits within these price parameters. This approach gives certainty to the council about the cost of this service.

4.2.4 All services currently delivered by Kumari and the BCC in house team will transfer to the new providers. This transfer will begin soon after the contracts begin and will be done in a safe and planned way that minimises the disruption for service users.

4.2.5 From the contract start date, any person that needs an out of hours home care service will receive this from the provider that has the contract for the part of the city in which they live.

4.3 All aspects of the new commissioning model, contracts, service specification and quality and performance requirements, will be the same as those for the delivery of daytime home care services. Any exceptions will be minimal and only where absolutely required.

4.4 If these changes to the current commissioning arrangements are implemented, it is expected to lead to:

4.4.1 Easier access to services – The new contract will require providers to flex their capacity to meet the council's demand for the type and level of service provision

4.4.2 Improved quality of services – The tender will require providers to demonstrate how well they recruit and train staff, the terms and conditions they offer and the impact this has on service quality.

4.4.3 People being more independent and having less need for these services – The new providers will be required to deliver services in a way that proactively supports people to become more independent and have a reduced reliance on these services.

4.4.4 Greater predictability and security of service provision – The new arrangements will offer long term contracts, with clear requirements of care providers. Two external providers will be commissioned and be required to offer contingency cover for each other, if required.

4.4.5 Reduced cost of the service – Services will be commissioned in a way that allows providers to operate more efficiently (e.g. reduced travel time) to deliver services of higher quality and lower cost than at present.

4.5 The key outcome from the consultation (see section 7 of this report) was a consensus on the importance of flexibility, reliability and predictability in the way home care services are commissioned and delivered. There are some very direct connections between these features and the improvements the council is proposing in this report, which are:

4.5.1 Flexibility – Providers are required to use their provision in a way that best meets people needs and requirements. This relates to how they can flexibly use their staff to allow them to take on care for more people and to make any changes (sometimes at short notice) required by the service user.

4.5.2 Reliability – The council will issue long term contracts to two providers to bring reliability to care providers. In the council's experience, providers pass on this commitment to their staff through better contractual terms and conditions, which encourages people to remain committed to the organisation. This will minimise the number of changes to a person's care (either through short term absence or staff leaving) and avoid the significant concern and disruption this can cause.

4.5.3 Predictability – People told us that they just want things to happen how and when they expect. We have split the city into two service delivery areas to reduce travel time and minimise the disruption this can bring, even at night. The impact of this, and some of the measures aimed at improving reliability, is that people who require care will receive this from the person they are expecting, who will arrive when they are expected and will deliver the care that is required.

5. Finance

5.1 If recommendations 1 and 2 of this report are approved, the current commissioning arrangements will be replaced by two long term contracts to ensure these services are delivered in the most effective and efficient way, providing high quality and value for money home care services. This will also create long term financial sustainability in the purchasing of these services.

5.2 The financial benefits of the proposed model are:

5.2.1 Completion of the shift from the council delivering these services at a high unit cost, to the council commissioning independent organisations to deliver these services at a much lower cost.

5.2.2 Reducing the risk of the council needing to enter into emergency arrangements for the provision of these services, which would be necessary if Kumari were to withdraw from their short term contract

5.2.3 Creating the possibility of paying a lower rate than currently charged by Kumari

5.2.4 Creating the possibility of lower demand for these services

5.2.5 Increasing the availability of these services, avoiding the need for people to receive alternative care (e.g. live in a care home) that is not appropriate to their needs or cost effective to the council.

Table 2: Total cost of Out of hours Service

	2014/15	**2015/16**	**2016/17**
BCC in house	£806,342	£462,700*	£65,229
Kumari	£74,504	£285,395	£446,468
Total	£880,846	£748,095	£511,697

*includes in house spend on out of scope services

5.3 Here is further explanation of the information provided in Table 2:

5.3.1 2014/15 – The vast majority of the out of hours home care was delivered by the council's in house team, with a small amount by Kumari. The total annual cost was £880,846.

5.3.2 2015/16 – The total cost of the service reduced as a significant amount was being delivered by Kumari (at a lower unit cost than that delivered by BCC staff). This change was largely as a result of a transfer of services from BCC to Kumari

5.3.3 2016/17 – The total cost further reduces as the proportion of the total service delivered by Kumari further increases. During 16/17 there has not been any transfer of service users, but all new service users are taken on by Kumari.

6. Options and impact

6.1 There are 3 different options for the future commissioning arrangements of the out of hours home care service. These options will now be described, with reference to recommendations at the start of this report and the expected impact of each option.

Option 1 – The recommendations in this report are not approved and no changes are made to the current commissioning arrangements.

6.2 In terms of service quality, none of the benefits of re-commissioning that are set out in section 4.4 will be achieved.

6.3 In the short term, these services will continue to be delivered by two providers (BCC and Kumari), that operate differently to each other and to how the council would ideally want these services to be delivered in future. The changes the council wishes to make, mark such a change from the current arrangements that this could only be done as the result of a full tender process to select the providers best able to deliver the new service model and the implementation of a new contract with the appropriate incentives and requirements.

6.4 It is unclear what will happen in the long term as this will depend on if Kumari choose to withdraw from their contract. If they do, the council would have to arrange out of hours care for approximately 100 people at very short notice, whilst it secures a long term solution.

6.5 The cost of this service would not fall and the council does not have the option to achieve further financial savings through:

6.5.1 Cost avoidance as more home care is available to more people

6.5.2 Demand reductions as people live more independently and require less home care

6.5.3 Price reductions as a commissioning exercise could result in the council paying a lower rate than at present.

Option 2 – Recommendation 1 is approved, but recommendation 2 is not. The council re-commissions the Kumari provision, but not the BCC in house provision

6.6 The services currently provided by Kumari would be commissioned from two providers, one for the north of Bristol and one for the South. This will secure the provision of services for existing service users and create additional capacity for new service users.

6.7 This option would also allow the council to commission services according to a contract and service specification that emphasises individual service user outcomes and requires providers to develop services focussed on maximising people's independence as far as possible.

6.8 Under this option, there would continue to be some services delivered by the BCC in house team. This would create a mixed approach with two providers operating under one contract and an internal provider operating in a different way.

6.9 This option would also forgo the significant part of the savings potential, as we would continue to pay the relatively high unit cost of the in house services (£42.05 per hour) and not the market rate that would be achieved through re-commissioning these services (£27.80 or below).

6.10 This option could lead to a reduction in the annual cost of the service currently provided by Kumari. If this option were agreed and implemented, the future unit cost for the part of the service currently delivered by Kumari is expected to be no higher than £27.80 (the current Kumari cost) and could be as low as £25.02 (10% less than the current Kumari cost). This would lead to an annual saving of between £0 and £44,646.

6.11 The cost of the BCC in house service would not be affected by this change and so would remain at £42.05.

Option 3 – Recommendations 1 and 2 are approved. The council re-commissions the whole of the planned long term out of hours home care service

6.12 This would lead to a single commissioning model, with two providers delivering all long term planned out of hours services in the same way as each other and that required by the council to maximise the benefits set out in section 4.4 and throughout this report.

6.13 This option could lead to a reduction in the annual cost of the service currently provided by Kumari and would lead to a decrease in the unit cost of the service currently provided by BCC.

6.14 The future unit cost of the whole service is expected to be no higher than £27.80 (the current Kumari cost) and could be as low as £25.02 (10% less than the current Kumari cost).

6.14.1 The annual saving on the element of the service currently delivered by Kumari would be between £0 (the same as the current unit cost) and £44,646 (10% less than their current unit cost).

6.14.2 The annual saving on the element of the service currently provided by BCC in house service would be between £39,137 (34% less than their current unit) and £43,051 (40% less than their current unit cost).

It is recommended that option 3 is approved.

7. Consultation and scrutiny input:

7.1 Over the last few years the council has been designing and implementing a home care strategy to improve the way that all different types of home care are delivered. This process began in 2013 and in 2014 a significant consultation exercise was undertaken that looked at all aspects of home care. The findings of this consultation have been used to influence the changes to different elements of home care services (one of which is out of hours care).

7.2 This consultation also obtained the views of key stakeholders (Members, health colleagues etc) and the focus of this work was to establish requirements of these services that were most important to the people that received them. The consultation then moved on to understanding how the services had to be commissioned, arranged and delivered in order to meet these requirements.

7.3 It was decided to undertake a single, wide ranging and comprehensive consultation exercise. This was to ensure that all aspects of the home care strategy could be discussed and designed together and to avoid repeatedly asking the same questions of the same people for each element of the home care commissioning arrangements.

Internal consultation

7.4 Elected Members: Consultation has taken the form of discussions with the Assistant Mayor, attendance at the relevant Scrutiny Commission and briefings for all Members.

7.5 Staff: DLT (People) and other key managers have been kept informed of the changes being planned for the commissioning of home care services. This message has been provided through regular staff communication channels (e.g. The Source) and specific engagement sessions have taken place with key staff in the People Directorate, especially those directly involved in assessing service user's needs and arranging services on their behalf (e.g. Care Management Team Managers).

7.6 During the formal 12 week consultation period, 3 separate events were held across Bristol. In total, over 100 council staff provided direct contributions to inform the home care commissioning arrangements, mainly from those people working most closely with service users.

External consultation

7.7 During the consultation and in the lead up to the production of this report, events were held for service users, carers, and members of the public. This included 13 specific consultation events held for these groups across Bristol. Most of these took place at Extra Care Housing Schemes and Sheltered Accommodation venues, to ensure the environment was local, appropriate and accessible to those wishing to attend. These events shared key information with the people that will be affected by these proposals and obtained detailed and useful feedback from them about the council's plans and their thoughts on what should happen. In addition, the proposals have also been shared and discussed with Partnership Boards, VOSCUR, The Care Forum, Bristol Older Peoples Forum, and the Quarterly meeting of The Supported Housing for Older People.

7.8 There was awareness raising across the city at the time of the consultation, which focussed on what the proposals were and how people could provide their feedback. This was done through press releases, 'Ask Bristol' e-bulletin, Health Watch, WellAware, Facebook / Twitter, 'Our City' newsletter and a local radio broadcast. Posters promoting

the consultation were displayed across the city in council offices, GP surgeries and libraries. Copies of the feedback survey have been distributed at libraries and by staff in the People Directorate.

7.9 The council also produced a survey to obtain direct feedback from service users and carers about the proposals. Service users were given the opportunity to send a written response by post / email, complete this over the telephone or on-line. Service users were also given the opportunity to complete this in their own home with a member of council staff, their care worker or a member of a specialist dementia organisation. There were separate surveys for i) service users and carers, ii) employees of care providers, iii) council staff and iv) other interested parties and member of the public. In total, 100 surveys have been completed by service user and carers.

7.10 There has been direct contact with care providers in relation to these proposals, through individual discussions and Home Care Provider Forum meetings.

Results of the Consultation

7.11 Key themes from service users

Theme	**Response**
Flexibility	Most service users stated a need for a service they can rely on. Flexibility is nice to have but would be secondary to reliability.
Reliability	Very important to service users to get their service when they expect to receive it, and where this can't be the case, they must be informed.
Predictability	Service users like to have consistent staff who know how things must be done.

7.12 Key themes from family, friend or carer of someone that receives home care

Theme	**Response**
Flexibility	Some carers expressed that they would like more flexibility in the short term, but most expressed that they want a service that is reliable and fits in with other aspects of their life.
Reliability	This is very important to carers, particularly where the service user has an impairment such as dementia and may not be able to identify and raise problems. E.g. care worker hasn't arrived or hasn't completed certain tasks.
Predictability	For carers it is important to have a service that is predictable. This allows them to plan their own life around the service and also gives them trust that when they are not present, things will still be done properly.

8. Risk management / assessment:

FIGURE 1

The risks associated with the implementation of the *(subject) decision* :

No.	RISK	INHERENT RISK (Before controls)		RISK CONTROL MEASURES	CURRENT RISK (After controls)		RISK OWNER
	Threat to achievement of the key objectives of the report	Impact	Probability	Mitigation (ie controls) and Evaluation (ie effectiveness of mitigation).	Impact	Probability	
1	Potential for the price paid for these services to remain stable,	**High**	**Medium**	Price parameters included in tender	**High**	**Low**	LG

	or even increase. This will impact on overall savings.						
2	Low engagement from the market and few if any provides for these contracts This may mean the council cannot re-commission these services	**High**	**Medium**	There has been and will continue to be significant discussions with providers about the key elements of the home care commissioning arrangements. These are well understood and have attracted interest from many providers wishing to be involved.	**High**	**Low**	LG

FIGURE 2

The risks associated with <u>not</u> implementing the *(subject) decision*:

No.	RISK	INHERENT RISK (Before controls)		RISK CONTROL MEASURES	CURRENT RISK (After controls)		RISK OWNER
	Threat to achievement of the key objectives of the report	Impact	Probability	Mitigation (ie controls) and Evaluation (ie effectiveness of	Impact	Probability	
1	Inconsistent service quality. There would be no way of addressing this situation under the current arrangements	**Medium**	**High**	Apply full quality assurance process to both in-house and external provision. Work with Kumari to establish standards	**High**	**Medium**	LG
2	Lack of formal contractual relationship may impact level of care currently provided externally and may result in increased prices	**High**	**Medium**	Market engagement. Negotiate stable rate and contract full, current provision with Kumari	**Medium**	**Medium**	LG

9. Public sector equality duties:

Public sector equality implications:

9.1 A full Equality Impact Assessment was carried out as part of the overall changes to home care services and is attached as an appendix to this report.

10. Eco impact assessment

10.1 A full Eco Impact Assessment was carried out as part of the overall changes to home care services and is attached as an appendix to this report.

11. Resource and legal implications:

Finance

Financial (revenue) implications:

11.1 The savings in the report are a combination of 2015/16 delivered savings (£369k) and 2016/17 projected savings. Total project benefits are estimated at £435k which is within the savings range identified for this project of between £268k to £536k.

11.2 In order to deliver the savings it is essential that current staff within this service are redeployed into other roles to reduce the internal spend.

11.3 Assuming staff are redeployed, the award of contracts for this service is within current budget and provides a budget saving which is not part of the current medium term financial plan.

Advice given by: **Michael Pilcher, Finance Business Partner (People Directorate)**
Date: **17th May 2016**

Financial (capital) implications:

11.4 There are no capital finance implications as a result of the recommendations in the report.

Advice given by: **Michael Pilcher, Finance Business Partner (People Directorate)**
Date: **17th May 2016**

Comments from the Corporate Capital Programme Board:

Legal implications:

11.5 The reports recommendations are lawful.

Procurement

11.6 Home care services are 'light touch' services for the purposes of the Public Contracts Regulations 2015 and will not be subject to the full European procurement regime. The tendering exercise must however still comply with the general obligations regarding fairness and transparency. Procedures will also need to comply with the Council's own procurement rules, which include a requirement for a formal tendering exercise.

TUPE

11.7 There may be TUPE issues in connection with any change in service provider for the services currently delivered by Kumari, which will need to be factored into the procurement process.

11.8 TUPE may also apply if the Council's in-house service is transferred to an external provider. The Council should ensure that it complies with its obligations to inform and consult with affected employees. If TUPE does apply the Council must ensure that appropriate pension provision is in place for the transferring employees at the start of the new contract.

11.9 If staff working on the in-house service are to be redeployed within the Council or offered voluntary severance this may increase the costs to the service in the first year of the new contract.

Public Sector Equality Duty

11.10 In deciding whether to approve the proposals, the Cabinet must have due regard to the public sector equality duty, that is to the need to advance equality of opportunity between persons with "protected characteristics" and others. "Protected characteristics"

are defined by the Equality Act 2010 and the effect of the proposals on people with protected characteristics is explained in the equality impact assessment attached to this report.

Consultation

11.11 The Council is required to make fair and reasonable decisions. To ensure a decision is fair, the Council must consult with those affected. Principles of proper consultation have been developed through case law and can be summarised as follows:

11.11.1 It must consider carefully who should be consulted and how (linked to those who are potentially affected by the decision and should include those who are likely to support the proposals as well as those who are likely to object);

11.11.2 Consultation must be at a time when proposals are still at a formative stage;

11.11.3 Sufficient reasons must be given for any proposal to enable intelligent consideration and response;

11.11.4 Adequate time must be given for consideration and response;

11.11.5 The product of consultation must be conscientiously taken into account in finalising any proposals.

11.11.6 Internal and external consultation has taken place as set out at section 4 of this report. The consultation undertaken has had due regard and is broadly compliant with principles set out above.

Advice given by: **Kate Fryer, Solicitor**
Date: **14th June 2016**

Land / property implications:

11.12 N/A

Human resources implications:

11.13 An in-house team currently provides out of hours care (amongst other out-of-scope out of hours services) to 14 service users totalling around 4 hours per night of delivered care. As it is recommended that out of hours provision is re-commissioned to an external provider, the provisions of TUPE will apply. However, Bristol City Council is working to either minimise or eliminate the impact of TUPE through Voluntary Severance or other measures.

Advice given by **Alex Holly, HR Business Partner (Business Change)**
Date **17th May 2016**

12. Appendices:

Appendix 1 – Map of zones (separate attachment)
Appendix 2 – Equalities Impact Assessment (provided below)
Appendix 3 – Eco Impact Assessment (provided below)

Ward Zone Boundaries

bristol.gov.uk/wardfinder

BRISTOL CITY COUNCIL

Avonmouth
11
Kingsweston
Henbury
10
Westbury-on-Trym
Southmead
Horfield
8
Henleaze
Lockleaze
Stoke Bishop
Bishopston
Redland
Eastville
Frome Vale
7
Hillfields
Cotham
9
Clifton East
Ashley
Easton
St George West
5
6
Clifton
Cabot
Lawrence Hill
St George East
Southville
4
Windmill Hill
1
Brislington East
Bedminster
Knowle
Brislington West
Filwood
Bishopsworth
Hartcliffe
3
Hengrove
2
Stockwood
Whitchurch Park

Corporate GIS Support team Job No 13-055

Appendix 2 – Bristol City Council Equality Impact Assessment
(Please refer to the Equality Impact Assessment guidance when completing this form)

Name of proposal	Commissioning of Out of Hours Home Care Services
Directorate and Service Area	People
Name of Lead Officer	Leon Goddard

Step 1: What is the proposal?

1.1 What is the proposal?
Out of hours home care relates to the care and support services delivered to people over 18 years old in their home between 22.00 – 07.00. This service operates every night of the year. As of May 1st 2016, the council commissioned a total of 44.25 hours of care every night 309.75 hours per week for 112 people. The figures taken on this date provide a snapshot, but the numbers are relatively constant over time. The type of care people receive varies as it is specific to their needs and situation. At the low end it would be a 15 minute visit a few nights per week to check on a person's wellbeing (typically for a short period soon after they leave hospital). At the high end it would be 2 x 30 minute visits every night around midnight and 04.00 to tend to their personal care and hygiene needs. Following a Care Management assessment from Health and Social Care to identify the outcomes that are important to the service user, providers will work with the service user to put together and work towards delivering an Outcomes Based Support Plan. Each individualised Support Plan will focus on the outcomes for the service user and will draw on the Providers' expertise to establish what steps need to be taken to achieve these outcomes and how can be done to reflect the service user's needs, circumstances and lifestyle. By providing care and support in this way, it is expected that more service users will be helped to live as independently as possible. Two providers will be commissioned to deliver out of hours care within the city; each provider will be responsible for one half of the city (known as the North and South 'Zones'). This model will replace the current single provider model which applies to commissioned out of hours care packages. **Summary of potential positive impacts:** Contributing to the home care market that places great emphasis on the quality of care and promoting independence presents an opportunity to ensure that service users from all equalities communities, and groups with protected characteristics, are able to access high quality and appropriate care and support.

Recognising that there will be times when service user will want choice and may have needs that are best met by an alternative provider, service users will always have the option to choose to take a direct payment.

Summary of potential adverse impacts

There is a risk that the services offered by the two chosen OOH Providers do not meet the needs or requirements of certain equalities groups. This would occur if the skills, competence and profile of staff are not aligned with the demand for services.
As with any proposal to implement change, this must reflect the views of people that are affected by the service. There would be potential for a negative impact if there was insufficient or inappropriate engagement and consultation with the groups and individuals most likely to be affected by these proposals.

Step 2: What information do we have?

2.1 What data or evidence is there which tells us who is, or could be affected?

The following Equality Data is taken from Controcc figures covering age, gender, disability and ethnicity, and are a true reflection of out of hours service users as at March 2016.

