BCF Planning Submission 23/25

Lewis Willing

New Priorities & Projects 23/25

Health Inequalities
Admission Avoidance
Discharge
Administration/Oversight/ Finance/Monitoring

Support the embedding of carers service with colleagues
Continuation of Mental health project in PCN North (share learning and explore roll out)
Explore Roll out of learning from LD health check project
Dementia Alliance and Dementia friendly Wokingham
Transport for BCF funded Services
Data Sharing process/procedure for LD/Carers

Support to Implement new CHC/FNC Policy and Procedure in Wokingham
MDT improvement
Business As Usual for KIT
Mental health and substance misuse
Admission and Attendance Data review report

Collaborative Reablement Project
Bariatric Discharge
High level needs Dementia Discharge
Repositioning Step Up/Down Beds

Income and Expenditure

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£1,075,656	£1,075,656	£1,075,656	£1,075,656	£0
Minimum NHS Contribution	£10,223,616	£10,802,272	£10,110,595	£10,682,813	£113,021
iBCF	£471,832	£471,832	£471,832	£471,832	£0
Additional LA Contribution	£1,185,690	£1,112,531	£1,165,131	£1,112,531	£20,559
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£66,150	£110,250	£0	£0	£66,150
ICB Discharge Funding	£678,000	£1,130,000	£744,150	£1,240,250	-£66,150
Total	**£13,700,944**	**£14,702,541**	**£13,567,364**	**£14,583,082**	**£133,580**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£3,320,348	£3,508,279
Planned spend	£4,118,695	£4,351,813

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£4,812,730	£5,085,130
Planned spend	£4,793,708	£5,065,129

Notes:
- Assumed same level of expenditure in year 2 for DFG, iBCF, Discharge funding
- Year 1 additional income from LA is underspend carried forward from 22/23 and used to support new priorities in 23/25

Metrics

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	140.2	94.5	141.3	124.0
	Number of Admissions	264	178	266	-
	Population	173,945	173,945	173,945	173,945
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Indicator value	140.2	94.5	141.3	124

Rationale-Currently performing well, last year hit target with a 7% drop and Berks West in top 10 nationally for this outcome. Increased population in borough with 13k new residents and increasing % of over 65 and over 80- As such we will look to maintain.

Continue:

- GP Health Checks
- MDT
- Intermediate Care and Rapid Response (2hr & 2day)
- Friendship Alliance (Social Isolation and befriending)
- MIND Wellbeing Service
- Moving With Confidence

New:

- Work to increase the number of people who have had an LD health check
- Increase the number of people through MDT
- Keeping in Touch service
- Data analysis for reasons for admission

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,951.6	1,417.0	1,727.4
	Count	635	463	563
	Population	30,779	30779	30779

Rationale- Data has been extracted from the SUS inpatients Episode data in line with given methodology: primary diagnosis code, external case code for fall found in a secondary diagnosis, episode order number of 1, admission method code starting in 2, admissions only included where a Local Authority code can be identified and patient aged 65+ at time of admission. Maintain 3 year average

Continue

- SCAS Falls & Frailties Service
- BHFT Falls service
- Moving With Confidence
- SHINE
- Steady Steps

New

- Pilot- Healthy Homes Assessor
- Pilot- Carer response service

Metrics

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.1%	90.9%	91.4%	91.0%
	Numerator	2,539	2,345	2,305	2,490
	Denominator	2,756	2,581	2,523	2,736
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Quarter (%)	92.1%	90.9%	91.4%	91.0%
	Numerator	2,539	2,345	2,305	2,490
	Denominator	2,756	2,581	2,523	2,736

Rationale- Well established and mature services, with a home first approach. Good Vol. Sec. and P0 outcomes, pressure on P1 & P3. Increasing Pop and % (as above) Maintaining will be challenging

Continue

- Home First Approach
- Home From Hospital Service (Via Age Uk)
- Keeping In Touch
- Friendship Alliance
- Reablement (Intermediate Care & START services)
- Infection Control Nursing (Keeping Care homes open for discharge)

New

- Collaborative Reablement (Surrey Model)
- Increased people through MDT (better shared care plans support better discharges)

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	212.6	351.1	279.0	284.7
	Numerator	65	112	89	93
	Denominator	30,571	31,901	31,901	32,666

Rationale- 20/21 we averaged 7.1 placements per month, 21/22 we averaged 7.6, 22/23 we averaged 7.4. We will drop the target to 7.75 per month. There is concern about this target, as a very small number of placements will sway the outcome very quickly.

Continue:

- 2hr/2Day response for Ageing Well
- Step Up/Down beds
- Discharge to Assess beds

New:

- Keeping in Touch,
- Increased cases through MDT
- Collaborative reablement project (Surrey Model)
- PCN Social Workers

Metrics

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	77.6%	84.9%	86.8%	86.8%
	Numerator	121	535	500	500
	Denominator	156	630	576	576

Rationale-We have had some success with our Collaborative Reablement Pilot, increasing the amount of trained carers delivering OT monitored reablement in the community. This has been extended to see if growing it would be a good option. Our ongoing reablement services continue (funded via BCF) and our UCR work continues.

Continue:

- Intermediate Care Team
- OPTALIS START Team

New:

- Keeping in Touch,
- Increased cases through MDT
- Collaborative reablement project (Surrey Model)
- PCN Social Workers
- Review/implementation of Berks Wide review of reablement services

Planning Requirements

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Lewis Willing
Head of Health and Social Care Integration
Lewis.willing@wokingham.gov.uk