Appendix 1

Slough Better Care Fund Programme

Annual Report 2019-20

The Slough BCF programme for 2019-20 continued in line with the plan agreed by the Health and Social Care Partnership Board (24th Sept 2019) and presented for information to the SWB on 13th November 2019. This plan was also subsequently reviewed and approved through the BCF assurance process coordinated between NHS England and the Association of Directors of Adult Social Services (ADASS).

1 Summary

The plan for 2019-20 outlined our programme of investment and activity to continue to progress in our journey towards personalised and integrated care that will achieve real and significant improvements in the experience of Sloughs residents, particularly for those living with frailty and complex conditions, and in the support for their carers. The programme also sees a shift away from reactive responses and towards proactive health and social care to enable more people to have healthier, safer and more independent lives in their own home and community for longer, receiving the right care in the right place at the right time.

Local services are being brought together through a systematic programme delivering an integrated approach which adopts good practice, easier to follow pathways and a focus on success being measured in outcomes for all residents. We are using the BCF pooled funding as a route through which to combine resources and reshape services to be delivered more seamlessly and around the needs of the person, with a broad spectrum of skills from different professional disciplines being coordinated and provided promptly from partner organisations.

2 Background

The Slough Wellbeing Strategy 2020-25 identifies integration as one of its four priorities and the BCF programme and investment plan, overseen by the Health and Social Care Partnership, is key in delivering our ambition for integrated care.

Our BCF plan also supports the delivery of the Council 5 year plan and the East Berks CCG vision and priorities which are informed by the local, place based population needs and priorities and the opportunities in working as a collaborative across the Integrated Care System (ICS).

The ICS System Operation Plan sets out the 5 year national and local priorities, initiatives and cross-cutting programmes that will maintain momentum and build a further transformational step towards an integrated health and care system fit for the future. It is a fundamental principle that all ICS partners place the health and wellbeing of patients at the heart of all programmes and that the consequences of change in one area may have on another part of the system are anticipated or addressed quickly. The needs and behaviours of patients are a continually changing environment and our combined resources need to respond and adapt appropriately.

Local partners have positively embraced the opportunity to develop Slough “place” within the Frimley Health and Care System and there is work currently developing our local place based strategy and action plan.

The BCF programme together with other local plans and strategies will address and positively impact life expectancy and premature mortality of Slough residents. Progress of these, alongside other opportunities and requirements against different timetables for delivery and review, create a dynamic and complex system identifying priorities for investment and decision-making.

The delivery of the BCF is driven through the Health and Social Care Partnership which has broad membership that include commissioners and providers as well as representation from the Primary Care Networks. It is well positioned to effectively oversee the improved population health outcomes at place and neighbourhood level and therefore effect real change for local communities.

The H&SC Partnership Board, and within it the governance of our BCF programme, continues to provide the integration framework between Slough Borough Council, East Berks CCG and Frimley ICS linking together our wider organisational, strategic priorities and resources with the needs of our local communities and residents.

3 Finance

Slough Borough Council host the Better Care Fund pooled budget which has been in place since 1st April 2015. The pooled budget agreement is signed by the two partners of Slough Borough Council and NHS Slough Clinical Commissioning Group under Section 75 of the National Health Service Act 2006.

The BCF pooled budget for 2019-20 was a total of £14,406m which included a 5.79% increase in the minimum contribution from the CCG from the previous year. The pooled funds also include additional funding streams which comprise of the following:

BCF funding streams	
Disabled Facilities Grant (DFG)	£1,005,311
Minimum CCG Contribution	£9,070,057
Improved BCF (iBCF)	£3,356,669
Winter Pressures Grant	£515,453
Additional LA Contribution	£459,000
Additional CCG Contribution	£0
Total	£14,406,490

There are also requirements set out through the planning guidance which required minimum spend amounts in NHS commissioned out of hospital services and adult social care:

Required Spend	**Minimum Required Spend**	**Planned Spend**
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£2,499,915	£3,059,532
Adult Social Care services spend from the minimum CCG allocations	£5,753,150	£5,858,082

In accordance with the section 75 agreement, the NHS funded services that are commissioned directly by the Clinical Commissioning Group do not require transactions to be via the Council. Consequently, the actual transfer of funding from the CCG to the council as a result of the fund was £5,781m.

