Slough Better Care Fund Programme

Annual Report 2021-22 (May 2022)

1 Summary

The Slough BCF programme for 2021-22 has continued in line with the plan submitted and assured in autumn of 2021. Our BCF Plan outlined our 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.

Our strategic direction is to continue to invest in areas that help us to 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.

This Annual Report is presented to the Wellbeing Board following the submission of the national year end return (27th May) with outturn on performance metrics, financial outturn and year end feedback.

2 Background

Our priorities for Slough Place in 2021-22 were agreed and set out within our Health and Social Care Plan developed between the Health and Social Care Partnership based on local needs analysis within our JSNA and the strategic ambitions of the partners. BCF supports local delivery of those priorities as well as those contained within the NHS Long Term Plan, Think Local Act Personal and of the Frimley ICS.

Areas of activity within our Health and Social Care 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

Key changes for BCF expenditure plan for this year 2021/22:

- 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
- A 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.

3 Finance

The value of our BCF pooled budget in year 2021/22 was £15,047,515. A full breakdown of the expenditure across the various schemes funded through BCF is included in the appendix.

3.1 Funding sources

DFG	£1,140,680
Minimum CCG Contribution	£10,034,713
iBCF	£3,872,122
Additional LA Contribution	£0
Additional CCG Contribution	£0
Total	**£15,047,515**

3.2 Required spend

	Minimum Required Spend	Planned Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£2,765,796	£2,812,029
Adult Social Care services spend from the minimum CCG allocations	£6,365,034	£7,686,181

Slough BCF investment exceeds the required minimum spend in both the out of hospital spend and that into Adult Social Care. The additional investment into Adult Social Care in 2021/22 has been vital to help maintain delivery of services, particularly those in the interface between hospital and the community, and to the work of the community and voluntary sector.

3.3 New or additional investment in 2021/22 was made into the following schemes:

- Reablement services - £468k
- Nursing home contribution - £100k
- Hospital Social Worker team - £447k
- Information and Advice services - £100k

3.4 Forecast outturn

There are two schemes current where we had underspends within the pooled budget. These will be carried forward in the pooled budget for 2022/23.

- OT/SALT system transformation - £35k
- Primary Care proactive frailty management (was enhanced support to care homes) - £114k

3.5 Carry forward investment

In addition to the current years funds the pooled budget hosted by Slough Borough Council also currently holds an additional £1.3m from previous years underspends which have been accumulated and carried forward. This money is still being held for investment in our shared objectives and priorities for investment but is non-recurrent. This therefore can only effectively be used to support transformation or transitional costs, or fixed term schemes.

3.6 There were several schemes agreed between the partners for one-off expenditure using this non-recurrent funding:

- Browns Intensive Support - £30k
- Virtual Review Team and post pandemic recovery - £140k (per year for 2 years)
- A business intelligence role - £60k (per year for 2 years)
- Frailty Practitioner pilot - £72k
- Additional resources in social care (winter capacity) - £180k

4 Performance and metrics

A new set of metrics were set in this year's plan which included

- Avoidable admissions (in place of all admissions)
- Length of stay (proportion of 14+ and 21+ stays (in place of Delayed Transfers of Care)
- Discharge to usual place of residence
- Care Home admissions (unchanged)
- Reablement (unchanged)

The BCF planning framework asked areas to set out their ambitions which have been agreed between partners at a local level. These should be stretching and demonstrate how BCF activity and investment will contribute to achieving these.

4.1 Table of BCF metric ambitions (from BCF Plan 2021/22) and outturn

Metric	Definition	BCF ambition				Achieved
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	650.0				Data not yet available
Length of Stay	Proportion of inpatients resident for:	**14 days or more (Q3)**	**14 days or more (Q4)**	**21 days or more (Q3)**	**21 days or more (Q4)**	

	i) 14 days or more ii) 21 days or more	9.0%	8.5%	4.5%	4.0%	i) 12.2% - 14+ days ii) 6.6% - 21+ days
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence				95.0%	92.4%
Residential Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)				478	289
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				65.2%	78.6%

4.2 Avoidable Admissions

At the time of this report the latest data has not been published on the Better Care Exchange. To reduce the number of avoidable admissions to hospital our Slough BCF programme has significant investment in 'out of hospital' services that support people to remain at home even when acutely unwell or have become very frail. This includes equipment services, the Disabled Facilities Grant, Reablement and rehabilitation services, integrated care services and the investment in Local Access Point and Integrated Decision Making multi-disciplinary teams (ICDM). The partnership work with Primary Care and the Community Trust is vital to this, not only in responding to urgent care needs but also in early intervention and management of people living with multiple or complex conditions.

