READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**15th JULY 2022**		
REPORT TITLE:	**INTEGRATION PROGRAMME UPDATE**		
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ORGANISATION:	**READING BOROUGH COUNCIL / BERKSHIRE WEST CCG**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an update on the Integration Programme and performance against the national Better Care Fund (BCF) targets covering the period January to March 2022 (Quarter 4).

1.2 The BCF metrics were updated in the planning guidance for 2021/22 and adopted for Quarters 3 and 4 reporting (i.e. October 2021 to March 2022). The targets were based on stretch targets and outcomes as at the end of March 2022 are outlined below:

a) The number of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions). **(Not Met)**
b) Reduction in length of stay of inpatients who have been in hospital for longer than:
(i) 14 days (**Not Met)**
(ii) 21 days **(Met)**
c) An increase in the proportion of people discharged home using data on discharge to their usual place of residence. **(Met)**
d) The number of older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population. **(Not Met)**
e) The effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation). **(Not Met)**

Detailed delivery against each of these targets is outlined in Section 4 of this report and demonstrates how close we were in achieving the targets that had not been met, which is testament to the hard work of all system partners.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board note the Quarter 4 performance and progress made in respect of the Better Care Fund (BCF) schemes as part of the Reading Integration Board's Programme of Work.

3. POLICY CONTEXT

3.1 The Reading Integration Board (RIB) is responsible for leading and overseeing system working with Local Authority Adult Social Care and Housing, Acute and Community health providers,

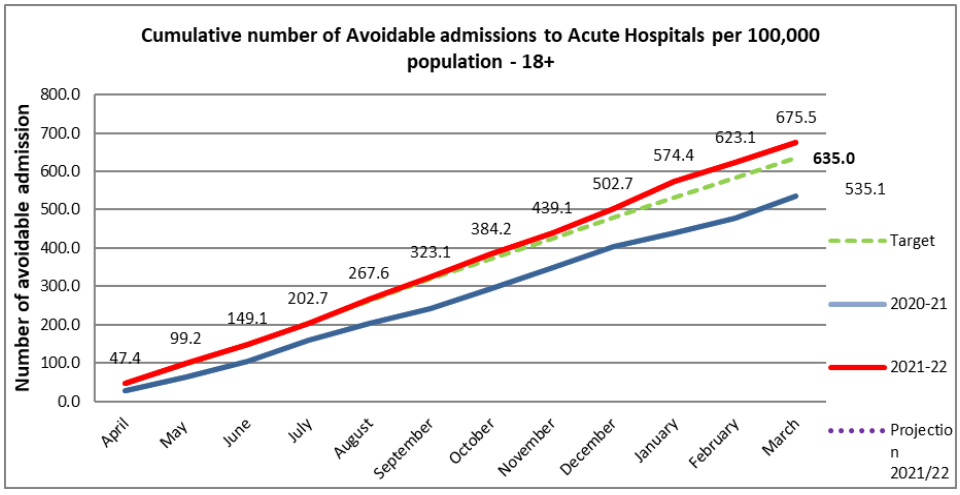
Primary Care, Clinical Commissioning Group, Voluntary Sector partners and Healthwatch, across Reading. The aim of the board is to facilitate partners and other interested stakeholders to agree a programme of work that promotes integrated working to achieve the national Better Care Fund (BCF) performance targets, as set out in sections 1.2 and 4.0 of this paper alongside local priorities.

4. PERFORMANCE UPDATE FOR BETTER CARE FUND AND INTEGRATION PROGRAMME (*aligned with metrics set out in planning guidance 2021/22)*

4.1 **Admission Avoidance:** Reduction in avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions), no more than 635, per 100,000 population, for the year.

We missed this target by just 6%, with a final number of 675. On a positive note, we had remained on track throughout the year up to the last quarter, and this outcome does reflect a performance improvement of 8% compared to the average (732) across 2018/19 and 2019/20. We had indicated in our BCF Plan that the admissions recorded for 2020/21 were skewed due to the pandemic and did not give a realistic picture on which to base our projections. We will work closely with our Better Care Fund Manager and our system partners to more accurately project performance for 2022/23. High levels of acuity have impacted on this measure but by way of mitigation we continue to contribute to the wider Berkshire West rapid response and intermediate care services funded through the Better Care Fund, to enable care to be provided at home and avoid unnecessary hospital admissions wherever possible.