Out of Hours

Gender:

The table below shows a breakdown by percentage of the total number of men and women that received out of hours care, split by age banding. 61% of service users are women and 39% are men.

Age Group	Male	Female
Under 50	2%	2%
50-64	2%	5.5%
65-74	4.5%	8%
75-84	18%	18%
85+	12%	28%

Age Group	Male	Female
20-49	50%	50%
50-64	29%	71%
65-74	34%	64%
75-84	50%	50%
85+	30%	70%

The above table shows a breakdown in percentage of the number of male and female Bristol residents from the ages of 18 – 85+.

The two tables above highlight the over representation of women using out of hours home care, as the population figures from the 2011 ONS survey show a fairly consistent divide between men and women, although the proportions of women in older age groups in the Bristol population are higher than men.

Ethnicity:

Of all out of hours service users:
90.3% are White and 9.7% are BME
Of the BME service users;
4.3% are Black
1.1% are Indian
1.1% are Eastern European
3.2% are from other BME groups

Based on available 2011/2012 Census data, we are able to tell that the BME population in Bristol has increased from 8.2% to 16% (22% if we include White other which would include the Eastern European population). The age profile of most BME communities is younger than that of the White British Community. The exception to this generalisation is the African Caribbean community where a majority of Bristolians are aged over 40 rather than under 40 years old. The age profile of most service users for this service is nearly 90% of service users are over 65 years old. Therefore it is not a matter of concern that only 10% of service users are BME as this matches the ethnic composition of over 65s in Bristol.

The table below shows percentages of BME service users split by age.

BME by age	All Service Users	BME
Under 50	4.3%	2.2%
50-64	7.5%	0%
65-74	11.8%	0%
75-84	36.6%	5.3%
85 Plus	39.8%	2.2%

Disability:

Of all out of hours service users:
85% have a physical or sensory impairment, are frail or have dementia
13% have a Mental Health need
2% have a learning disability

54% of the over 60 population in Bristol are disabled. Services provided by Health and Social Care are predominantly for people with limiting long term conditions or a disability and therefore we cannot compare with the general population.

Sexual Orientation:

Of all home care service users:
72% are Heterosexual
28% preferred not to state their sexual orientation or were uncertain
There has been a year on year increase in the number of service users identifying as LGB since the Health and Social Care department started collecting this data but less than 1% of people have identified as being LGB. Stonewall estimates that 1 million people over 55 years old in Bristol are lesbian, gay or bisexual. Out of hours services

will need to provide services for people who are in same sex relationships and have good relationships with LGB primary carers for whom the OOH service is offering respite

Religion:

Of all service users:
67.7% are Christian
8.6% are Christian-Roman Catholic
13% have no stated religion
10.7% are Jewish, Sikh, Muslim or Other

It should be noted that the data above on religion is taken from our financial records and so indicates the profile of service users.

Of the Bristol population:
62% are Christian
2% are Muslim
0.5% are Hindu and Sikh
0.2% are Jewish

Information taken from
http://www.bristol.gov.uk/page/council-and-democracy/census-2011

These figures indicate that people of faith are over represented amongst service users which is commensurate with the older age of the service user group.

2.2 Who is missing? Are there any gaps in the data?

There are gaps in the in-house service user data as this is not currently recorded on our financial records. Data relating to the 14 service users currently receiving in-house provided out of hours care will be obtained from relevant service user care plans ahead of the tender process, however there are gaps where some of the information is not recorded.

2.3 How have we involved, or will we involve, communities and groups that could be affected?

Consultation events for home care services took place throughout Bristol. Some questions related to the out of hours service and most recommendations are relevant for day time and nigh time services.

Venues for the consultation were chosen because of their geographical location and for accessibility. The table below lists the events. The consultation was advertised using a variety of media channels (e.g. BCC website) and more traditional methods (e.g. posters were sent to 27 libraries and many GP surgeries) to ensure that all service users and key people were aware of what was happening.

The table below details the various communication channels that were used to promote the Consultation.

Description	**Information**
All Bristol City Council Public	Posters and Surveys

Libraries	
GP Surgeries	Posters
Phone Calls to existing Service Users	A randomised list of Service Users in receipt of Home Care were contacted by telephone and provided with the opportunity to complete the survey over the telephone.
Mobile Libraries Outreach Worker	Surveys delivered directly to Service Users
Survey distribution	Surveys distributed through several community groups and by request
Attendance at various groups	Meeting slots were booked at a variety of community groups such as Bristol Older Peoples Forum, VOSCUR and Partnership Boards
Email Communication	Email to all known Equalities Groups
	Email to all Providers
	Email to all Care Traders signed up to Proactis Trading Portal
	Email to all Social Care and Health Staff
Ask Bristol	Online Survey emailed out in Ask Bristol newsletter (8000 readers)
Bristol City Council Website	Promotion slot on main BCC webpage
Our City Newsletter	News story within News letter
Radio News story	News story and interview on Jack FM Bristol and Silver Sounds.

Surveys were made available online and in paper format. Surveys were also produced on an audio CD, large print and were available in different languages. Interpreters were also booked for specific events.

Feedback.

All Equalities Groups with connections to Bristol City Council were contacted and invited to the Consultation events surrounding home care services and offered the opportunity for a Bristol City Council employee involved in these proposals to come to meet with them. Events were organised by request and an event was set up specifically for the South Asian Community, using a paid interpreter. The table below shows all of the comments made by the South Asian Community Group and other equalities related feedback.

The Consultation results have been analysed and the results were previously shared on the Better Home Care for Bristol Consultation page in the format of “You Said, We Did” ahead of the Home Care main provider tender launch. This information was shared in poster format in all Bristol City Council Libraries, in all venues where events were held and in an email / letter to anybody who 2registered their interest in the Consultation.

Culturally appropriate food	A request was made that food prepared for South Asian service users was culturally appropriate and it was suggested that care workers could help prepare and produce curries and chapatis from scratch.

Personal Care	Service users from a South Asian Community Event also stated that it was very important to have Personal Care delivered in a culturally sensitive way
Language	Several Service users expressed a wish for their care worker to be able to speak in their preferred language.

Step 3: Who might the proposal impact?

3.1 Does the proposal have any potentially adverse impacts on people with protected characteristics?	
ALL - Not all service users will be able to benefit from an out of hours home care service that focuses on improving or maintaining independence as some may not be able to do this.	However where OOH services are required, the providers need to ensure differential needs can be met. The Proposal may help to bring new opportunities by commissioning Providers who are able to work creatively with Service Users.
Age Providers may not focus on identifying outcomes which they view more suitable for younger Service Users.	Each individualised Support Plan will identify the outcomes needed and providers need to achieve these
Disability Providers may not have necessary expertise to support all disabled Service User's.	Social workers will be encouraged to ensure that the assessment of service users' needs/outcomes is suitable for LD or ASD service users. Providers will need to demonstrate during the tender process that they do have these skills.
Ethnicity Commissioned Providers may fail to provide carers who are able to deliver culturally aware and sensitive care for different ethnic communities. Some ethnic communities may not wish to engage with the provider for their geographic zone. Providers will be asked to deliver an innovative service, which may open up new opportunities for Service User's from different ethnic communities.	Both north and south providers will be required to demonstrate ability to work sensitively towards varying ethnic groups of service users during the tender process. Improvements in the terms and conditions of all out of hours care staff should attract more BME staff.
Gender The proposal may help increase the number of men taking up out of hours homecare services if the focus is on supporting independence instead of relying on care. It is	This would be a positive outcome as it is felt that the reason why men are under-represented is due to a lack of engagement in home care services.

hoped that by creating two Zones, the travel time of staff who are mainly women will be greatly reduced.	The focus on independence is supported by service users from all groups. Improvements in the terms and conditions of all out of hours care staff should attract more male staff.
Religion and belief Through creative and innovative service provision from commissioned Providers, service users may experience increased opportunities to practice and share their religion. Initial assessment informing the service users care plan will address relevant religious beliefs.	Providers will be expected to work with people to understand their lifestyle, circumstances and beliefs, i.e. who they are, to encourage and support them to live the life they want.
Sexual orientation At night time same sex couples will need to be able to be 'out' to home care providers	Successful providers will need to positively promote their services to be gay friendly to ensure LGB people are confident o use the OOH service. Essential awareness and understanding of the LGBT groups in the target population will form part of the service specification.
Carers The focus on Providers delivering support which helps to achieve service user's outcomes may result in improved outcomes for their carers too.	Providers will be required to be more flexible, where possible, than at present and adapt to the needs of the service users and carers.

Step 4: So what?

4.1 How has the equality impact assessment informed or changed the proposal?
The feedback received about the importance of culturally appropriate services will be addressed in the tendering, planning and delivery of services. The tender process will be designed to ensure providers can deliver differentiated services.
4.2 What actions have been identified going forward?
Promote equality of opportunity – Providers need to actively promote their services are welcoming to BME, LGBT and male service users. Eliminate discrimination – There is a need to ensure not only that policies are in place but that these are monitored to ensure no discrimination will take place and that there is a robust mechanism for complaining should discrimination occur. Promote good relations – There is clearly a need to ensure that providers are versed in the diversity of possible service users especially those who may be LGBT and or transgender and that the providers actively seek to promote their services to these communities. This may require Providers to demonstrate what provision they have for on-going training on Equality & Diversity issues are.
4.3 How will the impact of your proposal and actions be measured moving forward?
Clear policies will be expected of commissioned providers who will also be expected to

report against compliance.

Service Director Sign-Off: Mike Hennessey – Service Director (Care and Support – Adults)	Equalities Officer Sign Off: Anne James - Equality and Community Cohesion Team Leader
Date: 17/05/16	Date: 16/05/16

Appendix 3 - Eco Impact Checklist

Title of report: Out of Hours Home Care				
Report author: Leon Goddard				
Anticipated date of key decision 22 June 2016				
Summary of proposals: For BCC to re-commission out of hours home care, appointing one or more external providers to deliver care within two separate, distinct geographic zones within Bristol (North and South).				
Will the proposal impact on...	Yes/ No	+ive or -ive	If Yes…	
			Briefly describe impact	Briefly describe Mitigation measures
Emission of Climate Changing Gases?	Yes	-ive	Travel across the city associated with assessments and service delivery will emit carbon dioxide.	Council social care teams and service providers will produce Travel Plans that incorporate sustainable travel choices and travel reduction strategies. Use of two distinct geographic zones will enable localisation of service provision and reduce travel time.
Bristol's resilience to the effects of climate change?	Yes	+ive	Support and enablement of service users may have a positive impact on the resilience of service users to extreme weather events.	Business continuity needs to be considered, to ensure that the provider(s) are able to travel to deliver the service during extreme weather events, such as flooding.
Consumption of non-renewable resources?	Yes	-ive	Travel across the city associated with assessments and service delivery will use fossil fuels.	See mitigation measures for Emission of Climate Changing Gases.
Production, recycling or disposal of waste	No			
The appearance of the city?	No			
Pollution to land, water, or air?	Yes	-ive	Travel across the city associated with assessments and service delivery will emit pollutants and noise.	See mitigation measures for Emission of Climate Changing Gases.
Wildlife and habitats?	No			

Consulted with:
Summary of impacts and Mitigation - <u>to go into the main Cabinet/ Council Report</u>
This key decision to recommission the out of hours home care service as an outsourced service in two lots does not inherently introduce any significant environmental impacts. Service delivery will require travel around the city, but the hours of operation will mean that there will be minimal impact on traffic congestion, but more potential for noise disruption than during the day. Air quality impacts will be similar to daytime service delivery, since free flowing traffic and fewer people outside is balanced against lower night time wind speeds dispersing the pollution. The use of two geographic zones in the city, pre-planned routes and effective travel plans agreed by the council teams and the service provider(s), should mitigate these impacts by minimising travel distances. Travel distances and the resilience of the service to localised disruption (such as flooding) will depend on number and locations of providers, service recipients, and the modes of transport used. The procurement process and travel plans should include mitigation measures for travel distances, noise, pollution, and the resilience of service delivery in order to mitigate these impacts. The resilience of the vulnerable people they visit and support to extreme weather events may be enhanced, depending on the nature of services provided to individuals. The net environmental impacts are not significant for the proposal to improve service provision, but may be positive for service delivery (compared to existing service delivery), if travel impacts are well mitigated.

Checklist completed by:	
Name:	Leon Goddard / Giles Liddell
Dept.:	Energy Service- Place
Extension:	9224459
Date:	17/05/2016
Verified by Environmental Performance Team	Giles Liddell

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Commissioning Home Improvement Agency and Community Equipment Services	
Author, including organisation	Rob Logan, Service Manager for Contracts & Quality, Bristol City Council
Date of meeting	22 June 2016
Report for Decision	

Ward(s) affected by this report: ALL

Strategic Director: **Strategic Director for People**

Report author: **Rob Logan, Service Manager for Contracts & Quality**

Contact telephone no. & e-mail address: **0117 92 22913**
robert.logan@bristol.gov.uk

Purpose of the report:

To make a Key Decision to initiate a commissioning project for Home Improvement Agency (HIA) and Community Equipment Services.

RECOMMENDATION for the Mayor's approval:

1. **To initiate a commissioning project for Community Equipment Services and Home Improvement Agency (HIA) services, for implementation on 1 October 2018 (the end date of the current Community Equipment contract).**

2. **To make a further Call Off under the existing Framework Agreement in order to maintain the current HIA arrangements to 30 September 2018, in order to allow for a more coordinated procurement process.**

3. **To seek agreement from commissioning partners in the West of England region (such as other local authorities or CCGs) to participate in a joint procurement.**

4. **To delegate the implementation of the formal procurement process and contract award (including any associated collaboration arrangements) to the Service Director of Strategic Commissioning (Bristol City Council).**

1. Executive Summary

1.1. A Framework for commissioning HIA services was procured in 2012. It expires on 24 July 2016

1.2. Any decisions to extend the current services under this Framework must be taken prior to 24 July 2016.

1.3. Bristol City Council (BCC) and Bristol Clinical Commissioning Group (BCCG) recommend that the current service be extended by 23 months, to 30 September 2018, in order to align the procurement of the HIA with the current timescale for procurement of the Community Equipment Service.

1.4. All commissioning partners have been consulted. North Somerset Council and Bath & North East Somerset Council have agreed to the extend the current HIA arrangements to 30 September 2018, provided that BCC and BCCG agree this recommendation.

1.5. A commissioning project will include a number of informal stages, including a substantial period of public consultation and market engagement before a formal procurement process is implemented.

1.6. This report follows an informal report discussed and agreed by the Health and Wellbeing Board on 20 April 2016.

2. Context

2.1. An HIA service is in place, and is delivered by WE Care and Repair, and industrial & provident society based on Bristol and working across the West of England.

2.2. This HIA service delivers a total of 16,000 client interventions per year (the majority in Bristol), which are primarily physical adaptations intended to allow older and disabled people to live independently at home. The types of work delivered include:

- Handyperson
- Technical housing projects
- Hospital discharge projects
- Home Independence and Mobility Support
- Advice and Guidance

2.3. Cabinet in January 2012 agreed to commission the HIA service in a joint procurement involving, at that time, BCC, BCCG (the Bristol Primary Care Trust), NSC, B&NES, South Gloucestershire Council and South Gloucestershire CCG. (The South Gloucestershire agencies subsequently withdrew). WE Care and Repair was appointed, and received a formal contract (a 'call-off' from the Framework) lasting to 31 October 2016 – four years. An additional call-off of 23 months is therefore for a shorter period than the original call-off, and will be implemented at the point when the original call-off would have ended.

2.4. The City Council also has a separate contract in place with the different provider (Medequip) for the provision of Community Equipment Services (CES).

- This service provides physical pieces of equipment that support individuals, often with high or complex needs, to remain at home rather than in a hospital or care home. This includes large items such as specialised beds and chairs, and also smaller items such as commodes.
- This contract runs to 30 September 2018, and was procured jointly with South Gloucestershire Council and South Gloucestershire CCG. Each authority maintained a separate contract, which was procured in a joint process.

3. Opportunities

3.1. There are opportunities for efficiencies and process improvements if the procurement for the HIA and the CES are conducted at the same time and in a coordinated way.

3.2. This does not necessarily mean that the HIA and CES services would be provided by the same organisation. It is at least as likely that the current HIA and CES services could be structured such as they are provided by more than two organisations, depending how many 'lots' are procured, and for which elements of the services.

3.3. A significant period of pre-procurement analysis and consultation is needed to conduct this process safely, for a number of reasons:

- The current outcomes delivered by the services need to be reviewed;
- The range of outcomes sought need to be reviewed, particularly if the relative weight of different parts of the service has changed over time, for instance the balance of Hospital Discharge work, compared with Disabled Facilities Grants;

- The specification of each element in the services need to be developed, tested and consulted on – for instance commissioners have to be clear on which elements must be delivered by the same organisation, and which could be discrete;
- Significant market preparation will be required, such as there is an adequate level of competition, and such that individual organisations, including third sector organisation, have the ability to consider appropriate consortium arrangements where this may be beneficial;
- Contract mobilisation is likely to be significant. In particular, if there is a need to implement new technology and to review legacy equipment catalogues and processes, this may take longer than for simpler procurements.

4. Risks

4.1. Timescale

Once a decision is taken to call-off an extended service, this decision cannot be changed after 24 July 2016.

This means that, at present, BCC and BCCG can decide whether to provide an extension for either one or two years, but would not be possible to extend for one year and then decide to extend for another year – i.e. there will be an absolute deadline by which the procurement must have been completed. This would militate toward a longer rather than a shorter extension.

4.2. Partnerships

BCC and BCCG derive very strong benefits from commissioning jointly with partners, and it is important that these partnerships are maintained.

It is likely that not all partners will want the same range of services – for instance if NSC and B&NES choose a joint procurement with BCC and BCCG for the HIA services, it is possible they may not wish to procure CES services at the same time. This means that the menu of different ‘lots’ needs to be designed with all partners’ needs in mind.

It is also likely that South Gloucestershire colleagues may wish to collaborate with BCC and BCCG over the procurement of the CES service, but may wish not to be involved in the procurement of the HIA. This equally means that the offer for procurement options for the CES needs to reflect all partners’ views.

In 2012 an Inter-Authority Agreement (IAA) was established between the contracting authorities and remains in place. A similar IAA will be

needed to regulate the relationship between each public body.

5. Consultation and scrutiny input

5.1. HWB considered an earlier version of this report on 20 April.

5.2. Local authorities and CCGs from elsewhere in the West of England have been consulted, and it is anticipated that they will join a joint procurement process. It is envisaged that a Framework procurement will allow each commissioning body to procure the approach package of support for their needs – i.e. the level and type of services is likely to differ to some extend between Council/CCG area.

5.3. Scrutiny will be a key participant in future discussion of a future commissioning model.

6. Other options considered

6.1. Separate procurement

It would be possible to procure HIA and Community Equipment services separately. This would lead to a failure to capture financial efficiencies and service improvements.

6.2. Service termination

Some elements of the services are statutory, principally community equipment provision (e.g. in support in hospital discharge or admissions prevention), as well as those elements of Better Care (e.g. Disabled Facilities Grant) that commissioners choose to deliver through the HIA.

Nevertheless, not all services are statutory, particularly the high-volume, low-intensity services offered by the HIA, such as the handyperson service. Failure to re-provide these services would damage the ability of vulnerable older and disabled people to live independently at home, leading to increased pressure on residential and hospital services.

7. Risk management / assessment:

FIGURE 1

The risks associated with the implementation of the *decision* :

No.	RISK Threat to achievement of the key objectives of the report	INHERENT RISK (Before controls)		RISK CONTROL MEASURES Mitigation (ie controls) and Evaluation (ie effectiveness of	CURRENT RISK (After controls)		RISK OWNER
		Impact	Probability		Impact	Probability	
1	Failure to secure agreement from all commissioning partners	**Medium**	**Medium**	Effective communications with all parties to both current services.	**Medium**	**Low**	Rob Logan
2	Challenge to the procurement process	**Medium**	**Medium**	Compliance with terms of the current Framework, followed by thorough market engagement to build awareness of the integrated HIA/Community Equipment procurement.	**Medium**	**Low**	Rob Logan/ Corporate Procurement

FIGURE 2

The risks associated with <u>not</u> implementing the *decision*:

No.	RISK Threat to achievement of the key objectives of the report	INHERENT RISK (Before controls)		RISK CONTROL MEASURES Mitigation (ie controls) and Evaluation (ie effectiveness of	CURRENT RISK (After controls)		RISK OWNER
		Impact	Probability		Impact	Probability	
1	Failure to support independent living	**High**	**High**	Effective delivery of commissioning plan within agreed timescales	**High**	**Low**	Rob Logan
2	Failure to deliver financial efficiencies	**High**	**Medium**	Efficiency allocations of services to appropriate procurements 'lots' in a common Framework.	**Medium**	**Low**	Rob Logan

8. Public sector equality duties

8.1. A joint procurement of HIA and Community Equipment Services will positively affect groups with protected characteristics, particularly disabled people, who will have improved access to equipment and adaptations to support independent living.

