Appendix A

NHS Frimley Clinical Commissioning Group

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Slough Better Care Fund - narrative plan 2021/22 – *draft 8 Nov '21*

**Some detail and content of the plan may still be subject to minor changes and revision up to final submission date of 16 November 2021. This is to ensure sufficient detail and evidence to meet assurance requirements.*

Health and Wellbeing Board(s)

Slough Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

Local stakeholders are involved in planning and oversight of the BCF programme via the Health and Social Care Partnership. Partners represented include:

- Frimley CCG
- Frimley NHS Foundation Trust
- Slough Borough Council
- Berkshire Healthcare Foundation Trust
- Slough Council for Voluntary Service
- Slough Coproduction Network

An outline plan was presented to the partnership on 26th October 2021 for discussion and agreement on areas of new investment within the plan.

Discussions have also been taking place with relevant partners and stakeholders over narrative content and the setting of shared ambitions within the plan metrics.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

Our priorities for 2021-22 are outlined in our Health and Social Care Plan (attached below) which has been developed and agreed between the Health and Social Care Partnership based on local needs analysis within our JSNA and the strategic ambitions of the partners supporting local delivery of those within the NHS Long Term Plan, Think Local Act Personal and the Frimley ICS.

Areas of activity within the plan are focused around:

- Better Access to Care
- More integrated and pre-emptive service offers
- Use of locality-based models
- Improved outcomes for mental health

- Improved outcomes for frailty
- Responding to changing demands and needs post covid-19

Slough Health and Care plan.pdf

Key changes for BCF expenditure plan for this year

- Contract uplifts where applicable for staff pay increases/increments
- Additional investment to maintain capacity in social care (social care protection)
- Investment to retain current level of capacity and activity within Reablement / intermediate care (RRR service). This service is key to admission avoidance and supporting discharge and reablement in the community. It also provides end of life care to support people to remain at home.
- Investment in Hospital Social Work Team to ensure continued support safe and timely transfers of care, maintaining hospital flow back out to community through established Discharge to Assess pathways
- Additional BCF investment into the community and voluntary sector supporting primary prevention, vulnerable groups and communities
- Frailty Practitioner pilot supporting the anticipatory care element of Integrated Care Decision Making identifying patients living with frailty proactive screening and intervention supported by integrated community MDTs (clusters).
- Post covid-19 – pilot of a 'cold car' OT providing same day response for people visited by the GP who have deconditioned during covid period and need quick access to OT assessment and equipment.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The governance of our BCF programme in Slough is overseen by the Health and Social Care Partnership. The partnership is a sub-committee of the Slough Wellbeing Board and has membership of all our partners in the delivery of health and social care in Slough including local authority, CCG, acute trust, community trust, voluntary sector, Primary Care Networks, lay members and resident representatives from our co-production network.

The role of the partnership is to:

a) Agree strategic direction for the integration of health and social care within Slough.
b) Ensure commissioned services across the partnership are aligned to deliver efficient and effective services, designed to improve outcomes.
c) Consider any issue of health and social care strategic policy, public health strategy or general community concern within Slough
d) Deliver Priority Two – 'Integration' of the Slough Wellbeing Strategy 2020-2025 on behalf of the Slough Wellbeing Board.

The partnership has in this year been brought together with the Slough Place based committee. This is in order to:

- strengthen the place approach for all Slough health and care partners
- to enable us to jointly oversee the delivery of our shared integration priorities through our Health and Care Plan
- to create a stronger connection with the Health and Wellbeing Board deepening the connections between CCG, PCN and member colleagues in the local authority
- make best use of stakeholder's time
- to help strengthen the relationships between primary care and the local authority
- to avoid duplication of time and effort

Regular reports (minimum quarterly) are presented to the H&SC Partnership on BCF and related integration development and activity. In support of the Programme Management function there is a Better Care Fund Delivery group which is the core group which drives forward the delivery of the Better Care programme on behalf of the partners to the pooled budget agreement. It coordinates and operationally manages the BCF on behalf of the Health and Social Care Partnership as well as ensuring that it operates within the policy and guidance framework set nationally.