The expenditure plan (in appendix 1) comprises of 42 individual schemes grouped under the following:

- Proactive Care
- Single Point of Access & Integrated Care Services
- Strengthening Community Capacity
- Enablers, Governance & Social Care
- Grant funding
- Out of hospital services

The additional uplift in the CCG minimum contribution in this year supported several CCG commissioned out of hospital services (outlined below) together with additional funds to support social care.

There was an overall underspend in the pooled budget of £556k. The use of underspend was agreed between partners as per the s75 risk share agreement to meet demands and over activity and left a balanced budget at year end.

4 Progress within BCF projects

Integrated Care Decision Making (ICDM)

ICDM is the model for our integrated approach between health and social care across designed and developed across the Frimley Integrated Care System. It has several components which include:

- Community Multi-Disciplinary Teams (MDT)
- Anticipatory Care Planning
- Local Access Points
- Hospital in-reach /discharge (also referred to locally as IRIS – 'Integrated Referral and Information Service')

The Community MDT element sought to establish local multi-disciplinary teams (also referred to as 'clusters') to which health and social care professionals can refer complex cases to have input and discussion from a wider professional group on how best to meet their care needs. In support of this the BCF funds an Older Peoples Mental Health worker, a Physiotherapist and an Occupational Therapist as part of an integrated team along with the GP, social worker, psychologist, district nurse and social prescriber.

There are three cluster meetings (the community MDTs) held once a month in each locality. There are case co-ordinators who support these with list of cases prepared for discussion with representations from the relevant professional partners. These are now well established and aligned to our Primary Care Networks across Slough.

Regular monitoring reports on the before and after interventions from the Integrated Care Teams in the clusters are showing significant positive impact on reducing A&E attendances, elective (planned) admissions to hospital and non-elective (unplanned) admissions to hospital.

Local Access Point (LAP)

The development of the LAPs across East Berkshire have been the next stage in development of the integrated decision making model. The LAP for Slough was established in Jan 2020 and is a multi-disciplinary team based in Observatory House who are able to take and coordinate referrals for a same day response from the appropriate professional(s) and/or onward referral into the next cluster meeting discussion. The LAP operates Mon-Fri 9-5pm. BCF funding has been invested for additional staffing capacity to support the operation of the LAP. The team is led by the Community Integration Manager (CIM) and includes a Social Worker, an Older Persons Mental Health Practitioner, Community Matron and also access to OT and physio. There is a daily meeting of the LAP 'huddle' where cases are discussed and allocated.

High Impact Changes for Managing Transfers of Care

The High Impact Change model (HICM) is a framework developed between strategic system partners nationally building on lessons learned from best practice and promotes a new approach to system resilience and supports timely hospital discharges. The model is included in the Better Care Fund policy and planning guidance and progress reported through the quarterly submissions to the Better Care Support team.

There are 8 areas of high impact changes (an additional one has since been added following a review in 2020) and these encompass the principles of a Home First and Discharge to Assess approach. The position and progress against HICM at the end of quarter 4 is summarised in the table below:

	Q4 19/20 position	Challenges and any Support Needs	Milestones met during the quarter / Observed impact
Early discharge planning	Established	Consistency of discharge passport completion still variable but improving standards are undermined by frequency of staff rotation and turnover	Establishment of IRIS model to support proactive collaborative working as a dynamic process with regular MDT huddles to promote early decision making and planning
Systems to monitor patient flow	Established	Limited availablity of staff capacity to undertake detailed analysis of new data sets at different points in whole system flow to identify underlying issues	Disaggregated data sets between Wexham and Frimley now available
Multi-disciplinary/multi-agency discharge teams	Established	Coordination of social care representation at daily wards rounds to proactively plan for early discharge. Electronic exchange of information to facilitate discharge (discharge passport).	Embedding the D2A model supported by Slough's RRR service, plus introduction of pathway 3 model with pooled funding for rapid discharge of more complex patients.