9. Eco impact assessment

9.1. Improved coordination of HIA and Community Equipment services has the potential to positively affect the reduction in unnecessary journeys around Bristol and possibly to extend the contribution made by low-emission vehicles.

9.2. The Community Equipment services already contributes to the effective use of resources by recycling equipment after use and making available for future service users. This process will be sustained and strengthened by these proposals, particularly by improving use of sustainable products further up the supply chain.

9.3. Advice received from the City Council's Energy Service suggests that *'As this decision requires agreement to extend existing arrangements, an eco-impact assessment is not appropriate at this time. A full eco-impact assessment including eco-impacts & suggested mitigation measures, will be provided during the re-commissioning process, as it progresses towards 2018.'*

10. **Resource and legal implications:**

Finance

a. Financial (revenue) implications:

The proposals in the report to extend the current Home Improvement Agency contract for additional 23 months, commits to an annual spend for this period of £923,836, of which £102,070 p.a. is funded by Bristol CCG, and the remainder by the City Council. The City Council's spend is contained within current General Fund budget.

Aligning the contract period with that of Community Equipment Services contracts should increase opportunity for obtaining best value for money when re-procured.

Advice given by Michael Pilcher – Finance Business Partner
Date 06th May 2016

b. Financial (capital) implications:

None.

c. Legal implications:

The existing Framework Agreement expires on 24 July 2016. Call offs under a framework can be made any time up to its expiry and any such contracts would need to be awarded prior to that date. The terms of any call off (including their duration) must be consistent with the Framework and previous call offs. This is the case with the proposed contract.

Future joint working on the new co-ordinated procurement would require some form of agreement between the partnering bodies. The new commissioning arrangements will need to comply with the Procurement Regulations, so far as applicable, and the councils own procurement rules.
Advice given by Eric Andrews Team Leader – Corporate, Legal Services. Date 7th May 2106

d. Land / property implications:
None.

e. Human resources implications:
None

Appendices:
None.

Access to information (background papers):

Cabinet Report from January 2012
Health and Wellbeing Report from April 2016

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Sustainability and Transformation Plan, Bristol, North Somerset & South Gloucestershire, (BNSSG STP)	
Author, including organisation	Jill Shepherd, Chief Officer, Bristol Clinical Commissioning Group
Date of meeting	22nd June 2016
Report for Information	

1. Purpose of this Paper

The purpose of this paper is to update the Health & Wellbeing Board (HWB) on the development of the Sustainability and Transformation Plan (STP) for Bristol, North Somerset and South Gloucestershire.

A briefing note summarising the approach to the development of the local STP will be shared with the HWB at the meeting on 22nd June.

3. Process and timescales

At the HWB on 17 February 2016 the Board received a presentation from Justine Rawlings, Strategic Planning Manager, CCG, on the work taking place to develop the STP in line with NHS planning guidance.

An initial STP submission to NHS England is required by 30th June. This will represent work in progress and will not have been consulted on or approved across local governance structures including Health & Wellbeing Boards. This is in line with national guidance.

During July, each footprint will receive specific feedback from NHS England on their emerging proposals and this will inform further development of their plans locally.

4. Communication and engagement

The summary to be shared with the HWB at the meeting on 22nd June will include the approach to communication and engagement in outline, which is based on the current national guidance. Further to this a full timetable for communication and engagement will be produced in discussion with the three Healthwatch organisations.

Substantive engagement with the three HWBs will be included in this timetable and the timing for a detailed report to be brought to the Bristol HWB will be confirmed as part of this.

5. Recommendations

The HWB is asked to note the position and agree to receive a further report in due course

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Better Care Bristol: 2016/2017 Plan	
Authors, including organisation	Tim Wye, Head of Better Care Bristol Clinical Commissioning Group and Bristol City Council Graham Wilson, Urgent Care Transformation Programme Manager, Bristol Commissioning Group Lindsay Winterton, Operational & Strategic Support, Care and Support Adults, Bristol City Council
Officer presenting	Mike Hennessey, Service Director Care and Support Adults, Bristol City Council
Date of meeting	22nd June 2016
Report for Decision	

1. Purpose of this Paper

At the last Health and Wellbeing Board (HWB) meeting held on 20 April, the Board noted and supported the progress to develop a refreshed vision for Better Care Bristol (BCB): and in order to meet the NHS England deadline of 3 May gave delegated authority to the Chief Officer, Bristol Clinical Commissioning Group (CCG) and the Strategic Director for People, Bristol City Council (BCC) to submit the final narrative for the Better Care Fund Plan and template for 2016-17.

The purpose of this paper is to ensure that the HWB notes and considers:

1. **For Approval** - the proposed approach to the Section 75 Agreement prior to submission to NHS England by 30 June 2016 and the delegated authority to agree that final agreement
2. **For information** - the final version of the narrative plan for Better Care Bristol
3. **For information** – the outcomes of the work to refresh the Better Care Bristol Vision

2. Background and Context

Nationally, the £5.3bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is described as "one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single pooled budget to incentivise the NHS and Local Authorities to work more closely together around people, placing their well-being as the focus of health and care services."

The BCF is a critical part of the NHS operational plans and strategic plans as well as local government planning. In Bristol the fund is set at circa £32.6m and most of the money comes from existing sources within Bristol CCG and BCC. It is a common misconception that it is a new fund against which organisations can make bids.

Each year, the CCG and BCC are required to submit an annual plan that is agree through the HWB and sets out the targets and how the money is to be spent. The strategic direction of the plans for the 2016/17 fund were noted by the HWB on 20 April and the final version subsequently submitted and approved by the NHS Executive (NHSE) as meeting 97% of criteria. The outstanding actions were the absence of a formal Delayed Transfers of Care (DTOC) Plan (that is delays to patients being discharged from hospital when medically fit) and a risk share agreement in the event of DTOC being higher than anticipated.

The DTOC action plan has been addressed in the Better Care Fund Plan 2016/17 narrative submission, which is attached **for information** as Appendix 1 to this document. The proposal for a DTOC Risk Share arrangement between Bristol CCG and Bristol City Council has been agreed in principle, subject to some additional assurance work, which has been incorporated into the detail of the Section 75 Agreement.

Better Care Bristol has recently carried out an exercise to refresh its Better Care Vision and this paper also takes the opportunity to share **for information** the outcomes of this work with the HWB.

The next step following submission of the Better Care Fund Plan 2016/17 has been to establish a formal agreement around the pooled fund between the CCG and Local Authority in the form of a Section 75 Agreement, which is attached as Appendix 2. The headline details for particular note by the HWB are presented in the next section of this paper in order that **approval** can be given by the HWB prior to submission to NHS England (NHSE), which is required by 30 June 2016.

**A Section 75 Agreement is a way of formally pooling resources across organisations. Each contribution can be put into this pooled fund with a stipulation of how it can be used. Pooling money in this way does not mean that it, for example, the Disabled Facilities Grant can be used to offset an overspend in a hospital*

3. Better Care Fund and the Section 75 Agreement

The Better Care Fund was established by the Government to provide funds to local areas to support system working and the integration of health and social care to achieve a set of National Conditions, National Performance Indicators and to deliver our locally agreed BCF Plan.

We develop the Section 75 agreement annually after we have reviewed our Better Care Bristol plans and investments for the year, based on national guidance and local system priorities.

It is a requirement of the BCF that Bristol CCG and BCC establish a pooled fund arrangement for this purpose, which is achieved through a signed agreement under Section 75 of the National Health Service Act 2006. The full Section 75 Agreement is available from tim.wye@bristolccg.nhs.uk.

Key information identified by our auditors as areas for improvement in the 2016/17 agreement have been incorporated into the document which relates primarily to the development of Schedules to cover each of the main areas of spend, setting out how the funds will be used and benefits and outcomes captured.

Both the CCG and BCC have been developing the Schedules over the past few weeks for each area of investment. The Schedules will include the description of service, level of funding and how it is being used; the expected outcomes / benefits and how these will be checked through the monitoring of key performance indicators to provide assurance to the BCB Transformation and Commissioning Boards.

The detailed Schedules are not required for the submission to NHSE by 30 June. A deadline of the end of August has been agreed by the BCB Commissioning Board to complete and agree the final Schedules, which will be appended to the final legal document once the Section 75 Agreement has been signed and submitted to the NHSE.

The purpose of this section is to provide the details on the approach to develop the Section 75 Agreement overseen by the BCB Commissioning Board and seek final approval from the HWB on the following elements of the Section 75 Agreement for 2016/17:

1. Financial implications
2. Risk share / overspend / underspend arrangements
3. Proposals for Delayed Transfers of Care (DTOC) Risk Share

Attached as Appendix 2 is a spreadsheet which identifies the sources of financial contribution, fund type, risk share and underspend arrangements.

3.1 Financial Implications

The funds are hosted by whichever Commissioning body undertakes the lead contracting arrangements.

Under this Section 75 Agreement there are five types of funds totalling £32,641,871, which consist of £28,618,563 from Health and £4,023,308 from the Local Authority. The projects in 2016/17 are shown in Appendix 2, which includes the types of fund, sources of funding, risk share, overspend and underspend arrangements.

The types of fund within the overall Bristol Better Care Fund are illustrated below. The individual constituent schemes in each fund is indicated in Appendix 2:

Fund 1 is hosted by the Clinical Commissioning Group and totals £11.236m. The fund includes contributions from the CCG only, which have been paid to providers contracted to support our planned reduction in Hospitals Emergency Admissions. The CCG paid Bristol Community Health circa £3.665m and other primary care providers totalling £2.559m.The CCG controls this fund in its entirety and wholly owns any risk relating to this fund as per the Section 75 Agreement. In terms of accounting entries all expenditure incurred as part of this fund is accounted for by the CCG.

Fund 2 is hosted by Bristol City Council and totals £13.881m. The source of funding for this is a mixture of existing CCG expenditure streams with Bristol City Council and the former NHS England funding, previously transferred under Section 256 agreement in 2014/15, which now forms part of the CCGs allocation including funding allocated under Preparing for Better Care and Care Act Implementation.

In addition, this total also includes funding for Long Term Care (Section 117 including Mental Health and Learning Disability) £4.1m funded by the CCG. The Council controls this fund and owns total risk for BCC spend, and shares the risk on Health related to this fund as per the Section 75 agreement. In terms of accounting entries the contribution incurred as part of this fund is accounted for within the CCG accounts, with the Council accounting for the CCG contribution, this is dealt with as income and the associated expenditure with providers for this fund.

Fund 3 is hosted by Bristol City Council and totals £2.421m for Disabled Facilities Grant. The fund includes contributions from the City Council only, which are paid directly to providers. The City Council controls this fund in its entirety and wholly owns any risk relating to this fund as per the Section 75 agreement.

In terms of accounting entries all expenditure incurred as part of this fund is accounted for by the City Council.

Fund 4 is hosted by NHS England and totals £1.410m. The fund includes contributions from the NHS England only, which have been paid to providers contracted to support Early and Preventative Interventions. NHS England controls this fund in its entirety and wholly owns any risk relating to this fund as per the

Section 75 agreement. In terms of accounting entries all expenditure incurred as part of this fund are accounted for by NHS England.

Fund 5 arrangement is hosted by Bristol City Council and totals £3.693m where both the CCG and Bristol City Council contribute towards the sources of funding to create a pooled arrangement relating to the Equipment and Carers Fund. The Council is the Lead Commissioner for the services and will keep the other Partners and the Commissioning Board regularly informed of the effectiveness of the arrangements using due skill, care and attention and undertake performance management and contract monitoring of all Service Contracts. The Council controls this fund and expenditure. The risks are shared based on the area of spend. The CCG owns the risks for Health related spend and Bristol City Council holds the risk for Social Care related spend as per the Section 75 agreement.

Virements

Virements between Section 75 Schedules may only be undertaken, where the Commissioning Board has discussed and agreed this. These will be clearly documented in the bi-monthly finance report.

3.2 Risk Share / Overspend / Underspend arrangements

The majority of risk sharing, overspends and underspends principles agreed in 2015/16 have remained unchanged against the majority of schemes in 2016/17, with the following differences below.

- Long term care including mental illness and LD – This commissioner risk share arrangement will remain unchanged until the end of August. This is to enable a task and finish group review this area of spend and recommend a new approach to this, including risk share arrangements, which will be presented to the Commissioning Board for agreement. The current arrangement is the Local Authority holds 10% of the risks against Health spend and 100% of the risks against social care spend.

- Community Equipment has been included in the Better Care pooled arrangement in 2016/17. The commissioner risk share is 100% for Bristol City Council for Social Care related spend and 100% CCG for Health related spend.

- Carers have been included in the Better Care pooled arrangement in 2016/17. The Commissioner risk share is 100% for Bristol City Council for Social Care related spend and 100% CCG for Health related spend.

Where Bristol City Council or Bristol CCG is the Lead Commissioner for services included within the Section 75 Agreement, as a general principle they will hold 100% of the risk share for their agreed areas of spend, which is entirely within the Lead Commissioners who holds responsibility for decision making, control to manage and put in place appropriate mitigation to reduce risks. There are some exceptions to this and where this is the case, the risk apportionment is clearly shown in Appendix 2.

Underspends:

Underspends will be reported to the Commissioning Board for discussion and agreement on how these might be used to ensure an appropriate audit trail and decision is noted.

If there is an underspend in a Pooled Budget at the end of the Financial Year, any reimbursement in respect of the underspend shall be split on the same ratio as original contribution and returned to both parties.

Any underspends within Bristol CCG funded schemes resulting from non or part implementation of the scheme in a non-pooled fund will be reimbursed to the CCG, subject to appropriate assurances and reported to the Commissioning Board.

Any underspends within Bristol CCG funded schemes resulting from more efficient use of the funding to implement the scheme by the Local Authority, can be retained by the Lead Commissioner (Local Authority), subject to appropriate assurances the scheme is delivering as intended and formal agreement by the Commissioning Board on how the underspend will be used.

Any underspends within Bristol City Council funded schemes (DFG), will be for the Council discretion, subject to appropriate assurances the scheme is delivering as intended and formal agreement by the Commissioning Board on how the underspend will be used.

3.3 Proposals for a Delayed Transfer of Care Risk Share

A requirement of Better Care nationally for Health and Local Authority Commissioners to develop a Delayed Transfer of Care Action Plan and Risk Share Agreement which includes a stretch target to get to 2.5% national average. The proposed risk-sharing proposal is covered below.

What are delayed transfers of care?

According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem for the NHS as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients, which are not good for patients and can lead to increased dependence and take them longer to get back to their previous state of independence.

Delays can occur when patients are being discharged home or to a supported care facility such as a residential or nursing home, or require further, less intensive care and are awaiting transfer to a community hospital or hospice.

NHS England, the body responsible for monitoring delayed transfers of care nationally, defines a patient as being ready for transfer when:

- A clinical decision has been made that the patient is ready for transfer, and
- A multidisciplinary team has decided that the patient is ready for transfer, and
- The patient is safe to discharge/transfer.

As soon as an adult patient meets these three conditions and remains in hospital, the clock starts and they are classified as 'a delayed transfer'. All hospitals are required to collect this data and provide it to NHS England

There are clear dependencies at play, so for example people assessed as eligible for social care services in their own homes are dependent on there being enough domiciliary and reablement support commissioned by the Council and in place for their discharges to be progressed in a timely way. The other dependency is in the provision of care homes placements, particularly for people with complex needs, such as dementia.

It is therefore essential that the Bristol City Council's commissioning strategy includes sufficient supply and capacity for the above, taking into account both flow and turnover of both staff and packages.

Context for Better Care Bristol DTOC action plan and risk share

As part of national Better Care arrangements for 2016/17, health and social care systems have been asked to consider risk share agreements related to delayed transfers of care (DTOCs). As previously stated, Bristol's current BCF submission has NHSE approval with support, subject to developing a DTOC action plan and risk share agreement to gain final approval.

The Bristol system has agreed in previous years that fines are not appropriate to our joint working arrangements and future direction of travel, but with the current financial pressures and performance issues in the system, the BCB Commissioning Board have considered and approved in principle that a risk sharing agreement is developed between the main commissioners, which will present some helpful opportunities to improve provider performance.

The BCB Commissioning Board has considered and approved the DTOC action plan and in principle to establish DTOC risk sharing agreement between Bristol CCG and Bristol City Council Commissioners to enable Bristol to achieve the stretch target of 2.5% national performance for DTOC.

The implementation of the risk sharing agreement is subject to some additional assurance work in relation to DTOC coding and data sources and to enable the Local Authority to put in place appropriate plans to mitigate the risk prior to implementation.

Risk Sharing Agreement

The impact of implementing a risk share agreement between Commissioners is that DTOC bed-days, which is less than 2.5% per month of all available bed-days would

not be subject to a charge to the local authority from Health and all costs and risk will continue to be covered by the CCG.

The basis of the risk share is that activity in excess of 2.5% per month by Commissioner will be funded by the appropriate commissioner based on:

- The proportion of this activity which is attributable to Bristol CCG and Bristol City Council Commissioners;
- A 50% split between Bristol CCG and Bristol City Council as Commissioner towards the proportion of joint delays (Health & Social Care) which are in excess of the 2.5% target per month. This reflects the positioning of our discharge to assess delays within the joint responsibility fields.

It is proposed that this arrangement would commence from the beginning of quarter 3 (October 2016), subject to final agreement by the Commissioning Board in August 2016.

4. Refreshing the Better Care Bristol Vision

The refreshed vision is the synthesis of a highly successful half-day seminar held on 12th April which brought together around 120 stakeholders across primary, community and voluntary sector, social care, public health and acute hospitals. This generated a mass of useful and important feedback. (A full summary of the feedback from the day is available on request from tim.wye@bristolccg.nhs.uk). The vision was developed from this wealth of feedback by the Leadership for Change Team.

The Vision was subsequently sent to participants, who were invited to comment via an on-line survey. This survey broadly supported the summarised vision and participants agreed it was clear and represented the day. Participants did also note in feedback that it would be somewhat challenging to deliver (see table 1 below).

Table 1: how people responded when asked to rate the following statements in relation to the vision

Rate the following statement	Strongly Agree	Agree	Disagree	Strongly Disagree	No response
The concept is clear	0%	82%	15%	0%	3%
These represent a priority	23%	69%	8%	0%	0%
They are achievable	0%	62%	38%	0%	0%
If delivered, it would lead to significant system change	23%	69%	7%	0%	1%

Refreshed Vision

We were seeking a vision which:

- is forward looking, compelling and seeking to do better things
- signals a step change in our ambitions
- focuses on self-help and prevention
- creates a robust, sustainable system for people who use services and staff

Participants contributed their thoughts on what should be done differently in Bristol to achieve a health and care system, which meets the needs of our users.

Based on this input, our Vision for Better Care Bristol can be summarised as follows:

> Better Care Bristol will drive the transformation of care and reduction of inequalities by establishing **integrated local services where health and social care resources are brought together in a coherent, locality model**, targeting resources where the need is greatest
>
> Better Care Bristol will drive **prevention and self-care. Working on key priority areas, we will help people to manage their lives well, stay healthy and avoid deterioration. We will promote independence and help people and their carers to manage conditions once they are established.**
>
> Better Care Bristol will design and put in place **integrated pathways that support people in managing conditions from the earliest indications through to severe and complex needs. Through these we will deploy resources, at whatever point they are most relevant.**

To support this, Better Care Bristol will ensure that changes are supported by integrating IT and sharing data, with IT development based on the needs of users and carers. Better Care Bristol will co-ordinate with workforce development and mobilise workforce initiatives, which will enable the integration agenda.

Better Care Bristol must support teams through change – managing risk, supporting changes in behaviour, measuring progress, being open about change, making better use of voluntary sector and community assets, and empowering patients, service users and carers.

Next Steps

Whilst the Vision statement moves us forward in refreshing Better Care, there is clearly work required to develop a clear plan as to how we move towards implementation. The following are actions to develop that plan:

- The Leadership for Change Team will continue to meet to develop coherent deliverables/ plans to follow the vision. As part of this work we are planning an additional half-day session to agree the detailed narrative that will sit alongside the vision, to work through the links and interface with the Bristol,

North Somerset, South Gloucestershire (BNSSG) Sustainability and Transformation Plan (STP) and to refresh the current implementation plan.