Number of Unplanned hospitalisations for chronic ambulatory care sensitive conditions per 100,000 population - 18+, Acute hospitals, per quarter	
Average performance 2018/19 and 2019/20	732
Stretch target performance for 2021/22 (no more than)	635
Actual performance as at the end of quarter 4 (2021/22)	675



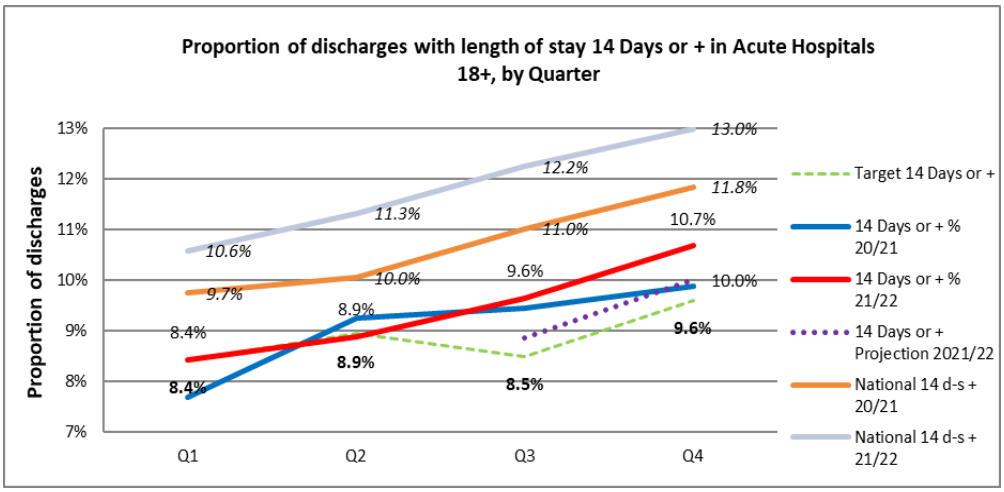
4.2 **Length of Stay:** Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days.

4.2.1 Length of Stay 14 Days

The National Health England ambition for reducing Length of Stay is to have no more than 12% of people with a length of stay over 14 days. Reading are still within that national range at 10.7% for the quarter, against a stretch target of 9.6%. We missed our planned

target by 10% for the quarter and by 6% for the whole year. We continue to work with hospital services to get people home at the earliest opportunity, once they are medically optimised, and we acknowledge the acuity levels which have impacted on these lengths of stay. It can take longer to arrange more complex packages of care, such as double-handed care (which requires 2 carers) or on Pathway 3, where the service users have more complex needs and require 24hr nursing care on discharge, and may exhibit difficult to manage behaviours, which can delay placement.

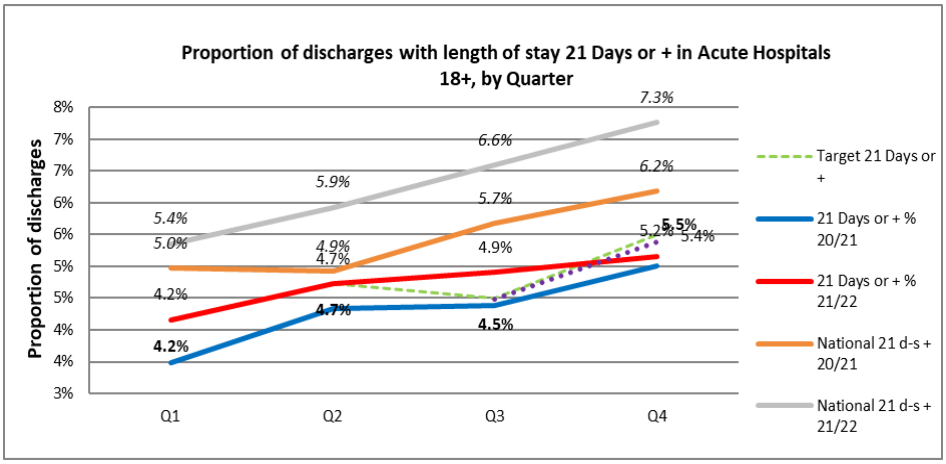
Proportion of inpatients resident for 14 days or more, per month	
NHS England National ambition for % patients with a length of stay of longer than 14 days	12.0%
Local stretch Target for quarter 4 (no more than)	9.6%
Actual performance for quarter 4	10.7%
Overall annual stretch target for 2021/22	8.9%
Actual annual performance 2021/22	9.4%



4.2.2 Length of Stay 21 Days

Performance improved against the 21day Length of Stay (LoS) at the end of Q4 (Jan to Mar), and as a result we have a positive position of 5.2% against our quarterly stretch target of no more than 5.5%. We are pleased that we have been able to meet the overall annual target of no more than 4.7%, especially given the complexity and acuity of cases, and particularly those requiring support in a care home setting. Timely hospital discharge has also been impacted by Covid outbreaks in care homes, thereby limiting capacity. Our hospital discharge team continue to work with our care providers to meet specific and complex needs for people who have had a lengthy hospital stay, and ensuring there is a therapy led service to address the likely deconditioning due to a longer length of stay.

