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

7 High level Objectives, 15 Projects, 23 Project Activities, 44 Deliverables

(Agreed at RIB June 2021)

=RIB/ICP Priority

RIB Objective	Link with NHS Long Term Plan and ASC Green Paper *(when published)*	Key Projects	Link with ICP / H&WB Strategy	Key Project Activities	RIB Deliverable	Status 2021/22 Q1	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	**Establish 3 MDTs to wrap around PCNs in the Reading Locality**	Target Q2: 3 MDTS in place supporting PCNs in Reading	**A**	Demand for GP services and vaccination programme is placing increasing pressures on GP time and GP's have less time to engage. Recent reorganisation of SR PCNs has delayed discussions as key roles have changed BHFT lead – BB seconded into Urgent Care Role and role currently vacant.
					Monthly project reporting through Project Team to RIB in place	**G**	
					Case studies of good integrated practice developed to share with PCNs by end Q2.	**NS**	BHFT are producing case studies, to be shared.
					No. of patients discussed at MDT (Max 15)	**A**	Baseline (Jan to Mar 2021)
					Reduction in GP contacts for people that have been reviewed by an MDT	**A**	Baseline and target to be agreed.
					Reduction in number of non-elective admissions and ED attendances for cases reviewed by the MDT	**A**	Baseline and target to be agreed.
					Number of complex cases where Care Plans have been amended, with improved outcomes for people that have been reviewed through an MDT.	**A**	Baseline and target to be agreed.
					Mental Health Workers aligned with each PCN to refer into MDT	**NS**	3 Mental Health Workers have been recruited in Q2, and it is expected that the remainder will be in post by January 2022.
					Each PCN is aligned with a Social Worker.	**NS**	Baseline and target to be agreed.
		Clinical Director engagement at RIB	ICP 1,2,3 & 4 HWB1,2 & 5	**Strategy for improved Engagement with PCN Clinical Directors in relation to Integration Priorities**	Increased number of CDs engaged at RIB on a quarterly basis (baseline at March RIB).	**G**	Two PCN leads engaged (AC/KI) and have taken on role of sharing information from RIB with their networks and feeding back into 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.	**NS**	Number of projects to be identified. Links in with Health Inequalities work.

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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	**Effective Enhanced Care model to ensure timely hospital discharges or avoid hospital admissions and potentially reduce the number of Admissions to Residential/ Nursing Homes.**	Business Case to be developed for future model of D2A for Reading by 30/06/2021.	**A**	Draft Business Case developed, currently a work in progress, engaging with system partners.
					Target performance per annum (no more than) 116 Admissions to Residential / Nursing Homes	**G**	
					95% of Reading Patients discharged same day as Medically Optimised for Discharge	**A**	Engaging with Rapid Community Discharge (RCD) Team to support initiatives.
		Engagement of Voluntary Sector to support improved outcomes on discharge pathways 0 and 1, for Service Users	ICP 1,2,3 & 4 HWB2 & 5	**Map voluntary sector providers to align support offer / responses in relation to Discharge to Assess**	Voluntary Sector engagement agreed and mapped against discharge pathways by end of Q1 (30/06/2021)	**A**	Mapping and outline plan to be developed through VCS Forums.
					VCS Forums scheduled - 3 per year; first forum to have taken place by end May 2021.	**G**	Future forums scheduled for 29th September, 24th November, 26th January.
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	**A review of Community Reablement Team capacity and model of service delivery**	Specification for CRT service review developed by end of Q1 (30/06/2021)	**G**	
					Strategic partner identified and project timeline completed by end of Q1 (30/06/2021)	**G**	
					Target performance per year (not less than) 1,200 people, per annum, referred to the Community Reablement Team.	**G**	
					90% User satisfaction ("Satisfied" or "Very Satisfied") upon exit from reablement service	**G**	