- The Better Care Team have held a session to discuss how the current programme of work based around “aims” aligns with the new vision themes. The team has concluded that the new vision is helpful in providing clarity to the role of the team and the project and programme management arrangements. The team will continue to use this approach in supporting the Better Care Programme.

- Part of the planning will include developing a timetable. The first key date in this is to deliver a high level, strategic view about what should be included in the recommissioning of community services. Following an initial Leadership for Change Team discussion held on 1 June 2016, Tim Wye, Head of Better Care, will draft a paper that sets out the options for integration, initially for discussion with the Leadership for Change Team and then for broader consideration. The second date is the March 2017 deadline for the integration plan. Both the Better Care refresh and recommissioning discussions will inform this final plan.

In taking forward the Better Care Vision, the team is aware of the need to align the vision with other initiatives, particularly the Sustainability and Transformation Plan but also the developing Primary Care Strategy. Discussions are being held internally to ensure that there is clarity between different party leads as to the role of Better Care and how it fits with other areas of work. Key to this is the close links that have been established with the Programme Management Office and the Head of Planning for the CCG.

5. Recommendations

The Health and Wellbeing Board is requested to:

1. Approve the approach to the Section 75 Agreement 2016/17 for Better Care as set out in this paper. In particular to note the detail of:
    - Financial implications
    - Risk share / overspend / underspend arrangements
    - Proposals for a Delayed Transfers of Care (DTOC) action plan and Risk Share Arrangements
2. Delegate to Chief Accountable Officer (CCG) and Strategic Director, People (Council) to sign off the final Section 75 Agreement, subject to any final changes required, for submission to NHS England by 30 June 2016
3. Note for information the final narrative submission for Bristol's Better Care Plan 2016/17
4. Consider and comment on the approach and outcomes to refresh the Better Care Bristol Vision

Appendices:

Appendix 1: Better Care Fund Plan 2016/17 – final narrative
Appendix 2: Section 75 Agreement, Schemes and Risk Share arrangements

Appendix 1:

Better Care Fund Plan 2016/17 – final narrative

Better Care Bristol Plan 2016/17

Contents

Appendices

1 Introduction

Bristol's Better Care Fund Plan 2016/17 should be considered as an update to our existing plans and narrative, which we developed in 2015/16. Whilst there have been some changes to governance, completion of projects and creation of new projects for Better Care, this update represents a refresh moving forward into 2016/17.

This document provides an update on progress to date and outlines our plans and outcomes for 2016/17 and includes our aspiration for transformational change and partnership working across the system as we establish Bristol's plan for wider integration and commissioning.

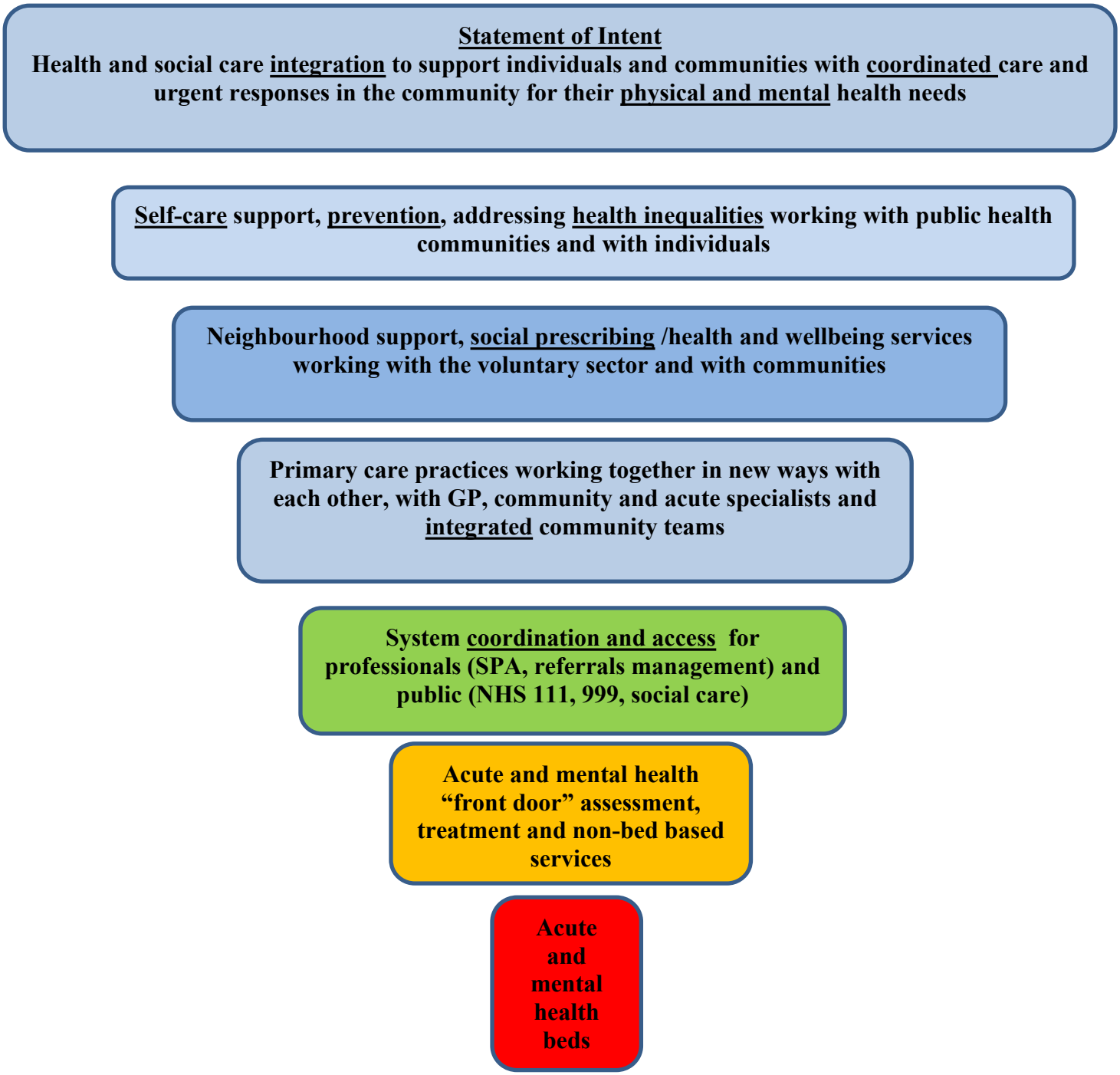
It should be noted that in conjunction with the signing of the Section 75 Agreement and agreement of our final plan to reduce DToC, Bristol will produce a public facing document that will describe in greater detail our plans around transformation, delivery and improved outcomes resulting from our work, which will incorporate our revised Vision for Bristol once agreed.

2 Governance and Structure

In a change to the 2015/16 plan, the Better Care Bristol (BCB) plan has been broken down into three programmes of work, which are focussed around 3 aims. These aims have been derived from the Care and Support Triangle illustrated in Figure 1 below:

Aim 1: We will help you to help yourself be well (the prevention agenda)
Aim 2: We will provide care in the right place (managing urgent care and short term interventions)
Aim 3: We will support you to be independent for longer (maintaining people in whatever care setting they are currently in)

Figure 1: Care and Support Triangle



The Care & Support Triangle used within Better Care Bristol is designed to;

- address wellbeing, early intervention and prevention
- provide services in the right place when people need them, and
- help people be independent for as long as possible

The key governance change in 2015/16 was the creation of the Better Care Bristol Transformation Board (which includes our main providers and voluntary sector) and the Better Care Bristol Commissioning Board (Commissioners only) and the standing down of our former Better Care Bristol Programme Board.

This change was made to support our aspirations around joint commissioning discussions; ensuring providers are involved in developing and shaping the transformation agenda and ensuring appropriate governance to manage any potential conflicts of interest. This enables the Commissioning Board to focus on making clearer and more transparent commissioning decisions and provides a forum to make decisions on investment and contract issues. It enables the Transformation Board to focus on delivery of our Better Care Bristol transformation plans and provide assurance to the Commissioning Board that these plans are delivering our agreed outcomes and investments.

These boards, and a number of key projects, are supported by The Better Care Bristol Team, who are a joint team working across the system with providers and commissioners to support delivery of the changes. £300k is allocated in the 2016/17 plan to support the implementation programme.

Full details of the revised governance structure are attached in **Appendix 1.**

3 Risk Assessment and Risk Management

Financial and delivery risks are reported to the Better Care Bristol Commissioning Board on a regular basis. The latest Better Care Bristol risk log is included in **Appendix 2.**

These risks are logged on our corporate risk register and – where these may impact on our operational plans – they are also fed into the risk log for the Clinical Commissioning Group (CCG) and Local Authority (LA).

4 The Local Vision for Better Care Bristol

The local vision for Better Care Bristol has not changed significantly since 2014/15 and aligns with the Bristol Health & Wellbeing Board Vision.

The Health & Wellbeing Board is responsible for developing services to support the needs of Bristol people. They have developed a vision that all partners, including the local community, can work towards.

Better Care Bristol has aligned the plans to the four themes agreed by the Health & Wellbeing Board, which have been informed by the Joint Strategic Needs

Assessment (JSNA). These four themes are that Bristol will be a city:

- that is filled with healthy, safe and sustainable communities and places
- where health and wellbeing are improving
- where health inequalities are reducing
- where people get high quality support when and where they need it

Under these themes a number of priorities have been agreed, which underpin our Better Care Bristol programme. These priorities are to support people to live healthy and independent lives, have timely and easy access to high quality and efficient public services, supported by thriving and connected communities. The priorities will be achieved by:

- 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

The Health & Wellbeing Board and Better Care Bristol Commissioning Board agreed that by March 2017 we would build on our vision and establish our plans for integration and commissioning.

The Better Care Bristol Commissioning Board authorised a group of system leaders from across health and social care. This group is known as the Leadership for Change group, which links back to the Better Care Bristol Commissioning Board. They will act as a 'think tank' for future and ongoing development of our joint vision for integration, and make recommendations for future consideration.

The Leadership for Change Group planned a series of events to take place over 2016/17 to fully engage stakeholders on refreshing and developing our vision for Better Care in Bristol. The first of these was a half day event which took place on 12th April 2016 and brought together stake-holders across acute, primary care, local authority, community and voluntary sectors to refresh the key priorities for Better Care Bristol and the wider integration work.

The day successfully generated a number of innovative ideas for engagement and collaboration across the community which will be incorporated into our refreshed vision and work. These include:

- prioritise prevention and early intervention at scale to empower citizens to manage their own care
- deciding on the appropriate building blocks for service provision but ensuring a consistent Bristol approach across providers
- simplifying the system and access to services through integration, as easy as possible, in the right place

- ensuring that equalities are addressed
- ensuring our vision fits with other key strategies and how they can support the Better Care Vision (e.g. housing and education)
- co-ordinating and planning investments to make the best use of resources, particularly including working with the voluntary and community sector

5 Better Care Bristol Plan and Programme

This section outlines how Better Care Bristol aligns with other areas of work across commissioning and provision including health, social care and the wider community and voluntary sector.

Re-commissioning of Community Health Services

Bristol CCG is currently developing its approach to recommissioning community health services and, in particular, looking at alignment and integration opportunities with social care. To help inform and support this process, the Better Care Bristol Commissioning Board set up a multi-agency design team to develop a number of ideas to generate new innovative system wide ideas for test and learn pilots as new projects. The potential pilots identified were:

1. Community Webs: using community assets in a GP cluster
2. Integrated community/practice nursing teams
3. Practice cluster multi-disciplinary teams (MDTs)
4. Community Wards
5. Nurse input into sheltered housing

The first three projects are due to go live in April / June 2016 and should significantly aid our thinking about planning and how we organise our commissioning intentions for integrated services for locality / cluster models, supporting new models of care.

The projects four and five were further investigated and would not deliver the anticipated outcomes. The evidence collected showed they did not deliver significant service improvements and they were therefore discontinued. The outcome should be considered a positive outcome of test and learn methodology and an example of our focus on achieving the Better Care outcomes.

Care Act Implementation

Bristol has met its statutory obligations under the Care Act from April 2015 and direct alignment with Better Care Bristol continues to play an important role in the transformation and sustained delivery of the requirements of the Care Act.

The work to develop the Council's responsibilities is encapsulated by the "Three Tier Model" for social care. The three tiers describe how we will support people in the future and is set out in the diagram below:

Figure 2: Three Tier Model for Social Care

The Three Tier Model relies on good information being available to people, local communities being central to supporting people, and that when people do need longer term support that they have an active role in achieving this.

Although closely aligned, the Three Tier Model has developed since the "Three Aims" of Better Care. Better Care is conducting a refresh of its vision (see section 4) and as part of this, Better Care will review how it can accommodate the Three Tier Model more formally.

The projects within Aim 1 of the Better Care Bristol programme underpin the Care Act duties for Information, Advice and Guidance (IAG) through the delivery of a new digital platform to provide IAG for people needing support in Bristol. This online platform for both people and staff will provide IAG on formal and informal options, and align the objectives of the Care Act with Better Care Bristol to help people live independently for longer.

To ensure the sustained delivery of the Care Act duties in 2016/17, Better Care Bristol funding (which equates to £1.16m for 2016/17) is being used to:

- encourage more people to live independently across Bristol
- learn more about what works to prevent demand and increase independence
- work with communities to build on resources to support people outside of council funded support
- reduce the need for ongoing support from adult social care

- ensure our support builds on the strengths and abilities of people, their families and their local communities
- tailor our on-going support we provide to individuals through personal budgets, creative support planning and building on people's strengths and resources to meet their aims
- reduce waiting times for people contacting adult care and support

Better Care Bristol funding has also been used to refresh the commitment to existing carers as well as identifying new carers, vital to the sustainability of all health and social care services in Bristol.

Joint Planning

Better Care Bristol works with the CCG's Programme Management Office to ensure alignment of Better Care Bristol aims with the CCG's operational plan. This ensures alignment with the wider system and, in particular, the development of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan.

In 2016/17 we will review the performance reporting of the Better Care Bristol projects to ensure that all our metrics and key performance indicators are robust in evidencing system wide impact on the Better Care national metrics.

Bristol City Council is also developing an Adult Social Care Strategy. Better Care is working closely with the development of this plan to ensure consistency with current aims both within Better Care and in the wider NHS planning process.

Both these and the wider integration work will feed into the development of the Sustainability and Transformation Plan (STP).

Our activity assumptions within the plan have been developed and shared with the Trusts as part of our Operational Plan development within the CCG. The relevant sections feed into our Better Care Plans for 2016/17.

Developing themes supporting Better Care and Integration

The Better Care Bristol programme contains a number of innovative and transformational projects. The current work to refresh Better Care Bristol's Vision takes learning from these projects to shape the work to facilitate Bristol's plans for integration. Emerging themes being considered by the Leadership for Change group, informed by the Vision event held in April 2016, include:

- reviewing system wide workforce capacity including building on our multi-agency Wellbeing Partner apprentice scheme.
- developing an organisational planning and delivery model based on learning from some of the cluster based "Test and Learn" Pilots.

- a stronger focus on technology and information sharing – BNSSG's (Bristol, North Somerset, South Gloucestershire) Connecting Care programme has made good progress, however there is still work to do towards sharing data across health and social care providers in real time, linked to issues with social care being able to access the NHS spine in a timely manner. This, including other information and system wide technical solutions will be built into the BNSSG Local Digital Roadmap as part of the STP work.
- making the cultural shift to prevention, building on the work of the CCG and Bristol City Council to reduce dependency on commissioned services through early intervention, and using Information, Advice and Guidance to support patients and customers at an early stage.
- reducing emergency admissions by building on existing projects and models to ensure patients access services in the right place.

6 Evidence to Support Change

Bristol's Joint Strategic Needs Assessment (JSNA) 2016

2015/16 has seen considerable progress on developing a new approach to development of the JNSA, which was agreed by the Health & Wellbeing Board. Public Health has worked with commissioners to understand what would be the most helpful format to support commissioning and planning for future services.

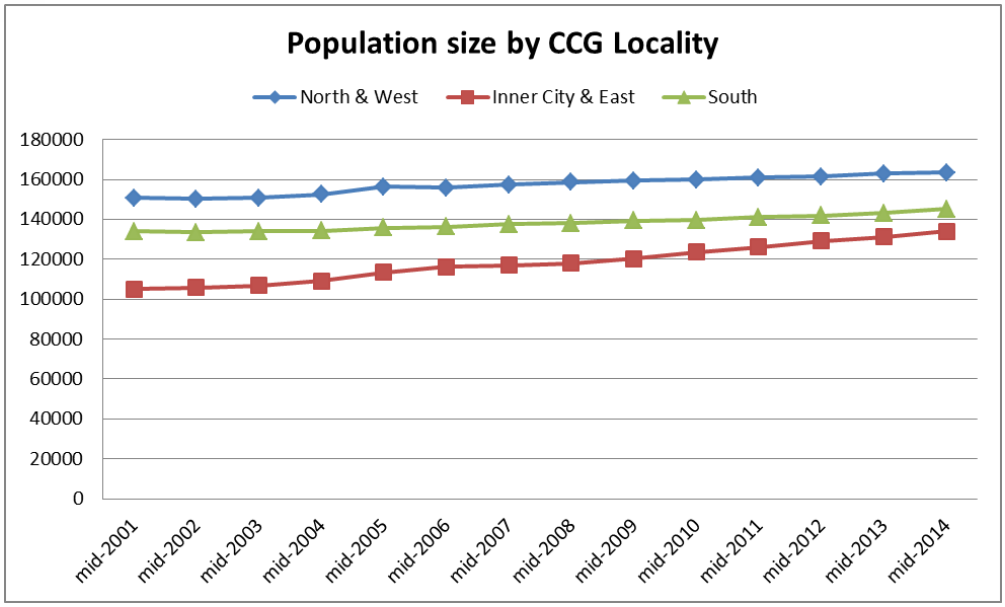
The latest data from the JSNA was considered by the Better Care Bristol Transformation Board in April 2016. This highlighted any new information that could be used to assess and inform the direction of our current and future transformation plans.

The key message was one of increasing demand and continuation of some of the particular issues that are faced by Bristol such as deprivation and its impact on different localities across the city. The overall conclusion of our Public Health colleagues is that to address the rising demand and limited resources we need to make better use of our preventative approaches and be looking to address inequality and an increasingly ageing population. This view is in line with the aspirations of our Better Care Bristol Plan.

The following tables provide an overview of the most relevant key indicators within Bristol's JSNA.

