Integration and Better Care Fund

Narrative Plan Template 2017/19

Area	Bristol
Constituent Health and Wellbeing Boards	Bristol Health and Wellbeing Board
Constituent CCGs	Bristol CCG
Version control	V5 Daniel Knight

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Introduction

At the heart of the 2017/19 Better Care Fund plans are patients, their carers and the health and social care professionals who support them to live well. This plan will describe in detail health and social care services across Bristol. However, in doing this we will ensure that the voice of the service user is at the forefront of our work so that health and social care services meet the needs of our population.

Bristol's Better Care 2 year plan for 2017/18 and 2018/19 should be considered as a continuation of the plan submitted in 2016/17. The Better Care Bristol plans focus is solely on schemes funded from the Better Care Fund and the Improved Better Care Fund, this approach will allow Better Care Bristol to clearly focus on driving integration between Bristol CCG and Bristol City Council.

This document outlines our plans and outcomes for 2017/18 and 2018/19 which includes our aspirations for transformational change and partnership working across the system, establishing a wider integration and commissioning plan for Bristol.

As per the table below, the Better Care fund for Bristol in 2017/18 is circa £40.7 million and in 2018/19 is circa £44.4 million. With the introduction of the Improved Better Care Fund (iBCF), which are additional funds for adult social care, it sees an increase to the overall fund.

	CCG Minimum Contribution	DFG	iBCF	Total
2017/18	£29,004,585	£2,651,566	£9,055,887	£40,712,038
2018/19	£29,555,673	£2,881,793	£12,008,960	£44,446,426

Bristol's Better Care Fund Template 2017/19, tab 3 "HWB Expenditure Plan" issued by NHSE and attached sets out Bristol's proposed investments for the Better Care Fund in 2017/18 and 2018/19.

Background

Health and Social Care Integration lies at the heart of the Better Care Fund national ambitions and is embedded within all BNSSG wide and/or Bristol focused strategies and plans. The CCGs and Local Authorities across the BNSSG have committed to work together to deliver health and social care services for local populations. The three CCGs are submitting an application to NHS England to merge to one CCG but will maintain links to local authorities and will continue to deliver plans and strategies as agreed.

We have taken some learning from our neighbouring CCG's and nationally to develop and review the Bristol Better Care Programme. This is vital when addressing the National DTOC target with the expectation to achieve a level of 3.5% by March 2018.

The Bristol Better Care Fund provides a focal point for all stakeholders and partners to monitor activity for commissioned services that contribute towards the BCF national metrics and to review progress against key activities that promotes the integration of health and social care services.

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:

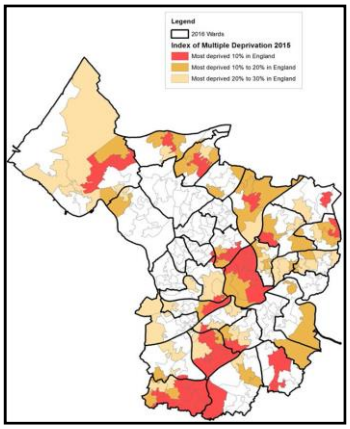
- That is filled with healthy, safe and sustainable communities and places
- Where health and wellbeing are improving
- Where health inequalities are reducing
- Where people get high quality support when and where they need it

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 key message from the JSNA 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.

Figure 1 - Bristol – Multiple Deprivation 2015

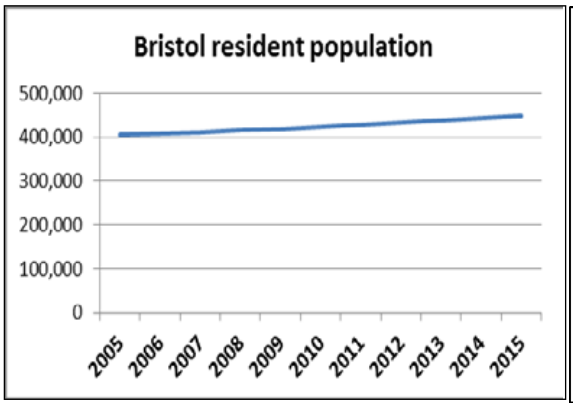


Deprivation is a key factor in determining life expectancy. After a projected reduction in 2012-14, although now rising, life expectancy remains lower in Bristol than the rest of England. The average life expectancy for men is 78.3 years and for women is 82.8 years, which has decreased by 0.1 for both men and women since the

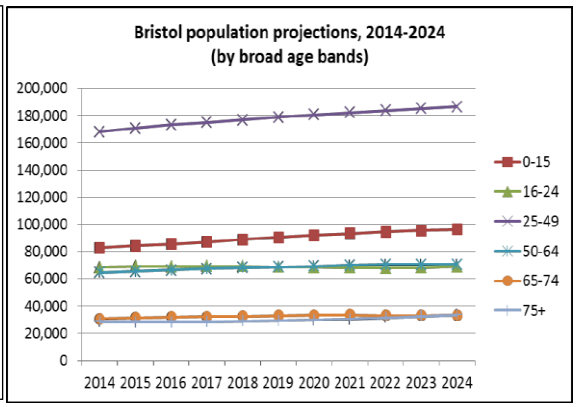
previous year. The gap in Bristol between the most deprived and least deprived wards persists, at 9.6 years for men and 7.0 years for women, which have both increased upon last year figures. This gap has not shown any clear signs of reducing in the last 10 years.

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 at a steady pace. Whilst Bristol has been a relatively "young" city, there are projected to be 7,700 more people 65 & over by 2024, a 13% rise (and potentially a 44% rise by 2039) shown in Graph 2.

Graph 1: Bristol – Population size



Graph 2: Projections for Bristol by CCG locality population 65 years and over



Bristol's vision and approach for health and social care integration

The local vision for Better Care Bristol has not changed significantly since 2014/15 and aligns with the Bristol Health & Wellbeing Board Vision. Integration between Health and Social Care in Bristol has seen a positive shift in previous years with the introduction of;

- Joint commissioning
- Joint service redesign
- Joint working
- Addressing key organisation pressures
    - Reablement
    - Care Home placement
    - Step Down facilities
    - Managing patients through acutes
    - 7 day working
- Pooled budgets

The vision is that in 2020 Bristol will have taken health and social care integration further, with both organisations taking a more preventative approach and working together to tackle key factors in deprivation.

There is a clear link between a person's deprivation index and their overall health. Integrating more preventative services between the Bristol CCG and Bristol City Council will acknowledge the link and reduce the need for people accessing services and subsequently putting pressure on the health and social care system in later years

Areas that the JSNA report highlights that we should aim to integrate by 2020 are:

- Education
- Employment
- Housing
- Homelessness
- Adult Safeguarding
- Substance Misuse

The table below indicates how the BCF programme has had a positive impact on the Protected Characteristics under the Equality Act 2010, However as part of further integration by 2020 we would expect to have a further impact on all protected characteristics.

Age	Gender Reassignment	Race	Disability	Religion/ Belief	Marriage/ Civil p'ship	Sexual Orientation	Sex	Pregnancy / Maternity	Health Impact
X		X	X				X		X

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.

The Better Care Bristol programme contains a number of initiatives and transformational projects. The work to refresh Better Care Bristol's Vision took the learning from these projects to shape the work to facilitate Bristol's plans for integration. Themes that were considered by the Leadership for Change group, informed by the Vision event held in April 2016, included:

- 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 which builds on the work of the CCG and Bristol City Council to reduce dependency on commissioned services. This will be done 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.

The Better Care Bristol Programme contains four main themes which each scheme aligns too, these themes are;

- Integrated Locality Based Services
- Prevention and Self-Care
- Integrated Pathway Redesign
- Business as Usual

Using the four themes, the Better Care Bristol Programme is summarised below: We are focussing our plan primarily on people with long term conditions (including those who also have mental health conditions and/or dementia), frail elderly, and those at the end of life, their families and carers, as well as frequent presenters to GPs with social issues better dealt with elsewhere.

Principles of Health and Social Care integration

Our principles for integration are that health and social care organisations will:

- Share common objectives and pursue common outcomes, working together effectively;
- Build services around people and communities at both efficient and effective scale that enable their needs, aspirations, capabilities and skills and build up personal autonomy and resilience; Prioritise prevention and rehabilitation, reducing inequalities and promoting equality and independence;
- Constantly seek to improve performance and reduce costs;
- Are open, transparent and accountable;
- Adopt a commonality of structure that works for local communities and for all commissioning and provider partners in BNSSG.

