High Level Reading Integrated Board (RIB) Programme Plan 2021/22

(Agreed at RIB June 2021)

=RIB/ICP Priority

RIB Objective	Link with NHS Long Term Plan and ASC Green Paper *(when published)*	Key Priority Areas	Link with ICP / H&WB Strategy	SRO	Responsible Group / Person	Key Sub Priorities	Notes	High Level Actions	RIB Deliverable	Status 2021/22 Q1	Q2	Q3	Q4	Commentary
Wider health and care Integration initiatives	Integrated Care Service (BOB) and Integrated Care Partnership (Reading)	**MDT Approach**	ICP 1,2,3 & 4 HWB1,2 & 5	Katie Summers	Eiliis McCarthy / Ben Blease / Bev Nicholson / PCNs	**Establish 3 MDTs to wrap around PCNs in the reading Locality**	One MDT is currently running in Central Reading.	Increase the number of MDTs in Reading from 1 per month to 3 per month to support all PCNs across Reading. In collaboration with BHFT and PCNs develop PHM based risk stratified criteria to ensure selection of patients for discussion to impact fully on admission avoidance	Target Q2: 3 MDTS in place supporting PCNs in Reading					
									Monthly project reporting to RIB in place					
									Case studies of good integrated practice developed					
									No. of new patients discussed at MDT					
									Reduction in GP contacts					
									Reduction in number of complex care packages					
									Reduction in number of non-elective admissions and ED attendances					
									Number of complex cases where Care Plans have been amended, with improved outcomes *(Outcomes based on Personalised Care Plans)*					
		Clinical Director engagement at RIB	ICP 1,2,3 & 4 HWB1,2 & 5	Katie Summers	Bev Nicholson / Eiliis McCarthy	**Strategy for improved Engagement with PCN Clinical Directors in relation to Integration Priorities**	Historically, engagement of Clinical Directors and PCNs at RIB has had it's challenges and the board are keen to address this. PCN involvement at Integration Boards is a key driver of the NHS Long Term Plan and Integrated Care Services. Integration with all system partners, to have joined up discussion and approach to caring for residents in our locality is critical to the success of the Inegration agenda, and we want to ensure there are mutually beneficial outcomes	CD Engagement Strategy, to be developed in collaboration with Clinical Directors and ICP. Focus on a Population Health Analytic support initiative.	Increased number of CDs engaged at RIB on a quarterly basis (baseline at March RIB).					
						Identify local projects to support the integrated approach to health and social care of Reading residents			Projects identified in partnership with PCNs based on PHM Analytics, through the Health Inequalities focussed work at RIB.					
Discharge to Assess - Future Model for Reading	DHSC Hospital discharge service: policy and operating model Updated 19 February 2021	**Review of D2A for Reading, proposal and implementation of future model.**	ICP 1,2,3 & 4 HWB2 & 5	Melissa Wise	Bev Nicholson / D2A Working Group	**Effective Enhanced Care model to ensure timely hospital discharges or avoid hospital admissions and potentially reduce the number of Admissions to Residential/ Nursing Homes.**	There are concerns that acuity levels are rising with higher levels of dependency, particularly post-Covid, for hospital discharges.	Identify the most appropriate model of discharge to assess for Reading residents, ensuring timely intervention and appropriate levels of care package to support them towards living as independently as possible.	Business Case to be developed for future model of D2A for Reading by 30/06/2021.					
									Target performance per annum (no more than) 116 Admissions to Residential / Nursing Homes					
									95% of Reading Patients discharged same day as Medically Optimised for Discharge					
		Engagement of Voluntary Sector to support improved outcomes on discharge pathways 0 and 1, for Service Users	ICP 1,2,3 & 4 HWB2 & 5	Melissa Wise	Bev Nicholson / Rachel Spencer / VCS	**Map voluntary sector providers to align support offer / responses in relation to Discharge to Assess**	BN and RS have met and started thinking about an outline plan to engage with Voluntary Sector services to support discharge pathways (e.g. 3 meetings a year to discuss with the wider voluntary sector)	Outline plan to engage with Voluntary Sector on discharge pathways (e.g. Age UK current project support), and interventions that focus on prevention, self-care, independence and wellbeing.	Voluntary Sector engagement agreed and mapped against discharge pathways by end of Q1 (30/06/2021)					
								VCS Forums schedule to share information about VCS capacity and capability with other system partners and identify opportunities for engagement and support of residents in Reading.	VCS Forums scheduled - 3 per year; first forum to have taken place by end May 2021.					
Community Reablement (CRT) Service Review	LGA Adult Social Care Efficiency Programme and Community health and care discharge and crisis care model: An investment in reablement DHSC Hospital discharge service: policy and operating model Updated 19 February 2021	**Review of Community Reablement Team (CRT) service**	ICP 1,2,3 & 4 HWB2 & 5	Melissa Wise	Michelle Tenreiro-Perez (RBC Transformation Team) / Sue Kelly CRT	**A review of Community Reablement Team capacity and model of service delivery**	Implementation of new software is imminent, to enable improved visibility of care visits, alerts and enabling care professionals to be more easily engaged when required, as well as providing readily accessible information for family members who are carers.	A specification of activities required to deliver a full and effective review and associated improvement of the CRT service to be developed to explore all possibilities for widening the scope of the service e.g. into a MH pathway. The aim of this work is to	Specification for CRT service review developed by end of Q1 (30/06/2021)					
								Procurement options to be considered to secure a strategic partner to deliver this review and resulting recommendations A timetable for this activity will be agreed by the end of June.	Strategic partner identified and project timeline completed by end of Q1 (30/06/2021)					
								Undertake Capacity and Demand planning to ensure people who are ready to be discharged (MOfD) can access appropriate support, where needed, in a timely manner.	Target performance per year (not less than) 1,200 people, per annum, referred to the Community Reablement Team.					

