Wokingham Integrated Partnership

BCF Annual Plan Submission 22/23

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Overview

The Wokingham Integrated Partnership completed their annual integration programme plan in May ’22 and budget in June ‘22. This submission is a formalised version of that plan. We are 6 months into programme delivery

NHSE released their template in July and we will be submitted a final version on 26th September ‘22 (following the agreement of the Chair of the Wellbeing board & Chief Officer of the ICB)

During the development of the annual integration plan and this submission, the Integration Team have been in touch with colleagues from the ICB, BHFT, RBH and the other West of Berkshire Local Authorities.

A draft version of this return was submitted to NHSE, to gather feedback and further enhance it. This was welcomed. The majority of the submission was noted as being good, with few areas of improvement. These have subsequently been addressed with support from partners.

Finance

- All of the minimum contributions have been met
- All of the national conditions have been met
- This is essentially the budget which was agreed by the Leadership Board in June

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£3,142,483
Planned spend	£3,953,323

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£4,554,921
Planned spend	£4,579,008

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£234,100	(1.9%)
Carers Services	£426,208	(3.5%)
Community Based Schemes	£1,734,338	(14.1%)
DFG Related Schemes	£1,075,656	(8.7%)
Enablers for Integration	£1,091,394	(8.8%)
High Impact Change Model for Managing Transfer o	£1,224,760	(9.9%)
Home Care or Domiciliary Care	£213,902	(1.7%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£546,250	(4.4%)
Bed based intermediate Care Services	£1,953,538	(15.8%)
Reablement in a persons own home	£1,630,632	(13.2%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£209,700	(1.7%)
Prevention / Early Intervention	£73,333	(0.6%)
Residential Placements	£1,419,817	(11.5%)
Other	£502,347	(4.1%)
Total	**£12,335,975**	

Funding Sources	Income	Expenditure	Difference
DFG	£1,075,656	£1,075,656	£0
Minimum NHS Contribution	£9,675,956	£9,675,956	£0
iBCF	£471,832	£471,832	£0
Additional LA Contribution	£1,112,531	£1,112,531	£0
Additional ICB Contribution	£0	£0	£0
Total	**£12,335,975**	**£12,335,975**	**£0**

Services

In Wokingham, here is a highlight of the services that we currently fund using BCF:

- The Health Hub (Referrals)
- Speech and Language Therapy
- Oak Wing
- START (social care reablement service) & Intermediate Care Team (health reablement service)
- Rapid Response and Treatment Service
- Care Home Support Team
- Multi Disciplinary Team Meeting Co-Ordinators
- Community Navigators (VCS)
- Step Down Beds
- Contributions to Hospital Liaison Team
- Moving With Confidence
- Home from Hospital Scheme (VCS)
- MIND Wellbeing Service
- Additional Physiotherapy support for reablement
- The Friendship Alliance (Social Isolation)
- PHM Analyst
- Project Joy (Social Prescription Application)

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Narrative Plan

Each of the LA have to complete a narrative plan, For brevity, I am including only a brief description. There are 7 questions:

- **Who has been involved in creating the plan**

Covered on slide 1

- **Executive Summary**

Summary of this years integration programme. We have 25 projects to cover our 5 priorities. (next slide)

- **Governance**

Summary of local and regional governance

- **Overall approach to integration**

How we work and commission jointly, what is new services we have commissioned and how we work together to keep people independent- including Delivery Group, Leadership Board, our work with PCN's.

- **Supporting Discharge**

How we implement 'Home First', does the BCF support timely discharge from hospital and do we have an agreed commissioning arrangement for discharge services

- **Disabled Facilities Grant and Wider Services**

How we strategically use the DFG to support people. This response was good, and has actions to improve our services for next year

- **Equality and Health Inequalities**

Cover what we are doing to support equality and reduce health inequality. A good response, with the work of our PHM analyst being key to improving our efforts for this year and embedding PHM across all the work that we do.