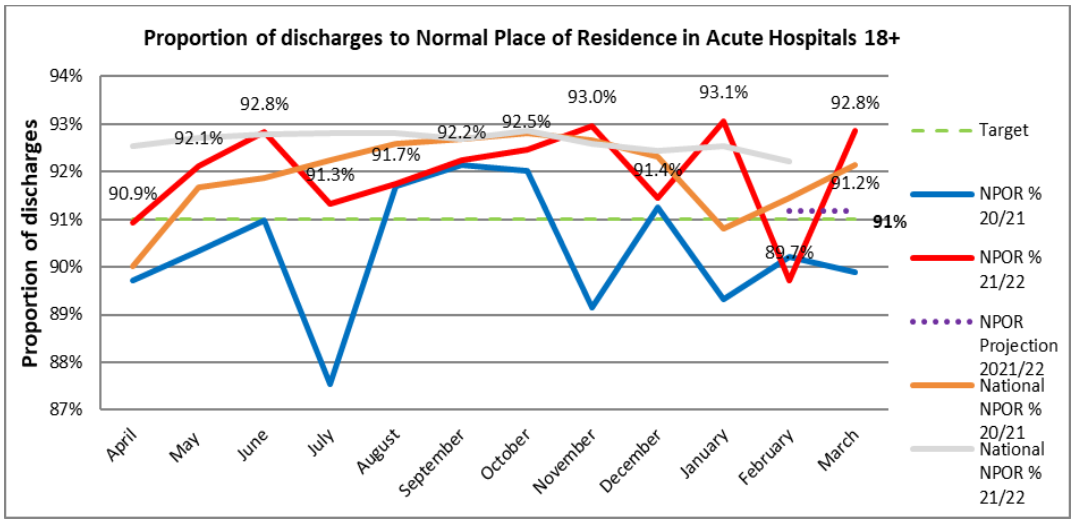
Proportion of inpatients resident for 21 days or more, per month	
Local stretch target performance quarter 4 (no more than)	5.5%
Actual performance quarter 4	5.2%
Overall annual stretch target for 2021/22	4.7%
Actual annual performance 2021/22	4.7%



We opened an Extra Care, Discharge to Assess facility at Huntley Place in January 2022 for short term support to provide additional Discharge to Assess capacity over the winter pressures period, supporting a reduction in acute hospital length of stay.

4.3 **Discharge to Normal Place of Residence:** An increase in the proportion of people who are discharged directly home, from acute hospitals is the aim of this measure, with a target of not less than 91%. This is based on hospital data for people "discharged to their normal place of residence". We exceeded the minimum target for quarter 4 and for the year. The aim of the hospital discharge service is to follow the "home first" principle, with support if needed through the use of TEC equipment that can be installed to support independent living, and reablement.

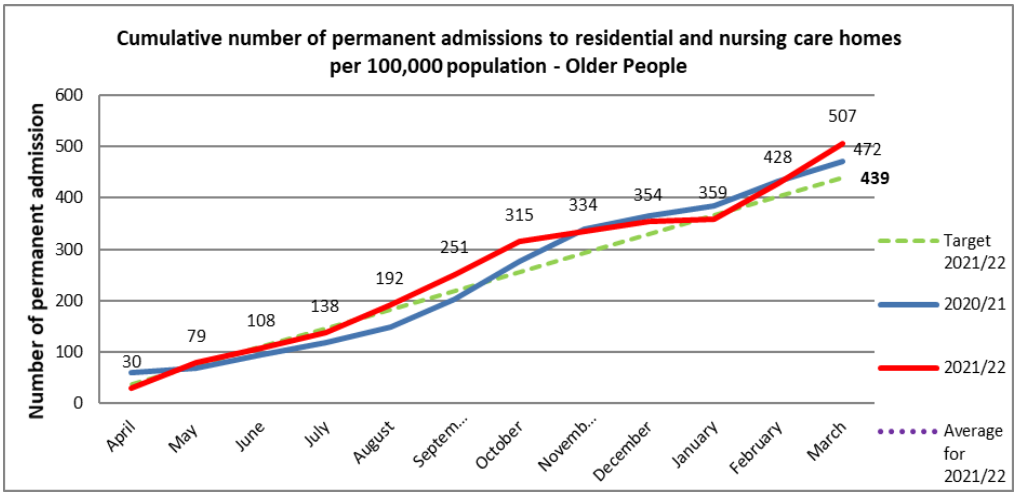
Proportion of discharges to Normal Place of Residence in Acute Hospitals 18+, per month	
Target performance per month (not less than)	91.0%
Actual performance March 2022	92.8%
Overall annual stretch target for 2021/22	91.0%
Actual annual performance 2021/22	92.0%



4.4 **Permanent Admissions to Residential/Care Homes:** The number of older adults (65+) whose long-term care needs are met by admission to residential or nursing care per 100,000 population has exceeded the maximum target of 439, by 13% for the year, at 507. It should be noted that the cumulative target was significantly reduced, as a stretch target, from 571 in the previous year, and was agreed with system partners in line with