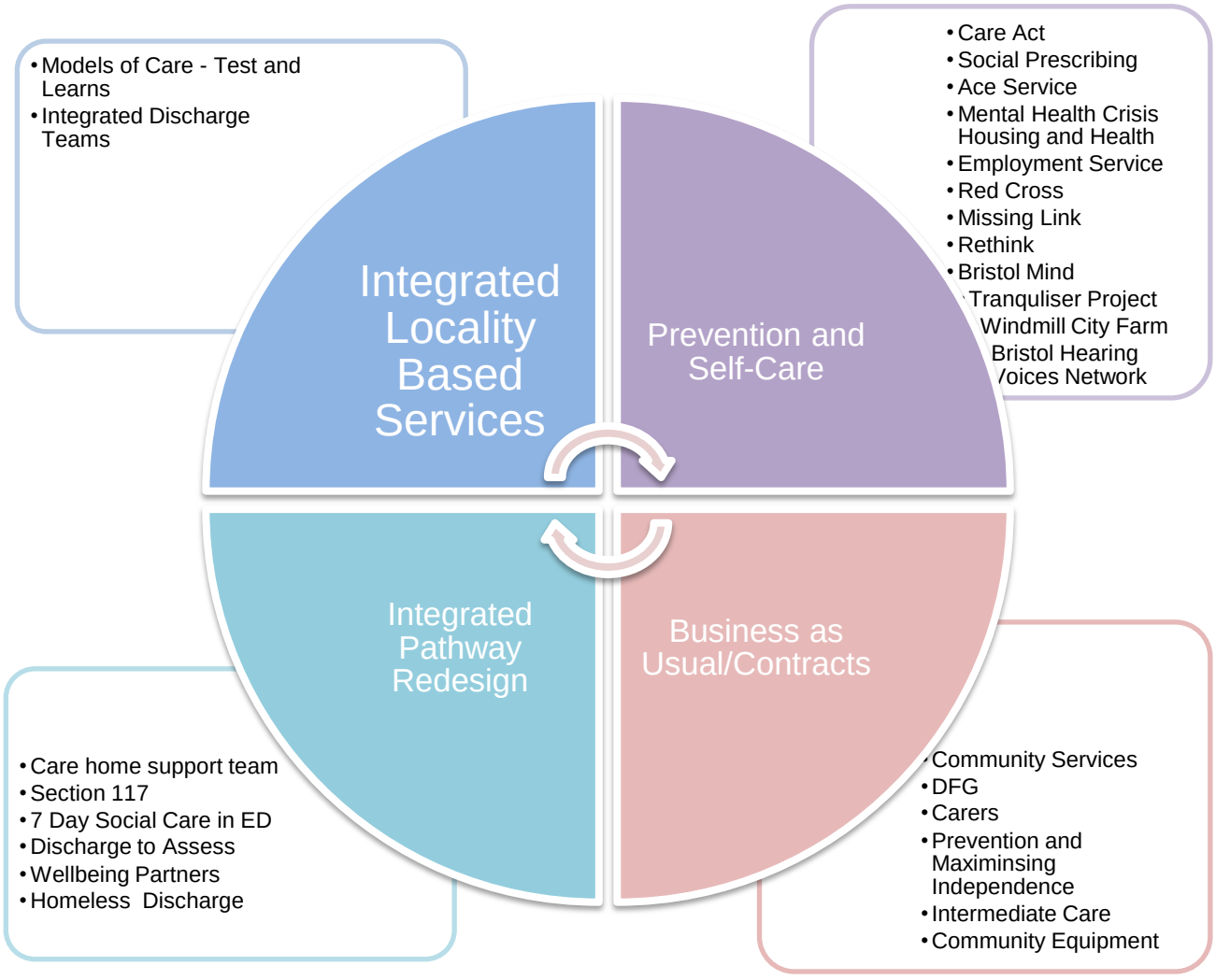
BNSSG Partnership Working

The CCG is part of a wider commissioning collaborative known as 'BNSSG CCGs' which includes Bristol, North Somerset and South Gloucestershire CCGs. These CCGs recently appointed a joint Chief Executive and they are in the process of developing a single commissioning 'voice' and leadership structure across the BNSSG area. In line with national policy, the BNSSG CCGs have come together with local partners to develop a joint Sustainability and Transformation Plan (STP) to support the delivery of the NHS's Five Year Forward View (5YFV).

The delivery of our ambitions is supported by having a single and strong commissioning voice across BNSSG, and strong partnership working across key partner organisations including Primary Care, Voluntary and Community Services, Local Authorities, Health and Wellbeing Boards and NHS England. It is also supported by involving the public, patients and their families in the redesign of services.

Our ambitions are aligned with the 5YFV's 'Triple Aims' of:

Improving the patient experience of care (including quality of healthcare):



We know that patients want a joined-up experience of care, close to home wherever possible and focused on keeping them well and out of hospital

Improving the health of the local population:

By focusing on the causes of premature and avoidable mortality and disability we aim to close the gap of health inequalities in the area

Achieving value and financial sustainability:

We are looking at how we can best use the resources we have in a joined-up way, removing perverse incentives and potential “cliff edges” when patients transfer from one part of the system to another

Transforming Out of Hospital Care: Health and Social Care Integration:

The BNSSG CCGs have made significant progress towards the integration of our health and social care systems both individually and as part of the Sustainability and Transformation Partnership (STP).

At present, the CCGs each operate a joint commissioning model with their respective local authorities with arrangements that support the alignment of commissioning intentions and pooled budgets. As part of the wider BNSSG CCGs’ transition programme to create a single commissioning voice and to support the further development and delivery of the STP’s Integrated Primary and Community Health Care plans, in 2017-19 the BNSSG CCGs are working towards greater alignment in their joint commissioning arrangements, including for Better Care Fund plans. The approach will be based on achievements to date and the areas for improvement that have been identified. The three local authorities are also working to deepen their co-operation and recently commissioned a review of the opportunities for increased collaboration across the local authority adult social care departments.

The STP’s Integrated Primary and Community Health Care plans underpin our vision for the integration of the BNSSG health and social care system with the aim to improve people’s care through:

- Early intervention and management to keep people as well as possible
- Enabling independence, enabling patients to enjoy the best possible quality
- Plans for 17-18 include: Integrated models of care at primary and community level with care planning and coordination provided via multi-disciplinary teams
- Integrated health and care hub providing a single standard service offer across BNSSG

Progress to date has resulted in significantly reduced Delayed Transfers of Care (DTOCs) across BNSSG.

BNSSG Work Programmes

We have identified priorities for the plan with reference to the requirements of our local BNSSG population, the Five Year Forward View and the NHS England planning guidance. This guidance includes the nine 'must do' priorities, which have been woven through the delivery of our programmes. Ensuring successful delivery of the plan is also in part through its alignment to the STP. In developing the STP with a variety of stakeholders across multiple health functions and bodies, this has led to a credible plan that has factored in the views from a number of specialties and health professions.

In delivering our priorities:

We will work as part of the BNSSG Sustainability and Transformation Partnership to deliver these priorities

The focus in 2017/18 will be on those that support the delivery of the system financial recovery plan

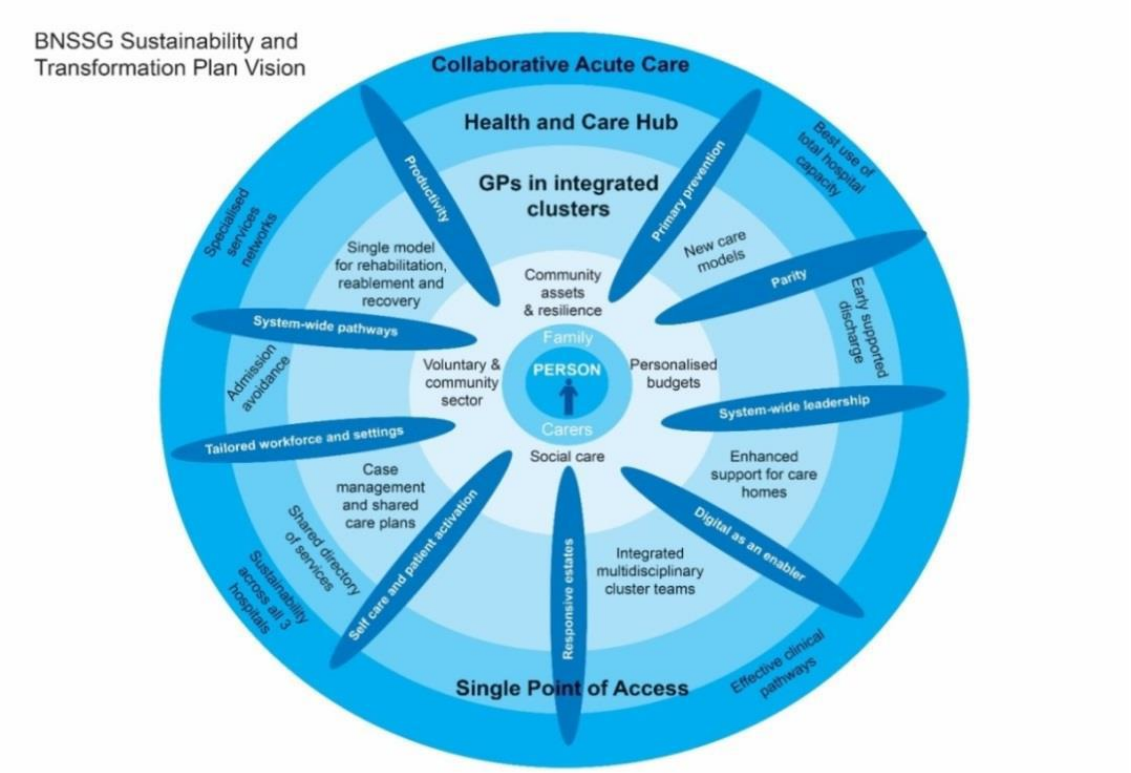
A system-wide control centre delivery mechanism will ensure accountability clarity and maintain momentum.

Community Services Programme Priorities

Priorities	We will achieve this by doing…
To develop capability and capacity in the community so that people with complex needs spend less time in hospital following an acute admission	Confirm scale and scope of BNSSG commissioning programme for community rehabilitation Establish alignment with existing local programmes (e.g. discharge to assess, community wards, 3Rs, stroke, vascular, T&O) Create a single demand and capacity model for community rehabilitation to inform operational decision making and long term planning, including in relation to community inpatient capacity Establish financial model and funds flow requirements, to include tariff unbundling where indicated Agree BNNSG commissioning programme for community including in-year, medium and long term priorities
To develop and enhance integrated Health and Social care services across BNSSG to support patients at home. Including working closely across STP to deliver People Centred	To Foster MDT working and clear accountability for individuals and integrated working. Working closely with physical health, mental health, social care and voluntary sector Increase the Social Care staff presence within wards and within ED and Medical Assessment Units Design a single and consistent 7 days a week Hospital

Integration	Discharge process to operate in each of the three main acute hospitals in the BNSSG STP area Develop and pilot "Trusted Assessor" arrangements Undertake an analysis of care/nursing home placements made on discharge from hospital by each of the three local authorities and CHC funded placements made by the three CCG's in the STP area. Development of community services that offer opportunities for pooled budgets and joint commissioning.