The role of the delivery group is:

- To manage the delivery of the Better Care fund programme for Slough in line with the agreed plan, budget and timescales
- To receive and monitor performance reports on key performance indicators (KPI) and take appropriate actions
- To oversee and monitor financial expenditure and forecasts within the Pooled Budget
- To review progress in delivery and performance of projects and schemes within the programme
- To review and update the risk register for the programme and those from specific projects and to escalate risks to the Health and Social Care Partnership as appropriate
- To consider new ideas and proposals for Better Care Fund activities and guide and steer development of business cases before being presented to H&SC Board for decision.

This year's BCF programme has broadly been a continuation and consolidation of our integration programme, particularly around embedding the Integrated Care Decision Making model, incorporating the community multi-disciplinary team and our Locality Access Point.

A draft of this year's plan and investments was presented to the Health and Social Care Partnership and Place Based Committee meeting on Tues 26th October for discussion and sign off of investment. The final plan will be presented and discussed at the November meeting.

Overall approach to integration

Brief outline of approach to embedding integrated, person-centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21

The vision and principles underpinning our commitment to integration remain largely unchanged since our last BCF plan where we described our ambition for a shift from reactive to 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.

Our vision for being integrated is for the local delivery of a broad range of health and social care services seamlessly, regardless of organisational boundaries. Working across a complex health and social care economy we continue to develop a proactive approach to the provision of health and social care and support in the community. This is delivered in partnership between

- GP practices and Primary Care Networks
- The acute trust
- integrated health and social care multi-disciplinary teams
- community-based health services
- adult social care services
- local care and housing providers
- community and voluntary sector
- Coproduction Network with Slough residents

Our joint priorities for Health and Social Care for 2021-22 are laid out in our Health and Care Plan for Slough which has been developed between the partners and are collectively aiming to promote good health and care outcomes and reduce inequality for the residents of Slough.

The plan is to develop, promote and maintain independence, because this is good for health, good for people, and good for the taxpayer and sustainability of services.

This approach is achieved through:

- **Prevention and promoting self-care** through information and advice
- **Connecting individuals to their communities** to reduce the need to present in institutional settings
- When support is needed, **delivering care in a seamless and integrated way**

BCF funds a number of schemes which support the delivery of shared priorities and is the way in which we can jointly commission and invest.

Proactive care approach – From the start of our BCF programme Slough was exploring ways in which we could use risk stratification tools and practice registers to identify patients with complex needs who were at risk of admission and proactively managing those cases. The investment in the

development of the Connected Care programme and the shared care records across ICS has become increasing more sophisticated and enabling us to have even greater insights that support this approach not only in the way we identify and manage frailty but also the anticipatory care approach to those who are at risk of moving into that higher frailty cohort. We are developing this not only in those living in the community but also residents with our care homes.

This year as part of the ICS Frailty Programme we are piloting a role of **Frailty Practitioner** which is a dedicated role to proactively identify people who are being flagged up in our frailty cohorts making some initial contact and screening, providing personalised care plans and, where appropriate, triaging to local access point or 'cluster' MDTs for support.

Ageing Well is a national programme being rolled out at Place to support older adults to live healthier and longer lives and avoid premature admission to hospital or residential care. The current focus of the programme is the delivery of the urgent care response and to provide 2 hours face crisis response to operate 8am-8pm, 7 days per week from April 2022. It also encompasses the anticipatory care approach outlined above and the enhanced healthcare in care homes framework to further address inequalities and variation in access to care and reduce risk of hospital admission.

