Wokingham Integrated Partnership Update and End of Year BCF Reporting

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Head of Health and Social Care Integration

Agenda Item 28.

End of Year Better Care Fund Return (2/22)

The Annual Return for the Better Care Fund (21/22) was submitted, and was signed off by the Wellbeing Board Chair and Lead Officer for the ICB

Key Points:

- A section 75 was completed to appropriately share the funds between the CCG and the Council
- The national conditions were met
- Income/Expenditure targets were matched
- The programme did not overspend
- 2 of 5 BCF targets were met

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BCF Year End Feedback

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	BCF continues to be a key vehicle and source of funding to support ongoing work on discharge, admission avoidance and health inequalities. It also supports a framework to enable us as a partnership to come together and enable further work to support our communities to remain healthy, safe and well (Our Wokingham Integrated Partnership Leadership and Delivery Groups). Provides scrutiny and ensures that we are meeting the needs of the people in the borough.
2. Our BCF schemes were implemented as planned in 2021-22	Agree	The schemes that we fund have been delivered this year, against a backdrop of covid and its associated complications, have been implemented as planned.
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The Wokingham Integrated Partnership have completed 15 of 19 projects in the programme this year, prepared 3 projects to move on to BAU or move on to the next phase of their work. Only one project did not move to completion this year. The programme, alongside the operation and monitoring of services that are purchased using BCF funding and the ongoing work of all the partners in the partnership have had a positive impact on integration in the locality.

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BCF Year End Feedback

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes
Success 1	3. Integrated electronic records and sharing across the system with service users	In the West of Berkshire, the BCF funds the use of the Connected Care software. This software is accessable by Health and Social Care partners to understand, the who, what, where and how of the care and support that people are getting. It is also key in use Wokingham Social Work team were not using the system as much as our health colleauges, and through investigation, it was due to the system not being as accessible for social care workers. The partnership in Wokingham worked closer with the Connected Care Programme Team, and more useful fuctionality was added alongside a training and profile raising excercise. This resulted in there being a 100% increase in the averager number of uses, and 100% increase in the average number of users by social workers in the borough. This has supported better transfers of care ffrom the hospital, supported better social care reviews and better quality data for MDT. All of which support better outccomes for people in the borough.
Success 2	6. Good quality and sustainable provider market that can meet demand	This year, the Collaborative Reablement Project was a pilot that supported Home Care providers to receive reablement training, alongside direct support from Occupational Therapists for goal setting and monitoring. The project was a success, with the Home Care providers getting an equivalent outcome for the people that were reabled via this new system. This pilot was a success, leading to a project this year to 'roll out' with more home care providers, supporting an increase in the amount of reablement service in the borough.

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BCF Year End Feedback

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges
Challenge 1	Other	The ongoing pandemic has been a challenge to the ongoing integration effort. Whilst we have had positive outcomes to 18 of our 19 integration projects this year, there were delays in moving projects along (staff-especially management and GP colleagues- focus on delivery, rather than innovation/project work). This was due in part to cover colleagues absence (Sickness/Isolation had a heavy toll on Health and Social Care workforce) as well as sickness of the people themselves, and the increased acuity and volume of people being treated overall.
Challenge 2	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	The only project that was not completed this year, was linked to gathering service user feedback regarding integration as a whole (i.e. the journey through, in and around the partner organisations). We have good feedback mechanisms about each individual services, which has generally very positive feedback, however limited feedback about the linkages between the services. This project was put on hold, as we were not able to agree implementation across the West of Berkshire.

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Performance

Avoidable admissions 52	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	495.0	Not on track to meet target	This year a challenging winter alongside a difficult COVID environment and a very challenging target, has meant that we have not met our target. However, when comparing our performance this year to 19/20 (the last non-COVID year), our performance is the equivalent of an 0.6 additional attendances a week this year. Our performance is better than any of the West of Berkshire systems and significantly better than the last set of national data that we have available.	Our primary care colleagues continue provide health checks for long term health conditions, which supports people in the community to get optimised care and treatment for their conditions.. The Ageing Well project has been operating, supporting people with admission avoidance. 'Keeping in Touch' Project- using the Vol. Sec.