Home first/discharge to assess	Established	Coordination of flexible, short-term interim care packages difficult to track and resource intensive activity from brokerage team. Redesigned pathway for interim support arrangements within Intermediate Care/RRR to provide designated resource for rapid assessment and flexible support.	Reconfiguration of discharge to Assess model supported by RRR services and expansion of pathway 3 model with pooled funding for more complex patients.
Seven-day service	Plans in place	Setting up of new packages of care over weekends can be a challenge as well as clinical/consultants capacity and presence to discharge people from hospital	In response to COVID extended Social work discharge support to a 7-day service. Prior implementation of daily ward rounds and dynamic discharge planning within Wexham following internal review and analysis of patient activity on 3 wards.
Trusted assessors	Established	The principles of Trusted Assessment are the building blocks on which our discharge passport ethos and protocols are built. We have a clinical trusted assessor jointly funded based in the acute trust who supports the prompt discharge of patients to Windsor Care Centre reablement unit.	Continued progress on opportunity for the use of the discharge passport for care home residents as part of the D2A programme.
Focus on choice	Established	Access to preferred care home options in the area can be a source of extended discussion with families.	Reprint and distribution of unified information leaflet to all patients and families for early awareness of journey through the hospital and onward discharge to appropriate location.
Enhancing health in care homes	Established	Consistent approach to clinical support to care homes that makes effective use of valuable GP resources together with nursing and pharmacy support together with preparation and of new primary care Direct Enhanced Service (DES) contract.	Demonstrable benefits to the Local Commissioned Service (LCS) contractual arrangements for some Slough care homes has led to reduced NEL, GP call outs and falls coupled with medication /prescribing optimisation programme in care homes.

The BCF funds additional Social Work, Occupational Therapy and Reablement capacity to support the Home First Discharge to Assess approach (scheme 21) as well as a risk share pooled fund to support more complex discharges that may otherwise be delayed. In 2019-20 there were several additional funding lines incorporated into the BCF expenditure plan which support delivery of the high Impact Changes (schemes 36-42). These are:

- A GP in A&E supporting discharges to the community
- Funding contribution towards the Alamac reporting system providing information to monitor and improve flow

- Paediatric hotline supporting GPs with access to advice and support from paediatric consultant
- End of Life Care advice line supporting professionals and families supporting people at the end of life.
- Community Beds for interim support in both community hospital and local care home
- Continuing Health Care service to carry of assessments and commission appropriate care placements and services.

5 Performance summary 2019-20

The BCF programme nationally reports against four performance metrics. The outturn for these indicators as follows:

5.1 Non-elective admissions (Total number of specific acute non-elective spells per 100,000 population)

Slough consistently achieved lower than the planned activity of number of non-elective admissions to hospital through 2019-20, and a marked reduction in rates from the previous year 2018-19.

Year	Quarter	Pop	Activity Plan	Activity Actual	Rate Actual	Variance
2018/2019	Q1	150,749	4444	4,622	3,066	4%
2018/2019	Q2	150,749	4619	4,142	2,748	-10%
2018/2019	Q3	150,749	5060	4,405	2,922	-13%
2018/2019	Q4	152,137	4838	4,509	2,964	-7%
2019/2020	Q1	152,137	5572	4,082	2,683	-27%
2019/2020	Q2	152,137	5590	4,182	2,749	-25%
2019/2020	Q3	152,137	5681	4,416	2,903	-22%
2019/2020	Q4	153,457	5564	3,814	2,485	-31%

5.2 Residential care admissions (Rate of permanent admissions to residential care per 100,000 population 65+)

Achieving lower rates of admissions to care homes is an indicator of success of community based interventions to support people to maintain their independence and remain living in their own home wherever possible. The BCF plan set a target to achieve no more than 78 care home admissions in 2019-20 (an annual rate of 512 per 100,000). Our outturn performance achieved 74 admissions from a population of 15236 (equivalent to a rate of 485.7 per 100,000 population).

5.3 Reablement (Proportion of older people 65 and over who were still at home 91 days after discharge from hospital into reablement / rehabilitation services)

Our local RRR (Reablement, Rehabilitation and Recovery service) takes referrals from both the community (to provide intermediate care to support an admission to hospital) and support to people being discharged to regain and maximise their independence. This indicator measures the success rate of those being discharged from hospital. We set a target success rate of 90% (forecast of 108 out of a 120 people discharged into the service). The outturn was 70% (39 out of 63 discharged).

It should be noted that the indicator is measured on a quarter's activity (Oct-Dec) and activity varies between community and hospital referrals through the year.

There has also been an increase in the complexity and acuity of the frail and older people leaving hospital but the service has managed to maintain low levels of readmission by rapid discharge and assessment of needs with interim support as part of the Home First (Discharge to Assess) programme coupled with community referrals to step up support and avoid admissions.

5.4 Delayed Transfers of Care (Average Number of People Delayed in a Transfer of Care per Day)

Slough's DTOC target was to achieve 7.0 or less daily delays (bed days) per 100,000 population. There were a number of actions outlined in our BCF plan as well as developing those areas of effective intervention outlined within the High Impact Changes framework.