As shown in Graph 1 below, the population of Bristol continues to grow with particular growth in inner city and east:

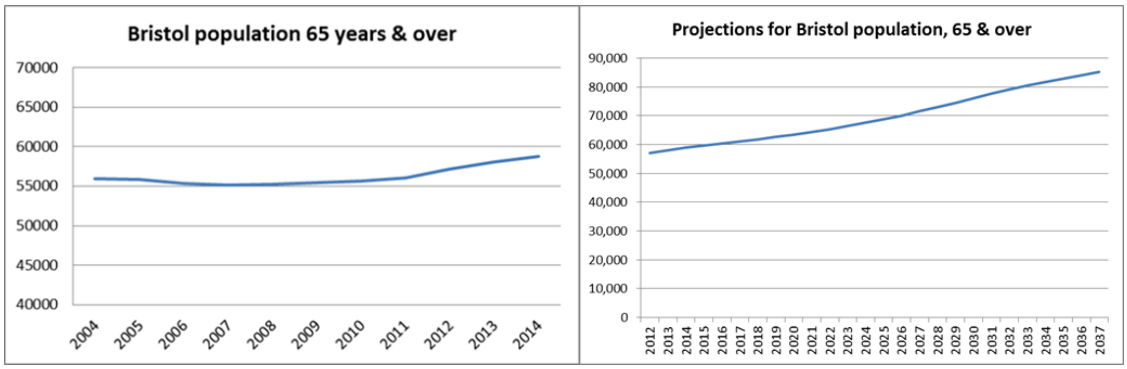
Graph 1: Bristol – Population size by CCG locality



Whilst Bristol has been a relatively "young" city, there is growth in the older population with a projected 14% rise (in 65+ and 85+) between 2012-22. This is illustrated in the graphs below:

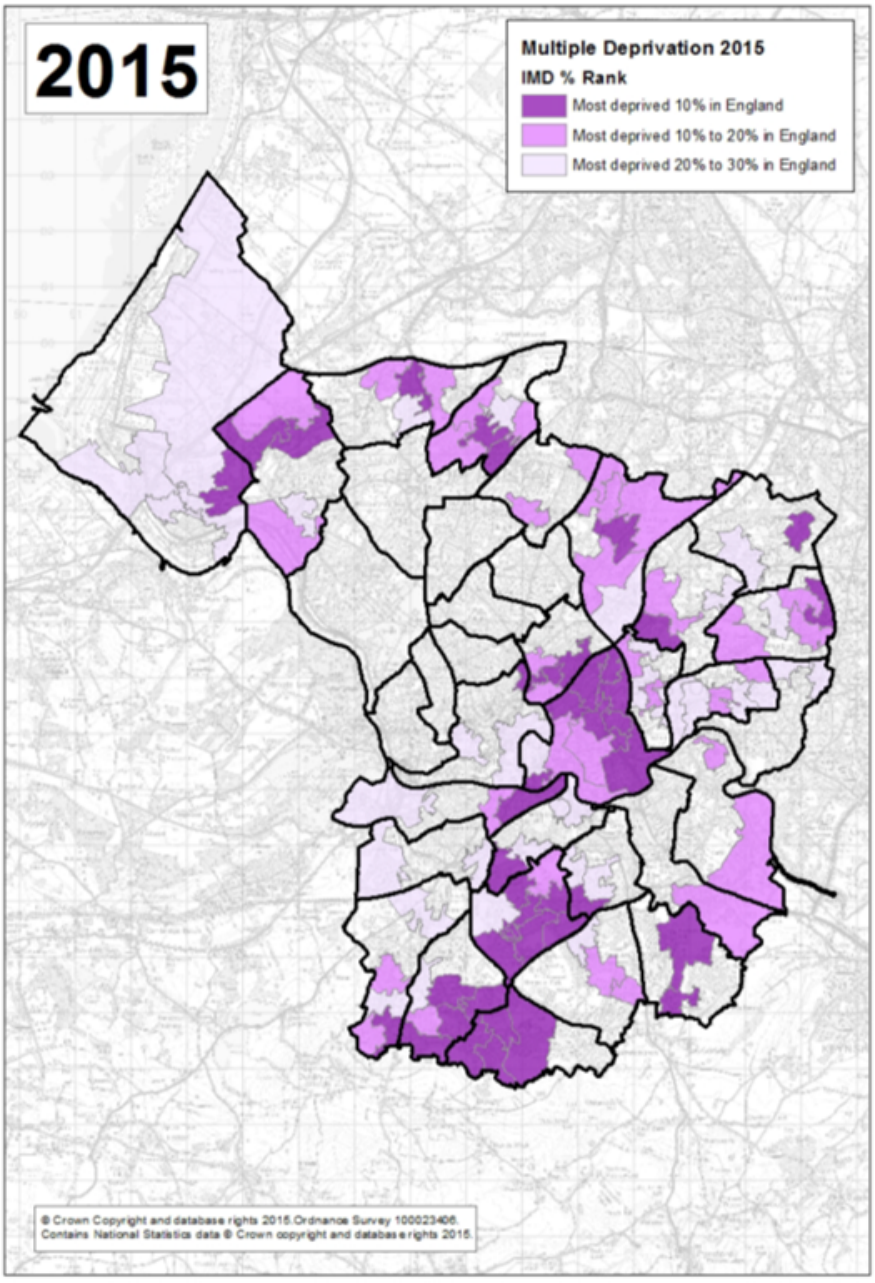
Graph 2: Bristol population 65 years and over

Graph 3: Projections for Bristol population 65 years and over



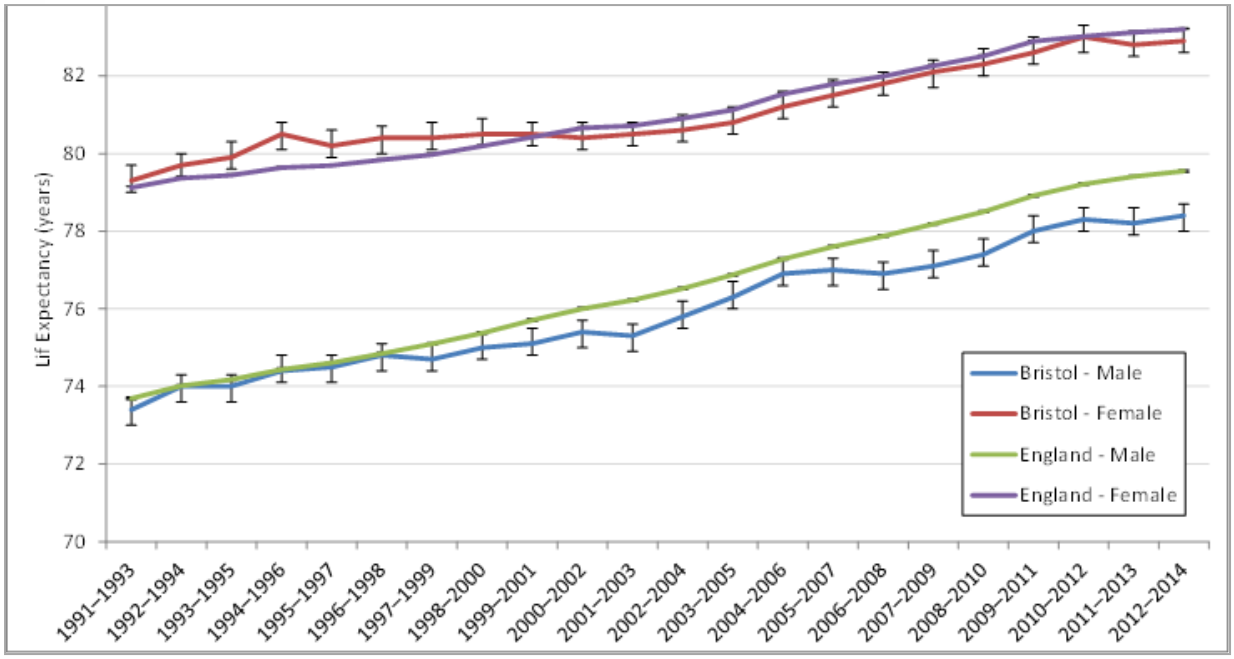
Deprivation remains a significant challenge for Bristol with Figure 3 clearly showing a significant number of wards in Bristol being in 10% most deprived in the country. Test and Learn pilots in our 2016/17 plan will focus on some of these more deprived areas.

Figure 3: Bristol – Multiple Deprivation 2015



Deprivation is a key factor in determining life expectancy. After a projected reduction in 2012-14 (as shown in Graph 4) although now rising, life expectancy remains lower in Bristol than the rest of England. The average life expectancy for men is 78.4 years; and for women it is 82.9 years. The gap in Bristol between the most deprived and least deprived wards persists, at 8.9 years for men and 6.6 years for women.

Graph 4: Bristol - Life expectancy at birth, 1991 - 2014



7 Key Achievements 2015/16

All projects within Better Care Bristol have gone through a robust business case development process with appropriate evidence to support these, including the JNSA evidence review (from Public Health) plus clear and defendable assumptions based around savings projections.

Where projects are not delivering predicted outcomes or benefits, they have been discontinued. For example, the sheltered housing test and learn pilot, where there were high rates of admission, was discontinued when it became evident that the majority of those admissions were appropriate.

A similar example of using evidence was that in 2015/16 we invested in a community matron to Extra Care Housing (ECH). The review of this pilot noted some benefits but assessed the model as not being completely fit for purpose. This led to the project being discontinued and a new business case is being developed based on the learning and outcomes from the initial project.

Metrics

In addition to the national metrics set out in the Better Care Fund template, the Better Care Bristol Transformation Board has identified the need for

- robust “live” metrics that reflect activity and agreed outcomes of each project
- early warning KPIs

These will align with the Bristol CCGs Programme Management Office.

Project Managers are developing clear project documentation, performance indicators and risk/issue logs that track the delivery of benefits and outcomes for projects which form part of the Better Care Bristol Programme. Those schemes funded via the pooled budget, report monthly to the Better Care Bristol Transformation Board to measure impact.

The following tables describe the key projects within the individual programmes within Better Care.

Programme - 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	Our public health driven pilot is 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. We currently have 10 pharmacies on the programme and another 15 have been invited to participate. The pilot benefits realisation is long term; however we have already seen increased public health activity since its launch.
Wellbeing Partner Pilot	Better Care Bristol has been successful in securing some external funding from the Health Education South West Membership Council Innovation Fund. The funding has been used to support a pilot to employ and train up young apprentices as 'Wellbeing Partners' 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 domiciliary care. 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 formally starts in apprentice week at the end of March 2016 with apprentices recruited by end May
HG Wells LTC (Diabetes) Pilot	In line with the NHS Five Year Forward View's emphasis on disease prevention Better Care Bristol have a 5 year Diabetes Transformation Programme which aims to support primary care with significant improvements in the diagnosis, management and treatment of diabetes and helps activate patient engagement in managing the disease through community-based lifestyle interventions. The project started with 5 practices in September 2015 and has been rolled out to over 30 practices since it launched.
Signposting for information	
Care Act Implementation - Information Advice and Guidance	A new digital platform which will deliver a self-assessment function to enable people to access their own care and support solutions. This will point directly to online Information Advice and Guidance services. The jointly commissioned contract with The Care Forum to deliver WellAware (IAG repository) has been extended until 31st March 2017 to enable integration with the new digital platform. Work to develop a clear digital roadmap is being progressed as part of this.
Public Health Wellbeing Hub	The Hub is a new service that is being developed by Public Health, the hub will be a single point of access to lifestyle interventions that support people to improve their health and wellbeing and where Health trainers will be available to offer advice, support and signposting to individuals who have been referred to Public Health services. A manager is now in post and making links with partner organisations and projects.
Making Every Contact Count (MECC)	Making Every Contact Count is an opportunity to empower people to improve their health or well-being. The idea is that front-line workers across sectors take opportunities to talk to others about their health issues. These conversations would cover health issues such as alcohol consumption, smoking, physical activity, diet, mental well-being and ageing well. We are currently scoping existing work on MECC in Bristol and aim to develop an implementation plan for Spring 2016.
Social Prescribing	This project aims to develop social prescribing in Bristol and agree a city wide vision. Its aims maximise the efficiency of funded services as well as harness the enthusiasm and capacity of the community and voluntary sector . Develop clear pathways to ensure the right people are able to access appropriate social prescribing services, including primary care. We are currently co-designing a pilot to address medicine waste and promote social prescribing with Wessex water who have committed funding in principle to the project

Programme - 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)	The Bristol Primary Care Agreement (BPCAg) is a transformational three year contract held with GP practices which incentivises them to work individually, in clusters and locality-wide across a number of key areas including urgent care, planned care, mental health, end of life and long term conditions including self-care. The contact's specification is high level to allow practices to innovate, and to reflect the local health needs of their population. The contract is primarily geared towards the frail and elderly although there is some flexibility on this depending on the population needs, with practices receiving the bulk of the funding proportionate to their over 75s as per the NHS England Call to Action guidance. The practice's initiatives are themed by admission avoidance and enabling discharge.
Keeping people at Home	The Care Home project set up in 2014/15 has seen two pilots evaluated and a new business case developed based on these pilots developed to implement during 2016/17. The 'Care Home Support Team' pilot identified the need both to scale the team up and to build in access to other professionals. For 2016/17 the team will comprise registered nurses with a virtual team supporting them including medicine management, dietetics and safeguarding. Their primary objective will be to improve the quality of the care provided in Care Homes with Nursing (CHwN) through supporting, training and upskilling the care home staff, with an emphasis on End Of Life Care planning. Our Extra Care Housing Nurse pilot providing nursing support to three Extra Care Housing (ECH) schemes. The pilot aligns with the Better Care fund priorities of providing a more integrated approach to elderly care across health and social care. Its aim is to reduce hospital admissions and emergency department attendances through: • early intervention • supporting self-management • case management of tenants who have been identified at risk of admission to hospital due to long term conditions or changing healthcare needs. Based on review, next year it will be run as a “virtual ward round” rather than a specific attached nurse.
	Empowering communities
Joint Front Door Model	Bristol CCG plan to commission a ‘Joint Front Door’ model at Bristol Royal Infirmary (BRI), working with University Hospital Bristol NHS Trust (UHB) and Primary Care, which encompasses an Urgent Care Centre (UCC) on the site of the existing BRI A&E Department. A key feature of the new service model will be streaming patients on arrival through the Joint Front Door so they can be directing to the most appropriate pathway, service or provide reassurance / immediate advice and discussion. The most transformation element will take place in 2017/18
Single Point of Access	We are continuing on our goal of creating a Single Point of Access (Telephony) to replace the current multiple single points of access across health and social care services. The Single Point of Access will provide triage / assessment / advice for Health Care Professionals to help manage patients and conditions to mitigate an acute episode. The Single Point of Access will via the Directory of Services signpost will support professionals to enable the patient to the most appropriate service to provide immediate, appropriate, and necessary treatment. The most transformational element will take place in 2017/18.
Discharge to Access (D2A) Project	This project has been designed to improve flow across the acute care system, reduce length of stay in acute and community beds, and reduce excess bed days and DTOCs. The multi-agency Integrated Hospital Discharge Hubs at both UHB and NBT facilitate 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 are be three pathways which launched in July 2015: • Pathway 1 – Home with Support (including packages of care and / or rehab / reablement) • Pathway 2 – Community Rehab Beds • Pathway 3 – Complex Assessment Beds (social care and/or full CHC assessments) Home is the default care setting for patients with or without rehabilitation needs, unless considered by the MDT and deemed unsafe or unsuitable. DTOCs have reduced by 57% at UHB, although this reduction cannot be solely attributed to the D2A, due to a rectified coding system. The total number of green to go patients has been steadily reducing since October 2015. We are currently refreshing this project for 2016/17 and allocated additional funding in Social Care for an enhanced brokerage service from both acute trusts .

Programme - 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 (ECH)	Bristol City Council has re-commissioned its existing 600 units of ECH. Crucially the Council has re-specified the service so that it will now cater for a more complex range of residents. At present about 20% of residents would be in residential care. The Council are going to move this to 50% over time, as existing residents move on, which will create more residential level capacity. We have also signed contracts for major developments that will see the number of affordable rental units with Council nominations grow by approximately 150 over next three years.
Aftercare Services Section 117	This project's aims to explore some issues that have arisen across Bristol CCG and Bristol City Council relating to section 117 of the Mental Health Act. The Mental Health Act expects that any individual on section 117 be reviewed at least annually. The aspiration going forwards is to hold joint reviews with BCC and Bristol Recovery Partnership to ensure people are still eligible for S117 aftercare and are receiving appropriate services. In addition to patient benefits of more robust supervision and review, It is anticipated that through the review process savings will be identified.
Integrated personal commissioning pilot	Better Care Bristol is leading on the development of the Integrated Personal Commissioning (IPC) Pilot as part of the South West Consortium. This region is one of eight national demonstrator sites. The IPC Programme is a 3 year pilot aimed at integrating health and social care support for people with complex health needs in order to increase their choice and control. The cohorts selected will have personal care and support plans created collaboratively between themselves and a care professional and will have the option to manage their own personal budgets in order to support this. We have two cohorts learning disabilities and children's and anticipate that the first budgets will be in place by July 2016.
Technology	
Connecting Care	Connecting Care is a joint NHS and Social Care partnership, involving Bristol, North Somerset and South Gloucestershire [BNSSG] . The programme has been created in response to the need to improve information sharing across primary, community and secondary care. This project aligns well with Better Care by enabling authorised professionals in hospitals, community settings, GP practices, out-of-hours services and social care teams to see a single electronic view of information about the person they are caring for and their care plans. We currently have more than 1,000 users of Connecting Care, the project aims to increase the number of users by approx. 2,000 per year as we move from a 'pilot version' to a system that can support 10,000 + users over the next few years.

8 Deliverables/Plans 2016/17

Our Better Care Plan pooled fund for 2016/17 is circa £31 million. Bristol's Better Care Fund Template 2016/17, tab 4 "HWB Expenditure Plan" issued by NHSE and attached to support this plan, sets out our proposed investments for the Better Care Fund in 2016/17, making up the Better Care Fund of £31m.

Whilst based on 2015/16 activity, plans for 2016/17 are still in development for the £7.5 million investment in social care (including carers, social services for health benefit and social care preparing for Better Care). Once agreed, this detail will form part of the Section 75 Agreement for 2016/17 and be included in our final plans, which will be agreed by Health & Wellbeing Board.

As part of the Section 75 agreement, we will also be supplying a detailed Project break down, with milestones. Appendix 3 sets this out where we already have this level of detail.

The following sections summarise our key plans for 2016/17 and show where they are specifically funded from the Better Care Fund. This should be read in conjunction with Section 9 which details plans that specifically support national conditions (including Discharge to Assess).

Test and Learn pilots (Aim 1 & 2)

Better Care Bristol will be running some test and learn pilots in 2016/17. Underspend of £100k within the 2014/15 Better Care Fund from last year is being used to support this project. These pilots were designed to drive integration to deliver more co-ordinated care and the outcomes will inform the adult community services re-commissioning.

The pilots were designed considering the 'Bristol Care and Support Triangle' (see Figure 1) focusing on:

- **Self-care** support, **prevention**, addressing **health inequalities** working with public health communities and with individuals,
- Neighbourhood support, **social prescribing**/health and wellbeing services working with the voluntary sector and with communities,
- Primary care practices working together in new ways with each other, with GP, community and acute specialists and **integrated** community teams.

Pilot 1 - Community Webs

This pilot aims to align assets in a community (GP practices, voluntary sector etc) so people can be supported to access community resources independently. This will help to relieve some of the pressure on health and social care services; aid the identification of complex, "at risk" individuals, and prevent expensive and potentially harmful over-medicalisation of social problems.

Expressions of interest applications were sent to practices at the end of March 2016 with a submission date of May 5th 2016, for implementation through 2016/17.

Pilot 2 - Multi-disciplinary Teams (MDT)

This pilot will maximise the skills and efficiencies of staff around GP clusters to test whether better co-ordination and MDT approach could provide more effective patient care and address citizens telling the same story twice. Integrated teams and multi-disciplinary teams will comprise, as a minimum, nurses, occupational therapists, physiotherapists, GPs, pharmacists, mental health staff, health and social care staff and will link with community dementia navigators. This will ensure that a holistic service is delivered around patients with multiple co-morbidities. This test and learn has the most resonance with the integration debate.

Pilot 3 - Integrated Nursing

This pilot aims to align community nurses, community psychiatric nurses and practice nurses around a cluster of practices with one deployment process and caseload. This model will create a robust single coordinated case load around patients in the community that will manage an individual's needs in the community, for example in the case of long-term conditions and treatment-based care. The model will use self-care techniques and anticipatory skills to reduce admissions and support discharge.

The model will allow staff to follow patients between settings for care, for example across practices and home. Part of the test and learn will be developing the delivery of care as a one stop, in clinic based settings if transportation and estates are provided.

This will reduce social isolation and could link with the Community Webs pilot to provide proactive intervention and consistency of care in a more cost effective model.

Frailty (Aim 1)

Bristol is currently reviewing its frailty services and looking to develop a strategy to support frail people. The strategy will aim to improve the quality of care, reduce harm and improve the consistency of access to services and care. This will be achieved by improving performance, meeting the current financial challenges and the efficiency targets for both health and social care in delivering system performance. Areas currently being reviewed include:

1. **Frailty Baseline Self-Assessment (Whole System)** – to review how an end-to-end integrated pathway for older people would look and to understand how it could be commissioned effectively using levers and incentives across providers.

2. **Acute Work Stream** - working with the acute trusts to improve the care for frail patients including using the Acute Care for Older People Toolkit (NHS Elect) and action plan
3. **Voluntary and Independent Sector** – Many older people have needs vital to their ability to stay out of hospital and thrive in their own home but which falls outside of the NHS and social care remit.

   Bristol aims to explore further ways to enable voluntary sector organisations in Bristol to work together to support frail and elderly before, during and after their discharge from hospital. This will be led by the British Red Cross and Bristol Aging Better.
4. **Primary and Community Care** – Align with Bristol Primary Care Agreement (BPCAg) work around the prevention agenda of patients >75years and enhanced services by providing GPs and Practice Nurses with a suite of tools to support the case finding, assessment and case management of frail older patients.