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Performance

		14 days or more (Q3)	14 days or more (Q4)	21 days or more (Q3)	21 days or more (Q4)			
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	7.8 %	10 %	3.6 %	4.2 %	Not on track to meet target	NHSE made a requirement to target performance as better than during the height of the pandemic, when Non Elective admissions to hospital were extremely low. CSU projections We have remained within 2% of our targets. Overall, we have achieved an annual performance of 8.7%, which is better than the 9.3% 19/20 (our last non-COVID year). 3 of 4 quarters this year are better than 19/20 also. The performance of the Wokingham system is significantly better than the England average, and better than the performance of West of Berkshire systems. .	The Community Reablement Project (OT guided and supported Home Care) was successful in increasing the amount of reablement capacity, to support discharge from hospital. Work with the community hospital and D2A project was a success, increasing the number of bed days used, the number of people who used the service, the amount of time the beds were in use and decreasing average length of stay . The centrally funded Rapid Community Discharge project (funding increased staffing, blocks of home care, care homes and nursing homes) also supported the system to achieve against a difficult winter and COVID environment.

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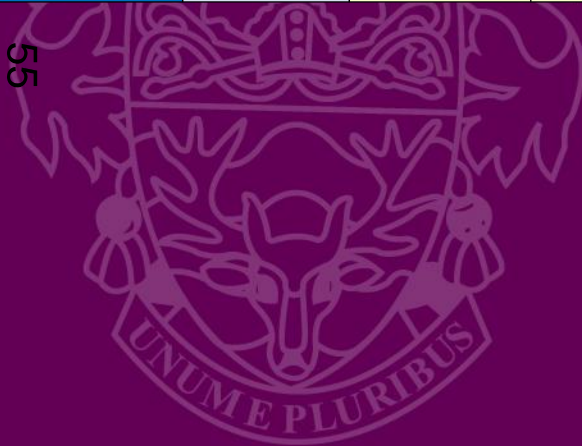
Performance

Percentage of people who are discharged from acute hospital to their normal place of residence	91.0%	On track to meet target	In terms of continuing to staff all of the Health and Social Care, as well as an increased acuity for the people leaving the hospital. Having staff off work due to ill health, as well as those having to isolate, has meant that there has been pressure to keep community services running. Despite this pressure, the Wokingham System has managed to hit exceed this target at 91.2%. The other major challenge here has been the increase in the number of people with Double Handed care. As people come out of the hospital 'sicker & quicker' we have seen triple digit % increases on pre pandemic levels in demand. This has used significant amounts of home care and reablement to enable discharges into the community.	Having frequent meetings across the West of Berkshire to discuss the Rapid Community Discharge programme meant that members of the Wokingham System were able to joint work to get people to the right services. Projects have included new OT posts at the hospitals to seek to 'right size' care packages, with OT from local authroity working closely with hospital colleauges. There is also training from these new OT to support more single handed care in the wards, to prepare patients for discharge with a single carer.
Rate of permanent admissions to residential care per 100,000 population (65+)	368	On track to meet target	Increased acuity of people being discharged (people have been moving out of hospital 'sicker and quicker') has meant that short term there have been more placements in care homes.	The hard work of OT, physio, community nursing and social work, there have been fewer permanent placements, as people have been moved on from care/nursing back to the community. Using the Rapid Communit Discharge services appropriately, meant that we were able to move people out and home and having increased home care and reablement capacity (see above), meant that whilst more people went into care homes short term, they did not stay. The Wokingham System did not, at any stage, use a residential or nursing bed for lack of home care.

Targets

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	90.0%	Not on track to meet target	The key challenge for this target is linked to counting patients discharged to our specialist reablement services as End of Life. Whilst appropriate for our most highly skilled community assets to support people in their own homes, to die with dignity, rather than in a hospital, their inclusion in reporting has resulted in 84% of patients being at home 91 days after discharge.. It is foreseen that our performance would exceed the 90%, should we remove the End of Life cases.	Using BCF funding, there has been an extension of the 'Home from Hospital scheme' during the winter months. This increased the number of people supported, but also the length of support that was on offer. This scheme was very successful. It is also important to note that Wokingham (and the West of Berkshire) continue to have very good performance at supporting people to successfully be discharged via pathway 0, meaning that we have lower numbers of people discharged on Pathways 1,2 &3.



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Integration Board Highlights- Some of what we delivered in 21/22

- MIND wellbeing service embedded and working toward capacity
- 18 of 19 projects on the programme completed or ready for phase 2 (despite COVID)
- Launch of 'Keeping in Touch'
- PHM Profiles for each of our PCNs
- Moving With Confidence
- Recruited Primary Care Network Social Workers (first nationally)
- 100% increase in number and uses of Connected Care by WBC Social Workers
- Virtual Group Clinics for new parents and also for Long Covid
- Friendship Alliance Phase 2

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