Programme Overview

Discharge Management	Repositioning Step Up/Down
	Close down of RCD/D2A
	Implementing the Surrey Model
Minimising Health Inequalities	Improving uptake of Learning Disability health checks
	Improving diet and exercise for people with a Learning Disability
	Identifying Minority Ethnic communities to work on Cardio Vascular Disease
	Performance & Contract Monitoring
	PCN Action Plans

Prevention and Admission Avoidance	Implementing Primary Care Network Social Workers
	Dementia Partnership
	Keeping in Touch
	Identifying improvements and services for Neurodivergent people
	Social Prescription, Community Navigation & Wellbeing Coaching
	Unpaid Carers
	Transport to/From integration funded Events/Services
	Developing Low/Moderate MH Services
	Developing MDT

Monitoring & Reporting	Monthly reporting
	BCF Quarterly returns
	Annual Plan & Budget
	BCF Annual Return
	Communicating with the public about Integration
PCN Specific Projects	North- Supporting Black Communities to access Mental Health Services
	South- Seated Exercise Classes
	Earley +- Hong Kong Integration Project

How does this support System Priorities:

Long Term Conditions Board
- CVD
- Multi-Morbidity & Care Planning
- Proactive Care

Urgent & Emergency Care Board
- Workforce
- Flow Through Hospital Beds

Primary Care Board
- Resilience of General Practise

Berkshire West Health & Wellbeing Strategy
- Health Inequalities
- Support People at High Risk of bad health outcomes
- Promote Good Mental Health & Wellbeing for all adults

NHS Planning Priorities
- Manage Increasing demand on MH Services
- Prevent inappropriate attendance at Emergency Departments, improve timely admission to hospital & reduce length of stay

Berkshire West ICP Flagship Priorities
- CVD
- Ageing Well

BOB ICS Service Priorities
- Urgent and Emergency Care

Targets

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual
Rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions (per 100,000 population) (See Guidance)	Rate per 100,000	125.9	126.5	165.0	140.3
	Numerator	219	220	287	244
	Denominator	173,900	173,900	173,900	173,900
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
	Indicator value	140	118	154	124

Targets have been set as a result of discussion and agreement from our partners at WBC, RBH, BHFT and CCG, and following guidance from NHSE.

All of the targets are challenging, but following work with analysts, they are potentially achievable.

Wokingham is consistently one of the best performers in BOB.

NHSE are keen to keep levels of performance high, especially as during the pandemic, unplanned hospitalisations and length of stay were very low. As such, they pressed to ensure that targets are challenging.

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Targets Continued

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual
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 (%)	91.6%	91.3%	92.4%	89.9%
	Numerator	2,527	2,530	2,609	2,364
	Denominator	2,759	2,771	2,825	2,631
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
	Quarter (%)	91.0%	91.0%	91.0%	91.0%
	Numerator	2,510	2,510	2,510	2,510
	Denominator	2,759	2,759	2,759	2,759

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 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	353.3	368.2	285.0	351.1
	Numerator	108	115	89	112
	Denominator	30,571	31,230	31,230	31,901

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.6%	90.0%	84.0%	84.9%
	Numerator	125	113	529	535
	Denominator	146	125	630	630

These targets are social care orientated.

8.3- This is a target set across the West of Berkshire. We will be looking to move this up to 93% next year and 95% the year after.

8.4- Please note that in the last 2 years, due to COVID, the performance was very good against the long-term placements piece. We are still making fewer placements than in a normal year, and have challenged ourselves to drop from 12 placements per month to 9.3 placements (essentially 10 or fewer).

8.5- This is conservative, given the pressures we will be expecting in the year to come

NB:- Locally agreed targets, KPI's and/or performance monitoring dashboard is in place to offer oversight of services and also other metrics linked to creating a good and efficient discharge and reablement journey for our customers/patients.

Demand and Capacity Template

A new addition to the submission this year- it needs to be completed, but is not going to be assured.

Lots of learning- areas for improvement have been identified for instance:

- Counting when service is not available,
- The system need to separate delivery from capacity
- Work out how capacity of linked/tangential services fits in
- Better representation of Vol. Sec. services

Currently, on paper demand looks like it will be closely met by capacity (in part down to few people leaving in longer than a month), but also as the information can be more accurate, there is still potential for delays in discharge

This also forms a part of the Berkshire West review of Rapid Response and Reablement review which will look to improve the capacity of reablement in the community