Across BNSSG elements of the proposed model are already implemented. We recognise the importance of building on some of the award winning care that already exists while also transforming and developing the service to provide an excellent and equitable service for all people in BNSSG. This work with contribute to achieving multiple Better Care Fund aims and objectives and as such will be included in operational and delivery reports.



As part of BNSSG working Bristol, North Somerset and South Gloucestershire Councils are seeking to create a Social Care Collaborative based on a commitment to working together:

- **With individuals** as partners in planning their own care and support.

- **With carers and families** as partners in the support they provide to the people they care for. We will ensure the support carers and families can sometimes require for themselves is recognised.
- **With communities** as partners in shaping the care and support available and in providing opportunities for people to get involved in their communities.
- **With organisations** across sectors, including our Community Planning partners and the Third Sector. We will work in partnership to co-commission, forecast, prioritise and take action together.
- **With our staff** as partners in developing and delivering our vision, valuing their knowledge, skills and commitment to health and social care.
- **To improve** demand management across the system and make best use of technology and on line digital services

Enablers

Digital

- Easy access to, and sharing of, information and electronic records across health and social care organisations and teams, including with patients and carers.
- Mobile working technology and real time access for community staff to update patient GP records.
- Technology to support care co-ordination, risk stratification and self-care.
- Read/write access to patient records to enable fully integrating community pharmacy with practices.
- IM and T infrastructure – to facilitate true mobile working for clinicians (improve efficiency/increase visits), hot desking across clusters/facilities.
- Telephony and software to support new workflows, SPA and the health and care hub.

Estates

- Practice redevelopment to accommodate MDT team working.
- More healthcare and social care services based and delivered in community facilities – taking services to the community and promoting ‘wellbeing and wellness’ rather than ’illness’.

People

- Workforce to deliver new and expanded roles where additional numbers and higher skill levels are required.
- Maximum support from voluntary and community sector to complement and enhance care and support provided by healthcare and social care professionals.
- Increased resources and skill levels in multi-disciplinary, community teams commensurate with more people being managed and more acutely unwell people being supported outside hospital.
- Workforce strategy that supports more sustainable careers and career preferences.

Evidence base and local priorities to support plan for integration

Programme Background & Evidence Base	
Summary of evidence and consequence/impact/driver	**Document or other evidence**
Five Year Forward View (October 2014)	https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
The Five Year Forward View for Mental Health (Feb 2016)	https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
GP Forward View (April 2016)	https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
New Care Models – MCP emerging care model and contract framework	https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf
Working Together, Joint Vision for Health and Social Care in BNSSG (Jan 2016)	https://www.bristolccg.nhs.uk/media/medialibrary/2016/02/govbody_23feb2016_item13.pdf
BNSSG Sustainability and Transformation Plan (June 2016 and October 2016)	https://www.bristolccg.nhs.uk/about-us/sustainability-and-

Programme Background & Evidence Base	
	transformation-plan/
BNSSG draft Primary Care Strategy (November 2016)	06 Draft BNSSG Primary Care Strateg
Integrated Primary and Community Care briefing on scenarios	IPCC workstream briefing on scenarios.

Some examples of our progress to date

This should include:

- Local demography and future demographic challenges
- Current state of the health and adult social care market
- Key issues and challenges that the plan will aim to address

The Better Care Bristol programme contains a number of innovative and transformational projects. In 2016, work took place to refresh Better Care Bristol's vision by using the outcomes from our key achievements to shape the work to facilitate Bristol's plans for integration.

In the previous year, the Better Care Bristol team identified a number of key area's to expand or improve on, to strengthen our approach to integration and system wide performance. These areas can be summarised as;

- Integration
- Expanding on a 7 Day Service
- Research and Evidence to inform future commissioning
- Workforce and Staff Retention
- Prevention
- Performance – *please see National Metrics section*

Key achievements are:

Developing joint working (Integration)

Expanding on *Bristol's vision and approach for health and social care integration* section, in 2016/17, the Better Care Bristol team's key focus was to expand on joint working, addressing each organisations priorities and pressures. This is underpinned by the team who are joint appointments, working across both organisations to further develop integration.

In Bristol the Joint Better Care Commissioning Board was created, with membership of senior system leaders across Bristol CCG and Bristol City Council. The board are responsible for agreeing the use of spend of the Better Care budget.

This has been vital in promoting a level of transparency across both organisations in regards to funding and performance. In 2016/17 this resulted in moving from having aligned budgets to pooled budgets, which Bristol City Council hosted and were for jointly commissioned services. This was a major step towards integration and sets the vision for future Health and Social care Integration.

Increasing Social care in acute trusts on weekends (7 Day Service)

Better Care Bristol successfully implemented Saturday working for Social care teams and Brokerage in both University Hospitals Bristol (UHB) and North Bristol Trust (NBT). Additionally we have implemented an Enhanced Brokerage Service to support Bristol patients in NBT and UHB to quickly move patients on to appropriate longer term services (mainly home care and care homes).

We have a Social Care Practitioner present in ED's in both UHB and NBT who are avoiding admissions, reducing length of stay and are seeing around 10 patients per week whilst working in partnership with the REACT team.

PAM's (Research and Evidence)

Bristol CCG successfully bid for Patient Activation Measure (PAM) licenses are currently finalising their PAM plans for 2017/18. The plans span over a 5 year period (2016/2021), with Bristol Community Health (BCH) taking the lead within the first year to utilise PAMs. In Bristol we will develop some small cohorts of patients where PAMs can be used, not only as an evaluation tool, but to help tailor services around the patients. Bristol recognises the value and importance of working alongside our South Gloucestershire and North Somerset partners. A BNSSG PAM implementation Group has been set up to help the three CCGs work collaboratively to reduce duplication and share best practice.

Wellbeing Partner Pilot (Workforce)

Better Care secured £147k in 2015/16 from Health Education South West for this pilot, which the funds have been carried forward. Workforce issues across Bristol have continued to be an area of concern, in terms of recruitment, effectiveness, skill mix, and training.

The Wellbeing Partners Pilot aimed to identify a different approach to tackle the main issues Bristol is facing, by creating a new apprenticeship involving UH Bristol Trust, Bristol City Council and a private domiciliary care provider - B&S Health Care.

This pilot was successfully implemented with nine apprentices starting a one year apprenticeship in July 2016. Throughout the year each apprentice spent 14 weeks in a care setting with each partner to learn transferable skills and identify which setting would be the best suit for the individual once the apprenticeship had finished.

There will be an evaluation of the pilot to identify key issues, lessons learnt and the potential to roll this pilot out across Bristol and the wider area.

Test and Learn pilots (Prevention)

Better Care Bristol along with partners, designed two test and learn pilots to be implemented in 2017/18; it should be noted that the source of funding for these pilots is from a previous years underspend. 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 with the main focus being 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.

Southmead Development Trust are leading on this pilot and have employed 1 Project Co-ordinator (4 days per week) and 2 Navigators (each 3 days per week). One Navigator will be working in Southville and Bedminster, receiving referrals from: Bedminster Family Practice, Malago Surgery and Gaywood House Surgery. The other Navigator will be working across the Northern Arc, receiving referrals from: Pioneer at Bradgate, Pioneer at Ridingleaze and Pioneer at Avonmouth. Both areas have a patient list of circa 30,000.

The Navigator in each area will spend up to 4 hour-long sessions with each client, providing a holistic person-centred supported referral service. So far we have received 133 referrals into the service and 79 patients have already been seen 1:1.

We have received positive exit questionnaires from clients to date, identifying their appreciation of the service and the extent it has met their practical, emotional and social support needs. There is also positive anecdotal feedback from GPs and practice managers, who identify the value of the service and the work the Community Webs team are doing. An increasing rate of health referrals suggests that the service is having a positive impact.

Bristol Ageing Better (BAB) are leading the delivery of this pilot and have also jointly funded the scheme to provide additional resources.

Pilot 2 - 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 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 different care settings, for example across GP practices and home. Part of the test and learn process will be developing a "one stop shop" clinic. 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.

The Integrated Community Clinic has been running weekly since 27th April 2017, which is staffed by nurses from 4 practices and BCH, including a Specialist in Wound Care. There are around 12 patients seen in the clinic on a weekly basis and it is expected for the numbers to rise once the second clinic has been set up in September 2017. It is also envisaged that the volunteers will be recruited in the near future to run the social aspect and transport for the clinic

Continuing Better Care across Bristol

The Better Care programme within Bristol has not changed significantly, it sees some additional schemes which relate to pressures in the system or promotes joint working to enable full integration. Below is a brief description of a selection of schemes within Bristol's Better Care Programme. **Appendix 1** provides more in-depth detail to show the impact and area of need of each scheme.

Both the BCF and iBCF plans have been produced to encompass the below:

- Protecting Adult Social Care
- Adult Social Care that reduces pressures on the NHS
- Avoidance of unnecessary admissions to hospital
- Reducing Care Home Admission
- Improving patient flow after admission;
- Ensuring prompt discharge from hospital either for further social care assessment or into a sustainable on-going care setting (community, residential or nursing) when patients are medically optimised.
- Stabilising the care market

Social Prescribing

Social prescribing aims to ensure that people throughout Bristol have access to quality social prescribing interventions and that social prescribing itself becomes an integral part of delivering health and wellbeing to the population of Bristol.