Integrated Care Decision Making has been a key part of our integrated care approach. This is an ICS designed model which is delivered at place being jointly commissioned and funded through BCF. Investment has funding additional capacity into supporting this activity including that of social worker, MH practitioner, physiotherapy and OT together with input from PCNs (GP, paramedic, social prescribers) to have integrated and multi-disciplinary discussion and care planning to support people with complex health and social care needs.

January 2020 also established our **Locality Access Point** which operates Mon- Friday 9-5pm giving direct daily access for multi-disciplinary triage and support to professionals. In this year this has also been extended to Care Home providers to help support them in care of complex patients in the care home and avoid unnecessary admissions to hospital and supported by the community consultant geriatrician.

Personalisation and person-centred care

Frimley ICS has established a Personalised Care programme to support delivery of the NHS Long Term Plan commitments for delivery of personalised care. This includes the comprehensive model comprising of six evidence-based standard components intended to improve health and wellbeing outcomes and quality of care, whilst also enhancing value for money.

Implementation is taking place through local delivery partnerships between statutory health and social care partners, the voluntary and community sector and people with lived experience. Deliverables of the programme include:

- Support and help train staff to have **personalised care conversations**
- Having **social prescribing link workers** to connect people to wider community support which can help improve their health and well-being and to engage and deal with some of their underlying causes of ill health.
- Accelerate the roll out of **Personal Health Budgets** to give people greater choice and control over how care is planned and delivered.
- By rolling out training to help staff identify and support relevant patients, to introduce **proactive and personalised care planning** for everyone identified as being in their last year

of life

Slough Borough Council has embarked on a large scale transformation programme (People Too) to deliver strength and asset-based approaches in Adult Social Care. This programme will develop new and innovate approaches to delivery of adult social care, coproduced with residents and staff. Asset based approaches seek to empower people to have greater choice and control over their care and support arrangements as well as giving high quality personalised support that gives greater flexibility and value for money.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

A programme of implementing a Discharge to Assess model of supporting discharges across the East of Berkshire had taken place prior to covid pandemic as part of our implementation of the High Impact Change model. This included

- a 'Discharge Passport' with supporting D2A pathway and protocols
- multi-disciplinary team working on hospital site whereby the acute trust, social work teams and VCS/community-based providers are information sharing and discharge planning at early stage of admission.
- Deployment of the reablement/step down beds in in Community Hospitals (Upton and St Marks) and a local Nursing Care Home provider
- Onward referral to RRR (Rehabilitation, Recovery and Reablement) intermediate care services for ongoing support to maximise independence
- Use of a pooled funding within BCF to facilitate timely discharge into placements or packages where further complex patient assessment are required

Through covid this Discharge to Assess model was opportunity to embed and consolidate this model further, although the MDT working was being done remotely between the partners on Teams.

Better Care Funds are supporting these schemes with discharge and flow within the system:

- Hospital Social Work Team at Wexham Park
- RRR (Reablement, Rehabilitation and Recovery) intermediate care service
- Integrated Care Teams (Berks Healthcare Foundation Trust)
- Intensive Community Rehabilitation (Berks Healthcare Foundation Trust)
- Discharge to assess capacity - interim care support packages at home
- Community step-down/interim care beds

BCF is also investing in services that keep people at home and prevent avoidable admissions:

- Integrated Care Decision Making
  including Locality Access Point and multi-disciplinary roles working in locality 'clusters' to have integrated assessment and interventions that support people at home

- RRR (Reablement, Rehabilitation and Recovery) intermediate care service
- Care Home support – a programme manager across East Berkshire and support to implementation of Enhanced Healthcare in Care Homes framework
- Responder service – early response to people who have fallen at home and/or need welfare checks and support
- Frailty practitioner – piloting under Ageing Well programme, proactively identifying people with moderate frailty for assessment and screening for early intervention and support
- Cold Car Occupational Therapist – same day response supporting home visiting GPs/paramedics with rapid access to OT assessment and equipment
- End of life advice line – 24/7 support to professionals and families supporting people at end of life helping to keep them at home

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Through DFG funding Slough has been delivering a range of adaptations to a disabled person's property to ensure they can remain independent in their own home. This approach met both the legislative framework provided by HGCRA Act (1996) and the Care Act 2014, including ASC to assess and to arrange for appropriate assistance, including statutory entitlements to community equipment and minor adaptation.