Whilst this was a challenging target from Oct 2019 through to Feb 2020 (where counting stopped due to Covid 19) Slough was consistently reporting under or close to target delayed days.

Slough

Period	Daily DTOC beds, all, per 100,000 population aged 18+	DTOC beds attributable to the NHS, per 100,000 aged 18+	DTOC beds attributable to social care, per 100,000 aged 18+	DTOC beds attributable to both NHS and social care, per 100,000 aged 18+	DTOC beds, acute per 100,000 aged 18+	DTOC beds, non-acute per 100,000 aged 18+
	Mean					
	Slough					
Jun 2019	9.7	4.8	4.0	0.9	5.5	4.2
Jul 2019	9.0	7.2	1.8	0.0	6.2	2.8
Aug 2019	5.9	5.4	0.4	0.2	5.2	0.8
Sep 2019	9.0	7.4	1.4	0.3	6.9	2.3
Oct 2019	5.2	3.9	1.2	0.0	4.0	1.2
Nov 2019	7.0	4.3	2.7	0.0	6.0	1.1
Dec 2019	5.3	3.3	2.0	0.0	4.0	1.2
Jan 2020	5.2	3.7	1.3	0.2	2.7	2.4
Feb 2020	7.4	3.3	3.6	0.6	6.2	1.2

5 Conclusion

The BCF programme of pooled funding and collaborative working has supported the integration working programme within Slough both as partners in the Frimley ICS collaborative and through delivery of local priorities within our place based approach.

Our programme of activity in 2019/20 has continued to build on and strengthen the investment made in community based integrated support services to meet the needs of the Slough population. The development of integrated care decision making model and investment to increase professional input to the multi-disciplinary care teams is having significant impact on the proactive management of people living with frailty and long term conditions. Our reablement services, integrated wellbeing, social prescribing and carers support services also all continue to deliver evaluated benefits for our local residents.

Overall our plan has contributed positively to the management of non-elective activity and succeeded in reducing overall rates reinforcing our commitment to, and delivery of, out of hospital based care supported through BCF investment.

The design and delivery of our Home First/Discharge to Assess programme has been supported by a wide range of BCF funded out of hospital initiatives ensuring that community resources are being reshaped to minimise delays as well as reduce the risk of readmission which can lead to the subsequent loss of independence for residents.

Slough continues to work with our local care homes and enhance the support to them in supporting our most vulnerable residents. Whilst we have a relatively small number of care homes for the population size we managed to maintain a low number of admissions from actively focusing on services that support people to return and remain at home even with high level of frailty and complex health and care needs, specifically through the continued development of our integrated care services within the ICDM clusters, and more recently the Local Access Point.

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BCF Programme Manager
2nd November 2020