There are three main parts to the social prescribing process. The first part being the initial referral for the individual which is provided by their primary care, such as: GPs, practice nurses and district nurses. Then a link worker, often referred to as a 'Social Prescriber' will work with the individual to decide on activities which may improve their health and wellbeing, helping them to engage with their wider community. The activities and/or services which an individual can access with support from their link worker and/or volunteer can be drawn together virtually into a wellbeing centre/volunteering network.

There is emerging evidence that suggests that social prescribing helps to both improve mental health and wellbeing, whilst also reducing social isolation and exclusion. In addition to this, it can lead to fewer primary care consultations for the individual involved, and reduce hospital utilisation, easing pressure of these services.

Integrated Carers' Team

Bristol City Council and Bristol Clinical Commissioning Group have come together to jointly fund, improve and streamline the support provided for carers. The budget available has been used to set up the Integrated Carers' Team (ICT) to respond to the needs of Carers' that care for someone who lives within the Bristol local authority boundary.

The ICT assess the impact of caring on the Carers health and well-being and work to find ways to improve the situation that will directly benefit the Carers. The aim of the Integrated Carers' Team is to support the Carer to look after themselves in their caring role.

Carers can ask for a carer's assessment, even if the person cared for doesn't receive services from either the NHS or Bristol City Council, there is no cost for a carer's assessment. Permission from the person you're caring for is not required to enable the Carer to receive a Carers' assessment; carers are entitled to an assessment in their own right as outlined in the Care Act.

In preparation for 2018/19, over the coming months Bristol Clinical Commissioning Group plan to review carers services alongside both North Somerset and South Gloucestershire CCG's to move towards a more sustainable and equitable service.

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 ambition was to provide residents of Bristol with a high level of awareness and 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 work to develop the Council's responsibilities is encapsulated by the "Three Tier Model" (Figure 1) for social care. The three tiers describe how we will support people in the future and is set out in the diagram below:

Figure 1: 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.

To ensure the sustained delivery of the Care Act duties in 2017/19, Better Care Bristol funding (which equates to £783,695 over the two year period) 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 the 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

Prevention & Maximising Independence in Home Care

The original intention remains to have Maximising Independence (MI) as a core part of homecare commissioned and delivered in Bristol. Changes to the existing homecare model will be coming with immediate effect as a result of a homecare

‘hothouse’ held this week by Bristol City Council, with partner and provider involvement and a longer term transformation plan / project within the auspices of the new adult social care programme is likely to be developed to deliver a redesigned homecare model including MI, reablement and traditional homecare.

Intermediate Care

Intermediate care services include urgent or planned healthcare assessments for people in their own homes or in residential home; support can also be provided when a patient leaves hospital to return home. The teams are made up of specialist practitioners who aim to help people maintain their health and live as independently as possible.

Homeless Discharge

A previous NHS England needs assessment highlighted that Bristol has one of the highest numbers of rough sleepers in England, second only to Westminster, 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.

Care Home Support Team

The Care Home Support Team (CHST) was established to improve the quality of the care provided in care homes with nursing through supporting, training and upskilling care home staff and has been funded for 2017/18. The CHST aims to reduce the number of care homes with organisational safeguarding issues and support a reduction in avoidable admissions to hospitals.

The team will continue to host care home training conferences twice a year, with the support of some key stakeholders inc. Brisdoc, SWAST and CQC.

The team will continue to work with homes identified as needing additional support; offering in house training around clinical care, preventing malnutrition and dehydration, medicines management and mental capacity assessments. The team are also rolling out NEWS training, including the use of SBAR communication tools to escalate for urgent clinical care when a resident is deteriorating. All of the training

packages are shared with the homes and a suite of flash cards with key pieces of information is being finalised and will be sent to care homes for staff to use at the point of care.

A care home training programme has been developed to tackle the top reasons for admissions and ED attendances and includes sessions on:

- EOL Management
- Medicines Management in relation to End of Life care and falls management
- Training for chefs/staff and care home managers in preparing appropriate textured foods

Working closely with CHC, SWAST, our GP LES and colleagues from both the CCG and LA, we are developing quality dashboard to help identify themes and homes that require additional support to provide the best quality care to its residents and avoid unnecessary hospital attendances and admissions.

Disabled Facilities Grant

In 17/18 and 18/19 the Disabled Facilities Grant (DFG) continues to be held within the Better Care Fund and resourced at a level of £2.65m in 2017/18 and increases to £2.88m in 2018/19. 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, Bristol City Council, in conjunction with local housing authorities, are also considering a number of other ways to utilize this funding to meet some of the Better Care outcome objectives to reduce hospital admissions, readmissions and speeding up transfers from care: proactively for older and vulnerable households. The options currently being considered are:

- Providing funding for one of our jointly commissioned services, West of England Care and Repair, to assist quicker discharge from hospital through the funding of house clearances and minor alterations;
- Provision of assistive technology which will help with continued independence for items that the City Council would not normally fund;
- Provision of pendant alarms for high risk patients;
- Dementia friendly work or assistance to help the individual/family members/carers maintain independence
- Improving lighting within the home and work around falls prevention;

These options will shortly be reviewed by Bristol City Council and if agreed work will start on implementing these proposals in the autumn 2017.

Integrated Community Equipment Service (ICES)

The Integrated Community Equipment Service (ICES) is a jointly commissioned service between Bristol CCG and Bristol City Council, providing equipment to support people in their own homes, to help them remain independent, to prevent emergency admissions and to support timely discharge from hospital. It also provides equipment to palliative care patients to support them to remain at home at the end of life.

Changing patterns of care e.g. more people leaving hospital earlier and more people leaving hospital to die in their own home is driving demand. This is seen as a very positive thing and is in line with National Guidance on Better Care, which the CCG and Local Authority are working with providers to deliver, and other CCG strategies and policies.

ICES is a core service to support Bristol CCG and Bristol City Council system wide transformational and service improvement schemes (such as Discharge to Assess) as they are reliant on timely access to equipment.

7 day - Social Care Services & Enhance Brokerage Team

As part of our commitment to develop 7 day working, Better Care Fund will continue to allocate funds to ensure that social care teams are available to support discharge; therefore reducing 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 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 Care Home provisions 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 Bristol City Council software system which will encourage competitive prices for individual services.

Ace Service

This service aims to support and provide outreach services to individuals who live complex and chaotic lives to reduce their fear and mistrust of health and social care services whilst increasing engagement with such services, enabling them to work towards recovery. In addition to this, it also provides education and training to organisations who work with these individuals to improve understanding and support of this client group.

Integrated Discharge Teams

A team of clinicians who try to find alternative places of recovery for patients who they have assessed as no longer requiring a hospital bed. The scheme aims to make sure that hospital beds are made available for those who are in need of hospital care, and to encourage those patients who leave hospital to follow their recovery in a more homely environment to help general physical and emotional wellbeing.

Red Cross

The service provides an assisted discharge primarily from A&E and other areas within the BRI and Southmead Hospital to resettle patients and avoid them being admitted into hospital.

Missing Link

Missing Link provides a range of housing and support to women in Bristol who suffer from mental health issues. As well as mental health support, they also provide support services for victims of domestic abuse, rape and sexual abuse.

Rethink

Rethink provide a range of services supporting people suffering from mental illnesses, including: advocacy, carer support and crisis services; they aim to bring people together to support each other through the services they offer, groups and campaigns.

Bristol Mind

Bristol Mind is a mental health resource for people living in Bristol and the surrounding areas. They provide: information and signposting on further services, advocacy, low cost counselling, a confidential helpline, whilst also providing volunteering and training opportunities for the individuals they support.

Tranquiliser Project

Support service and helpline for people addicted to prescribed drugs, whose services are free and confidential.

Windmill City Farm

Mental Wellbeing drop-in service which is ran once a week by two facilitators, volunteers and a specialist recovery practitioner.

Bristol Hearing Voices Network

This network promotes positive explanations of voice hearing, intrusive thoughts and unusual experiences in order to help individuals to develop their own ways of coping in order for them to take control of intrusive thoughts and voices.

Improved Better Care Fund (iBCF)

The iBCF plans have been produced ensuring they relate to the guidance associated with the fund, which include:

- Stabilising the care market
- Protecting Adult Social Care
- Adult Social Care that reduces pressures on the NHS
- Avoidance of unnecessary admissions to hospital;
- Improving patient flow after admission;
- Ensuring prompt discharge from hospital either for further social care assessment or into a sustainable on-going care setting (community, residential or nursing) when patients are medically optimised.

The plans are in line with the Adult Social Care Strategic Plan and the 3 tier model. Alongside this the Council has considered the funding in line with the following themes:

- Homecare/systems flow
- Care Homes
- Tier 1 prevention and demand management
- IT and Collaboration
- Adults of working age
- Review capacity
- Accommodation strategy

The schemes within the iBCF plans are summarised below;

iMPOWER approach to Demand Management

Bristol has been working on the three tier model approach to demand management and this has already started to yield results. There is a need to broaden the work so it is embedded throughout the care system and beyond to other key stakeholders.

Improved information and guidance

A comprehensive advice and guidance information system encouraging people to self-care and be signposted early to appropriate levels of support.

Increasing use of technology

Technology can be a powerful resource for helping people remain in their own homes. We intend to commission a one-off diagnostic which links with the iMPOWER work and ensures the use of assistive technology and other technology solutions at all stages of a person's involvement with social care.

Improving engagement with GP clusters

Building on the work already under way, we would want to increase social care capacity with GP clusters to increase engagement with MDTs and build a more comprehensive approach to community support. This will include more social work and community navigator capacity.

BNSSG Common Process Work

The three local authorities recently commissioned a review of the opportunities for increased collaboration and common processes relating to adult social care discharge arrangements.

There is also a need to discuss price and market engagement with a view to greater consistency across the three authorities.