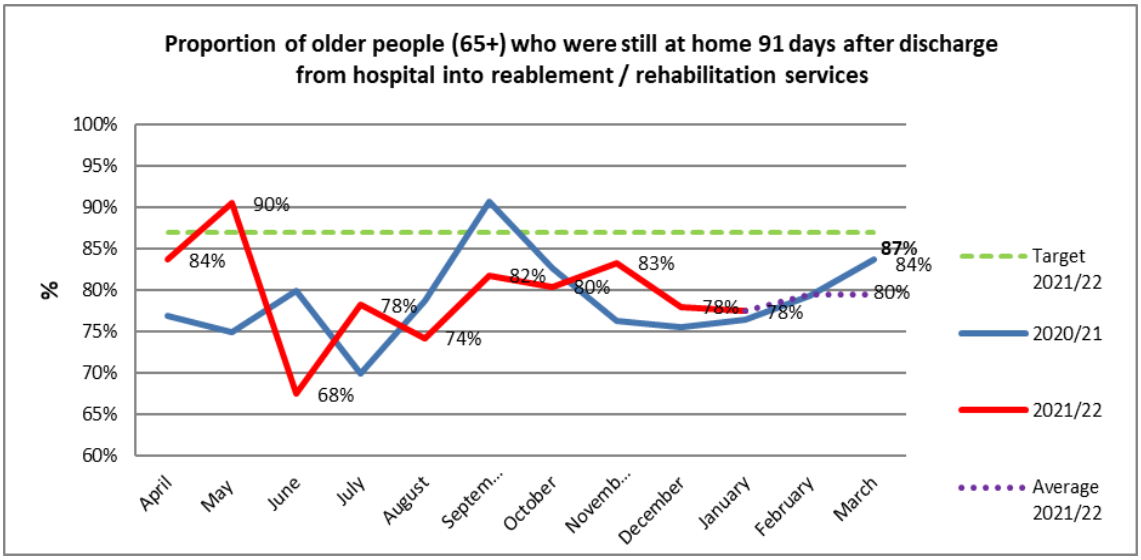
BCF planning requirements. Our performance in 2020/21 was skewed, due to the pandemic, with 535 admissions per 100k. It should also be noted that whilst the Hospital Discharge Service funding was available, throughout 2021/22, the Council would have placed more people, who would otherwise have been self-funders and would not have required the support of the Council. There has been reduced capacity in the home care market which has also impacted on achieving this target, particularly for complex cases requiring 1 to 1 care.

Cumulative number of permanent admissions to residential and nursing care homes per 100,000 population - Older People	
Target performance per annum (no more than)	439
Actual annual performance as at end of quarter 4	507



4.5 **91 Day Rehabilitation:** The effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation). Performance against this target continues to be challenging, at 9% below the target of 87%. NHS England require inclusion of the number of people who had been referred into reablement but had passed away within that 91 day period. Sadly 4 of the 32 people, who did not remain at home, had passed away. Performance rates without those service users being included would have been 86%, just 1% away from the target. We continue to work with system partners to ensure those people who are at end of life are referred into appropriate end of life care pathways.

Proportion of all older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	
Target performance (not less than)	87%
Total number of people discharged from hospital into reablement services in December 2021 – reported in March 2022 (91 days)	41
Of those at home 91 days later (in March 2022)	32
Actual performance (%) for the month	78%
Actual performance (%) for the month- Excluding those that had died	86%



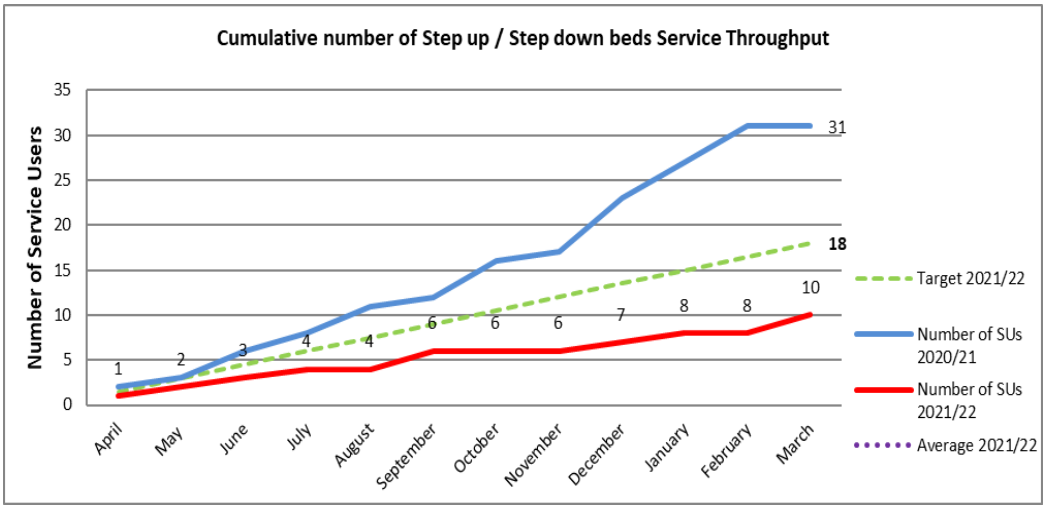
(based on people discharged in December 2021, who were still at home in March 2022 - the December cohort)