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								Service users invited to provide feedback after each intervention.	90% User satisfaction ("Satisfied" or "Very Satisfied") upon exit from reablement service					
Reducing Health Inequalities	Place Based Approaches for Reducing Health Inequalities (PBA), and PHE Health Inequities Guidance	**Using a Population Health Management Approach to identify areas of inequality within the Reading area.**	ICP 1,2,3 & 4 HWB1,2 & 5	Melissa Wise / Katie Summers	Dr Aparna Balaji/ Dr Ganesh Sharma/	**South Reading Nepalese Diabetic Project**	RIB input will be the involvement of system partners as it is expected that there will be health and social care needs, alongside community engagement. The project progress and outcomes will be reported into RIB	The Nepalese community is known to have poor diabetic outcomes. Full diabetic reviews and group consultations as interventiions will give the community better insight into personal management of their condition resulting in better health outcomes. Project commencing in June 2021 and completion 31 March 2022	Average HbA1c for the selected cohort will be reduced by 5% by 31/03/2022					
									To bring the blood pressure of 50% of patients in range by 31/03/2022					
									Group Consultations will continue as a method of supporting diabetics within practices by 31/03/2022					
									The prevalence of AF in this cohort will increase by 10% by 31/03/2022					
									Patients will have greater awareness of self management by 31/03/2022					
			ICP 1 & 4 HWB1,2 & 5	Melissa Wise	David Munday - PH / Performance Team	**Sub-Group created for RIB to agree priorities for Reading and develop specific project plans based on those priorities.**	There is an assistant PH member of staff that will be joining RBC and this might be someone that could engage with the Health Inequalities project.	Production of a PHM dataset for Reading Localities. To demonstrate key Health Inequalities across Community Groups and areas of deprivation e.g. CVD/ Diabetes/ COPD	PHM Dataset for Reading Population.					
								Agreement on Priorities for Reading Locality derived from PHM dataset as above	Priorities identified based on PHM Data insights.					
								Projects identified within Reading Locality according to agreed priorities	Project Plans drawn up and actioned in line with priorities.					
			ICP 1 & 4 HWB1,2 & 5	Melissa Wise	David Munday - PH / Performance Team / Bev Nicholson	**Develop PH Analyst Capacity & Capability in Reading**	1.0 fte data analyst funded by BCF - requires training and development in respect of PHM datasets	Identify PHM information sources available to PHM analysts and enable access. Devise a Development and Training plan in respect of PHM Datasets to produce relevant and timely data to enable PHM work.	Analyst is using a PHM approach to analysing data for Reading localities. By September 2021.					
							Potential to shadow other staff in this role in Social Care PH Data team.	Development and Training plan in respect of Power BI analytical tool,	Analyst is able to use Power BI effectively to produce intelligence to support prioritisation of activities and effective presentation to programme boards by September 2021.					
			ICP 3 & 4 HWB 1 & 2	Melissa Wise	Bev Nicholson / Janette Searle	**Identify all current projects in relation to Health Inequalities**	There are a number of projects ongoing across the locality and with various partners.	All Health Inequality focussed projects to be co-ordinated to avoid duplication and encourage integrated working	Alignment of ongoing and planned Health Inequalities projects. By July 2021.					
			ICP 1 & 3 HWB 1 & 2	Katie Summers	Eilis McCarthy / PH Team / Comms	**Covid Vaccination Hesitancy**	Working with RBC Community Engagement team/Comms teams and voluntary sector	Engage with and inform communities of the importance of taking up the opportunity of a covid vaccine. By understanding specific community needs enable a more equal access of communities to the vaccine	Data collected weekly on uptake per racial group against cohorts and action taken is in line with data.					
			ICP1,2,3 & 4 HWB 1,2 & 5	Melissa Wise	Bev Nicholson / Rachel Spencer / PH Team / VCS	**Engaging Voluntary Care Sector to support the needs of people in Reading based on a PHM data driven approach.**	Engagement with VCS has commenced, to include RVA lead and other third sector providers within the Reading locality.	Set up VCS Working Group to support RIB in developing a VCS Strategy with aim of supporting Reading residents (e.g. to address debt management issues or develop post Covid activities such as enabling older people to re-engage with communities.)	Strategy by end of Q1 (By 30/06/2021), together with Action Plan and agreed timelines.					
Service User Engagement & Feedback	Local Government and Public Involvement in Health Act 2007	**HealthWatch to collect the experiences of Service Users in relation to the Discharge Pathways.**	ICP 1 & 3 HWB 1 & 5	Melissa Wise	Bev Nicholson / Pat Bunch	**Identify what Service User feedback is available from HealthWatch and further engagement opportunities.**	Patient/service user experience can be measured in the following ways: • using an existing national measure such as the Family and friends test • using an existing local measure from data which has already been collected (interviews, service reviews, surveys etc.) • using a newly developed local measure, i.e. new case studies, interviews, service reviews etc. If	HealthWatch reports identified to raise awareness of issues for residents within the Reading locality (e.g. Experience of rapid community discharge pathways, Telephone access to GPs)	HealthWatch report agreed to enable evaluation of Service User experience in Reading (by Q4 2021)					
		Engage Service Users and Carers in co-production of services; ensuring representation at Boards and other events.	ICP 1 & 3 HWB 1 & 5	Melissa Wise	Bev Nicholson / Pat Bunch	**Identify meetings and Boards where Service Users/Carers could be invited to take part.**		RBC Service Managers to provide a list of meetings at which Service Users/Carers could attend and participate.	Agendas include Service User/Carer feedback and enagement item, and Service User/Carer representatives invited to attend.					