Investment in home care capacity/ system flow

Engagement with the local sector to increase capacity, quality and ensuring a different approach to workforce, which encourages a more appropriate way of working with all people in receipt of homecare, including those with dementia, to take a reablement and maximising independence approach and move away from time and task. This will link to outcome based commissioning.

Assistive Technology

Following on from our diagnostic, it is understood that there should be more investment in assistive technology from low level equipment to that which supports people with complex needs. There is tremendous innovation in the market now and we need to learn from the diagnostic and invest in this area.

Extra investment adults of working age

There is a need to invest in support for adults of working age, as there are many people with mental health problems awaiting discharge into supported living; this will include additional Social Work resource to support discharges from Callington Road Hospital.

Increasing independence for vulnerable adults 18-25 by individual assessment and improved market management

There are a number of younger people coming through the system who are ill-served by the current market and put pressure on all services. There is a need for some specific work in this area.

Increased investment in mobile working and related approaches to improving productivity in the workforce

Given demand pressures there is a need to invest in new technology for social workers, reablement staff and to work on the STP digital workstream. This would improve productivity and improve flexibility in the workforce.

Improving capacity in care homes

There is a need to invest in improving quality incentivising providers to work collaboratively on raising quality standards. Develop a predictive indicator tool as early warning of quality and safety issues to prevent bed closures.

Also a need to address out of city placements with a view to returning people closer to Bristol. Introduce 7 day working and a Trusted Assessor approach. Appoint more OTs to assist with reviews and work closely with care providers

Joint working on the accommodation strategy

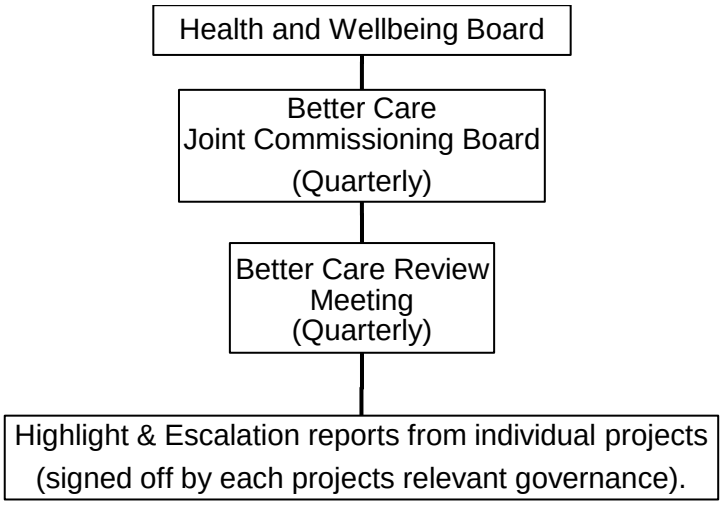
Bristol is currently undertaking a strategic review of its housing stock, it would be advantageous to appoint dedicated social care staff to support this work and produce a strategy that helps meet the needs of vulnerable adults.

Increase reviewing capacity

Across Bristol, there is a need to increase investment in to social workers and practitioners to enable providers the capacity to review care packages more frequently, ensuring that service users continue to receive the right level of support and care to meet their needs and maximise their independence using the three tier model, subsequently freeing up care capacity.

Programme Governance

The diagram below illustrates the new and revised governance structure for the management of the Better Care Programme. All meetings include both Bristol CCG and Bristol City Council representatives:



In the revised governance arrangements, the Better Care Joint Commissioning Board will meet quarterly to align with NHSE's quarterly submission dates.

Better Care Bristol Joint Commissioning Board scope and responsibilities remain the same. They continue to provide leadership and strategic direction to develop stronger and deeper integration between health and social care and to enhance joint working, including the pooling of budgets where appropriate. Additionally this group is responsible for signing off the Better Care submissions.

Each project funded through the Better Care Fund for 2017/19 is required to submit a quarterly highlight report to the Better Care Team. The report includes key activity during the quarter, deliverables for the next quarter, any risks and issues and KPI/ Metric information. Outside of the regular reporting arrangements, project leads will escalate any appropriate issues/risks by exception to the Better Care Team.

The reports will inform the quarterly review meeting between Bristol City Council and Bristol CCG. This meeting will be an opportunity for both partners to align work, review exceptions and challenges. Both the Council and CCG have the opportunity to invite project leads to attend these meetings to report on their individual projects when appropriate.

A finance report will continue to be generated on a monthly basis and discussed at the monthly Better Care Finance Meetings; this meeting is attended by Bristol CCG and Bristol City Council. Finance reports are in line with the Section 75 Accounting Judgements table, which sets out the level of risk share on over/underspends for every budget.

The finance reports will be circulated to the Better Care Joint Commissioning Board and will contain the following:

- Overall position of the Better Care Fund
- Budget movements
- Financial risks
    - Including risks of level of funding towards Social Care protection and ensuring the CCG meets its minimum contributions.
- Recommendations

All transformational projects within Better Care Bristol go through a business case development process to evidence and support the investment, including the JNSA evidence review.

Where projects are not delivering predicted outcomes or benefits, they have been discontinued. For example, the Extra Care Housing Nurse Lead project in 2016/17 was discontinued when it became evident that whilst key stakeholders were involved in the design of the model, that a model where Associate Community Matrons were only attached to a housing facility one day per week, would not have the desired impact.

As part of the Section 75 agreement, we will also be supplying a detailed Project break down, with milestones, which also clearly outline the following;

- Overview
- Aims & Outcomes
- Services
- Financial Contributions
- Financial Governance Arrangements
- Governance Arrangements for the Partnership
- Assurance & Monitoring
- Risk & Benefit Share Arrangements

- Duration & Exit Strategy

All of the above are also monitored through the Better care Bristol governance process and escalated to the Better Care Joint Commissioning Board

Risk

Risks are discussed at the quarterly Better Care Review meeting between Bristol City Council and Bristol CCG. If an escalation report is received, a risk is added and circulated to the Review meeting members. Risks can be in relation to a project/scheme's delivery or financial risk's, each risk will be assigned an owner who will attempt to mitigate or eliminate the impact to performance or finance, providing an update at each meeting on progress until the risk is removed. Below is the most current Better Care Bristol risk register;

REF	Date risk raised	Category	Description: 1. What is the risk? 2. What is the cause of the risk? 3. What is the likely impact?	Inherent Risk Score			Current Risk Score			Mitigating Action (Treat, Transfer, Terminate, Tolerate)	Review Date
				L	S		L	S			
4	Aug-16	7 Day Working	Avoided admissions are difficult to track and could lead them to be double counted within REACT.	3	3	9	3	3	9	Work with BI team to ensure accurate counting	31/10/2017
5	Aug-16	7 Day Working	Lack of provider 7 day services means that discharges at weekends may not be as identified in the business case, causing patients to remain in hospital until the Monday	3	4	12	3	4	12	Enabling Discharge workstream reviewing 7 day working model Ongoing use of Rapid home care (Pulse) and review and reprocurement of additional home care secondary providers	31/10/2017
16	Aug-16	STP	There is a risk to several projects within the programme that plans and implementation are diverted by the focus of the STP which risk causing either delay as projects are refocussed or a fundamental shift in emphasis	4	3	12	4	3	12	Management arrangements for Better Care have transferred to Richard Lyle and Emma Moody. Better Care team to ensure alignment with STP through CCGs Portfolio management Office	31/10/2017
18	Dec-16	Section 117	Lack of dedicated project management for Section 117 will impact on the desired outcomes.	5	4	20	3	4	12	Updated 01/05/2017 - Project manager allocated from the BCF team and will also work on MH DTOC	31/10/2017
19	Dec-16	Section 117	Projected Overspend for Section 117 will affect the financial position of the CCG and the LA	5	4	20	5	5	25	Linked to risk 18 - A project manager will work on MH DTOC and Section 117	31/10/2017
20	Dec-16	Delivery of programme	Delivery of Better Care programme may slip if project do not deliver desired outcomes	4	3	12	4	3	12	Currently 2 projects have been paused (IPL and Front Door) a BNSSG business case has been written for IPL and has been agreed.	31/10/2017
21	Jan-17	D2A	Bristol City Council are reviewing funding for reablement services as part of the budget setting process.	4	3	12	4	2	8	There will be a detailed consultation regarding these proposals and change will be managed within a programme approach to change.	31/10/2017
23	Aug-17	Planning	Due to delayed BCF planning guidance there is now only one round of asurance for BCF plans. Plans will not be finalised in time for the next HWB to sign off	2	2	4	2	2	4	Paper has been written to delegate authority to Co-Chairs of HWB to sign of plans. A decision will be made on 16th August	31/10/2017

National Conditions

National condition 1: jointly agreed plan

Plans have been signed off by the Better Care Bristol Commissioning Board, which consists of members from both the local authority and CCG, and by the Health & Wellbeing Board. The Section 75 agreement, including risk shares, will be presented to the Better Care Commissioning Board for final approval, ahead of the Health & Wellbeing Board for formal sign off.

Within the Section 75 Agreement, each budget will have a risk share arrangement based on the investment and commissioner. The risk share arrangements will not affect national condition two as Bristol exceeds the minimum contribution to Bristol City Council for the protection of adult social care services.

The Better Care Bristol plans also include the additional iBCF funding which have been proposed by both Bristol City Council and Bristol CCG, with formal agreement in the Better Care Bristol Commissioning Board on 31st August 2017.

Joint Planning

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

Bristol City Council has also developed an Adult Social Care Strategy. Both these and the wider integration work will feed into the development of the Sustainability and Transformation Plan (STP).

National condition 2: social care maintenance

In 2017/18 the CCG's minimum contribution to Adult Social Care increased by £169k to a total of £9.627m which was an increase of 1.79% on 2016/17. As in previous years, Bristol CCG has allocated additional funds to Social care and the total to be transferred to Bristol City Council will be £16,161,881.