4.6 Local Schemes funded through BCF

4.6.1 Discharge to Assess (D2A) Step-down/step-up beds at Charles Clore Court

There are four independent living D2A flats, within a wider complex of extra care flats. These D2A flats have carer support for people who are not able to return directly home after a period in hospital (Step down), or for people who require some additional support to avoid a hospital admission (Step up). The minimum number of people placed in the commissioned Discharge to Assess beds at Charles Clore Court has not been met. We expect a minimum of 18 people to have used the service within the year but due to longer lengths of stay for some complex cases, we have only had 10 people using the service. We have now moved on long stayers to appropriate long-term care and currently have 3 flats in use and one available. The overall Length of stay has reduced significantly from 15.3 weeks to 6.3 weeks, and we expect this trend to continue to reduce as we have introduced a more therapy led service, following the positive learning from the Huntley Place model that was implemented during the winter pressures period.

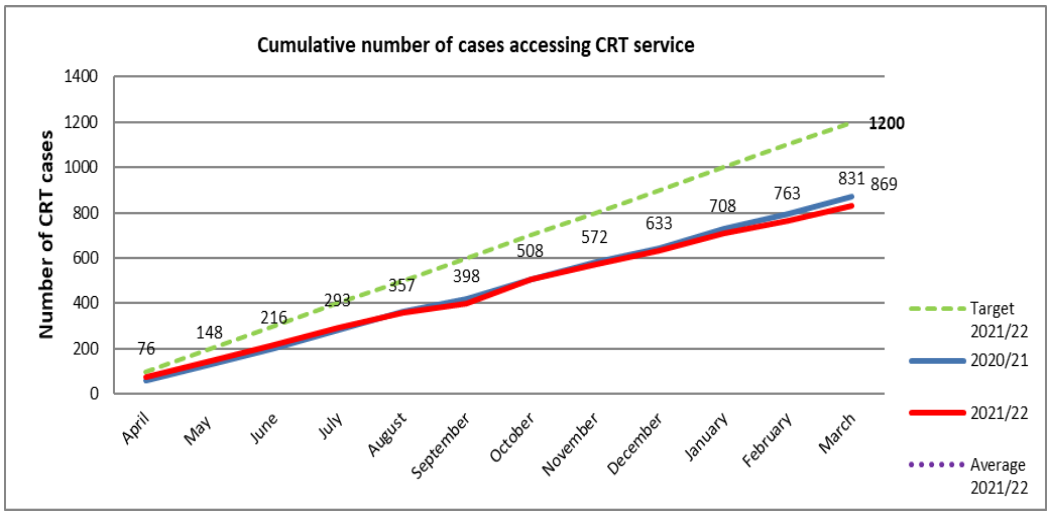
Cumulative number of Step up / Step down beds Throughput	
Target performance per year (not less than)	18
Actual performance this month	0
Cumulative number of cases FY to date	**10**
Status change since last month	↓



4.6.2 Impact of Community Reablement Service

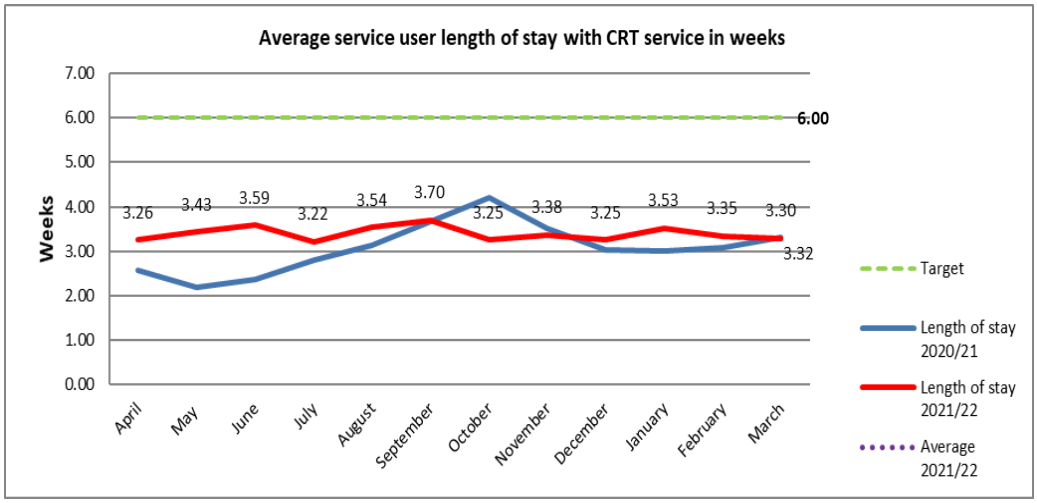
Numbers accessing the service: The number of people accessing support through the Community Reablement Team (CRT) service is currently significantly below the expected level of not less than 1,200 per year, with an intake of 831. The majority of referrals are made following discharge from hospital but not all of these people have reablement potential. People entering the service are sometimes not well enough to start reablement, which can impact on numbers, or in some cases (63) refuse reablement although capacity was allocated for the referral. Vacancies, and staff absence are all impacting on capacity and we have had some delays in moving people on from reablement to other providers due to capacity in the care market. Of the total packages of care started, 19% have been complex, e.g. double handed care (requiring a minimum of 2 carers), compared to 15% in the previous year, which requires additional hours of capacity. The review of the CRT service is ongoing and this will include assessment of the target and whether it should be adjusted to show the capacity and demand in hours, which we believe would give a clearer picture of how effectively the service is utilised.