However, following the national DFG Review (Feb 2018) we wanted to take some of the learning from the many examples of good practice, innovation and recommendations and in 2019/2020 commissioned Foundations UK to look at how DFG might can be further used to meet the wider health and social care needs of service users. The aim of this work was to produce a revised operating model, consider the future of how DFG should be delivered and develop pathways to further extend our offer to improve patient flows, promote independence and expand our assistive technology offer.

The service has been working to a traditional Disabled Facilities Grant (DFG) delivery model to provide mandatory DFG's to customers based around criteria from the 1996 Act. This provided grants and services such as:

- **Relocation Grant** to support Slough residents eligible for a DFG where it is more suitable and practicable to move rather than remain in their current property
- **Hospital Discharge Grants** to support Slough residents aged 65 years and older being discharged from hospital and require small grants for heating/minor repairs that would otherwise delay a hospital discharge
- **Handyperson services** – to help with small building repairs, minor adaptations to prevent hospital admission
- **Fast-track applications** – to help with minor adaptations using trusted assessors and other professionals
- **Funding in Excess of the Maximum Amount** – to fund adaptations with a clear return on

investment in excess of the DFG grant limit if £30,000

Through adopting a new Housing Assistance Policy our ambition is to transform these services from a fairly rigid DFG technical-based service to one which is more flexible to the needs of residents and supports Social Care to help disabled and vulnerable people to remain living independently at home for as long as they wish, and it is safe for them to do so. Slough also wanted to be able to promote greater resident choice regarding the adaptations completed in their home and ensure they are happy with the service they receive.

The service has been based upon technical surveyors with some support staff and provided very limited opportunities for individual support to those customers who needed help to navigate the often complex process of applying for a DFG. This led to delays and complaints from residents as well as increased work for the Occupational Therapy team who are trying to support customers without any clear remit or understanding of the DFG process.

Our recent changes through a newly adopted DFG policy will provide a more personalised approach to people who require adaptations that is based more individual needs and will remove barriers wherever possible. This moves away the traditional more 'technically-based' DFG service to that which is more customer focussed one, whilst retaining the necessary core technical skills for more complex work such as those which require building adaptations.

The DFG capital grant 'allocation' from Government for Slough in 2021-22 is £1,140,680 and this is expected to maintain this level of investment or possibly increase further in the future. The anticipated staffing requirements to deliver the full DFG spend within budget is approximately 2 full-time technical officers and 2 caseworker type roles along with administrative and management support. The 2008 Services and Charges Order allows the charging of fees for technical and OT services for preparing and delivery of DFG and therefore the proposal is that the posts should be capital funded from the DFG allocation on a fixed fee basis.

The current Independent Living Team is located within Adult Social Care, albeit as a separate team. This provides us with significant opportunity to more closely integrate social care and adaptation services and reduce overall delivery costs. A significant amount of the works will not require technical input and will be directly appointed/ordered by the assessing OT or appropriate support staff; including all stairlifts and hoists and ramp works. As Adult Social Care already provides support to residents those support roles will to be increased and enhanced to include support for the casework side of applying for a DFG. Technical skills will still be available for DFG work but these will also be within the Adult Social Care structure providing better response and outcomes for residents whilst still having oversight of standards and quality of work.

The statutory DFG will remain as a means tested grant. However social care currently carries out means tests under the Care Act and therefore looking at potential for that team to provide support to the delivery of the DFG, with appropriate training provided, to carry out the DFG means test as well. To ensure a consistent, person-centred approach to the delivery of aids and adaptations we will also be moving toward both the clinical and technical side to DFG to sit within single manager under the OT Manager's remit.