In 2018/19 the CCG's minimum contribution to Adult Social Care will increase by 1.9% taking the Social Care allocation to a total of £9.809m, however Bristol CCG will allocate additional funds to Adult Social Care, totalling £16,349,684.

Bristol CCG and Bristol City Council have discussed the option to frontload funds within the 2 year plan and have decided against this option the intension is to use the monies to both increase capacity in the local market and transform the overall shape and direction for the social care system over the next three years and beyond. We have also taken this approach as any change in funding could destabilise the health and social care market and with the financial situations of both organisations we would want to mitigate against this.

Consequently we have calculated a revised cost for all independently provided care which we will introduce from October, as well as an increase in capacity for intermediate care and reablement with the priority of ensuring there is sufficient capacity in the system to get through this winter and beyond. We have also identified where we can make best use of one-off funding to improve the system such as IT and mobile working opportunities which will make efficiencies for the future. We feel we can make these changes in a strategic and incremental way so that they are made in a sustainable and robust manner without having to front load too much of the expenditure.

National condition 3: NHS commissioned out-of-hospital services

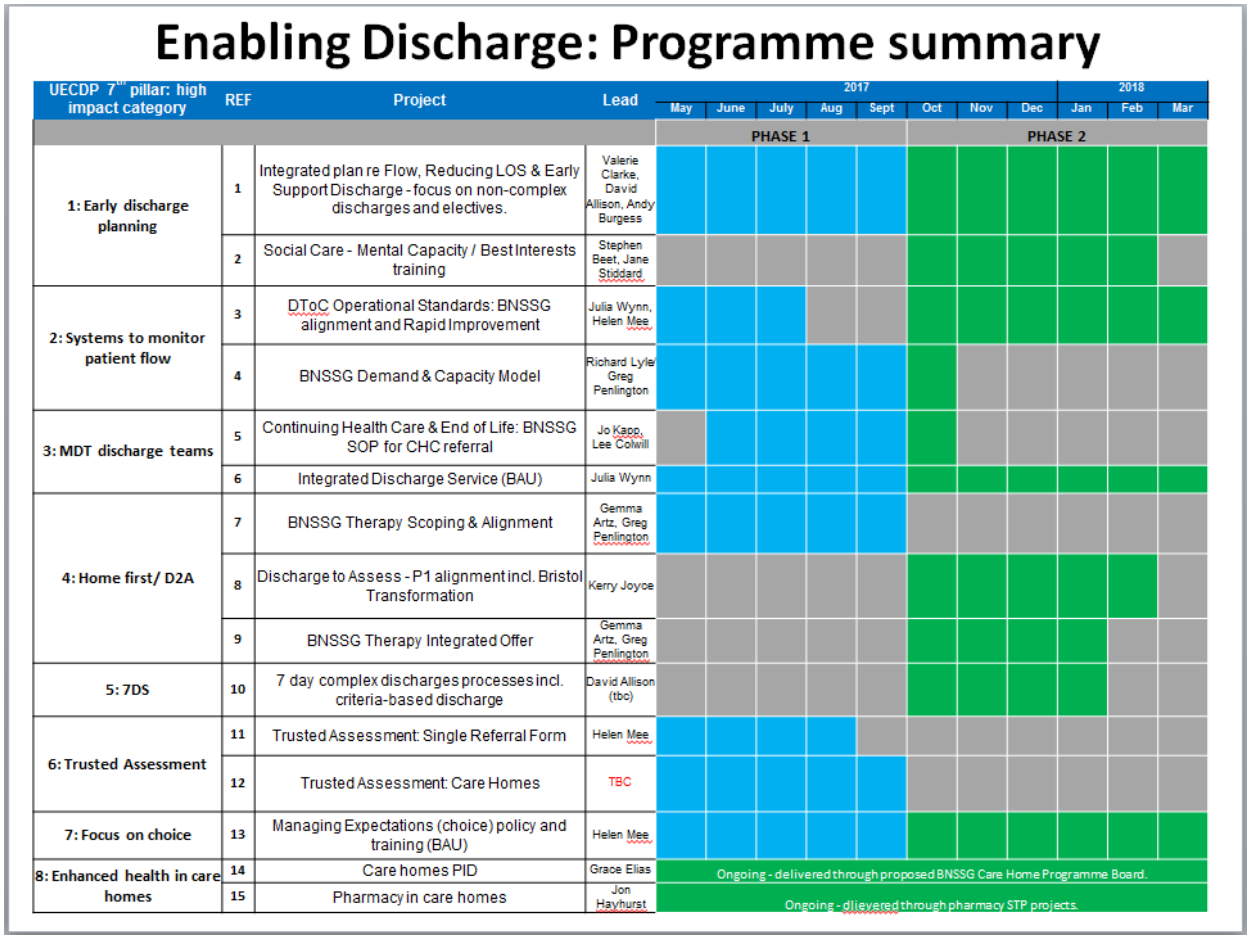
A breakdown of how the Better Care Funding contributes to Commissioning Out Of Hospital services can be seen in the table below;

Out of Hospital Services		
Scheme name	**Estimated Investment**	**OOH Service**
Community Services	£7,455,912	Y
Carers	£1,007,360	Y
Community Equipment	£1,034,000	Y
Better Care Team Infrastructure - P4BC	£300,000	Y
Care Home Support Team Training	£25,000	Y
Discharge to Assess - GP Cover to Pathway 2 & 3 Beds	£30,324	Y
Discharge to Assess - Pathway 2 Rehab Beds	£1,379,044	Y
Discharge to Assess - Pathway 3 Increase Social Workers	£248,657	Y
Discharge to Assess - Pathway 3 Complex Assessment Beds	£921,752	Y
Section 117	£4,100,000	Y
Care Home Support Team	£138,000	Y
Ace Service	£912,033	Y
Integrated Discharge Teams	£41,443	Y
Mental Health Crisis Housing and Health	£921,320	Y
Employment Service	£403,880	Y
Red Cross	£167,793	Y
Missing Link	£118,540	Y
Rethink	£103,350	Y
Bristol Mind	£225,919	Y
Tranquiliser Project	£65,498	Y
Windmill City Farm	£13,520	Y
Bristol Hearing Voices Network	£3,059	Y
Totals investment for Out of Hospital Services (Estimated figures)	**£19,616,404**	

National Condition 4: Managing Transfers of Care

Using the National guidance to deliver the High Impact Change Model, Bristol will deliver this through the Enabling Discharge Board which has representatives from commissioners and providers. This will tackle each of the changes and has been designed with partners and providers to ensure a robust and sustainable change is implemented.

In previous years Bristol CCG in partnership with Bristol City Council had already been working towards and delivered the Discharge to Assess (D2A) service, this will be monitored through the Enabling Discharge Board and expanded where possible. Below is an outline of the Enabling Discharge Programme, which details the schemes that will deliver each High Impact Change Model:



In addition to the above Enabling Discharge Programme summary, Bristol City Council have benchmarked their schemes against the High Impact Change Model to reduce DToC, these can be summarised below;

All of our proposals will contribute to the development and improvement of performance in High Impact change Model to reduce delayed transfers of care:

Change 1 -Early discharge planning

Investment into care services which are responsive and developing Bristol's Tier 1 community offer to support early discharges home.

Change 2 - Systems to monitor patient flow

Bristol City Council are working with Acute Trusts to develop technology IT solutions that join up data between partners to reduce delays.

Change 3 - Multi-disciplinary discharge teams

In Bristol there already is a well-established integrated discharge service within both Acute Hospitals, including investment in voluntary/ community sector. In addition to this, Bristol City Council are investing in a virtual IDS team to support Mental Health discharges. The IBCF is being used to work with health partners to develop their knowledge around signposting patients to community (Tier 1) resources that reduce pressure on traditional care services.

Change 4 - Home first/discharge to assess

Discharge to Assess pathways are well established and the IBCF will invest in additional reablement and home care capacity to ensure that a greater number of patients can be assessed at home after leaving hospital with services that maximise their independence

Change 5 - Seven-day services

Weekend working is in place in both Acute Trusts and currently being reviewed to increase impact on weekend discharge opportunities. The IBCF investment in home care and care homes will include work to enable providers to accept new packages and placements on weekends and bank holidays.

Change 6 - Trusted assessors

Single referral form developed with all partners now in place which includes element of Trusted assessment. The IBCF workstream around BNSSG common process work will include trusted assessment across the 3 Local Authorities will also be looking at Trusted assessment amongst care homes.

Change 7 - Focus on choice

Managing choice protocols are well established in both Acute Trusts. Further embedding of Bristol's 3 Tier model will ensure a strength based approach to ensure that patients are empowered to live in the way that they choose.

Change 8 - Enhancing health in care homes.

IBCF will develop improved contracts with care homes including shared commissioning approaches across BNSSG.