Self-care (Aim1)

Bristol CCG's Self Care Strategy was approved by the CCG Governing Body in the summer of 2014. The Strategy aims to work towards a future state in which patients are empowered to self-care, taking responsibility for their own health and wellbeing, and where health and social care professionals are equipped with the tools, techniques and resources to support patients on this journey. Alongside the Self-Care Strategy an action plan has been published, which was the principle means through which the Strategy would be delivered. Any actions requiring investment are subject to the CCG's planning and investment processes.

The Better care Team is currently working with Wessex Water to develop a business case to develop a social prescribing project aimed at reducing wasted medication and in particular people disposing of unwanted medication into the water system.

Investment into Primary Care

£3.97m of the Better Care Fund is ongoing in 2016/17 to Bristol Primary Care. A transformational three year contract held with GP practices which incentivises them to work individually, in clusters and locality-wide across a number of key areas including urgent care, planned care, risk stratification, mental health, end of life and long term conditions including self-care.

Joint Front Door – Primary Care Lead (Aim 2)

Bristol CCG plans to commission a Primary Care Lead 'Joint Front Door' streaming model at Bristol Royal Infirmary (BRI) which encompasses an Urgent Care Centre (UCC) on the site of the existing BRI Emergency Department (ED), working with Primary Care and United Hospitals Bristol.

A key feature of the new service model will be the streaming of patients on arrival through the Joint Front Door by Primary Care. Patients will be directed to the most appropriate services e.g. Primary Care and /or wider community services. They may also be provided with reassurance, immediate advice or be re-directed to their own GP Practice, the Urgent Care Centre or ED.

A dedicated non-clinical navigator will assist patients in registering with a General Practice and/or accessing more appropriate services, including booking alternative appointments (GP Practice, Out of Hours (OOH) or other community service if appropriate.)

Single Point of Access (Aim 2)

A Single Point of Access will be created to replace the current multiple single points of access for health and social care services for professionals.

The Single Point of Access will provide triage / assessment / advice for health care professionals and patients on care plans to help manage their conditions to help mitigate an acute episode. The Single Point of Access will, via the Directory of Services, signpost patients to the most appropriate service to provide immediate, appropriate, and necessary treatment.

The Single Point of Access which will provide 24 hours a day, 365 days per year, will be included in the development of the Urgent Care Centre and OOH service. Therefore this project will need to work closely with the Joint Front Door and Urgent Care Centre Project.

This project is still being scoped and will be in three phases, with the most transformational element taking place in 2017/18.

Homelessness (Aim 2)

A recent NHS England needs assessment highlighted that Bristol has one of the highest numbers of rough sleepers in England, second only to Westminster and with numbers near 100 each night. Studies suggest that people who are homeless attend ED six times more than the housed population, are admitted four times as often, and stay three times as long.

In light of this we are running an 18 month pilot located within the Integrated Discharge Hub at UHB called the ‘Homeless Discharge Team’. The purpose of the team is to co-ordinate the health, social care, housing and other needs of homeless patients to enable a safe, timely and effective discharge from hospital which is appropriate for the circumstances of each individual; improves patient experience and reduces the likelihood of re-attendance and re-admission. If the model is successful we hope to roll it out to North Bristol Trust (NBT).

Extra Care Housing Nurse Pilot (Aim 2)

We are launching a two year pilot providing nursing support to three Extra Care Housing (ECH) schemes. The pilot aligns with the Better Care fund priorities of providing a more integrated approach to elderly care across health and social care. Its aim is to reduce hospital admissions and emergency department attendances through:

- Early intervention,
- Supporting self-management
- Case management of tenants who have been identified at risk of admission to hospital due to long term conditions or changing healthcare needs

The 16/17 Better Care Fund has allocated £98k to support this project this year.

Care Home Support Team (Aim 2)

An existing pilot has been redesigned for our Care Home Support Team, whose primary objective will be to improve the quality of the care provided in Care Homes with Nursing (CHwN) through supporting, training and upskilling the care home staff, with an emphasis on End Of Life Care planning.

The team will help to develop links with GPs, community services and the acute hospitals to ensure all healthcare professionals can provide the best possible care to the patients.

The Care Home Support Team aims to reduce the number of care homes with organisational safeguarding issues and reduce avoidable admissions to hospitals. If successful this will improve bed capacity issues and overall patient flow which in turn will benefit the system as a whole.

The 16/17 Better Care Fund has allocated £425k to support this project this year.

Care Act Implementation - Information, Advice and Guidance & Self-Assessment (Aim 1)

Our ambition is to provide Bristol residents with a high quality way of receiving Information, Advice & Guidance (IAG) about health and social care services, specifically with the aim of enabling and increasing the rate of self-service under the 'Help to Help Yourself' element of the Three tier model. The roadmap to deliver and agree is under review.

This programme of work is resourced through the allocation of £1.17m Care Act implementation as part of the 2016/17 Better Care Fund.

First Contact Checklist (Aim 1)

Better Care Bristol has been involved in the designing of Bristol's First Contact Checklist which is being developed by Bristol Ageing Better and will be piloted in June 2016.

The checklist is a series of simple questions that can be asked by professionals, the public and volunteers in their day-to-day contact with older people, with simple onward referral mechanisms to services such as fire service, debt advice and the wellbeing hub. This project aligns with the prevention and self-care agenda. It also contributes to condition five around ensuring a joint approach to assessment and care planning.

Wellbeing Partner Pilot (Aim 1)

Better Care has secured £147k from Health Education South West for this project. Workforce issues are an area where there is consensus that further action is required, in terms of recruitment, effectiveness, skill mix, and training. The Wellbeing Partners Pilot is a good example of how we are beginning to address this as well as other examples of work including:

- initial discussions with the Council's Care Provider Forums and education about various initiatives to encourage a more positive view of care as a profession for example links between providers and schools and other education
- commissioning contracts that set targets for apprenticeships in care contracts
- the Care Home Support Team and Extra Care Housing pilots which aims to upskill staff in those care facilities

Disabled Facilities Grant (Aims 1 and 3)

In 16/17 the Disabled Facilities Grant (DFG) is held within the Better Care Fund and resourced at a level of £2.42m, this represents an increase. Through the Better Care Commissioning Board, the City Council has reviewed how the programme will be delivered.

Rather than continuing to use this funding just to install aids and adaptations following a referral from the client through Care Direct, the City Council is also considering a number of other ways to utilize this funding to proactively install adaptations in accommodation used by older and vulnerable households. The options currently being considered are:

- Pro-actively adapting flats within Very Sheltered Housing (VSH) units which are currently empty, to install adaptations or ensure the accommodation is fully accessible and are adaptable for the changing needs of the occupiers as their conditions change. Some of the first VSH units built were not fully accessible when they were originally built ;

- Providing funding for one of our jointly commissioned services; West of England Care and Repair, to fund the capital costs of installing urgent adaptations or repairs to enable residents to be discharged quickly and from hospital to their homes.

Aftercare Services - Section 117 (Aim 3)

Work is being developed to ensure that the patient experience around Section 117 is improved with more robust assessment and review.

In addition the current investment could be used more efficiently. Bristol CCG currently contributes £4.1 m under Better Care towards the costs of the "health" component of Section 117. In 2015/16, Section117 was an area of significant spending and cost pressure across health and social care. Scope for managing spend and patient experience better through tighter control is being explored, alongside plans for regular review and re assessment of care packages. This is subject to development of a business case.

9 Meeting the Better Care National Conditions

Condition 1 - Plans to be jointly agreed

Plans to date have been signed off by the Better Care Bristol Commissioning Board in March and by the Health & Wellbeing Board on 20th April 2016. The final plan and Section 75 agreement will go to Health & Wellbeing Board for final approval by 30th June 2016.

Condition 2 - Maintaining Provision of Social Care Services (Not Spending)

Under Better care circa £17m has been allocated to social care in 2016/17 to help maintain provision of social care services that have a health benefit. The majority of this resource is allocated to the specific projects as described in this section, section 8 and the template submission. Bristol City Council is currently developing plans for £6.5m of this fund in 2016/17 showing how it is proposed to use this funding for agreement with Bristol CCG, which will be incorporated into the Section 75 Agreement and our final plans for 2016/17.

Condition 3 – 7 Day Working

Existing Services

Bristol provides and has further developed a number of services 7 days a week in the community through its Community Health Services Contract.

These include:

- Community nursing
- Out of Hours (Primary Care)

- GP Support Unit (BRI) and GPST (NBT) Continuing funding of £1.34m has been in allocated in 16/17 for this
- Urgent Care Centre (South Bristol)
- Walk In Centre (Broadmead)
- Rapid response
- End of Life Care Coordination Centre
- 7 day working in MH in community teams and crisis team as well as inpatients

The End of Life Coordination Centre is a 7 day a week service linking palliative care home support and continuing healthcare fast track nurses to provide rapid assessment and service delivery for patients.

It reduces unnecessary hospital admission, facilitates hospital discharge for patients at the end of their life and supports people at the end of their life and their family and carers to provide high quality care and access to support. These services offer a response of new and existing patients who require support over the weekends or night time.

In 2015/16 a number of pilots to expand 7 day working were explored and have informed service developments and plans for 2016/17. There has been capacity and evidence led expansion of 7 day a week services for community nursing. These services can be contacted directly or via the Urgent Care Single Point of Access.

Under Better Care Bristol we have a commitment to further develop 7 day working which is demonstrated by the plans to introduce the following 7 days services in 2016/17:

- 7 day social care services including social care practitioners in ED and an enhanced brokerage
- Discharge to Assess
- REACT

7 day - Social Care Services & Enhance Brokerage Team

As part of our commitment to develop 7 day working, Better Care Fund has allocated £375k funds to ensure that social care teams are available to support discharge and reduce avoidable emergency admissions 7 days a week in the Emergency Department of both acute trusts (NBT & UHB) with our Rapid Emergency Assessment Care Team (REACT) and implement an Enhanced Hospital Brokerage Team.

This team will work within Hospital Social Care Teams in both acute hospitals to ensure care services can be sourced more quickly. They will also have the time and capacity to work closely with families to facilitate decision making around choosing a

care home and discharge with all the advantages of the central brokerage service. The business case has been developed and will roll out in 2016/17

The Hospital Brokerage team will work closely with the contracts, commissioning and quality teams, to ensure any safeguarding concerns or quality issues are raised and dealt with quickly and efficiently to ensure that placements are only made with those Care Homes meeting the required quality standards.

It is hoped that this project will ensure that care purchased is more consistent. Bristol CCG has recently created a new joint contract, and it is envisaged that the majority of Bristol City Council (BCC) Care Home provision for older people will be commissioned on a block basis. Any spot purchased placements under the new Care Home contract will be made via a BCC software system which will encourage competitive prices for individual services.

Discharge to Assess (D2A)

A total of 3.72m is allocated to Discharge to Assess pathways in 16/17. In addition, the CCG have allocated £1.03m community equipment which supports discharge.

The Discharge to Assess model is currently working on a 6 day model; this is helping to alleviate pressures Monday to Friday. The next phases of the project will specifically work to support discharge across the week, on the day patients become medically stable to step down:

- **Pathway 1** (Home with Support) – a redesign to existing services will facilitate a single access point for all D2A referrals. Using a trusted handover from acute to community staff, patients will be able to step down from hospital in a more timely manner. A pilot using dedicated capacity from the reablement service will commence in May. This service is already able to accept patients at weekends.
- **Pathway 2** (Community Rehab Beds) – trusted handover will facilitate more discharges on the day the patient is medically optimised to transfer. Provided the discharge is well planned, all of our Pathway 2 providers will accept transfers at weekends.
- **Pathway 3** (Complex Assessment Beds) – all providers will accept well planned admissions at weekends. All struggle to assess at weekends due to limited or no management cover within the homes.

Social Care Teams in REACT

Having Social Care Practitioners (SCP) join the REACT team allows access to social care records to review patients' home situations, or identify community concerns in order to facilitate early discharge from the A&E queue at the front door, therefore avoiding an admission. Additionally their presence has helped create an increased awareness amongst the wider health care staff on the services available.

This role has also been supporting discharge from hospital, picking up referrals from the Older People Assessment Unit (OPAU) at UHB to facilitate discharge from these wards without people needing to be transferred to long term acute wards.

This service is funded by better care under D2A pathway 1

Condition 4 – Use of NHS Number between Health and Social Care

All providers and the LA record the NHS Number where available. Our health providers have access to the NHS spine and have the capability to use the NHS Number in their correspondence.

The Local Authority does not have this capability to do this routinely as they do not have access the NHS Spine. A plan is in place for N3/NHS spine access to be implemented – a NHS Number Batch Tracing Service is in place.

Bristol City Council implemented a new Care Management System called Liquid Logic in July 2015. The Liquid Logic system gives Connecting Care the ability to use the NHS number using the LA matching engine Next Gate. Plans are being developed to use this as one of the identifiers and gain agreement if this can be considered as a primary identifier. This means that we now have the technical capacity to use the NHS number to identify individuals across health and social care for read and write purposes.

Although Bristol City Council does not routinely have extended access to the NHS Number batch service, there is the mechanism described above for using the number via Connecting Care. The Better Care team are monitoring the national plan to resolve the issues with HSCIC and will ensure a local plan is in place for the LA to access the N3/NHS spine once the a NHS Number Batch Tracing Service is in place.

The community provider has also recently changed to the system EMIS which will be the same system that Bristol primary care uses. This has enabled read and write facility.

The Connecting care BNSSG programme which is funded by all partners will contribute to the delivery of this condition.

Condition 5 - Joint Approach to Assessment and Care Planning

Bristol CCG and Bristol City Council have several services and schemes in place to support Joint Approaches to Assessment and Care planning. These can be summarised as follows:

Intermediate Care Services: Our Intermediate Care Services work jointly across Health and Social Care and have a long history of joint assessment and joint care planning across health and social care

Making Every Contact Count: This is a Public Health initiative designed to make contact with people across a range of services and interventions meaningful and an opportunity to engage with them about health and wellbeing issues

First Contact Checklist: This is developed by Bristol Aging Better. It is about asking simple questions that the public and voluntary staff can ask in their day to day contact with older people to facilitate simple on referral.

Dementia Pathway: Devon Partnership Trust have been commissioned to provide "dementia navigators" to support service users and their carers in accessing support and services as they move through their dementia journey, whether they be supported at home or in a care home.

Information Advice and Guidance: As part of the Local authority's response to the Care Act an on line self-assessment and referral platform is being developed. This will allow people to self-assess and will lead them either to full assessment if appropriate or to a series of on line resources to address their social care and health needs

Section 117 management: We currently have a joint approach to people on S117 in that high cost packages are reviewed and plans agreed at a case discussion forum.

Test and Learn pilots: As detailed elsewhere the three test and learn pilots will provide significant opportunities to explore joint assessment and care planning, particularly through the MDT and the integrated nursing Pilots

Connecting Care: Connecting Care continues to be an enabler to joint assessment and care planning (see Condition 4 above)

Condition 6 - Agreement on impact on providers

This plan has been developed and shared by members of the Transformation Board made up of CCG, Local Authority and all local acute and community providers.

Providers are mindful that it can be difficult to track individual projects within Better Care to wider, multifaceted targets such as DToCs or NEAs. In response to this, and for the Section 75, the Better Care Team are reviewing the monitoring and activity measurements, to makes it easier to track the projects within the Better Care Find.

As evidence, we include the statement from University Hospital Bristol received in response to our 16/17 submission

"The Trust is an active member of the Bristol Better Care Fund and has been involved in developing the 2016/17 Plan. The Trust has developed contingency plans for managing the impact of reduced activity and is committed to working with commissioners and others providers to reduce the reliance on acute care"

Condition 7- Agreement to invest in Out of hospital

Bristol CCG is investing considerably more than the minimum requirement of circa £8 million in out of hospital services in the community, as set out above and within our planned expenditure set out within the national template. Our plans for 2016/17 show an investment of £21.8 million in out of hospital services.

Condition 8 - Agreement on local target and plan for DToC

As set out in the template submission, the Better Care Board agreed to work towards the national average of 2.5% over available beddays for DToC. A refreshed joint DToC plan has been developed for Bristol and included in Appendix 4 that builds on the services already outlined earlier that are supported by Better Care (for example Discharge to Assess, 7 day working for social work, investment in community equipment).

A crucial component of that refreshed plan will be a risk share agreement, which has been developed between Bristol CCG and Bristol City Council who are currently discussing allocation, data quality and sharing of risks for DTOC for UHB. This will be agreed and included within the Section 75 Agreement.

Document ends

Appendix 1 - Governance Structure

Better Care Bristol Governance Structure

BNSSG System – wide Leadership

Bristol CCG (Relevant Org Sign Off)

Key Responsibilities:
- Agreement to proceed
- Own Governance Arrangements

Health & Wellbeing Board

Key Responsibilities:
- Leadership across the System
- Authorisation to proceed
- Sign Off Care & Support Triangle and receive regular updates
- Health Equalities / Prevention
- Authorises Section 75 Pooled Budgets arrangements

Bristol City Council (Relevant Org Sign Off)

Key Responsibilities:
- Agreement to proceed
- Own Governance Arrangements

Better Care Bristol Commissioning Board (Adults)

Key Responsibilities:
- Commissioners only
- Co-commissioning
- Better Care Fund Assurance
- Includes all Adults not just >65s
- Agrees Lead Commissioning Organisation
- Co-ordinated Commissioning Discussions Across Organisation / System
- Joint Commissioning Discussions / Decisions
- Agree System Delivery Model (Bristol Care & Support Triangle)
- Agreement & Recommendations to proceed to Commissioning Orgs & H&WB
- Authorise test and learn pilots at Neighbourhood and Locality Level
- Develops Section 75 Pooled Budget Arrangements (Single Pooled Budget) for Integrated Services and monitors all projects within
- Responsible for Governance / Finance / Process / Assurance

Better Care Bristol Transformation Programme Board

Key Responsibilities:
- Commissioners and Providers
- Clinical Chair
- Develop Better Care Fund Schemes
- Develop QIPP / Transformation Schemes
- Recommendations to proceed to Better Care Bristol Commissioning Board
- Includes all Adults not just >65s

Better Care Bristol Design Team (Task & Finish)

Key Responsibilit
- Commissioners &
- Develop Proposals Bristol Care and reverse)
- Clinical Input from

Monitoring Business as usual:
- Business as usual
- Section 75 and all projects within (Carers Breaks, Disabled Facilities Grant etc.)