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Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Our Health and Social Care Plan is aimed at reducing health inequalities in our residents alongside promoting and developing independence through integration. Our approach to reducing inequalities applies across all stages of the lifecycle and aligns to the ICS' three core pillars of **starting well, living well** and **ageing well**.

For each segment, the aim is to build individuals' capacity to care for themselves without escalating into institutional settings.

This can only be achieved by the Slough Partnership Board member organisations **working together in an integrated way**. This applies both to meeting complex needs with multiple services but also in the messages and interactions individual organisations have, that need to develop, promote and maintain independence.

Our Health and Social Care plan identifies the cross-cutting, priorities that within partners' individual delivery plans, and reflect where partners are working together to support the delivery

Health Inequalities and impact of Covid-19

Slough is an urban area just outside London with one of the most ethnically diverse populations in the UK. 54% of our population is from an ethnic background many of whom are living in the most deprived areas within the Frimley ICS.

Early in the pandemic we identified the potential for there to be a disproportionate impact on our residents. Existing inequalities were being brought into greater focus by COVID-19 in both loss of life and on livelihoods. We were therefore quick to establish a programme of Covid-19 response aimed at mitigating that impact through a collaborative approach to working to support our ethnically diverse communities.

Our programme between the NHS, voluntary sector and local authority focused on the following

- Engagement and communication with communities
- Reducing and preventing harm from COVID-19
- Clinical management of those experiencing symptoms
- Gathering intelligence to tailor and target interventions

The core aim of this project was to strengthen the ability of individuals and communities to work in partnership with the NHS, local authority, public health and voluntary/community sector

organisations in order to protect themselves from the direct and indirect harms of the Covid-19 virus and, through collaboration, provide a holistic approach to support the population of Slough.

It was vital that we worked quickly in bringing together the latest clinical evidence and data around impact and risk of Covid-19 on BAME communities into our local management plan and, most importantly, proactively engaged with our community and voluntary sector. We knew from initial information being published about the additional risk to people from BAME backgrounds that Slough's diverse population was at disproportionate risk of Covid-19 due to a number of prevalent risk factors:

- 54% of the population from BAME background, including 11% white non-English
- Over 8000 (about 6.2%) don't speak English well, or at all
- In 15.5% households no one speaks English as first language
- Its a high-density population combined with areas of high deprivation (59.5% of Sloughs residents live in deprivation deciles 2-4)
- Large multigenerational households and many of multiple occupation
- Significantly higher prevalence of Hypertension, Obesity and Diabetes for 50-59 year olds

Our goals were to

- keep people healthy so that they are better health before any Covid-19 infection.
- support our diverse communities to understand and adopt national messages to reduce transmission rates through culturally appropriate communication
- Support anyone infected with enhanced monitoring and pulse oximetry to identify silent hypoxia and ensure early and appropriate hospitalisation (this was art of national pilot with data being audited by Nuffield Trust and ULC).

To achieve these goals, we not only needed to support the clinical response but work across partners to proactively identity our communities and individuals with risk factors and provide with information and means of support to reduce risk of infection and reduce impact should someone develop Covid-19 symptoms.

The challenge was to mobilise quickly to contain the spread of infection and minimise risk whilst developing culturally centred interventions that built on existing assets and projects. We needed to reach communities with up-to-date messages and the importance of taking protective measures in different languages, formats and multiple media. The community team and public health worked together with cultural local leaders, faith and community groups and the local radio station, Asian Star.

The programme enabled Slough to focus on greater protection of the BAME community and reduced the spread of infection and impact of Covid-19 on lives, ill health and livelihoods. The collaboration and engagement through this project strengthened our partnerships between the community and statutory sector enabling us to work very closely with an holistic approach to reducing inequalities and improving health and wellbeing.