The investment in the Connected Care programme across the Frimley Integrated Care System is providing quick and easy access to a Shared Care Record providing information collated from different record systems. This is used to inform clinical decision making and more personalised health and care delivery. The Connected Care system is also driving improvements in our Population Health Management whereby we have much greater source of data to have more targeted health interventions and help reduce health inequalities in our population.

As an ICS system we are also working on delivery of the Ageing Well Programme which includes providing Urgent Care Response (2-hour response 8am-8pm, 7 days a week), Anticipatory Care and

Enhanced Health in Care Homes, all of which contribute to supporting people to be supported in the community and avoid unnecessary admissions to hospital.

Our challenge is to increase the capacity within ICDM model to become more proactive in supporting people in the earlier stages of becoming frail by identifying risk factors and having earlier intervention. We have invested in a Frailty practitioner role to pilot this approach in Slough but have not yet been able to recruit to this role.

4.3 Length of Stay

The length of stay metric in BCF in 2021/22 replaced the previous Delayed Transfer of Care indicator. The emphasis is particularly on reducing the number of people with a hospital stay that exceeds 14 or 21 days. There are several schemes of BCF investment which contribute to reducing length of stay, guided by the national framework of High Impact Changes for Managing Transfers of Care. These include Discharge to Assess people at home or in an interim community bed along with other support to improve flow of people out of hospital.

This year was particularly challenging for maintaining flow and capacity, not only in the acute hospital but across the wider system with not only the regular winter pressures but the additional impact of covid. The restrictions and infection control measures in health and care settings affected bed capacity and ability to transfer, along with the impact of sickness and absence of staff to maintain services and sufficient staffing levels throughout. National data published on the Better Care Exchange shows that Slough averaged a proportion of 12.2% (14+ days) and 6.6% (21+ days) in the period Oct-Feb which is greater than our stretch ambition we set in our plan.

4.4 Discharge to normal place of residence

This is a new indicator for BCF in 2021/22. Best Practice nationally would be to achieve over 95% of people returning to their normal place of residence after a stay in hospital and we set our ambition to achieve this. However, as with other indicators this has been adversely affected by impact of covid, particularly the extended periods of care home closures. This meant that more people had to be discharge to another interim care setting before returning to their normal place of residence. Our outturn figure was 92.4% which is closely in line with the national average for Wellbeing Board areas of 92.6%.

4.5 Residential admissions to care homes (65+)

The inclusion of the care home metric is the ambition to support more people to remain in their own homes for longer and minimise the number of permanent placements in care homes. Slough has a relatively small number of care homes for its population and through investment into reablement and rehabilitation services aims to support people to remain at home wherever possible. Our metric was set at no more than 76 permanent placements (a rate of 478 per 100,000 people 65+) and maintaining our position on the previous against an increase in population. This has been an unusual year, again with the impact of covid have impacted on availability of care home beds for a significant period of the year. The final outturn figure was therefore much less than the ambition set in the plan with only 45 permanent placements being made during 2021/22.

4.6 Reablement

Reablement, Recovery and Rehabilitation services (known as RRR in Slough) are central to supporting people to return home from hospital, as well as providing additional short-term support to someone to remain at home and avoid an admission to hospital. BCF now invests over £2.8m into these services that help safely transition and transfer people between hospital and community-based care. The BCF metric is specifically aimed at measuring how many people supported to return home from hospital through these intermediate care services and continue to remain at home more than 91 days later. It takes a snapshot of discharges in intermediate care for one quarter of the year (Oct-Dec). Our ambition was to achieve over 65% success rate and final figure was 78.6%. However, the total number discharged into RRR was less with 56 supported following discharge against our plan of 66.

It should be noted that for the purposes of BCF metrics this figure does not include those supported by RRR through step-up, escalation routes that put in support to remain at home which accounts for around half of the overall activity within the service.

