NHS
Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Better Care Bristol: 2016/2017 Plan	
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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.

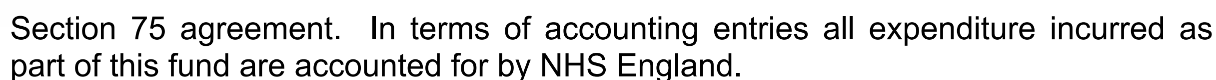
Fund 2 is hosted by Bristol City Council and totals £13.881m. The source of funding for this is a mixture of existing CCG expenditure streams with Bristol City Council and the former NHS England funding, previously transferred under Section 256 agreement in 2014/15, which now forms part of the CCGs allocation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

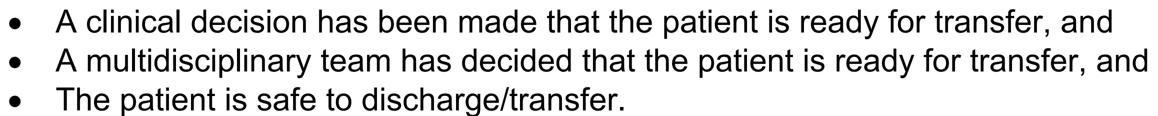
A requirement of Better Care nationally for Health and Local Authority Commissioners to develop a Delayed Transfer of Care Action Plan and Risk Share Agreement which includes a stretch target to get to 2.5% national average. The proposed risk-sharing proposal is covered below.

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

NHS
Bristol Clinical Commissioning Group

Better Care Bristol Plan 2016/17

Contents

1. Introduction
2. Governance and Structure
3. Risk Assessment and Risk Management
4. The local Vision for Better Care
5. Better Care Bristol Plan and Programme
6. Evidence for Change
7. Key Achievements 2015/16
8. Deliverables/Plans 2016/17
9. Meeting the Better Care National Conditions

Appendices

Appendix 1: Governance Structure

Appendix 2: Risk Log

Appendix 3: Project table including National Metrics and Milestones

Appendix 4: Delayed Transfer of Care Plan

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

Statement of Intent
Health and social care integration to support individuals and communities with coordinated care and urgent responses in the community for their physical and mental health needs

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

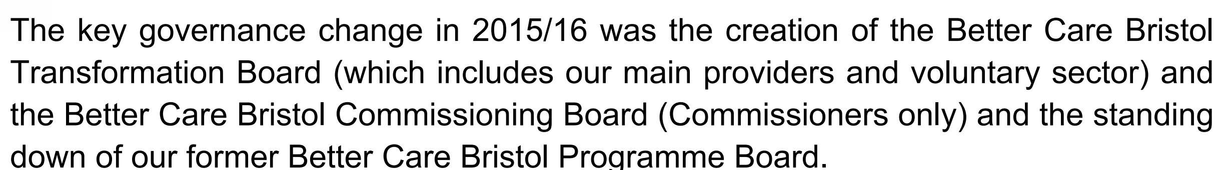
System coordination and access for professionals (SPA, referrals management) and public (NHS 111, 999, social care)

Acute and mental health "front door" assessment, treatment and non-bed based services

Acute and mental health beds

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

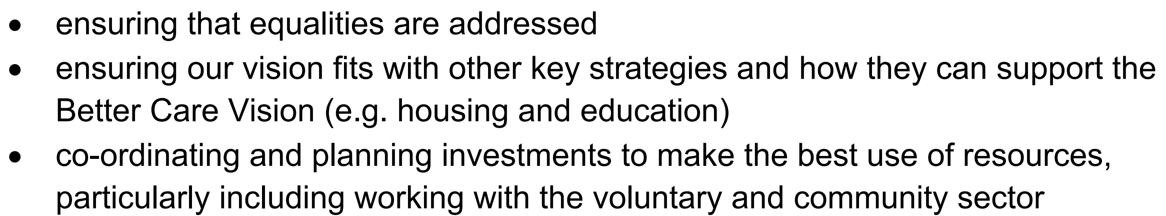
The Health & Wellbeing Board and Better Care Bristol Commissioning Board agreed that by March 2017 we would build on our vision and establish our plans for integration and commissioning.