Cumulative number of cases accessing CRT service	
Target performance per year (not less than)	1200
Actual performance this month	68
Cumulative number of cases FY to date	**831**



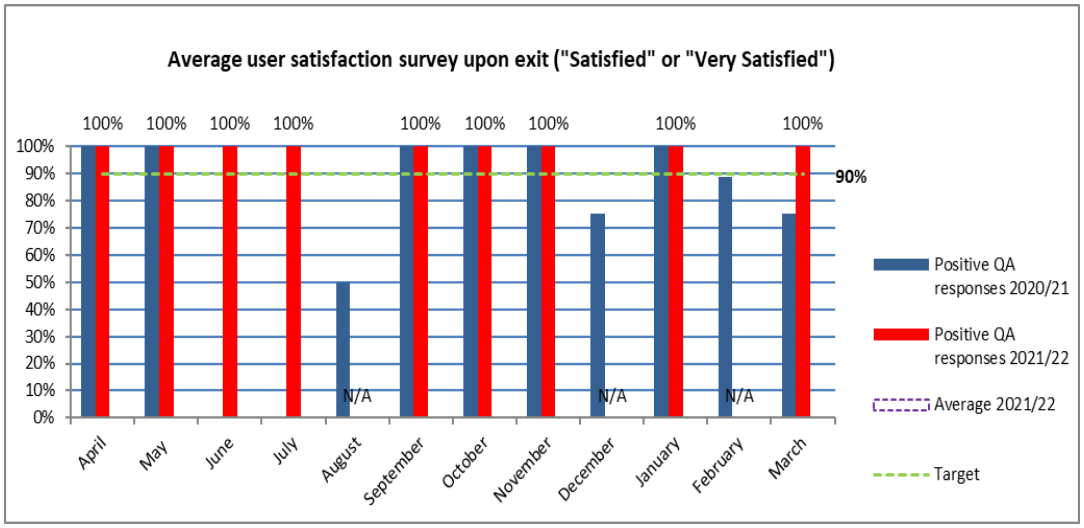
Average length of stay: The average length of stay with the reablement service continues to be well below the 6 week maximum target, at 3.3 weeks, as at 28th February 2022. This indicates that people receiving reablement services are being effectively supported and enabled to quickly regain their independence.

Average service user length of stay with CRT service in weeks	
Target performance per month (no more than)	6.0
Actual performance this month	**3.3**



Level of satisfaction: The satisfaction levels of service users with the reablement service has remained strong in Quarter 4, with service users invited to complete a feedback form at the point of leaving the service giving an overall satisfaction rate of 100%, against a target of 90%.

Average user satisfaction survey upon exit ("Satisfied" or "Very Satisfied")	
Target performance (not less than)	90%
Actual performance for the quarter (based on surveys submitted)	100%