Appendix 1 - Slough BCF 2019/20 expenditure plan

Workstream	Scheme ID	Scheme Name	Commissioner	Provider	Source of Funding	2018-19 Expenditure (£)	2019-20 Expenditure (£)	Outurn 2019/20	Variance 2019/20
Proactive Care	1	Anticipatory Care Planning	CCG	CCG	CCG Minimum Contribution	60,000	60,000	60,000	0
	2	Falls Prevention Service	Local Authority	Private Sector	CCG Minimum Contribution	90,000	90,000	90,000	0
	3	Stroke Support Service	Local Authority	Charity / Voluntary Sector	CCG Minimum Contribution	57,000	57,000	57,000	0
	4	Dementia Care Advisor	Local Authority	NHS Mental Health Provider	CCG Minimum Contribution	30,000	30,000	30,000	0
	5	Children's respiratory care	CCG	NHS Acute Provider	CCG Minimum Contribution	95,000	130,000	137,000	7,000
Single Point of Access	6	Single Point of Access	Local Authority	NHS Community Provider	CCG Minimum Contribution	150,000	150,000	142,858	-7,142
Integrated Care	7	Telehealth	Local Authority	Private Sector	CCG Minimum Contribution	100,000	100,000	5,620	-94,380
	8	Telecare	Local Authority	Private Sector	CCG Minimum Contribution	62,000	70,000	70,000	0
	9	Disabled Facilities Grant	Local Authority	Local Authority	Local Authority Contribution	931,655	1,005,311	1,005,311	0
	10	RRR service (Reablement and Intermediate Care)	Local Authority	Local Authority	CCG Minimum Contribution	2,214,000	2,295,000	2,295,000	0
	11	RRR service (Reablement and Intermediate Care)	Local Authority	Local Authority	Local Authority Contribution	459,000	459,000	459,000	0
	12	Joint Equipment Service	CCG	Private Sector	CCG Minimum Contribution	663,000	710,802	710,802	0
	13	Joint Equipment Service	Local Authority	Private Sector	CCG Minimum Contribution	130,000	130,000	130,000	0
	14	Nursing Care Placements	Local Authority	Private Sector	CCG Minimum Contribution	400,000	400,000	400,000	0
	15	Care Homes - enhanced GP support	CCG	CCG	CCG Minimum Contribution	146,000	146,000	114,040	-31,960
	16	Care Homes - programme manager	CCG	CCG	CCG Minimum Contribution	35,000	35,000	22,452	-12,548
	17	Integrated Care Services / ICT	CCG	CCG	CCG Minimum Contribution	755,500	809,141	809,141	0
	18	Intensive Community Rehabilitation	Local Authority	Local Authority	CCG Minimum Contribution	82,000	82,000	82,000	0
	19	Intensive Community Rehabilitation	CCG	NHS Community Provider	CCG Minimum Contribution	170,000	182,070	182,070	0
	20	Responder Service	Local Authority	Private Sector	CCG Minimum Contribution	100,000	110,000	120,000	10,000
	21	High Impact Change delivery	Local Authority	Local Authority	CCG Minimum Contribution	372,000	300,000	134,200	-165,800
	22	Integrated Wellbeing Hubs	Local Authority	Local Authority	CCG Minimum Contribution	342,000	90,000	90,000	0
	23	Connected Care	CCG	Private Sector	CCG Minimum Contribution	200,000	200,000	200,000	0
	24	Integrated Cardio prevention service	Local Authority	Private Sector	CCG Minimum Contribution	151,000	151,000	151,000	0
Community Capacity	25	Carers	Local Authority	Charity / Voluntary Sector	CCG Minimum Contribution	216,000	216,000	216,000	0
	26	EOL Night sitting service	CCG	Charity / Voluntary Sector	CCG Minimum Contribution	14,000	15,217	15,217	0
	27	Community Capacity	Local Authority	Charity / Voluntary Sector	CCG Minimum Contribution	200,000	200,000	200,000	0
Enablers	28	Programme Management and Governance	Joint	Local Authority	CCG Minimum Contribution	260,000	260,000	260,000	0

Appendix 1 - Slough BCF 2019/20 expenditure plan

Other	29	Out of Hospital transformation	CCG	NHS Acute Provider	CCG Minimum Contribution	576,563	-	-	0
	30	Care Act funding	Local Authority	Local Authority	CCG Minimum Contribution	296,000	296,000	296,000	0
	31	Additional Social Care protection	Local Authority	Local Authority	CCG Minimum Contribution	600,000	753,816	753,816	0
		Unallocated CCG minimum contribution			CCG Minimum Contribution				0
	32	Winter Pressures	Local Authority	Local Authority	Winter pressures	-	515,453	515,453	0
	33	Improved Better Care Fund	Local Authority	Local Authority	Improved Better Care Fund	2,841,790	3,356,669	3,356,669	0
Integrated Care (ICDM)	34	Integrated Care Decision Making (cluster MDT and CIM)	Local Authority		CCG Minimum Contribution		294,000	169,583	-124,417
	35	Local Area Access Points	Local Authority		CCG Minimum Contribution		80,000		-80,000
Out of Hospital CCG commissioned services	36	Systems resilience (GP in A&E)	CCG	NHS Acute Provider	CCG Minimum Contribution		50,000	50,000	0
	37	Systems resilience (Alamac)	CCG	Private Sector	CCG Minimum Contribution		47,016	47,016	0
	38	EOLC Advice Line	CCG	Charity / Voluntary Sector	CCG Minimum Contribution		137,354	137,354	0
	39	Paediatric hotline	CCG	NHS Acute Provider	CCG Minimum Contribution		44,893	44,893	0
	40	Community beds interim support (Windsor Care)	CCG	Private Sector	CCG Minimum Contribution		72,748	72,748	0
	41	CHC pressures/commissioning	CCG	Local Authority	CCG Minimum Contribution		220,000	162,365	-57,635
	42	Community beds interim support (BHFT)	CCG	NHS Community Provider	CCG Minimum Contribution		55,000	55,000	0
							14,406,490	13,849,608	**-522,887**
		Risk Share overspend (split between partners)							33,995
		SBC underspend (additional social care allocation to meet increased activity)							240,325
		CCG underspend (carry forward)							282,563