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		Produce a High Level Strategy to develop what good engagement looks like in the Reading Locality and identify what is meaningful for Service Users and System Partners.	ICP1,2,3 & 4 HWB 1,2 & 5	Melissa Wise	Bev Ncholson / Eiliis McCarthy / Pat Bunch / Rachel Spencer	**Develop a Working Group involving Service Users/Carers and other key stakeholders**	providers are developing a new local measure, they can consult the Picker framework to access the 18 questions developed by the Picker Institute and Oxford University.	Draw up Terms of Reference for Stakeholder Engagement Working Group, and arrange regular meetings.	First Stakeholder Engagement Task & Finish Group Meeting to has taken place by the end of Q2					
Data and Digital Solutions	Integrating Care: Next steps to building strong and effective integrated care systems across England.	**Ensure regular and appropriate reporting of relevant datasets including a suite of Population Health focussed reports to support PCNs and system partners in identifying local activities that will have the most impact in their localities.**	ICP 1 & 2	Katie Summers	Bev Nicholson / Zanna Rojenko	**Review of RIB Dashboard**	RIB Dashboard contains some datasets that are no longer relevant to the RIB agenda.	Identify appropriate measures to be monitored and reported on the RIB dashboard, including frequency	RIB Dashboard reviewed and updated in line with statutory BCF and local targets					
			ICP 1 & 2	Katie Summers	Bev Nicholson / Zanna Rojenko	**Develop Summary Report for RIB**		Focussed Summary report template to be agreed, to include a brief narrative regarding impact of any under performance.	Summary report provided for each RIB meeting monthly					
			ICP 1,2,3 & 4 HWB 1 & 5	Melissa Wise	PH / Performance Team	**Develop Suite of Population Health reports**	Using MS Power BI to interrogate datasets and feed into an agreed set of reports for system partners.	Implement MS Power BI within Analyst teams locally, including training of analysts, to support system wide intelligence gathering for an integrated approach.	Suite of Population Health Management reports made available to system partners (by 30/09/2021)					
		Identification of Digital Solutions, in partnership with other Social Care and Health Providers in the Berkshire West locality.	ICP 1,2,3 & 4 HWB 1,2 & 5	Melissa Wise	Bev Nicholson / PH team / RBC Social Inclusion Group	**Review of opportunities and benefits at RIB**	e.g. Connected Care development / Discharge pathway digital platform / OT Technology Enhanced Care (TEC), Digiral inclusion for Reading residents.	Key outputs and baseline measures to be agreed	25% Reduction in Admin time spent on populating and sharing discharge spreadsheets and other information *(baseline needed)*					