BCF funds an Integrated Wellness service to support and coach residents of Slough to may present with a variety of risk factors likely to impact on their health and wellbeing. Managed through a single provider, Solutions for Health, this enables trained health coaches to support individuals with bespoke, personalised approach to support people with lifestyle, activity and dietary changes that will impact positively on their health.

Through the covid pandemic there was a huge response from the community and voluntary sector to support vulnerable residents and communities in Slough. Statutory and voluntary sector partners came together to establish #OneSlough approach. Through this equal partnership Slough was able to coordinate support from the surge of volunteers that came forward to support with the vaccination programme, the provision of meals and shopping support to people who were isolated or shielding, ensuring trusted advice and information was being shared (through Community Champions network), help with medication, prescriptions as well as welfare support and befriending. Partners to #OneSlough are working to build on a longer term and sustainable legacy of this community response as our local 'community deal'.

Through the covid pandemic Slough has been developing its support to asylum seekers and those who are homeless. Through Improved Access to General practice funding we have a GP and nurse providing primary care support to rough sleepers and people in temporary hostel accommodation. Establishing regular clinics and drops ins means improved access for people who otherwise are difficult to reach due to chaotic lifestyles and drug and alcohol problems. Through this service and that of an outreach bus we were able to provide our homeless cohorts their covid vaccinations. Additional funds have now been secured to have a dual diagnosis worker for people with Mental Health needs.

Last year a contingency accommodation hotel was opened in Slough for Asylum seekers arriving in the county whilst applications and ongoing arrangements in place for placements in dispersal accommodation. Working with primary care services we have been offering initial health and wellbeing checks, primary care support and mental health support to those arriving at the hotel and providing translation and interpretation services as required. The mobile vaccination service has also been able to visit the hotel and ensure that everyone is being offered their covid vaccination,

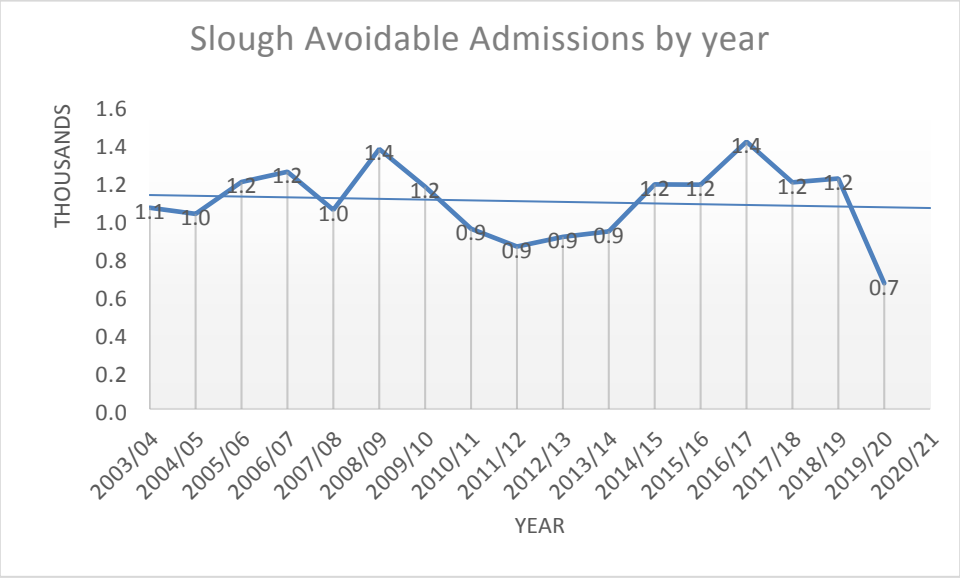
Following the learning from the BAME programme and with the focus of our plan on wider inequalities we have formed a new Health and Inequalities Board for Slough Place bringing together local partners from public health, CCG, local authority and voluntary sector. The group is in its early development but looking at establishing an action plan to address local priorities and reduce health inequalities in target groups and health conditions.