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

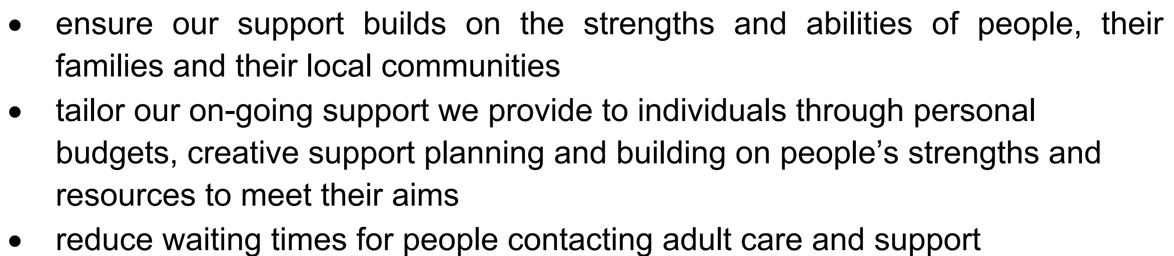
The Three Tier Model relies on good information being available to people, local communities being central to supporting people, and that when people do need longer term support that they have an active role in achieving this.

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.

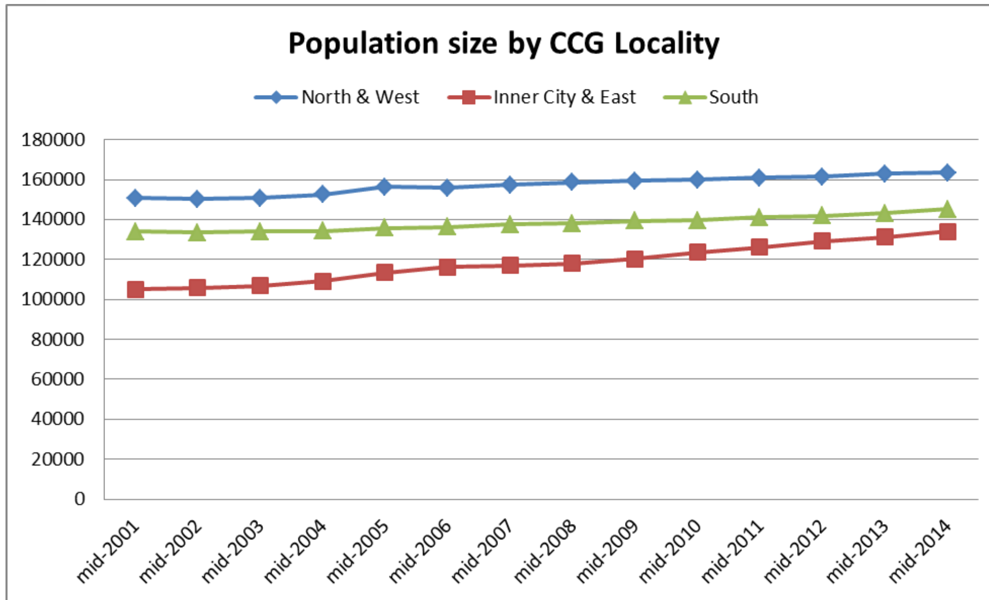
The latest data from the JSNA was considered by the Better Care Bristol Transformation Board in April 2016. This highlighted any new information that could be used to assess and inform the direction of our current and future transformation plans.

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:

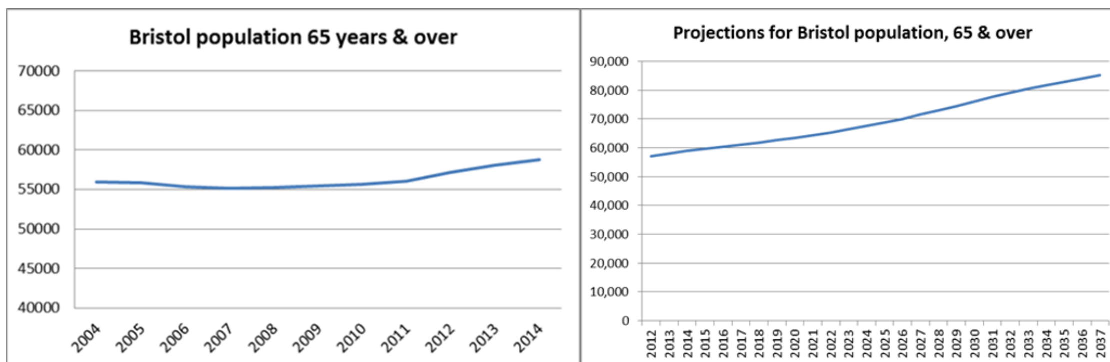
Graph 1: Bristol – Population size by CCG locality