Decision Making
- Integrated transport
- Technology
- Healthy neighbourhoods
- Expert patients
- Self-care integration
- Care Forum website consultation website

PROJECT AREAS

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
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	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	Ensuring, where necessary, people get the ongoing support they need to be safe and to live as independently as possible

Appendix 2: Risk Log

Bristol Clinical Commissioning Group Better Care Register June 2016

CCG Principal Objectives

The CCG has agreed the following Principal Objectives contained in the Governing Body Assurance framework to:
PO1 improve the health of people in Bristol
PO2 improve patient experience and access to healthcare
PO3 work with Bristol City Council to reduce health inequalities
PO4 work with our partners to ensure there is a sustainable and affordable healthcare system in Bristol
PO5 ensure cost effective delivery of QIPP and financial arrangements
PO6 be an organisation that embraces its corporate social responsibility

Risk is assessed by multiplying the impact of a risk materialising by the likelihood of it materialising using the risk assessment matrix set out in the CCG Risk Management Strategy
Risks are also mapped against the CCG risk appetite and accepted risk limits to provide an indicative acceptable risk level. where a risk maps to more than one principal objective the lowest level of risk appetite and risk limit is given. It is for the Governing Body to decide if these risk limits are appropriate for each individual risk

Ref CRR	Risk Description	Principle Objective ref	entered on register	original impact	original likelihood	original risk rating	Current Internal Controls and Evidence/Assurance	current impact	current likelihood	current risk rating	gaps in control/evidence and assurance	Actions to mitigate (treat, transfer, terminate, tolerate)	Further Actions to mitigate risk,	Risk limits/appetite	Risk Owner	target date	Review Date
Bristol Clinical Commissioning Group Corporate Risk Register																	
01	If partners have insufficient capacity then the delivery of the programme to timescales agreed will be compromised	p04, P01, P05,	24/07/2015	4	4	16	**Control** Programme support infrastructure funding allocated, Programme Director in place, Programme team in place in CCG Governance structure established **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4	4	3	12	Turn over in current team due to fixed term contracts impacting on capacity Gap analysis with proposals to increase capacity for specific areas of non delivery with timescales to be reported to Transformation Board for approval	Partners to identified and allocate capacity on an ongoing basis Transformation Board to approve gap analysis and plans to address gaps. Further investment in 7 day working at front & back door	Recruitment process to complete capacity in place and ongoing June 16 - All posts fully recruited to transformation PM resource for Front Door secured from CSU & PM for SPA from within Better Care team. Delays in recruitment for reablement is impacting on DTOC particulary and NBT. Update to be reported to next Transformation Board	High	Operations Director	01/01/1900	13/11/2015
02	If cultures across all partner organisations remain unchanged then delivery of programme will be compromised	p04, P01, P05,	24/07/2015	4	4	16	**control** Engagement established at senior levels across partner organisations through the Governance Structure and senior leadership groups Leadership for Change Team established and working with programme director **Assurance** Delivery of Better Care monitored through governance structure and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4	4	3	12	Ensuring engagement at all levels particularly front line staff to enable new ways of integrated working	Design team developing new models of working Design team made up of service delivery level managers to ensure engagement workforce and Org Develop group established	Active engagement with internal communications June 16 - Development of STP promoting interagency working. Test & Learns agreed. Design team no longer meeting, workforce group to be re-established.	low1-3	Operations Director		13/11/2015
03	If financial models do not accurately predict savings and cost avoidance opportunities then programme will fail to deliver financial opportunities	p04, P01, P05,	24/07/2015	4	4	16	**Controls** National financial models established and used to develop local financial and operational plan Quarterly national reporting to Better Care Task Force **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure to Commissioning Board and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4 Internal Audit report on Performance, monitoring and management Q4	4	5	20	Limited evidence linking admission avoidance to individual projects Evidence is that admissions are rising Performance and activity data indicates that QIPP schemes are not delivering to target. CCG now formally in turn around position (BCF = £3.6 m of gap)	Work in train to understand profile of increase in Emergency Admissions. DTOC action plan & risk share being developed for further investment in Social Care to deliver 7 day working & brokerage.	June 16 - Robust QIPP assurance process in place. BCB using PMO documentation & reports. Minutes of Commissioning board to be shared with Governing Body. Revised Governance arrangements being developed to include assurance to group.	low1-3			13/11/2015
04	If fail to deliver admission avoidance and excess bed days financial savings will not be released and CCG takes further financial risk	p04, P01, P05,	24/07/2015	4	4	16	**Controls** Urgent Care and Planned Care QIPP schemes in place with providers **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure to Commissioning Board and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4 Internal Audit report on Performance, monitoring and management Q4	4	5	20	Limited evidence linking admission avoidance to individual projects evidence is that admissions are rising Data re excess bed days not yet available from NBT Admission avoidance schemes with NBT to be established performance and activity data indicates that QIPP schemes are not delivering to target. CCG now formally in turn around position	Work in train to understand profile of increase in Emergency Admissions. Secured NBT membership for new transformation board Recovery Plan in development with additional schemes relating to admission avoidance, including 7 day working, DTOC action plan & Risk share.	June 16 - Robust QIPP assurance process in place. BCB using PMO documentation & reports. Minutes of Commissioning board to be shared with Governing Body. Revised Governance arrangements being developed to include assurance to group.	low1-3			13/11/2015
05	If savings are counted across two programmes then actual savings will be overestimated	p04, P01, P05,	24/07/2015	4	4	16	**Controls** Better Care outcomes aligned to CCG operational plan financial reporting systems in place allocating savings across QIPP schemes monitoring through Planning Meeting PMO working with BC Team **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure to Commissioning Board and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4 Internal Audit report on Performance, monitoring and management Q4	1	2	2	No gaps at moment - continue to monitor situation		June 16 - Robust QIPP assurance process in place. BCB using PMO documentation & reports. Minutes of Commissioning board to be shared with Governing Body. Revised Governance arrangements being developed to include assurance to group. **Risk closed. To be removed from the register in future updates.**	low1-3			13/11/2015
06	If new models of care and ways of working are not financial viable and do not deliver recurring savings costs will increase	p04, P01, P05,	24/07/2015	4	4	16	**Controls** Better care team monitoring Vanguard projects to identify cost effective models discussions being held with Vanguard Project Leads to identify learning transferable to Bristol context Design Team Business Plans considered by Transformation Board and Commissioning Board and to inform recommissioning Adult Community Services Governance structure in place **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure to Commissioning Board and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4 Internal Audit report on Performance, monitoring and management Q4	4	4	16	New models of care as listed in SYFV not in development	Head of Better Care investigating mechanism for the development of new models of care in line with SYFV	June 16 - 3 Test & Learns and Primary Care Home pilots agreed. Robust monitoring of projects through PMO mechanism. STP provides potential opportunity for developing new models.	low1-3			13/11/2015
07	If existing contracts and payment mechanisms are not sufficiently adaptable to support new models of care there will be duplication of costs	p04, P01, P05,	24/07/2015	4	4	16	CCG exploring local tariffs with regulator monitor pilot established in other areas evidence that other commissioners have agreed local tariffs **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure to Commissioning Board and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4 Internal Audit report on Performance, monitoring and management Q4	4	4	16	Models not established and local tariffs not in place. NBT data continues to be a challenge	Continue to explore potential. South Glos leading discussions on NBT coding.	June 16 - Ongoing	low1-3			13/11/2015
08	If key projects and or significant numbers of small projects slip then there will be a material impact on the delivery of savings and future delivery	p04, P01, P05,	13/11/2015	4	4	16	**Controls** Monthly highlight reports presented to Transformation Board project support at full capacity Clinical leads in place as appropriate Transformation Board provides exception reports to Commissioning Board **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure to Commissioning Board and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4 Internal Audit report on Performance, monitoring and management Q4	4	5	20	Ability to obtain clear milestones and trajectories from partners in highlight reports project reports not highlighting risks. Lack of KPI reporting by LA on benefits linked to investments.	BC Team to support Project Management. Operations support identified within Local Authority monthly meetings to review highlight reports with Aim 2 Programme Manager. Performance/ BI support to be identified within the Local Authority.	June 16 - Robust QIPP assurance process in place. BCB using PMO documentation & reports. Revised Governance arrangements being developed to include assurance to group. LA to resource Business Inteligence & KPI reporting.	low1-3			13/11/2015
09	If Section 75 budget is not fully utilised pathway changes are not fully enacted		06/06/2016	4	4	16	**Controls** Bi- Monthly finance report to Commissioning Board. Detailed Section 75 agreement in place for 2015/16 **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure to Commissioning Board and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4 Internal Audit report on Performance, monitoring and management Q4	4	4	16	Final Section 75 for 2016/17 to be agreed by August including detailed schedules Revised Governance arrangements will include bi-monthly assurance meetings	Section 75 & underpinning schedules currently being negotiated.		low1-3	Operations Director	30/06/2016	31/07/2016
10	The developed of the STP & focus on BNSSG could reduce the focus on Bristol specific activity		06/06/2016	4	3	12	**Controls** Monthly highlight reports presented to Transformation Board project support at full capacity Clinical leads in place as appropriate Transformation Board provides exception reports to Commissioning Board **Assurance** Delivery monitored through QIPP assurance group and reported to Finance, Performance and Planning Committee through monthly report and to Governing Body in monthly finance report Delivery of Better Care monitored through BC governance structure to Commissioning Board and reported to Finance, Performance and Planning Committee and to Governing Body through monthly finance report Internal Audit Report on Better Care Fund Q4 Internal Audit report on Performance, monitoring and management Q4	4	3	12	No gaps at moment - continue to monitor situation. Potential for STP plans to be different to local system plans, potentially impacting on existing schemes.	Internal CCG out of hospital group meeting regularly to check STP development & ensure alignment.		Moderate	Operations Director	31/10/2016	31/10/2016

Appendix 3: Project table including National Metrics and Milestones

National Metric	Local Scheme/ Intervention
NEA	Healthy Living Pharmacies HG Wells Public Health Wellbeing Hub First Contact Checklist MECC BPCAG Keeping people at home Front door SPA Extra Care Housing IPC GPST GPSU 7 Day Working Social Prescribing Connecting Care
Long-term support need of older people aged 65+ met by admission to residential and nursing homes, per 100,000 population	BPCAG SPA IPC Social Prescribing
Proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into Reablement/rehabilitation service	Discharge to Access SPA Social Prescribing
Delayed Transfer of Care from Hospital per 100,000 population aged 18+	BPCAG Keeping people at home SPA 7 Day Working Discharge to Access Connecting Care

National Metric	Local Scheme/ Intervention
Emergency hospital admissions aged 18+	Healthy Living Pharmacies HG Wells Public Health Wellbeing Hub First Contact Checklist MECC BPCAG Keeping people at home Front door SPA Discharge to Access GPST GPSU 7 Day Working Extra Care Housing Social Prescribing IPC Connecting Care
Patient/Service user experience	Healthy Living Pharmacies Wellbeing Partners Public Health Wellbeing Hub First Contact Checklist MECC Community Webs Keeping People at Home Front Door Discharge to Access Extra Care Housing Section 117 Social Prescribing IPC 7 Day Working Connecting Care

Key Milestones (Projects within Better Care Fund)	
BPCAg	May - 100% of GP practices sign intent to deliver BPCAG contract May - Each GP cluster to identify 1 GP & 1 practice manager to work with CCG on STP planning June - 90% of practices reporting ALAMAC data daily
Keeping people at home - Care Home Support Team Pilot	April - Recruit 2 FTE nurses / Mgr and admin support June - Staff in post June - Training review for what is available for Care Home Staff/ gaps
Keeping people at home - Extra Care Housing Nurse Pilot	April - Recruit staff May - Confirm the ECH schemes nurses will be working with June - Staff in post March 2017 - Evaluation of last 12 months of pilot, decision to be on continuation into 2nd year
Front door/ SPA	May 2016 - FPP to agree pilot July 2016 - Pilot begins streaming and treating adults in front of ED Nov 2016 - FPP to agree Front Door stage 2nd business case Feb - May 2017 - Conduct Procurement exercise to agree lead provider for streaming hub and UCC Oct 2017 - Front door to be fully operational
Discharge to Access	May - pilot on 3 wards of dedicated reablement capacity for pathway 1 May - pilot of 72hr assessment bed for D2A at front door. June - 20 additional beds for people with dementia in pathway 3.
7 Day working	June 2016 - recruitment of social care and brokerage to cover weekends. July 2016 - Staff trained in post.
Section 117	June - task and finish group to meet and design a work stream
Community Webs Integrated community/ practice nursing teams Practice cluster multi-disciplinary teams (MDTs)	May: selection of Pilot site. June Project manager in Post September First results
Wellbeing Partners Pilot	July, start of the 1 year course. Further milestones within 2017/18
Care Act	May - Roll out Carers RAS pilot May - Safeguarding Pathway - Revised DoLS pathway in place May - Self-Assessment questions agreed and configured June - Reviewing strategy developed for Review pathway Aug - Digital IAG & Self-Assessment – Go live date

Appendix 4 – Delayed Transfer of Care Action Plan

Actions to Reduce DTOCs

No.	Subject	Action	When
1	Action carried forwards from NHSE plan: Review of the **UHBT workforce planning strategy** to secure support for initiatives aimed at addressing workforce shortages and achieving a permanent workforce with normal vacancy rates before next winter.	Board Seminar planned for 13th May when workforce plan will be presented in draft prior to formal approval at June Board.	June
2	Action carried forwards from NHSE plan: Access to timely **dossette boxes and other medications TTA.**	The Pharmacy should produce an urgent plan for addressing issues with the production of Dossett boxes, affecting the ability to discharge patients.	April
3	**Strengthening of criteria led discharge**	As part of "Plans for the Weekend" new processes for criteria led discharge will be trialled, including a consultant led weekend planning session on the Thursday afternoon at which each patient's plan will be reviewed.	18-23 May
4	**Integrated Discharge Hub (IDH)**	A separate action plan to be developed (*and embedded here*) aimed at embedding joint working practices and efficiencies in the IDH. A new role as lead for the IDH is being scoped and this person will lead the review and action plan.	June
5	**North Somerset discharge processes**	Continue monthly meeting with colleagues from the NS system (NSCCG, NSCP, and NSC). Action plan to be reviewed *and embedded here* for monitoring.	From April and ongoing
6	**Single Referral Form** for all complex discharges will simplify processes and release time to care.	Single Referral Form to be piloted on A605 and A522	31 June
		Single Referral Form roll out across the Trust	31 July
7	Reconfiguration of the **Community Discharge Co-ordination Centre (CDCC)**	Reconfigured CDCC will act as a single point of access for D2A pathways and will release time to care back to the wards.	31 June
8	**D2A Pathway 1** (see also Pathway 1 project plan *to be embedded here*)	Pilot on A522 and A605 using dedicated capacity from reablement	31 June
		BCF investment in reablement to provide an at scale home from hospital service. Goal for the majority of patients with	TBC

		complex needs to return home for assessment by the reablement service. Currently at business case stage requesting that recruitment progress at risk for permanent staff.	
9	**D2A Pathway 2** (see also Pathway 2 project plan *to be embedded here*)	New system to record and report all delays in community beds using a coding system aligned with UHB's	June
		Review of bed stock across the Pathway 2 system, to include revised models of care and agreed LOS	July
		Scoping of integration of therapy resources across Acutes and Community (to include SG and NS)	July
10	**D2A Pathway 3**	Revised SOP to be finalised for pathway 3.	May
		Addition of 20 block beds for PWD for Pathway 3 (joint block between BCC and BCCG)	Mid July
		Meeting to review actions agreed for handover of operational management of Pathway 3 to BCC, and reporting arrangements for agreed KPIs.	29 June
11	**Bristol City Council Discovery Team Review of D2A Pathways**	outcome to be reviewed	TBC
12	**Demand and capacity modelling for D2A pathways**	Impower demand and capacity model to include UHB data. Currently being developed by CSU.	June
13	**Early Discharge Planning** In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow all expected dates of discharge to be set within 48 hours.	**For elective patients:** CCG and ASC commissioners are discussing how community and primary care coordinate early discharge planning. Ideal scenario is for early discharge planning to occur for all planned admissions by an integrated community health and social care team or response. **For emergency admissions:** Emergency admissions have a provisional discharge date set in within 48hrs which the whole hospital is committed to delivering. Evidence to demonstrate X% patients go home on date agreed on admission	
14	**Systems to Monitor Patient Flow** Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand),	UHB demand data to be added to the iMpower demand and capacity modelling. Results to be tracked via Alamac kitbags. Increasingly integrated response via enhanced hospital brokerage teams. Community delays to be recorded and reported on Alamac. D2A reablement expansion (including	June June June TBC

	and to plan services around the individual.	dedicated D2A team) is planned. Currently at business case stage as posts are fixed term, but request submitted for permanent posts “at risk”. Aim is for capacity to match demand.	
15	**Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector** Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	Trusted assessment / single referral form planned as part of D2A Pathway 1 pilot. Daily navigation meetings planned at UHB for the IDH. Further work needed to develop the IDH, including recruitment of IDH Leader, cross cover by IDH reps at board rounds, embedded community nurse to pull patients out, target for the majority of CHC complex assessments to be completed outside hospital.	June June June
16	**Work with care home sector**	Goal for all care home assessments to be completed within 48 hours of referral. Use of single referral form to replace face to face assessments where possible (probably not be people with very complex needs).	TBC July
17	**Seven-Day Service** Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people’s needs.	Negotiations with care providers to assess and restart care at weekends. Plan to move to 7 day working across UHB system being drawn up.	TBC TBC
18	**Trusted Assessors** Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.	Single referral form / trusted assessment to be piloted as part of Pathway 1 pilot.	June
19	**Focus on Choice** Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options.	Actions required to ensure: Patients and relatives planning for discharge from point of admission; All staff understand choice and can discuss discharge proactively; Voluntary sector fully integrated as part of health and social care team both in the trust and the community.	TBC
20	**Enhancing Health in Care Homes** Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse	Care Home Project Board to advise on actions to ensure: Care homes manage the increased acuity in the care home; No unnecessary admissions from care homes at weekends;	TBC

	teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	Community health and social care teams working proactively to improve quality in care homes.	
21	**DTOC Lead for Bristol system** Have a full time member of staff(s) working across disciplines and purely focussed on auditing, challenging and problem solving those on the Green to Go / LHPD lists.	They would only need to save 3 or 4 days per week to cover their costs, however the potential saving even using the current charging methodology is potentially much higher.	TBC

Appendix 2

Section 75 Agreement – Source of Financial Contribution, Fund Type, Risk Share and Underspend

Section 75 Schemes										
Scheme name	Commissioner	Source of Funding	CCG Investments (£)	LA Investments (£)	Total Budget	Fund No.	Risk Share		Underspend	
							Overspend % BCC	Overspend % CCG	% BCC	% CCG
Early and Preventative interventions and reduction in hospital admissions in primary care (BPCAG £2.559 & NHSE DES £1.4m)	CCG	CCG/ NHSE	£3,969,000	£0	£3,969,000	1,4	0%	100%	0%	100%
Community Services	CCG	CCG	£3,600,105	£0	£3,600,105	1	0%	100%	0%	100%
Adaptations (DFG)	Local Authority	Local Authority Social Services	£0	£2,421,339	£2,421,339	3	100%	0%	100%	0%
Carers (100% Risk share for BCC & CCG based on % of Partner contribution)	Local Authority	CCG/ Local Authority	£1,057,360	£725,520	£1,782,880	5	100%	100%	*	*
Intermediate Care (Beds)^	Local Authority	CCG	£2,000,000	£0	£2,000,000	2	100%	0%	0%	100%
Adult Safeguarding and DoLs^	Local Authority	CCG	£300,000	£0	£300,000	2	100%	0%	0%	100%
Prevention & Maximising Independence ^	Local Authority	CCG	£4,700,000	£0	£4,700,000	2	100%	0%	0%	100%
Care Act implementation ^	Local Authority	CCG	£381,334	£0	£381,334	2	100%	0%	0%	100%

7 Day Working^	CCG	CCG	£375,666	£0	£375,666	2	100%	0%	0%	100%
Preparing for Better Care (Overspends 100% by host organisation for staff)^	CCG	Preparing for Better Care	£350,000	£0	£350,000	2	100%	100%	0%	100%
Long term care including mental illness and LD (Risk share up to end of August on Health Spend only 10% BCC on Health overspend)	Local Authority	CCG	£4,100,000	£0	£4,100,000	2	10%	90%	0%	100%
Preparing for Better Care - To be developed	Local Authority	Preparing for Better Care	£100,000	£0	£100,000	2	-	-	-	100%
Care Home Support Team	CCG	CCG	£145,155	£0	£145,155	1	0%	100%	0%	100%
Investment in Primary Care (ST)	CCG	CCG	£367,000	£0	£367,000	1	0%	100%	0%	100%
Extra Care Housing - Nurse lead	CCG	CCG	£98,000	£0	£98,000	1	0%	100%	0%	100%
Investment in Primary Care (SU)	CCG	CCG	£974,356	£0	£974,356	1	0%	100%	0%	100%
Wellbeing Partners Apprenticeship	CCG	CCG (Additional Funding)	£147,000	£0	£147,000	2	100%	0%	0%	100%
Preparing for Better Care - Discharge to Assess^	Local Authority	Preparing for Better Care	£1,100,000	£0	£1,100,000	2	100%	0%	0%	100%
Community Equipment (Risk Share 100% BCC for Social Care Equipment and 100% CCG for Health Equipment)	Local Authority	CCG/ Local Authority	£1,034,000	£876,449	£1,910,449	5	100%	100%	*	*
Discharge to Assess - GP Cover to Pathway 2 & 3 Beds	CCG	CCG	£30,000	£0	£30,000	1	0%	100%	0%	100%
Discharge to Assess - Pathway 1 - ANP React	CCG	CCG	£250,000	£0	£250,000	1	0%	100%	0%	100%
Discharge to Assess - Pathway 1 & 2 Expansion of Community Discharge Co-ordination	CCG	CCG	£400,000	£0	£400,000	1	0%	100%	0%	100%
Discharge to Assess - Pathway 2 Rehab Beds	CCG	CCG	£1,320,000	£0	£1,320,000	1	0%	100%	0%	100%

Discharge to Assess - Pathway 3 Co-ordinator Posts	CCG	CCG	£20,000	£0	£20,000	1	0%	100%	0%	100%
Discharge to Assess - Pathway 3 Increase Social Workers^	CCG	CCG	£200,000	£0	£200,000	2	100%	0%	0%	100%
Discharge to Assess - Pathway 3 Complex Assessment Beds	CCG	CCG	£1,350,000	£0	£1,350,000	1	0%	100%	0%	100%
Care Home support team - provider training improvement	Local Authority	Preparing for Better Care	£150,000	£0	£150,000	2	0%	100%	0%	100%
Homeless Discharge	CCG	CCG	£99,587	£0	£99,587	1	0%	100%	0%	100%
Total			£28,618,563	£4,023,308	£32,641,871					

*Underspends on fund 5 budgets will be split based on the % of Commissioner Contribution into the Fund

Underspends where funding is CCG but LA is commissioner (ie all Marked ^are subject to clauses 12.8 and 12.9 of the Section 75 agreement which stipulates that whilst the CCG receives 100% of any underspend, this can be used by the LA if schemes have delivered on targets in efficient ways (subject to agreement by Commissioning Board))

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Health and Wellbeing Board – next steps 2016 and beyond	
Author, including organisation	Kathy Eastwood/Becky Pollard, Bristol City Council
Date of meeting	22nd June 2016
Report for Discussion and Decision	

1. Purpose of this Paper

To provide a framework for discussion and decision on Ways of Working for the HWB, developing the Strategy, JSNA and aspects of the work programme.