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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	**South Reading Nepalese Diabetic Project**	Average HbA1c for the selected cohort will be reduced by 5% by 31/03/2022	**G**	
					To bring the blood pressure of 50% of patients in range by 31/03/2022	**G**	
					Group Consultations will continue as a method of supporting diabetics within practices by 31/03/2022	**G**	
					The prevalence of AF in this cohort will increase by 10% by 31/03/2022	**G**	
					Patients will have greater awareness of self management by 31/03/2022	**G**	
			ICP 1 & 4 HWB1,2 & 5	**Sub-Group created for RIB to agree priorities for Reading and develop specific project plans based on those priorities.**	PHM Dataset for Reading Population.	**A**	
					Priorities identified based on PHM Data insights.	**G**	
					Project Plans drawn up and actioned in line with priorities.	**A**	
			ICP 1 & 4 HWB1,2 & 5	**Develop PHM Analyst Capacity & Capability in Reading**	Analyst is using a PHM approach to analysing data for Reading localities. By September 2021.	**G**	
					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.	**A**	The BCF Analyst is developing skills in relation to Population Health Management. We are working towards the ability to access the right level of data through the analytical platform (Power BI) for Connected Care and a proposal will be put forward for a working group of PHM Analysts to work together across Berkshire West and BOB.
			ICP 3 & 4 HWB 1 & 2	**Identify all current projects in relation to Health Inequalities**	Alignment of ongoing and planned Health Inequalities projects. By July 2021.	**G**	
			ICP 1 & 3 HWB 1 & 2	**Covid Vaccination Hesitancy**	Data collected weekly on uptake per ethnic group against cohorts and action taken is in line with data.	**G**	
			ICP1,2,3 & 4 HWB 1,2 & 5	**Engaging Voluntary Care Sector to support the needs of people in Reading based on a PHM data driven approach.**	Strategy by end of Q1 (By 30/06/2021), together with Action Plan and agreed timelines.	**A**	Voluntary Sector engagement is happening, with representation at the Forum and also within Working Groups to develop project plans and action plans linked to H&WBB/ICP Strategy. A document is yet to be drawn up in relation to the formal strategy for engagement.

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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	**Identify what Service User feedback is available from HealthWatch and further engagement opportunities.**	HealthWatch report agreed to enable evaluation of Service User experience in Reading (by Q4 2021)	**G**	
		Engage Service Users and Carers in co-production of services; ensuring representation at Boards and other events.	ICP 1 & 3 HWB 1 & 5	**Identify meetings and Boards where Service Users/Carers could be invited to take part.**	Agendas include Service User/Carer feedback and enagement item, and Service User/Carer representatives invited to attend.	**NS**	
		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	**Develop a Working Group involving Service Users/Carers and other key stakeholders**	First Stakeholder Engagement Task & Finish Group Meeting to has taken place by the end of Q2	**NS**	
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	**Review of RIB Dashboard**	RIB Dashboard reviewed and updated in line with statutory BCF and local targets	**G**	
			ICP 1 & 2	**Develop Summary Report for RIB**	Summary report provided for each RIB meeting monthly	**G**	
			ICP 1,2,3 & 4 HWB 1 & 5	**Develop Suite of Population Health reports to be made available to system partners**	Suite of Population Health Management reports made available to system partners (by 30/09/2021)	**G**	
		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	**Review of opportunities and benefits at RIB**	25% Reduction in Admin time spent on populating and sharing discharge spreadsheets and other information *(baseline needed)*	**A**	Connected Care and Rapid Community Discharge project group are working together to develop functionality within Connected Care to provide live data and timely updates in relation to discharge pathways. Direct feed of data from RBC into Connected Care is awaited.

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Business As Usual - BCF		**Key Priority Areas**	**Link with ICP / H&WB Strategy**	**Key Sub Priorities**	**RIB Deliverable**	**Q1**	**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	**Focus on admission prevention initiatives to support people to stay well and fit in their own homes.**	Target of no more than 10,607 (per 100,000 population) for the year.	**G**	
		Reducing admissions to Residential / Nursing Homes	ICP 1,2,3 & 4 HWB 1,2 & 5	**System wide partners focus on anticipatory care and crisis prevention.**	No more than 571 people per 100,000 are permanently placed into residential/nursing homes	**G**	
		Discharge to Assess	ICP 1,2,3 & 4 HWB 1,2 & 5	**Partners focus and system wide oversight and COVID funding to support 7 day working.**	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	**A**	Discharge to Assess service - Future Model to address current hospital discharge delays.
		Effective Reablement Service	ICP 1,2,3 & 4 HWB 1,2 & 5	**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.**	Outcome measure agreed with all partners: Post 91-day review - 87% remain at home.	**A**	75% at end of April (January discharges). There were 39 people, out of 51 being discharged into reablement from hospital in January, who were still at home after 91 days in April. Of the 12 people who were not still at home after 91 days, 5 had sadly passed away.

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