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:

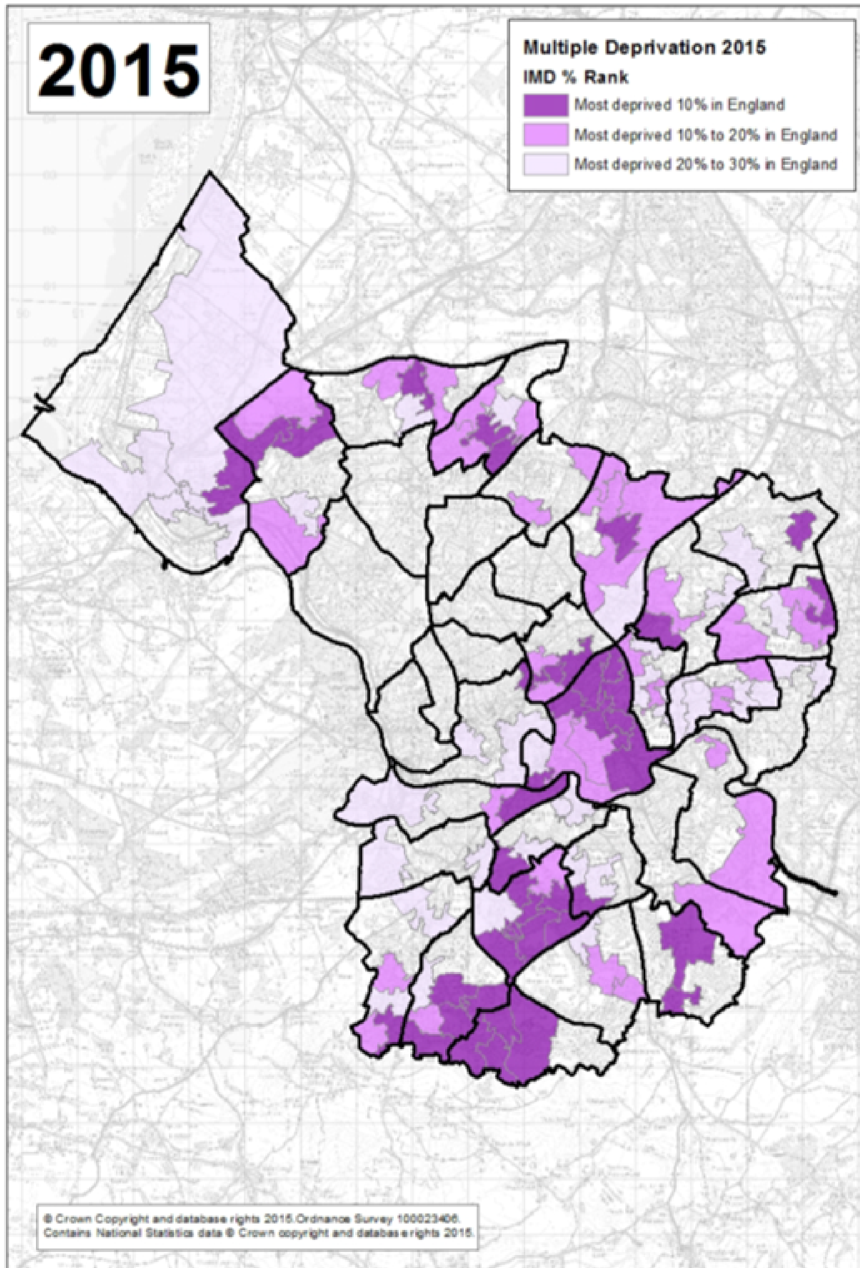
Graph 2: Bristol population 65 years and over