The below table outlines how each of the BCF and iBCF schemes contribute to the eight High Impact Changes;

BCF/iBCF	High Impact Changes									
	Scheme name	Estimated Investment	Change 1	Change 2	Change 3	Change 4	Change 5	Change 6	Change 7	Change 8
	Community Services	£7,455,912	Y		Y		Y			
	Adaptations (DFG)	£2,651,560								
	Carers	£1,007,360				Y				
	Intermediate Care	£2,035,800		Y		Y			Y	
	domiciliary prevention)	£5,095,191				Y			Y	
	Care Act implementation	£388,160				Y			Y	
	7 Day Working	£382,390	Y	Y			Y			
	Better Care Bristol Infrastructure (Preparing for Better Care)	£300,000	Y						Y	
	Section 117	£4,100,000			Y					Y
	Care Home Support Team	£138,000								
	Discharge to Assess	£3,699,993		Y		Y			Y	Y
	Community Equipment	£1,034,000	Y		Y	Y				
	Care Home support team - provider training improvement (Preparing for Better Care)	£25,000			Y					Y
	Homeless Discharge	£66,424			Y					
	Social Prescribing (Preparing for Better Care)	£300,000								
	Ace Service	£912,033								
	Integrated Discharge Teams	£41,443	Y	Y	Y	Y			Y	
	Mental Health Crisis Housing and health	£921,320				Y				
	Employment service	£403,880								
	Red Cross	£167,793	Y			Y				
	Missing Link	£118,540								
	Rethink	£103,350								
	Bristol Mind	£225,919								
	Tranquiliser project	£65,498								
	Windmill City Farm	£13,520								
	Bristol Hearing Voices Network	£3,059								
iBCF	iMPOWER approach to Demand Management	£220,000		Y						
	Improved Information and Guidance	£100,000		Y						
	Increase of Technology	£40,000		Y						
	Improving engagement with GP clusters	£300,000	Y		Y					
	Building on Asset Based Approach	£500,000								
	BNSSG Common Process Work	£250,000				Y	Y	Y		
	Investment in Home Care Capacity/ System Flow	£2,500,000		Y		Y			Y	
	Assistive Technology	£400,000	Y		Y	Y				
	Extra Investment in Adults of Working Age	£500,000		Y						Y
	Improved Market Management for Vulnerable Adults	£500,000	Y	Y					Y	
	Increased Investment in Mobile Working	£750,000		Y						
	Improving Capacity in Care Homes	£2,000,000							Y	Y
	Accommodation Strategy	£100,000		Y						Y
	Increase Reviewing Capacity	£650,000	Y		Y					

Bristol will continue working towards the previous National Conditions, as they are seen to be critical enablers for integration, with some falling into the Enabling Discharge Group who tackle the High Impact Change Model and the remaining National Conditions such as Data Sharing, being embedded across Bristol with the Connecting Care approach.

The High Impact Change Model comprises of various schemes to enable and facilitate timely discharge from acutes. The iBCF also contributes to the previous National Conditions, such as expanding on 7 day services and Joint approach to assessments and care planning.

National Metrics

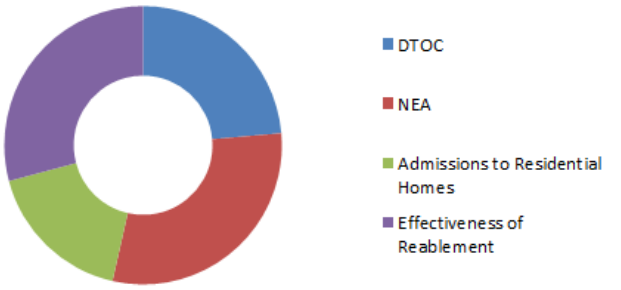
As part of the Better Care Bristol Plan, we will continue to measure ourselves against the four National Metrics. Local areas are no longer required to report the performance of the previous local metrics. A recent review and mapping exercise of the schemes within the neighbouring CCG's previous plans, highlights a consistent approach to meeting the Better Care Fund performance metrics. We will continue to work together to align work streams to maximise the impact to achieve the below metrics.

Our Better Care Fund plan will strengthen our performance management capacity and the quality of the information. The positive impact of multiple schemes across the whole health and social care system is key to building the momentum for successful change and improving out of hospital care. However, as we proceed towards one CCG Commissioning Voice working with three Local Authorities, we must link outcomes to our financial investments across the system and identify which activities are delivering or contributing to which high impact changes. Understanding these nuances is critical to our performance monitoring plan and defining and delivering our stretch targets.

Measuring performance via a BNSSG set of performance indicators will enable us to compare investment and output across similar and different BNSSG schemes. A single management system that maps and monitors local schemes and their impacts will enable the BNSSG partnership to significantly improve the pace and scale of change. This will include closer working with the A&E delivery group which will incorporate specific Better Care Fund metrics.

The schemes that contribute to each metric can be seen in the table below;

Metrics					
Scheme name	Estimated Investment	DTOC	NEA	Admissions to Residential Homes	Effectiveness of Reablement
Community Services	£7,455,912	Y	Y	Y	Y
Adaptations (DFG)	£2,651,566			Y	Y
Carers	£1,007,360		Y	Y	Y
Intermediate Care	£2,035,800	Y	Y	Y	Y
Prevention & Maximising Independence - (Formally reablement, dementia and domiciliary prevention)	£5,095,191	Y	Y	Y	Y
Care Act implementation	£388,160	Y	Y	Y	Y
7 Day Working	£382,390	Y	Y		Y
Better Care Bristol Infrastructure (Preparing for Better Care)	£300,000	Y	Y		Y
Section 117	£4,100,000	Y	Y		Y
Care Home Support Team	£138,000		Y	Y	
Discharge to Assess	£3,699,993	Y	Y	Y	
Community Equipment	£1,034,000	Y	Y	Y	Y
Care Home support team - provider training improvement (Preparing for Better Care)	£25,000	Y	Y		Y
Homeless Discharge	£66,424	Y			Y
Social Prescribing (Preparing for Better Care)	£300,000		Y	Y	Y
Ace Service	£912,033		Y	Y	Y
Integrated Discharge Teams	£41,443	Y	Y		
Mental Health Crisis Housing and health	£921,320	Y	Y	Y	Y
Employment service	£403,880		Y		Y
Red Cross	£167,793	Y	Y		Y
Missing Link	£118,540		Y		Y
Rethink	£103,350	Y	Y		Y
Bristol Mind	£225,919		Y		Y
Tranquiliser project	£65,498		Y		Y
Windmill City Farm	£13,520		Y		Y
Bristol Hearing Voices Network	£3,059	Y	Y		Y
iMPOWER approach to Demand Management	£220,000	Y	Y	Y	Y
Improved Information and Guidance	£100,000		Y	Y	Y
Increase of Technology	£40,000	Y		Y	Y
Improving engagement with GP clusters	£300,000	Y	Y	Y	Y
Building on Asset Based Approach	£500,000	Y	Y		Y
BNSSG Common Process Work	£250,000	Y	Y		Y
Investment in Home Care Capacity/ System Flow	£2,500,000	Y	Y	Y	Y
Assistive Technology	£400,000	Y	Y	Y	Y
Extra Investment in Adults of Working Age	£500,000	Y	Y		Y
Improved Market Management for Vulnerable Adults	£500,000	Y	Y	Y	Y
Increased Investment in Mobile Working	£750,000	Y	Y	Y	Y
Improving Capacity in Care Homes	£2,000,000	Y	Y		Y
Accommodation Strategy	£100,000	Y	Y		Y
Increase Reviewing Capacity	£650,000	Y	Y	Y	Y



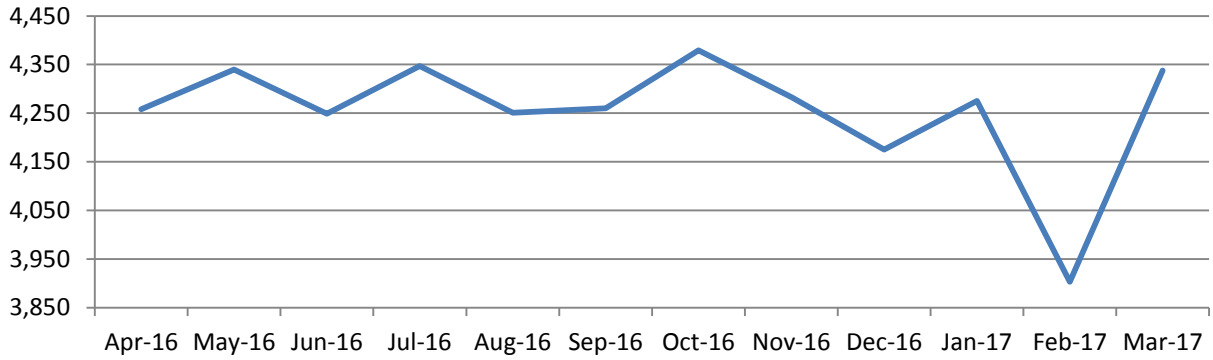
In addition to the above table, the pie chart illustrates the proportion of the Better Care Fund and Improved Better Care Fund contribution of each of the National Metrics.

Non-elective Admissions

In previous years, the Non-elective Admissions target aligned with Bristol CCG's operational plans and no further reduction was applied. This approach will continue into the 2017/19 using the BNSSG operational plan.

When looking at the previous year's performance it was decided that we should not apply an additional reduction in NEA's, as the performance indicated that we contained growth within 16/17 and may not see the reduction we would anticipate. In addition to the previous year's performance, some schemes are still in implementation stage, therefore it would not be realistic to achieve a further reduction

Performance within 2016/17 across the CCG was consistent throughout the year whilst containing growth, as shown in the graph below.