5 - BCF Expenditure Plan 2021-22

Scheme ID	Scheme Name	Commissioner	Provider	Source of Funding	Risk	Part or Full	Risk category	2021-22
1	Stroke Support Service	Local Authority	Charity / Voluntary Sector	CCG Minimum Contribution	SBC	Part	1	**57,000**
2	Dementia Care Advisor	Local Authority	NHS Mental Health Provider	CCG Minimum Contribution	SBC	Full	1	**30,000**
3	OT/SALT whole system transformation	CCG	NHS Acute Provider	CCG Minimum Contribution	CCG	Full	1	**35,000**
4	Integrated Wellbeing Service	Local Authority	Private Sector	CCG Minimum Contribution	SBC	Full	1	**241,000**
5	Telehealth	CCG	Private Sector	CCG Minimum Contribution	SBC	Full	1	**25,000**
6	Telecare	Local Authority	Private Sector	CCG Minimum Contribution	SBC	Part	3	**72,000**
7	RRR service (Reablement and Intermediate Care)	Local Authority	Local Authority	CCG Minimum Contribution	SBC	Full	1	**2,858,239**
8	Hospital Social Work Team	Local Authority	Local Authority	CCG Minimum Contribution	SBC	Full	1	**446,824**
9	Joint Equipment Service	CCG	Private Sector	CCG Minimum Contribution	CCG	Full	1	**710,802**
10	Joint Equipment Service	Local Authority	Private Sector	CCG Minimum Contribution	SBC	Part	3	**130,000**
11	Nursing Care Placements	Local Authority	Private Sector	CCG Minimum Contribution	SBC	Part	3	**500,000**
12	Primary care proactive frailty management	CCG	CCG	CCG Minimum Contribution	CCG	Part	2	**114,000**
13	Care Homes - programme	CCG	CCG	CCG Minimum	CCG	Part	3	

	manager			Contribution				**25,000**
14	Integrated Care Services / ICT	CCG	NHS Community Provider	CCG Minimum Contribution	CCG	Part	3	**836,009**
15	Intensive Community Rehabilitation	Local Authority	NHS Community Provider	CCG Minimum Contribution	SBC	Full	3	**82,000**
16	Intensive Community Rehabilitation	CCG	NHS Community Provider	CCG Minimum Contribution	CCG	Full	3	**188,136**
17	Responder Service	Local Authority	Private Sector	CCG Minimum Contribution	SBC	Full	1	**130,000**
18	High Impact Change delivery (D2A)	Local Authority	Local Authority	CCG Minimum Contribution	CCG	Full	1	**284,200**
19	High Impact Change delivery (Alamac/GP)	CCG	Private Sector	CCG Minimum Contribution	CCG	Full	1	**97,016**
20	Community beds (D2A)	CCG	Private Sector	CCG Minimum Contribution	CCG	Full	1	**129,572**
21	ICDM / LAP - SBC	Local Authority	Local Authority	CCG Minimum Contribution	SBC	Full	1	**283,656**
22	ICDM/LAP/cold car OT - CCG	CCG	NHS Community Provider	CCG Minimum Contribution	CCG	Full	1	**203,257**
23	Community Ijntegration Manager (CIM)	Local Authority	CCG	CCG Minimum Contribution	CCG	Full	2	**81,000**
24	Disabled Facilities Grant	Local Authority	Local Authority	Disabled Facilities Grant	CCG	Full	1	**1,140,680**
25	Connected Care	CCG	CCG	CCG Minimum Contribution	CCG	Part	3	**200,000**
26	Winter pressures social care	Local Authority	Local Authority	CCG Minimum Contribution	SBC	Full	1	**180,000**
27	Carers	Local Authority	Charity /	CCG Minimum	SBC	Full	1	

			Voluntary Sector	Contribution				**216,000**
28	End of Life Advice Line	CCG	Charity / Voluntary Sector	CCG Minimum Contribution	CCG	Part	1	**144,732**
29	Paediatric hotline	CCG	NHS Acute Provider	CCG Minimum Contribution	CCG	Part	3	**46,382**
30	EOL Night sitting service	CCG	Charity / Voluntary Sector	CCG Minimum Contribution	CCG	Part	3	**15,597**
31	Community Capacity	Local Authority	Charity / Voluntary Sector	CCG Minimum Contribution	SBC	Part	3	**218,000**
32	Information and Advice	Local Authority	Charity / Voluntary Sector	CCG Minimum Contribution	SBC	Full	1	**100,000**
33	Programme Management and Governance	Joint	Local Authority	CCG Minimum Contribution	Joint	Full	2	**260,000**
34	Care Act funding	Local Authority	Local Authority	CCG Minimum Contribution	SBC	Full	3	**296,000**
35	Additional Social Care protection	Local Authority	Local Authority	CCG Minimum Contribution	SBC	Part	3	**798,291**
36	Improved Better Care Fund	Local Authority	Local Authority	Improved Better Care Fund	SBC	Part	3	**3,872,122**

15,047,515

Risk categories

1) **Category 1** - Entire Scheme within BCF, risk of Overspend owned by ONE Partner
2) **Category 2** - Entire Scheme within BCF, risk of Overspend shared between Partners
3) **Category 3** - Fixed Contribution towards a budget held by one Partner