Appendix 1b – BCF Plan 2021-22

The following excerpts are from the BCF Plan for 2021/22 – as the template is a fixed document and not all the content could be viewed in Appendix 1. Only those sections that could not be expanded on Appendix 1 have been included here:

From the Income Tab 4:

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Reading	£305,000	£70k – Carers Information and Advice Service (total service costs £95k and CCG provided £25k) £75k – Carers grants and respite (total service budget is £150k and CCG provided £75k) £160,119k – Narrowing the Gap services: Peer support for families affected by long term conditions, and Carers Breaks service.

From the Metrics Tab 6:

8.1 Admission Avoidance

	19-20 Actual	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	535.0	635.0

Target Setting- Currently, we and our colleagues across the Berkshire West system, are operating well below the national average (896.53, per 100k). Last year, due to the pandemic, there were an abnormally low number of NELs, this has led to a very strong performance against this metric. Looking at previous years, and the current pressures on health services it would be appropriate for our stretch target to be based on the percentage decreases between our 18/19 (756) and 19/20 (707), data, especially as we have noted a 29% increase in expected cases in the first quarter of 2021/22, compared to 2020/21, where figures were skewed due to the pandemic. The stretch metric proposed represents a 10% reduction on 2019/20 actuals. Enabling Actions: The Berkshire West CCG has several groups set up to look at specific conditions that sit within this list of conditions. Currently, the system is supporting work with Diabetes and Cardiovascular Disease (including pilots for blood pressure monitoring).

8.2 Length of Stay

		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 (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	8.5%	9.6%
	Proportion of inpatients resident for 21 days or more	4.5%	5.5%

Target Setting- Reading are currently performing better than the national average at both the 14 and 21 day measure. We have noticed a pattern in our data that shows an increase between Q3 and Q4 for both 14 and 21 day datasets. We believe that we have included a realistic stretching target for 14 days. The 21 day target will be to maintain the average performance achieved across both 2019/20 and 2020/21 for Q3 and Q4, particularly as we are about to enter the difficult Winter period, with Influenza, Norovirus and Covid still in circulation. This target has been agreed with our Acute hospital system partners and shared with the Berkshire West Rapid Community Discharge Steering Group (including Hospital, Community Nursing, CCG and Social Services management teams).
Enabling Activity- The Better Care Fund is used to commission Reablement Services. These include bed based reablement, Step Up/Down beds in the local community and community reablement (from community nursing, as well as social care providers). This wide array of services support people with a variety of needs to leave the hospital. As a part of our Rapid Community Discharge governance, regular conference calls take place to keep people moving from ward to the community. The Better Care Fund has also funded extra social workers and occupational therapy to support an increase in the flow of patients leaving hospital.

8.3 Discharge to Normal Place of Residence

	21-22 Plan
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)	91.0%

Target Setting- Following consultation with the Berkshire West Rapid Community Discharge Group (Consisting of senior management staff from the Royal Berkshire Hospital and the Hospital Discharge Team, Community Nursing, the BW CCG and Social Workers). We have compared data over 3 years and in 2019/20 there was an average 5% decrease in performance, compared to the previous year. In order to improve but remaining mindful of the challenges, we have set what we feel is a realistic target, which represents an average 1% increase on 2020/21 data. Enabling Activities such as strong local governance is key here. The Rapid Community Discharge Steering Group meet monthly to understand trends and issues, moving blockers to increase performance. The Rapid Community Discharge Working Group meet weekly to look at details, review lengths of stay and reasons, as well as assess risks, taking a "Home First" approach. Other enabling factors are the use of wearable TEC,

such as fall sensors and alarms as well as other equipment to support people to return home with some assistance, where needed.

8.4 Residential Admissions		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	567	419	472	439
	Numerator	116	85	96	92
	Denominator	20,461	20,270	20,335	20,953

Target Setting- The Reading System are currently on track to reduce the number of admissions against the actual for 2020/21 and have aimed for a 9% reduction. We are mindful of the impact of Covid and have set what we believe to be a realistic but stretching target for 2021/22. Reading has an increasing number of older people. Reducing the target below this figure, with an increased older peoples population, alongside an increase in the need of people that have been through hospital with Covid will be challenging. Enabling Actions: RBC commission reablement services (including health and social care) and have increased the amount of care packages, for care at home, that are available from providers, together with support through the use of wearable TEC (Technology Enhanced Care) and other equipment to support people to remain at home.

8.5 Reablement		19-20 Plan	19-20 Actual	*20/21 not included due to skewed data from pandemic*	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 (%)	92.9%	77.1%		87.0%
	Numerator	367	81		456
	Denominator	395	105		524

Target Setting: When looking at the performance of our reablement teams this year and last, we believe that it is an appropriate target, and is a 10% improvement from actual in 2019/20. We have increased the number of referrals into reablement, and the target is considered a stretch, especially when taking into account the pressures of Covid. Enabling Actions: We have specialist reablement services in place for social care and nursing support. BCF has supported an extension of OT services and also physiotherapy in the borough. We are working towards an admission avoidance model and there is a current review of our reablement service underway, with a view to providing a model that is able to support more people in the community and increasing the number of people that remain at home 91 days after they are discharged from hospital. It has been a challenge to meet targets as a result of the inclusion of people within reablement referrals who are actually on end of life pathways, which is then identified by our Reablement Team and referred onto CHC. However, it is noted that these referrals to reablement are still included in the statistics as per NHSEI guidance.