Throughout 2016/17 the Bristol Programme had a total of 13 schemes that contributed towards reducing NEA's. Going forward into 2017/19 we have increased the number of schemes towards this metric to a total of 24. The schemes within iBCF also have added a further 13 interventions to contribute to the reduction in NEA's, therefore we would expect to see a steady decline in NEA's. The below table shows all the BCF and iBCF schemes to reduce Bristol's NEA's as well as the expected investment total to reduce this metric;

Scheme name	Estimated Investment	NEA
Community Services	£7,455,912	Y
Carers	£1,007,360	Y
Intermediate Care	£2,035,800	Y
Prevention & Maximising Independence	£5,095,191	Y
Care Act implementation	£388,160	Y
7 Day Working	£382,390	Y
Section 117	£4,100,000	Y
Care Home Support Team	£138,000	Y
Discharge to Assess	£3,699,993	Y
Community Equipment	£1,034,000	Y
Care Home support team - provider training improvement	£25,000	Y
Social Prescribing	£300,000	Y
Ace Service	£912,033	Y
Integrated Discharge Teams	£41,443	Y
Mental Health Crisis Housing and health	£921,320	Y
Employment service	£403,880	Y
Red Cross	£167,793	Y
Missing Link	£118,540	Y
Rethink	£103,350	Y
Bristol Mind	£225,919	Y
Tranquiliser project	£65,498	Y
Windmill City Farm	£13,520	Y
Bristol Hearing Voices Network	£3,059	Y
iMPOWER approach to Demand Management	£220,000	Y
Improved Information and Guidance	£100,000	Y
Improving engagement with GP clusters	£300,000	Y
Building on Asset Based Approach	£500,000	Y
BNSSG Common Process Work	£250,000	Y
Investment in Home Care Capacity/ System Flow	£2,500,000	Y
Assistive Technology	£400,000	Y
Extra Investment in Adults of Working Age	£500,000	Y
Improved Market Management for Vulnerable Adults	£500,000	Y
Increased Investment in Mobile Working	£750,000	Y
Improving Capacity in Care Homes	£2,000,000	Y
Accommodation Strategy	£100,000	Y
Increase Reviewing Capacity	£650,000	Y
Total	£37,408,161	36

Admissions to residential care homes

Performance against the reduction in care home admissions across Bristol has been on a positive trajectory throughout 2016/17, with Better Care Bristol investing heavily into schemes that contribute to achieving this metric. This will continue into 2017/19 with the schemes shown above which will contribute to achieving this metric.

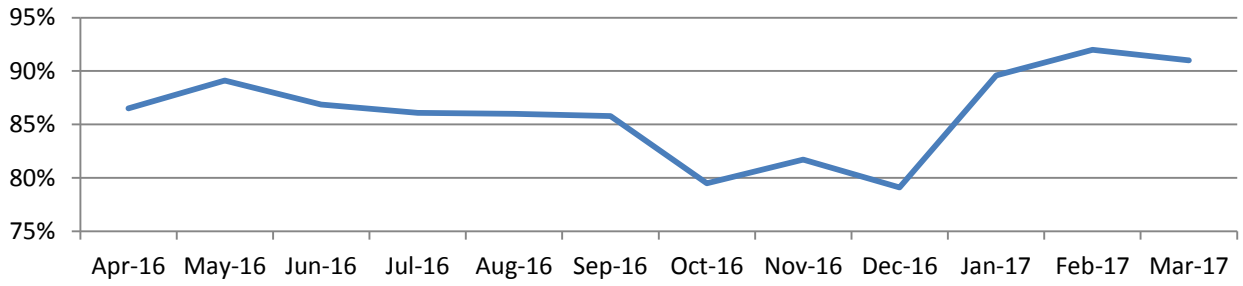
In the previous year we were able to maintain admissions below the target. We had managed to support people to remain independently at home and avoid needing an admission to a care home whilst ensuring this is still the most cost effective option.

The below table sets out the schemes that will contribute towards the reduction in care homes admissions;

Scheme name	Estimated Investment	Admissions to Residential
Community Services	£7,455,912	Y
Adaptations (DFG)	£2,651,566	Y
Carers	£1,007,360	Y
Intermediate Care	£2,035,800	Y
Prevention & Maximising Independence	£5,095,191	Y
Care Act implementation	£388,160	Y
Care Home Support Team	£138,000	Y
Discharge to Assess	£3,699,993	Y
Community Equipment	£1,034,000	Y
Social Prescribing	£300,000	Y
Ace Service	£912,033	Y
Mental Health Crisis Housing and health	£921,320	Y
iMPOWER approach to Demand Management	£220,000	Y
Improved Information and Guidance	£100,000	Y
Increase of Technology	£40,000	Y
Improving engagement with GP clusters	£300,000	Y
Investment in Home Care Capacity/ System Flow	£2,500,000	Y
Assistive Technology	£400,000	Y
Improved Market Management for Vulnerable Adults	£500,000	Y
Increased Investment in Mobile Working	£750,000	Y
Increase Reviewing Capacity	£650,000	Y
Total	£31,099,335	21

Effectiveness of reablement

Better Care Bristol has remained consistent with the performance against keeping people at home for 91 days after discharge. Although Bristol fell slightly short on this target, it has shown a significant improvement on previous year's performances, as shown in the below graph.



Looking at the previous year's performance we have significantly increased the number of schemes that would contribute to keeping people at home after discharge. In 2016/17 there was a total of 13 schemes that contributed towards this metric, throughout 2017/19 there will be a total of 36 schemes, with 22 will be from BCF and 14 from iBCF, as indicated in the table below;

Scheme name	Estimated Investment	Effectiveness of Reablement
Community Services	£7,455,912	Y
Adaptations (DFG)	£2,651,566	Y
Carers	£1,007,360	Y
Intermediate Care	£2,035,800	Y
Prevention & Maximising Independence	£5,095,191	Y
Care Act implementation	£388,160	Y
7 Day Working	£382,390	Y
Section 117	£4,100,000	Y
Community Equipment	£1,034,000	Y
Care Home support team - provider training improvement	£25,000	Y
Homeless Discharge	£66,424	Y
Social Prescribing	£300,000	Y
Ace Service	£912,033	Y
Mental Health Crisis Housing and health	£921,320	Y
Employment service	£403,880	Y
Red Cross	£167,793	Y
Missing Link	£118,540	Y
Rethink	£103,350	Y
Bristol Mind	£225,919	Y
Tranquiliser project	£65,498	Y
Windmill City Farm	£13,520	Y
Bristol Hearing Voices Network	£3,059	Y
iMPOWER approach to Demand Management	£220,000	Y
Improved Information and Guidance	£100,000	Y
Increase of Technology	£40,000	Y
Improving engagement with GP clusters	£300,000	Y
Building on Asset Based Approach	£500,000	Y
BNSSG Common Process Work	£250,000	Y
Investment in Home Care Capacity/ System Flow	£2,500,000	Y
Assistive Technology	£400,000	Y
Extra Investment in Adults of Working Age	£500,000	Y
Improved Market Management for Vulnerable Adults	£500,000	Y
Increased Investment in Mobile Working	£750,000	Y
Improving Capacity in Care Homes	£2,000,000	Y
Accommodation Strategy	£100,000	Y
Increase Reviewing Capacity	£650,000	Y
Total	£36,286,715	36

Delayed transfers of care

In previous years the DTOC target aligned with Bristol CCG's operational plan. NHSE have mandated a DTOC trajectory for Bristol to achieve a level of 4.5% (Delayed Transfers of Care (delayed days) from hospital per 100,000 population, aged 18+) by September 2017 and reducing to 3.5% DTOC rate in March 2018 which has been agreed with partners across the Bristol footprint.

To achieve the 4.5% target by September will be a challenge for both Health and Social Care as at the end of March 2017 the DTOC position was 8.8%, this is mainly due to Mental Health delays which are now being included.

Work is already underway with partners and providers to address this issue, including the creation of a Mental Health Enabling Discharge Board which monitors and addresses blockages within the system. A result from the first meeting was the additional creation of task and finish groups addressing key area such as, coding, capacity and accommodation. The task and finish groups are tasked with focusing on reducing DTOC across BNSSG, however Bristol's Mental Health DTOC is higher than neighbouring CCG's and there is the potential to learn from other CCG's and adopt a single approach for discharging mental health patients.

We would anticipate that mental health DTOC would reduce rapidly primarily due to a potential coding issue and patients being counted as a DTOC prematurely.

Similarly the Enabling Discharge group (physical health) is more established and schemes are moving into implantation stage and we would therefor expect to see a further reduction in both acute trusts.

DTOC performance is also monitored through the A&E delivery board, which the Enabling Discharge board reports directly too, ensuring that system wide performance is monitored at every level with partners and providers.

In the previous year, Bristol's BCF programme had a total of 12 schemes to contribute towards the reduction on DTOC across the system. Throughout the next two years we have a total of 16 schemes funded from BCF with an additional 13 within iBCF, as shown in the table below;

Scheme name	Estimated Investment	DTOC
Community Services	£7,455,912	Y
Intermediate Care	£2,035,800	Y
Prevention & Maximising Independence	£5,095,191	Y
Care Act implementation	£388,160	Y
7 Day Working	£382,390	Y
Section 117	£4,100,000	Y
Discharge to Assess	£3,699,993	Y
Community Equipment	£1,034,000	Y
Care Home support team - provider training improvement	£25,000	Y
Homeless Discharge	£66,424	Y
Integrated Discharge Teams	£41,443	Y
Mental Health Crisis Housing and health	£921,320	Y
Red Cross	£167,793	Y
Rethink	£103,350	Y
Bristol Hearing Voices Network	£3,059	Y
iMPOWER approach to Demand Management	£220,000	Y
Increase of Technology	£40,000	Y
Improving engagement with GP clusters	£300,000	Y
Building on Asset Based Approach	£500,000	Y
BNSSG Common Process Work	£250,000	Y
Investment in Home Care Capacity/ System Flow	£2,500,000	Y
Assistive Technology	£400,000	Y
Extra Investment in Adults of Working Age	£500,000	Y
Improved Market Management for Vulnerable Adults	£500,000	Y
Increased Investment in Mobile Working	£750,000	Y
Improving Capacity in Care Homes	£2,000,000	Y
Accommodation Strategy	£100,000	Y
Increase Reviewing Capacity	£650,000	Y
Total	£34,229,835	28

Approval and sign off

This plan has been created in partnership with Bristol City Council and formally signed off by Bristol CCG and Bristol City Council ahead of the Better Care Joint Commissioning Board as well as the Bristol Health & Wellbeing Board, who delegated authority to Co-Chairs Marvin Rees, Mayor of Bristol & Martin Jones, Clinical Chair Bristol CCG.