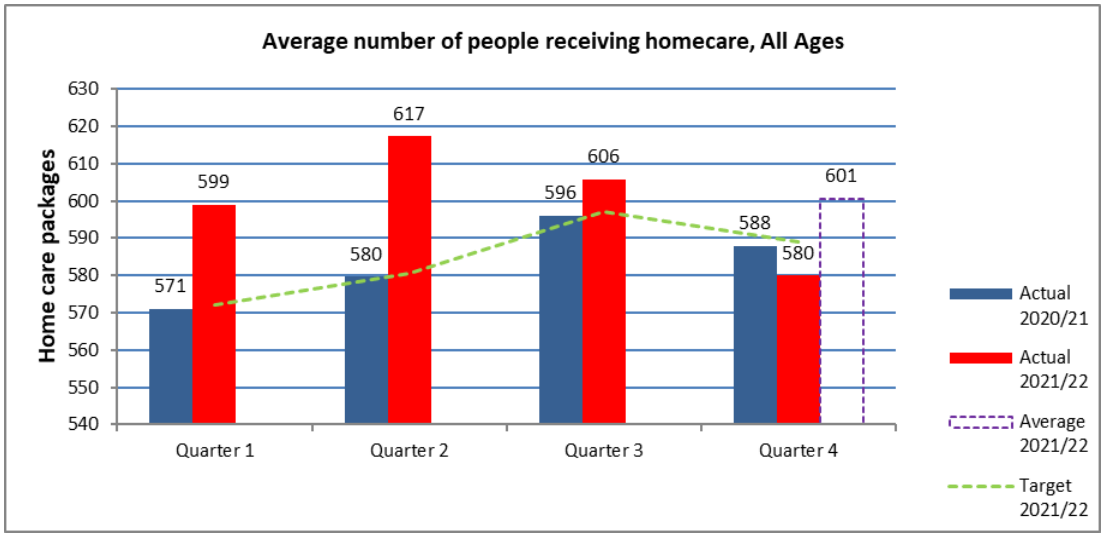


4.7 Additional BCF Funding for accelerated Integration (iBCF)

The target reflects the impact of the iBCF funding's investment in reablement services, to support people's independence at home. Whilst we have not achieved the quarterly target

of 589 for Quarter 4 (Jan to Mar), the overall annual performance shows a positive position, at 601, exceeding the minimum target of 585 care packages.

Marginal increase in home care packages	
Target performance quarter 4 (not less than)	589
Actual performance in quarter 4	580
Average Annual Target performance	585
Average Annual performance (based on performance FY to date)	**601**



4.8 Reading Integration Board (RIB) – Programme Update

The Reading Integration Board Programme Plan was developed in collaboration with system partners from Health, Social Care and Voluntary Care Sectors. The programme encompasses three key priorities:

4.8.1 Multi-Disciplinary Teams (MDT)

An MDT is a meeting that is held within the Primary Care Networks (PCNs) -a group of GP surgeries comprise a PCN. There are several members of the health and care services in attendance at a Multi-Disciplinary Team meeting that can review cases from all aspects of the care required to support that person to stay well.

Meetings were held with Primary Care Network (PCN) representatives to agree the clusters and themes for the MDT meetings that were scheduled from January 2022. There are three MDT Clusters established and there will be a theme for each meeting that will address high areas of need based on population health management data through the shared care records system, Connected Care. Cases are submitted for MDT review where there is a high risk of poor health outcomes.

Cluster	PCN
1	Tilehurst
	Reading West
2	Caversham
	Whitley
3	Reading Central
	University

- 2 Cluster meetings were held in January and all 3 MDT Clusters meetings were held in February and March.
- Since the project began in January 70 patients have been brought to MDTs

- In February 24 new cases were identified using Connected Care data
- Two examples of cases discussed are shown below

Patient A *- Referred by Occupational Therapist from Intermediate Care service, regarding falls, self-neglect and pressure sores which are being treated by a District Nurse. GP has referred to social prescriber for extra support and befriending. Patient has agreed to increase their care package and get a pressure cushion in place. Befriending are visiting weekly and social care are to do another assessment to increase the care. Review to take place to make sure care package is in place and all needs have been meet.*

Patient B *- A patient with BMI>60, uncontrolled diabetic, self-neglect and a hoarder. Sleeps on a mattress on floor. Fall risk as place cluttered. Social Prescriber heavily involved also older people's mental health, and social care (Housing). New property found for patient, and visited with support worker, but refused to move in so now adaptations being made to current property. Fire Service arranged to make an assessment and update SCAS and Police. CMHT to take patient back to Complex Needs Panel to support anxiety.*

Regular outcome reports are submitted monthly to the Reading Locality Manager, with updates to the Reading Integration Board (RIB).

4.8.2 <u>Discharge to Assess future model for Reading</u>

A Discharge to Assess service team comprises Social Workers, Occupational Therapists and reablement services, which focus on a timely discharge of people from hospital, ensuring they have the right level of support and avoid readmission. The aims of our service are also to enable outreach into the community to avoid hospital admission, putting in care and equipment to keep people well, at home, with short term respite care if needed.

The short-term service that was implemented at Huntley Place during the Winter pressure period from January to April 2022, provided 10 Extra Care Flats which were supported by a dedicated team, providing a 'strengths-based' approach. Occupation levels were positive as well as turnaround times (see fig.1), with the average length of stay being 9 days *(*excl. complex cases with environmental issues to be resolved before returning home. The average length of stay for all service users was 13 days)*. There were 439 bed days saved, and members, from the different service providers engaged in the project, all agreed that it felt like a "one team approach". One member stated that "freeing up hospital beds has a massive impact and could in fact contribute to saving lives" as a result releasing those hospital beds as quickly as possible. The resulting cost avoidance, in respect of hospital bed day costs, of implementing this service was £55,470.36.