To consider opportunities for how the Health and Wellbeing Board can work with the city office and Bristol plan.

2. Executive Summary

2.1 The Health and Wellbeing Board agreed a "Ways of Working" paper in 2014. This was up-dated to reflect the Council's constitutional change, enabling the Mayor to take Key Decisions at HWB meetings.

2.2 It is now timely, at the start of a new municipal year, to review aspects of working arrangements to enable the HWB to further develop its role and functions. An informal seminar was held in April 2016, the outputs from that seminar are reflected within the recommendations of this report.

2.3 Sections in this report are:

- Ways of Working - recommendations from April seminar, including a HWB planning group, structured agendas, membership and sub-structure, developing work programme, section 3

- Relationship to other Strategic Partnership Boards, section 4
- Joint Strategic Needs Assessment , section 5
- Re-freshing the Joint Health and Wellbeing Strategy, section 6
- Progress on the Alcohol Misuse Strategy and Action Plan, section 7

3. Ways of Working – Key issues

3.1 Notes from the informal seminar are attached as Appendix 1 for information. Key Points have been extracted for the Board's agreement.

3.2 A better balance needs to be struck on **agenda setting**. It was suggested that too much time was dedicated to taking formal decisions and too little time on more creative discussion. These formal decisions include Mayor's Key Decisions, Better Care Plans etc. It is suggested that the agenda is structured to allow at least 50% of the meeting to be used for creative/strategic discussions. (At meetings where there are no formal decisions, this will not be relevant)

3.3 It is also recommended that a **Planning Group** is established between the CCG and BCC. This will help to better plan future agenda's and enable strategic planning officers from both organisations to jointly plan local implication and action on national policy initiatives.

3.4 It is recommended that a **sub-group structure** is formalised, to provide a mechanism for wider involvement. This would also provide an opportunity to devolve some of the work to the sub-groups, and have the potential to free up more time for "creative work" at HWB meetings.

3.5 It is suggested that the "Planning Group" make recommendations on this sub-structure and bring back to the HWB in October 2016.

3.6 It is recommended that stronger links are developed with **other strategic partnerships** to enable more co-ordinated work on issues such as prevention and early intervention. Also there is the potential to commission pieces of work from other partnerships.

3.7 It is recommended that the possibility of developing a **Core**

Cities Health network should be explored. (Note: there is already a Core Cities health and employment group).

3.8 **Membership**: It is recommended that the HWB should not take additional members to represent particular conditions or groups, as this would undermine the purpose of HealthWatch. It is recommended that mechanisms for the involvement of providers needs to be developed, but not necessarily as members of the Board. Arrangements for political membership remain the same.

3.9 It is recommended that an annual HWB **public forum/public engagement event**, is considered to provide further opportunity for questions to be raised to enable a direct debate between the HWB and members of the public. Collective communication from the HWB also needs development.

3.10 It is recommended that further exploration of how partners hold each other to account is undertaken, with the development of a simple format for **reporting performance on the agreed strategy priorities.** This could be a score card approach. An **Action Log** should also be established.

3.11 It is recommended that the role of **"Champions**" is reviewed as part of the Strategy re-fresh process.

4.0 Relationships with other strategic boards.

4.1 It is recognised that there are other public sector led partnerships in the city that have many shared objectives with the HWB. All of them will have an interest in prevention, early intervention and self-care.

4.2 The HWB already has a shared priority with the Safer Bristol Partnership Board of tackling Alcohol Misuse. There will be many other examples of shared objectives and priorities, developed through the city plan. It is also important to make sure that issues do not fall down the gaps by making assumptions about their focus and priorities.

4.3 Links can be made to these Partnerships, where possible by members who sit on both bodies. However, strategic planning officers within the Council and the CCG can develop ways of linking up priorities and themes.

5.0 Joint Strategic Needs Assessment

5.1 The JSNA 2015 data profile report was published in December 2015, highlighting the changes to health and wellbeing indicators for Bristol, differences in health outcomes within Bristol, and emerging challenges. It was written to support the refresh of the Health and Wellbeing Strategy, plus inform local commissioning & service delivery.

5.2 During the first 3-4 months of 2016 the focus has been on dissemination of the JSNA 2015, to BCC and CCG Leadership teams, Partnership Boards, CCG Locality Clinical Forums, BCC commissioning teams and other groups.

5.3 It is noted that there is great potential for the JSNA process to support the work of the Mayor's City Office, as a key evidence base.

5.4 JSNA development plans for a more effective JSNA process, based around a JSNA Chapter approach, were approved via the HWB in 2015, and are now being implemented. The new process was on hold pending the JSNA 2015 data profile work and the restructure of Public Health. A programme of training with Public Health leads is being held May – July 2016, and priority JSNA Chapters have been agreed.

5.5 11 priority JSNA Chapters have been proposed through the JSNA Steering Group. A further 13 JSNA Chapters are also planned as part of required public health work-streams. The proposed 11 priority JSNA Chapters are listed in Appendix 2.

5.6 It is recommended that a standard requirement of demonstrating the use of evidence (eg via JSNA) is included within the template for all HWB papers. It is also recommended the HWB endorse this approach for all partners into their respective business plans and decision pathway templates (some partners already do this). This would further embed evidence-led decision making, as well as providing an opportunity to consider the enhanced JSNA process.

6. Joint Health and Wellbeing Strategy

6.1 The Health and Wellbeing Board has already expressed a view that prevention and early intervention should be a key theme running through any strategy priorities.

6.2 The HWB has also agreed a set of criteria for selecting the key priorities. These are attached as Appendix 3.

6.3 There is an informal seminar of the HWB preceding the HWB on 22nd June. This meeting will discuss the outcomes of the prioritisation process undertaken by the Strategy Development Sub-group. There will be a verbal up-date on this item.

7. Progress on Alcohol Strategy and Action Plan

7.1 The HWB established a short-life working group to develop a strategy and action plan for tackling alcohol misuse in the city.

7.2 Three work streams were developed, led by the CCG, BCC and the Police.

7.3 A draft strategy and action plan has now been developed. A workshop is planned for the afternoon of Thursday 21st July. This will be a practical session aimed at making sure that any further opportunities to develop actions have not been missed. HWB and Safer Bristol Board members will have been invited to this meeting.

7.4 This work was started in parallel to the HWB strategy re-fresh process because it was felt that it could not wait.

8.0 Key Risks and Opportunities

There is significant opportunities to make real progress on health and wellbeing priorities through focussing on a fewer number of key issues.

There are opportunities for the JSNA to support the work of the Mayor's City Office, as a key evidence base.

9. Implications (Financial and Legal if appropriate)

None arising directly from this report.

10. Recommendations

The Health and Wellbeing Board is asked to agree

(i) Changes to "Ways of Working" in sections 3 and 4.
(ii) JSNA priority Chapters in paragraph 5.4
(iii) To integrate the requirement to consider evidence and the JSNA within the HWB template and to endorse this approach for all partners
(iv) To endorse the direction of travel of the re-freshed Joint Health and Wellbeing Strategy

The Health and Wellbeing Board is asked to note

(v) Progress on the Alcohol Misuse Strategy outlined in section 7.

11. Appendices

Appendix 1: Notes of Informal Seminar on 20th April

Appendix 2: Proposed JSNA Chapters

Appendix 3: Agreed criteria for prioritising the Health and Wellbeing Strategy

Appendix 4: Draft work programme

Appendix 1
Health & Wellbeing Board – Review Session

20 April 2016

Summary notes

What has gone well	
	• People (organisations, agendas) have come together in a way that they never have before. • High levels of attendance at Board meetings, demonstrating commitment. • There is a strong positive will to work well together. • There are some examples of effective joint working which help demonstrate how the Board has "made a difference": e.g. working together on alcohol misuse: this was a "must do" for all - it is a shared priority and work on this is being delivered jointly. • The co-chairing arrangements are working well
What we are worried about / any issues	
	• Some issues should be reported through the HWB but aren't – one example of this was the Green Capital partnership work – it seemed there was a clear cross-over with health, but it didn't come through the HWB (not necessarily for final decision, but for collaboration). • Agendas seem skewed/over-weighted by items that are 'key decisions' and formal reports – although it is recognised that these decisions must be formally taken. Need more space on the agenda for more creative discussions • Need to be aware that some decisions may have unintended consequences / impacts on particular organisations / stakeholders. Partners must retain the confidence to challenge each other. More focus needed on exploration of unintended consequences *before* decisions are made. • Need to ensure that the Board "makes a difference" and adds value, and is seen to do this. Also need to make the right linkages and connections with other strategic boards; and make sure the new Joint HWB strategy links with other key strategies that are also currently being refreshed. • Some organisations and individuals don't feel represented (and some repeatedly ask to be) on the Board; and some don't know how best to feed into the HWB. • NHS England are missing from around the table. • There are some issues that there is not common agreement on – for example the future of primary care, so how are these to be progressed? It is timely to talk

	about this now • The role of "champions" on the HWB could be better developed. "I don't think that I project this role back in and out"
What needs to happen / what are the opportunities	
	• Comments from Mayor – feels there should be more/**enhanced focus on "wellbeing" and the preventative / early intervention element** of the Board's remit; consider linking in to the 2017 "City of Sport" theme, linking with Bristol Sports Partnership. Consider also a HWB "award" scheme to help celebrate achievement and identify local champions; and promote our successes, including via social media. • Develop **links with other strategic partnerships**, with the potential to commission pieces of work from them • Strike a better balance on **agenda setting**: CCG and BCC to discuss / forward plan the agenda, perhaps in an agenda planning group. Would welcome a balance for e.g. 50% of meeting time being dedicated to key decisions / formal reporting, with 50% being used more creatively, e.g. to engage the Board around identified themes / issues. CCG and Council planners need to work together • There could be a **sub-group structure**, with appropriate "delegations" providing a mechanism to reflect wider stakeholders / those who currently feel they are not represented, without them being "Board members"; also providing an opportunity to devolve some of the work to the sub-groups, and free up "creative work / engagement" time at HWB meetings. • Explore the possibility of developing a **Core Cities Health Group**. The strength of 10 big cities coming together with one voice is very powerful • Need to ensure that the Board **retains its ambition**, "**makes a difference**" and adds value, and is seen to do this. Identify issues that the Board can galvanise around – e.g. social prescribing. • Shared and improved **communications** (from the collective Board 'outwards'). • Further exploration of how partners **hold each other to account**, and development of some sort of simple/ standard performance scorecard against strategy. • Involvement of **providers** (e.g. acute trusts) could be considered but not necessarily as Board members • Agreement that we should not have new board members to represent particular conditions or groups, as this would undermine the purpose of HealthWatch • Potential for, for e.g. an annual or six monthly HWB **public forum/public engagement** event, to provide further opportunity for questions to be raised, to invigorate a direct debate between the Board and members of the public. • Create an **Action Log** to make sure issues that are raised get followed up

Appendix 2 – JSNA priority chapters

JSNA priority Chapter	Lead PH Consultant(s)	Proposed Chapter reference group
Healthy life expectancy	Jo Copping	tbc
Employment and health	Leonie Roberts	tbc
Domestic violence and abuse	Leonie Roberts	Safer Bristol
Alcohol misuse	Leonie Roberts	Safer Bristol
Healthy weight - children / adults	Jo Williams / Sally Hogg	tbc / tbc
Mental health and wellbeing - children / adults	Jo Copping / Leonie Roberts	Children & Families Board - sub-group tbc / tbc
Falls (in older people)	Viv Harrison	Better Care Transformation Board
Stroke	Viv Harrison	CCG Steering Group – Long Term Conditions
Respiratory disease	Viv Harrison	CCG Steering Group – Long Term Conditions
Cancers	Viv Harrison	CCG Steering Group – Cancer
Women's health	Leonie Roberts	Women's Health Task Group

Appendix 3. Health and Wellbeing Strategy prioritisation criteria

1. Is there a problem we are trying to solve? (Why are we doing this?)

2. Is there evidence of need and potential impact? (Burden on the health of the local population/health inequalities).

3. What can and will be done differently if this priority is in the Joint Health and Wellbeing Strategy?

4. Is this an issue that partnership working can impact upon?

5. Is the Health and Wellbeing Board the right body/partnership to lead on this? (or is another body already leading on this?)

6. Does this fit well with partners organisational must-do's (or HWB must-do's)?

7. Is it a priority for all partners on the Health and Wellbeing Board? (is this covered above?)

8. Is it feasible to make some demonstrable progress on this in a 2 – 3 year period?

Appendix 4.

Bristol Health and Wellbeing Board Draft Work Programme 2016/17

All meetings from 2.30pm to 4.30 pm unless otherwise stated

Wednesday 22nd June 2016	• **Key Decision**- Out of Hours homecare • **Key Decision –** Home Improvement Agency • Sustainable Transformation Plan • Better Care Bristol Section 75 • 2016/17 Health and Wellbeing Board next steps, including JSNA up-date, strategy, membership, development ***For information: Scrutiny report on Mental Health***
Wednesday 10th August 2016	• **Key Decision –** Substance Misuse Commissioning • **Key Decision** - Adult Community Support Services Re-commissioning • Sustainable Transformation Plan • DPH Annual Report 2015 • Endorsement of Children and Families Plan 2016 – 2020 • Oral Health Strategy • Scrutiny report on Mental Health • Integrated Healthy Lifestyles service - principles
Wednesday 19th October 2016	• Childrens Safeguarding Board Annual Report • Adults Safeguarding Board Annual Report • Possible Health Protection Annual Report • Health and Wellbeing Strategy • Alcohol Strategy and Action Plan
Wednesday 14th December 2016	
Wednesday 15th	• **Key Decision** – Integrated Healthy Lifestyles

February 2017	service
Wednesday 12th April 2017	

BRISTOL OVERVIEW AND SCRUTINY

Report of the People Scrutiny Mental Health Working Group

February 2016

1. Executive Summary

Bristol City Council's Scrutiny function plays a key role in helping the Mayor to develop policies that will improve services for citizens. The People Scrutiny Commission opted to undertake a review of mental health services as part of their work programme for 15/16 in order to ascertain whether there were additional opportunities to raise the profile of mental health issues and join up provision citywide.

It was agreed that due to the scale of provision, this piece of work would focus mainly on adult mental health services, and would not specifically address dementia, which was the focus of a number of existing priorities.

The full recommendations from the Working Group can be found in section 4 of this report, but the headline findings can be summarised as follows;

1. There was a need to develop a Mental Health Strategy for the whole city and enhance partnership working
2. There were a number of quick wins that the City Council could do to raise the profile of mental health at local and national level
3. Additional steps should be taken to increase communication around the full range of mental health services available and how they could be accessed

2. Background and Context

There is growing awareness regarding the scale of mental health issues and the myriad of problems that can occur when conditions are left untreated. This has led to a nationwide initiative to improve both prevention and care.

Mental health services have gone through a radical transformation over the past 30 years. A model of acute and long-term care based on large institutions has been replaced by one in which most care is being provided in community settings by multidisciplinary mental health teams. These teams support most people in their own homes but have access to specialist hospital units for acute admissions and smaller residential units for those requiring long-term care.

Mental health services in Bristol are overseen by the City Council in conjunction with the Clinical Commissioning Group (CCG) and NHS England. In the spring of 2011, NHS Bristol, with the support of the then shadow Bristol CCG, took the decision to re-commission Bristol's mental health services following feedback from patients, primary care professionals and clinicians. The new mental health services were co-designed with all key stakeholders with the overarching objective of promoting quicker access to support and whole person approached care.

In November 2013, the Mayor launched his vision for the city and identified 'A healthy and caring Bristol' as one of his six priorities, highlighting mental wellbeing as a particular priority.

The People Scrutiny Commission felt it was timely to take a detailed look at services around mental health and opted to hold two workshop sessions where they could learn more about the range of provision available and identify any opportunities for change. One of these workshops focussed on the Lawrence Hill area of the city as a case study, which proved to be

an effective way to gain a deep understanding of how services fit together in one area.

Public Health is located within the Neighbourhoods Directorate and the Chair of the Neighbourhoods Scrutiny Commission was invited to attend the working group meetings. Full details of the programmes for each of the Working Groups can be found at Appendix 1.

3. Background Papers

A pack of information was provided to all attendees in advance of the event, which included a broad range of relevant reports to help delegates to prepare. The papers detailed key facts and figures regarding the local housing situation and also Bristol City Council's relevant policies and frameworks. The full papers can be found below;

Background Papers

4. Recommendations

The People Scrutiny Commission identified the following recommendations;

A Strategy for the City and Partnership Working;

- R1 - Develop a Mental Health Strategy for the city, including a focus on public mental health and wellbeing, and ask the Health & Wellbeing Board to consider this as a priority within its Strategy refresh process.
- R2 - Use the Mental Health Strategy as the mechanism to strengthen relationships with key partners including the Police and the Universities. One specific example was that the Health & Wellbeing Board should be asked to add representation from Avon & Somerset Constabulary to its membership.
- R3 - Bristol City Council to facilitate a mental health summit for Bristol to bring all key partners together to identify gaps in provision and opportunities for additional joined up working. This could take place on 10th October 16 to coincide with International Mental Health Day.
- R4 - Avon & Somerset Constabulary to be invited to work with Bristol City Council's scrutiny function to monitor the appropriateness of use of the S316 Suite (accommodation used for those admitted or detained on mental health grounds).
- R5 – A review of the support available for the voluntary sector to be undertaken to develop a whole city approach and link all partners together and maximise opportunities, particularly for those providing social prescribing services. Where new initiatives are successful best practice should be shared more effectively.

Opportunities for the City Council

- R6 - Bristol City Council to use its influence to press for changes regarding national policy in respect of mental health by lobbying the government to introduce statutory Personal Social and Health (PHSE) teaching in schools.
- R7 - Schools to be encouraged to purchase the Jigsaw teaching resource (for PHSE) and work towards gaining the Mayor's Award for Excellence as a Health Improving School.

- R8 – The City Council's Overview and Scrutiny Management Board to be asked to make provision for scrutiny of mental health services city wide and across all related areas to take place at least annually (to include health and public health, but also other services such as planning, housing, pollution control and transport etc).
- R9 - The Mayor and elected Members to be asked to sign up to;
  - The Local Authority Mental Health Challenge (http://www.mentalhealthchallenge.org.uk) thus becoming a champion for mental health across the area; and
  - Time to Change (http://www.time-to-change.org.uk) which is the campaign to challenge mental health stigma and discrimination.
- R10 - Recognise the positive relationship between adult learning and mental health and recommend that the Learning City Partnership develop a targeted programme linking education, employment and training.

Communication and Increasing Access to Services

- R11 – Renew approaches towards communication regarding mental health services across all providers, including web resources but should include traditional hard copies to reach all audiences.
- R12 – Develop a social prescribing pathway to enable residents to access services from voluntary and community groups, and promote the benefits amongst both potential service users and providers, including the Neighbourhood Partnership Wellbeing Grants Panels.
- R13 – Produce commissioning guidance for safe use of mindfulness for use in schools, workplaces and communities.

5. Next Steps

The draft report will be formally ratified at the first meeting of the People Scrutiny Commission in the 16/17 municipal year, before being referred to meetings of the Cabinet and the Health & Wellbeing Board. Where recommendations are accepted by the Mayor, an action plan for implementation will be produced and monitored by the Scrutiny Commission as appropriate.

6. Appendices

Appendix 1 – Agendas and Presentations

Appendix 1

Mental Working Groups Agendas and Presentations.pdf