Slough Health and Inequalities Group 1

Slough BCF metrics 2021-22

1. **Avoidable Admissions**

- The indicator value is the indirectly standardised rate (ISR) of admissions per 100,000 population.
- 2020-21 data at HWB area level has not been published, so 2021 has been included in forecast data for the graph below.
- Anecdotally all hospital admissions were lower than previously for large portions of the year.
- Historical data in the graph below shows the variation since 2003/4 with the lowest activity in 2019/20 = 659.7 which was nearly half that of the previous year (1209.7)
- From discussion with Frimley NHS Trust we anticipate that 2021/22 will be closer to 2019/20 in terms of activity although are also forecasting that overall Non-Elective admissions are at 19/20 levels plus around 3%.
- Our stretch ambition will therefore be to maintain a figure of that for 19/20 with 3%



Our BCF investment that supports our avoidable admissions indicator are:

- RRR (Rehabilitation, Recovery and Reablement) is our Intermediate care / step- up service which provides short-term intensive reablement for up to 6 weeks for people needing additional support to avoid a hospital admission.
- Locality Access Points – triage and coordinate same day response to referrals of patients who are frail and complex in terms of co-morbidities in order to provide an integrated assessment and intervention from appropriate professionals whether that be nursing, OT, mental health, social work or combination of these.

- MDT 'cluster' is our monthly multi-disciplinary team reviewing complex patients in order to coordinate integrated personalised care to people who are frail.
- Responder service is our first response support to people who may have fallen or need welfare response. This avoids unnecessary ambulance responses and conveyances to hospital where people can be attended to and supported at home.

2. Reducing Length of Stay in hospital

Slough has historically performed well on reducing delays out of hospital, particularly social care delays and has long established hospital social worker team based within the acute hospital. The team has been integral to delivery of the Discharge to Assess pathways and 'Home First' approach supported by the Discharge Passport.

Reviewing LoS activity and metrics together with acute sector partners in light of the current system capacity and pressures already occurring approaching winter it was highlighted that hospital discharges and support should continue to retain significant focus on reducing the 0-6 days as that is where the largest cohorts of patients are and need to continue to support capacity and flow by returning safely to the community in a timely way.

Analysis of the longer stayers (14+/21+ days) showed that Length of Stay increases with the higher number of co-morbidities and the complexity of health needs for these patients. Whilst as a system the community can support with reducing excess bed days (time beyond that when person was medically stable and ready for discharge) influence to reduce the longer stay metrics is limited where people are still acutely unwell and require intensive medical care.

Capacity on beds in the hospital has been reduced as a result of covid (due to Infection prevention control) and occupancy has increased by 107% from 2019/20. Overall as a system in order to maintain capacity and flow the Trust is aiming for a 20% reduction in length of stay across the board (all ages and spells in the hospital).

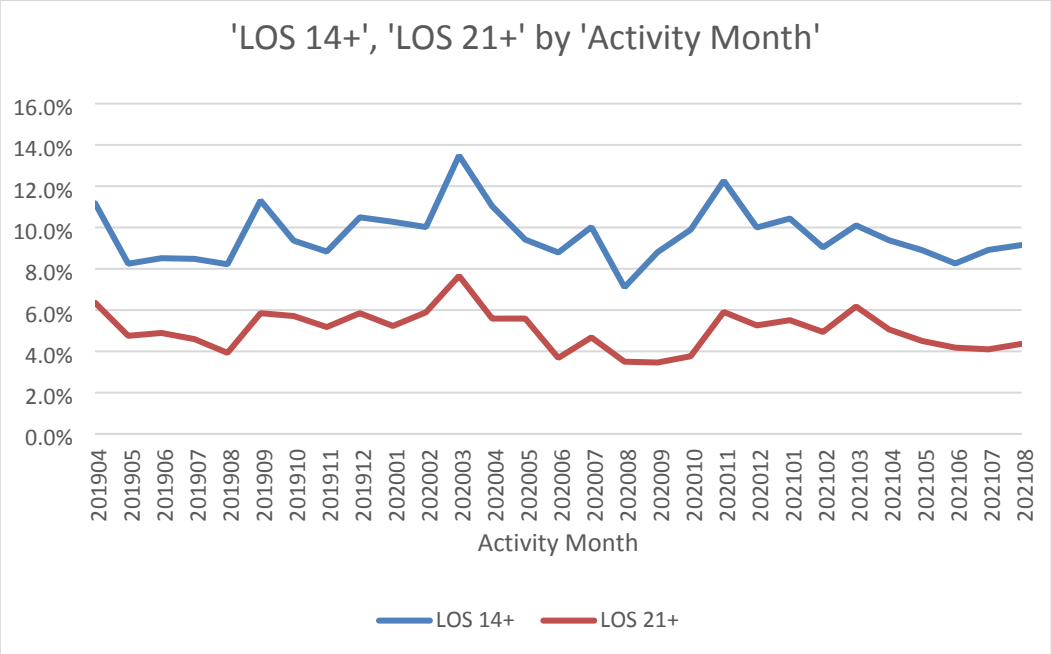
14+ stays have reduced 4% between 19/20 and 20/21 (= 1% per quarter). Our baseline is 9.6% from average performance Apr 19-Aug21. Our ambition for 14+ is to achieve no more than 9% in Q3 and 8.5% in Q4

Slough's 21+ day performance has averaged 5% since April 2019 and in past four months has exceeded this to an average of 4.3%. Our rate is already below the national average but know that we are anticipating additional demand and capacity pressures this coming winter. We are setting an ambition to achieve maintained position of 4.5% in Q3 and stretch to reduce to 4.0% in Q4.

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	Proportion of inpatients resident for 14 days or more	9.0%	8.5%
	Proportion of inpatients resident for 21 days or more	4.5%	4.0%

Our plan is to manage this through:

- Continued focus of dedicated Hospital SW Team supporting D2S pathways and flow
- Discharge to Assess capacity in the community, ensuring access to interim residential beds in care homes and assessment and provision of care support packages at home
- Community Rehab & intermediate care service from community trust intensive rehab support and RRR (Rehabilitation, Recovery and Reablement)
- 3x weekly system calls across partners and escalation process to daily when required



3. Discharge to normal Place of residence

Plan is to achieve 95% in line with national best practice which is an improvement from our overall average this year from 92.3%. Our aim is to continue to facilitate timely discharge through D2A with Home First approach. Covid restrictions in place for care homes are impacting on ability to discharge people back to their care home.

Interim arrangements in step-down community beds also used where necessary to facilitate discharge and maintain flow and capacity in acute hospital. Significant capacity pressures in the acute hospital currently from covid and forecast to be exacerbated into winter.

4. Residential Admissions

Slough has a relatively small care home market within the boundaries of the borough and the emphasis is therefore to support people to return and remain in their own home wherever possible. Our ambition is to maintain current level of care home placements (76) in proportion to an increasing older population and no additional care home beds coming online. This is a reduction in

the rate of care home admissions per 100k from 489 to 478. This represents a stretch target in the light of increased demand on care home sector during the covid pandemic with D2A and the need to increase flow out of the hospital.

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 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	512	467	489	478
	Numerator	78	71	76	76
	Denominator	15,236	15,204	15,557	15,884

5. Reablement

In 2020/21 Reablement achieved 76.6% at home 91 days after discharge but numbers were lower (36/47). Our plan is to increase numbers into reablement from D2A by 5% and the proportion remaining at home. Plan is to refocus D2A interim support packages with external sector and release greater capacity from skilled Reablement Assistants to support reablement and rehab.

		19-20 Plan	19-20 Actual	21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%	61.9%	65.2%
	Numerator	108	39	43
	Denominator	120	63	66