Business As Usual - BCF		Key Priority Areas	Link with ICP / H&WB Strategy	SRO	Responsible Group / Person	Key Sub Priorities	Notes	High Level Actions	RIB Deliverable	Q1	Q2	Q3	Q4	Commentary
BCF Monitoring	Integrated Care Service (BOB) and Integrated Care Partnership (Reading) / DHSC Hospital discharge service: policy and operating model (Updated 19 February 2021) Improved Better Care Fund (iBCF) – Principles of Discharge (28th October 2020)	**Reducing Non Elective Admissions (NELs)***	ICP 1,2,3 & 4 HWB 1,2 & 5	Melissa Wise / Katie Summers	RBC / CRT / D2A	**Focus on admission prevention initiatives to support people to stay well and fit in their own homes.**	*Moving to Admission Avoidance 2021/22 but awaiting Metrics	Reduction in total Non-elective spells (specific acute) per 100,000 population via interventions detailed in the objectives for D2A, CRT and Reducing Health Inequalities Sections above:- *D2A Future Model for Reading *CRT Review *MDTs *Milman & Kennet OSS *Delivery of Nepalese Diabetic project *Multi morbidity work for LTCs	Target of no more than 10,607 (per 100,000 population) for the year.					
		Reducing admissions to Residential / Nursing Homes	ICP 1,2,3 & 4 HWB 1,2 & 5	Melissa Wise / Katie Summers	RBC / CRT	**System wide partners focus on anticipatory care and crisis prevention.**		Implementing an anticipatory care model, in line with the High Impact Change Model (2021) to support people in their own homes, to live independently and healthily in order to prevent admission.	No more than 571 people per 100,000 are permanently placed into residential/nursing homes					
		Discharge to Assess	ICP 1,2,3 & 4 HWB 1,2 & 5	Katie Summers	RCD / RBC/ CRT VCS	**Partners focus and system wide oversight and COVID funding to support 7 day working.**	A future model for Reading is in the process of being developed for implementation in 2021	Improve co-ordination of services regarding discharges ensuring an integrated approach between Health and Social Care services to speed up the discharge process, once patients are Medically Optimised For Discharge (MOfD). Engagement with VCS in relation to Pathways 0 and 1 for improved experience and outcomes for service users.	95% same day Av. days on MOFD (RTG List) No. bed days lost 75% (min) pathway 0 16% (min) pathway 1 8% (max) pathway 2 1% (max) pathway 3					
		Effective Reablement Service	ICP 1,2,3 & 4 HWB 1,2 & 5	Melissa Wise	RBC / CRT	**Patients are able to return home when MOfD, or to stay at home with support from reablement and therapy services to improve their physical mobility and independence, and to avoid admission to hospital.**	Accelerator funding and SDF funding goes to CCG, along with BCF funding (iBCF).	Ensure timely and holistic care packages are delivered, including therapies to build confidence and support independent living, as appropriate.	Outcome measure agreed with all partners: Post 91-day review - 87% remain at home.					

Emerging Strategy and objectives for 2021/22 from Integrated Care Partnership and Health and Wellbeing Board

ICP Strategic Objectives:

ICP1	Promote and improve health and wellbeing for Berkshire West residents
ICP2	Create a financially sustainable health & social care system
ICP3	Create partnerships and integrate services that deliver high quality and accessible H&S Care
ICP4	Create a sustainable workforce that supports new ways of working

Top emerging priorities from the Joint Health and Wellbeing Strategy:

HWB1	Reduce the differences in health between different groups of people
HWB2	Support individuals at high risk of bad health outcomes to live healthy lives
HWB3	Help children and families in early years
HWB4	Good mental health and wellbeing for all children and young people
HWB5	Promote good mental health and wellbeing for all adults

bRAG Status Key:

NS	Not yet started
B	Completed
R	There is a problem but, at this time, we do not have a plan to address it
A	There is a problem, but we have a plan to address it
G	On Track