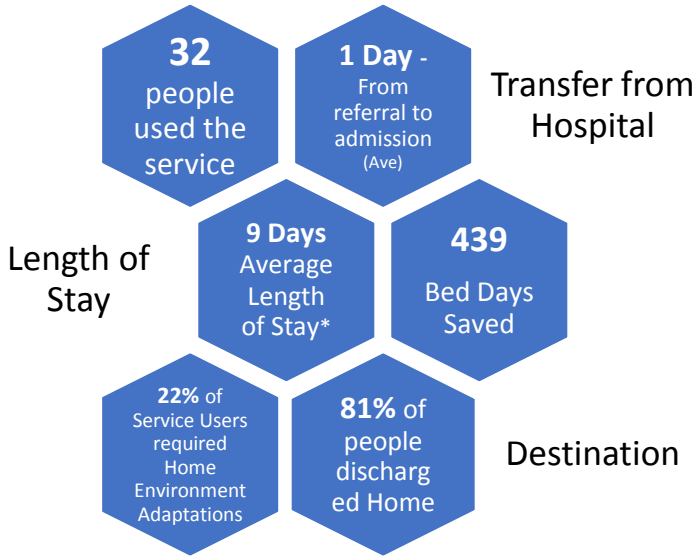


Fig.1

Key learning from the project was that our current discharge to assess flats need to have a therapy led "strengths based" support service to improve the flow.

We continue to maintain links with the voluntary care sector to provide settling in services from hospital which enable people, who live alone, to return home safely and have any immediate needs met such as some basic shopping and checking that utilities are functioning, with referral onto other services where appropriate.

Detailed process maps and Standard Operating Procedures have been agreed by the project team and letters written to system partners to advise the impact of the loss of the national Hospital Discharge Scheme funding by the end of April 2022. The project team are undertaking a demand and capacity review to identify any potential significant gaps in service delivery.

4.8.3 Nepalese Diabetes project

The South East Asian population is well known to have a higher prevalence of diabetes. This was a major cause of hospital admission as well as requirement of medical services across primary and secondary care due to the systemic effects and potential complications of diabetes. The subsequent effects on Social Care provision was also a challenge. Interventions through this project gave the community better insight into personal management of their condition resulting in better health outcomes. The project focused on the Nepalese community and started in July 2021. There have been three group consultations with Nepalese patients - two virtual and one face to face, supporting 24 people overall, as this was targeted exercise for a specific group. The programme has now been extended to two further GP practices, in line with the aims of the initial trial, following confirmation of further funding from the Oxford Academic Health Science Network (AHSN).

Connected Care, the shared care records system, is being used to identify appropriate cohorts of patients to be referred into the programme. Feedback from the patients who have participated in the project so far has been positive, indicating improved awareness and knowledge of managing their diabetes effectively.

Feedback from patients who took part in the group consultations:

- *"I feel more confident in managing my diabetes as I was able to understand and ask questions in my own language"*
- *"I now understand that sugar is only part of the problem and that I also need to cut back on my rice intake as this also affects my diabetes. It is also about quantity of food on my plate"*
- *"As a result of this meeting, I have made new friends with similar problems and we will meet up to discuss our issues and form a walking group."*
- *"I am happy to have these group consultations in the future as we can learn from others as well"*

Outcomes:

The main measure was to reduce Hba1c scores in this cohort over the course of the intervention and to enable them to better manage their condition. HbA1c is your average blood glucose (sugar) levels for the last two to three months. If you have diabetes, an ideal HbA1c level is 48mmol/mol (6.5%) or below. If you're at risk of developing type 2 diabetes, your target HbA1c level should be below 42mmol/mol (6%).

Group 1: Hba1c % decrease - Average 11%

Group 2: Hba1c % decrease - Average - 8.5%
Group 3: Hba1c % decrease - Average – 16.7%

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The purpose of this section is to ensure that proposals contained in reports are in line with the overall direction of the Berkshire West Health and Wellbeing Strategy by contributing to at least one of the Strategy's five priorities, listed below.

1. Reduce the differences in health between different groups of people
2. Support individuals at high risk of bad health outcomes to live healthy lives
3. Help children and families in early years
4. Promote good mental health and wellbeing for all children and young people
5. Promote good mental health and wellbeing for all adults

The Reading Integration Board (RIB) are leading on delivery against priorities 1 and 2 for Reading and draft action plans have been developed in collaboration with the members of RIB, which involves representation from system partners, including Acute hospital, Community care providers, Primary Care and Voluntary Care Sector. RIB will be supported by a number of groups, such as the Long-Term Conditions Board and Voluntary Care Sector groups, in order to achieve the expected outcomes of the delivery plans and will focus on up to 3 actions in the short-term, against this 10 year delivery plan.

5.2 While the Better Care Fund (BCF) does not in itself and in its entirety directly relate to the Health & Wellbeing Board's strategic aims, Operating Guidance for the BCF published by NHS England states that: *The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners* […] *HWBs also have their own statutory duty to help commissioners provide integrated care that must be complied with*.

The Reading Integration Board (RIB) