Wokingham Integrated Partnership

Annual Project Review End of 2021- Month 9

Lewis Willing

Overview

During our workshops at the beginning year, the Wokingham Integrated Partnership decided that this year we would have 6 priorities:

- **Mental Health and Social Inclusion**
- **Deconditioning/Rehab/Physical Activity**
- **Frailty Monitoring**
- **Inequality and Poverty**
- **Social Prescription (including Data & IT to support Integrative working)**
- **Better Care Fund, Monitoring and Administration**

These Priorities led to a total of 19 projects to support the partnership to integrate being initiated. The programme has projects being led by the Primary Care Networks, Berkshire Health Foundation Trust, Public Health, and the Integration Team

Overall- 13 Successful Projects, 5 that will need continued work and 1 on hold- Excellent progress given the COVID Environment

Mental Health and Social Inclusion

Implement MIND service & Establish MH Alliance- SUCCESS (CLOSE/BAU)

- Service has been set up, engaged with the entire Health and Social Care System and is receiving referrals from all PCN's.
- Quarterly MH Alliance meetings are now taking place to support the system to work together on mental health. Patients are reporting good outcomes and give good feedback. 73% of the 243 people are reporting an increase in wellbeing (Dec '21)

Implement Friendship Alliance Phase 2 (including Look to increase Digital Inclusion for the most vulnerable in the community)- SUCCESS (CLOSE/BAU)

- Friendship Month a massive success
- Digital Devices issued to over 45 elderly people & families. A mid-year review has resulted in a further 25 devices being made available
- Progress against the majority of KPI's has been really positive, either meeting or exceeding targets- across 11 schemes, there have been 2214 interactions (Dec '21) as a result of these projects

Deconditioning/Rehab/Physical Activity

Reablement Review/Implementation- SUCCESS (POTENTIAL ROLL OUT)

- A review of the services has taken place.
- The triage system has been reviewed and a new system has been implemented.
- The 'Surrey model' was piloted and was a success.
- Wokingham System is performing better than Berkshire West and BOB average at regarding 14 and 21 day BCF metric.

Moving with Confidence- SUCCESS (CLOSE-BAU)

- Feedback from customers has been positive (in terms of outcome and experience).
- Despite redeployment to support the COVID effort, the staff have delivered: 418 visits, 75 completed programmes & Received 121 referrals

Deconditioning/Rehab/Physical Activity Continued

Leg Ulcer Pilot- FURTHER WORK

- Renovation of treatment area
- 'Soft Launch' in November in 2 PCN's for pilot. Official Launch on 26th January- 12-month pilot to start officially then
- Positive feedback from patients that have been through the service so far

Reducing Hospital Pressure with Bed Based Services-FURTHER WORK

- The project has focused on the Oak Wing so far. There has been an increase in performance-
  - Increased usage, in number of customers and bed days
  - Decreased longest length of stay & average length of stay (patients are 'in and out' as a D2A service and not lingering)
  - Increased number of accepted referrals
- A review of how Step Up/Down beds are operating is due to be completed by BHFT, this will take place in the next financial year.

Frailty Monitoring

Social Work Liaison Implementation- FURTHER WORK

- 2 PCN senior social workers have been hired in Jan ‘22
- A work plan has been developed, ready for their start in March ‘22
- Delays have resulted from recruitment- Social Workers have been in high demand.

Inequality and Poverty Analysis and Reporting (PHM approach)- FURTHER WORK

- New Analyst in post
- Work to support PCN profiles (first available Feb ‘22) & Action plans
- Support with creation of HK Webinar to support new residents
- Focus on Health Inequalities

Social Prescription (including Data & IT to support Integrative Working)

Project Joy- SUCCESS (BAU)

- Has supported 2016 people in the borough (Jan '22), against a target of 1700 (national target for 1% of GP interactions should be Social Prescription)
- Resulting in 96% acceptance rate for those referrals,78% attendance rate for those referrals, 5/5 Client review of service (rolling average) with 88 services added to the market place.

Connected Care Review- SUCCESS (BAU)

- A doubling of the number of staff accessing care records per month
- At the start of the project, 2-3 staff were retrieving 6-10 records per month. We are now regularly seeing approx. 40 users per month, retrieving approx. 200 records per month
- This enables better care, as all partners are able to see key health and social care information. It supports MDT working, without having to access professionals from either health or social care

Social Prescription- Continued

Creating Healthy Communities- FURTHER WORK

- Despite COVID and Winter Pressures we are holding a CHC event in one PCN
- Further work will need to be done to complete these events for each PCN in ongoing years

Service User Experience- ON HOLD

- A business case and presentations took place with other Integration Boards, who were not keen to take this opportunity up. Placed on hold, as CCG colleagues are looking to run a West of Berkshire solution.

Social Prescription – SUCCESS (BAU)

- A shared Training Syllabus has been developed for non-clinical workers
- A shared induction standard has been developed for non-clinical workers
- Involve run forum for all of the non-clinical staff in the borough
- This supports non-clinical workers to have a good shared grounding across health & social care

Social Prescription- Continued

Virtual Group Clinics- SUCCESS (POTENTIAL ROLL OUT)

- 100% of respondents advised that the programme exceeded their expectations.
- 100% of respondents agreed/strongly agreed that the programme increased their confidence in caring for themselves.
- Improved self-management of Long COVID
- 2nd cohort is starting in February

Better Care Fund, Monitoring and Administration

National and local performance reporting(annual/quarterly/monthly)- SUCCESS (REPEAT NEXT YEAR)

- All national and local reporting has been completed on time and were accepted by partners

Reviewing and updating our Monthly Dashboard- SUCCESS (BAU)

- A fully refreshed dashboard, which offers:
  - A highlight of important data to see performance
  - Captures performance of all services which are funded via BCF
  - Captures all data that is required for the WIP to report to NHSE

BCF Performance- Best in Berkshire West and better than national average in Avoidable Admissions, 14&21 day stays. This year, will be the best performance in the last 3 years for new permanent placements in Care Homes (Circa 50% less compared to last year at month 9). 91.7% of people are returning to their normal place of residence from the hospital.