Graph 3: Projections for Bristol population 65 years and over



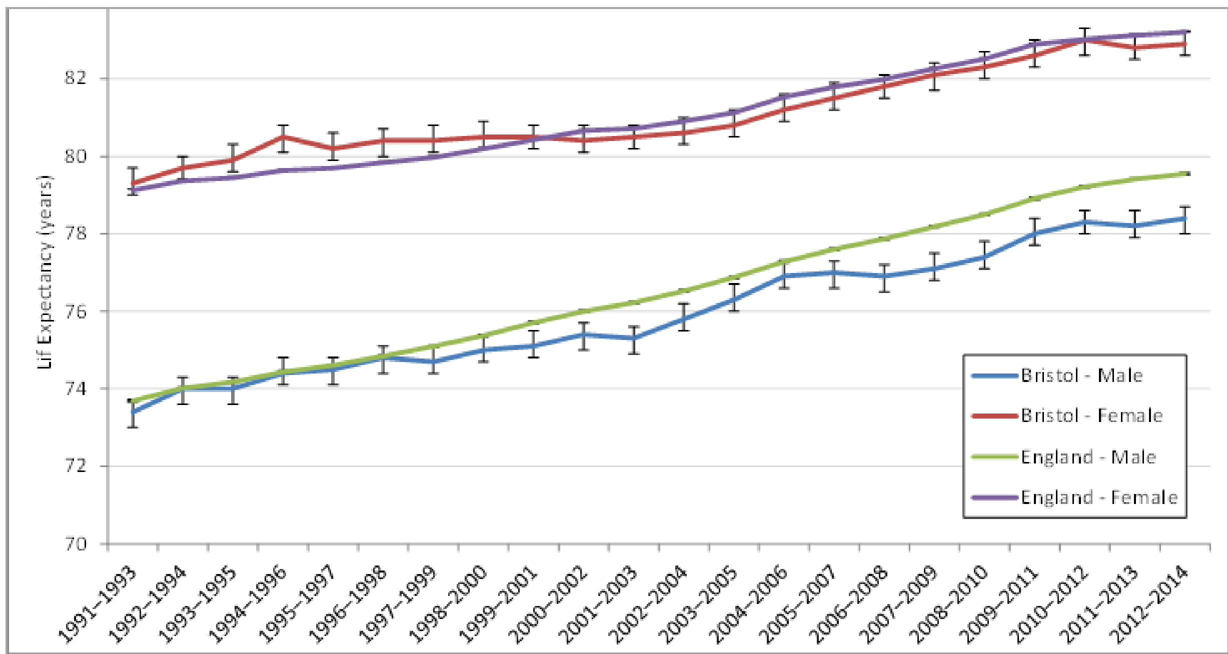
Deprivation remains a significant challenge for Bristol with Figure 3 clearly showing a significant number of wards in Bristol being in 10% most deprived in the country. Test and Learn pilots in our 2016/17 plan will focus on some of these more deprived areas.

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



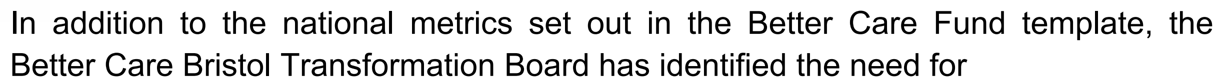
7 Key Achievements 2015/16

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)

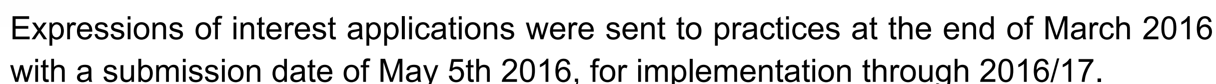
Better Care Bristol will be running some test and learn pilots in 2016/17. Underspend of £100k within the 2014/15 Better Care Fund from last year is being used to support this project. These pilots were designed to drive integration to deliver more co-ordinated care and the outcomes will inform the adult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

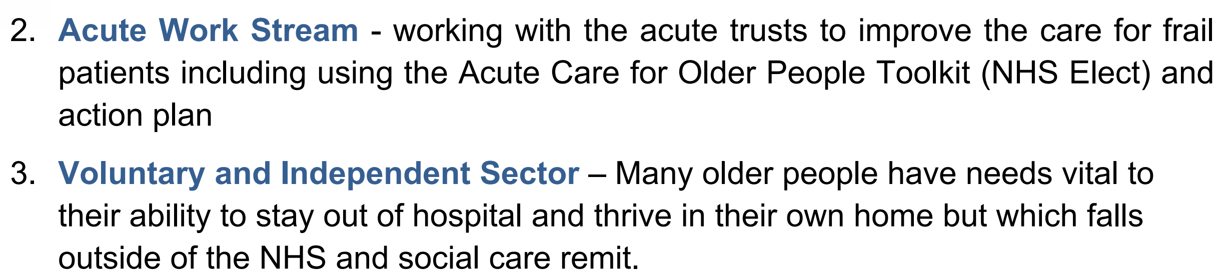
The model will allow staff to follow patients between settings for care, for example across practices and home. Part of the test and learn will be developing the delivery of care as a one stop, in clinic based settings if transportation and estates are provided.

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.

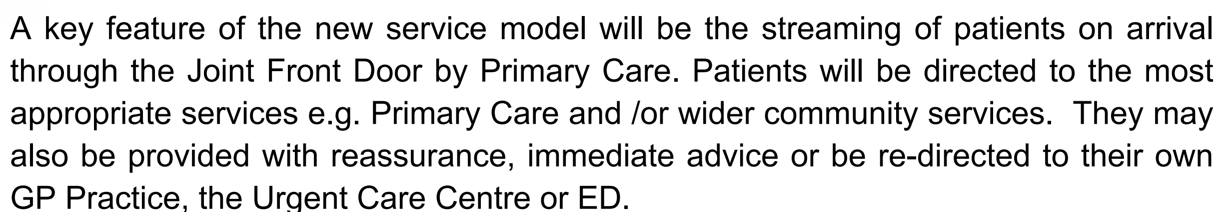
The Better care Team is currently working with Wessex Water to develop a business case to develop a social prescribing project aimed at reducing wasted medication and in particular people disposing of unwanted medication into the water system.

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:

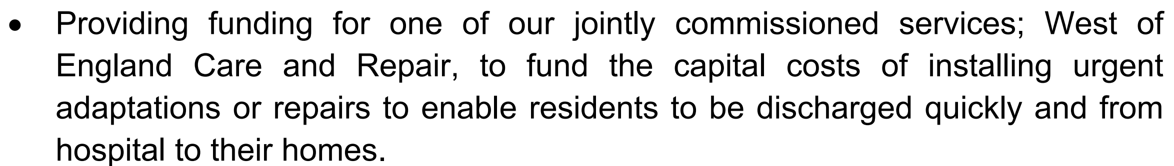
- initial discussions with the Council's Care Provider Forums and education about various initiatives to encourage a more positive view of care as a profession for example links between providers and schools and other education
- commissioning contracts that set targets for apprenticeships in care contracts
- 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.

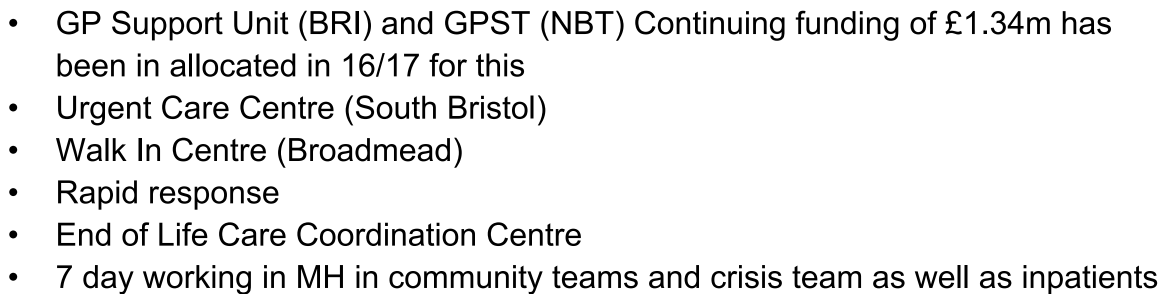
Condition 3 – 7 Day Working

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.

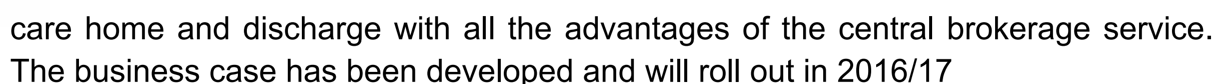
Under Better Care Bristol we have a commitment to further develop 7 day working which is demonstrated by the plans to introduce the following 7 days services in 2016/17:

- 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)

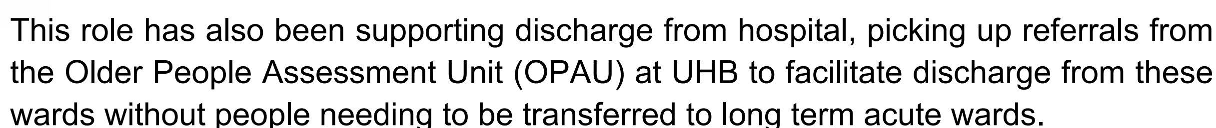
A total of 3.72m is allocated to Discharge to Assess pathways in 16/17. In addition, the CCG have allocated £1.03m community equipment which supports discharge.

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.

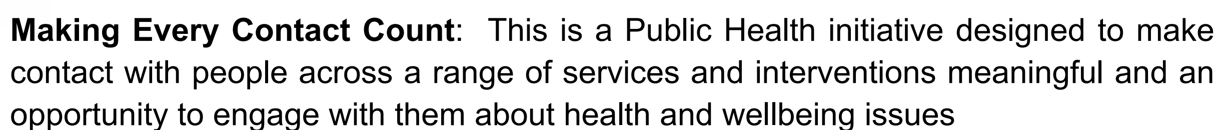
The community provider has also recently changed to the system EMIS which will be the same system that Bristol primary care uses. This has enabled read and write facility.

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

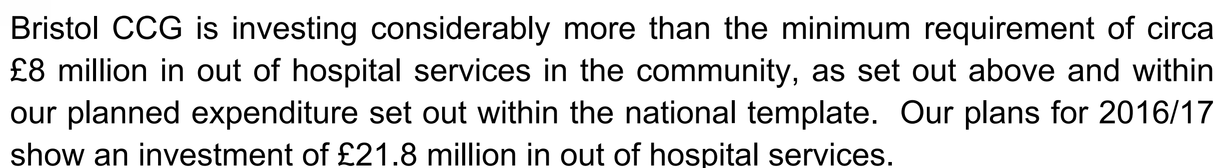
This plan has been developed and shared by members of the Transformation Board made up of CCG, Local Authority and all local acute and community providers.

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.

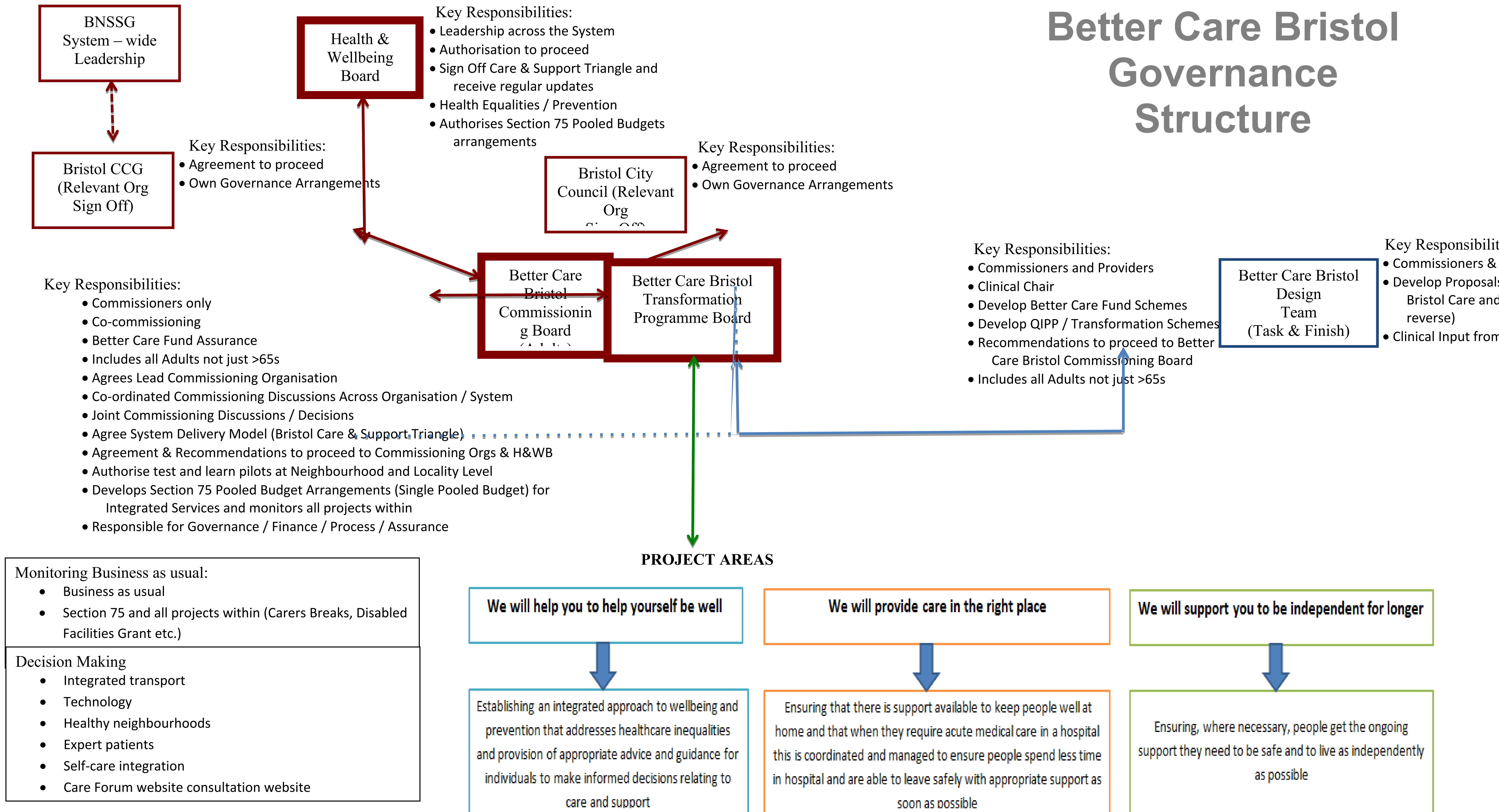
Condition 8 - Agreement on local target and plan for DToC

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



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, PO1, PO5,	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	16	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, PO1, PO5,	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, PO1, PO5,	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, PO1, PO5,	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, PO1, PO5,	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, PO1, PO5,	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 5YFV not in development	Head of Better Care investigating mechanism for the development of new models of care in line with 5YFV	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, PO1, PO5,	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, PO1, PO5,	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.		low 1-3	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

<table>
<tr><th colspan="2">Key Milestones
(Projects within Better Care Fund)</th></tr>
<tr><td>BPCAg</td><td>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</td></tr>
<tr><td>Keeping people at home - Care Home Support Team Pilot</td><td>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</td></tr>
<tr><td>Keeping people at home - Extra Care Housing Nurse Pilot</td><td>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</td></tr>
<tr><td>Front door/ SPA</td><td>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</td></tr>
<tr><td>Discharge to Access</td><td>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.</td></tr>
<tr><td>7 Day working</td><td>June 2016 - recruitment of social care and brokerage to cover weekends.
July 2016 - Staff trained in post.</td></tr>
<tr><td>Section 117</td><td>June - task and finish group to meet and design a work stream</td></tr>
<tr><td>Community Webs</td><td rowspan="3">May: selection of Pilot site.
June Project manager in Post
September First results</td></tr>
<tr><td>Integrated community/ practice nursing teams</td></tr>
<tr><td>Practice cluster multi-disciplinary teams (MDTs)</td></tr>
<tr><td>Wellbeing Partners Pilot</td><td>July, start of the 1 year course.
Further milestones within 2017/18</td></tr>
<tr><td>Care Act</td><td>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</td></tr>
</table>

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))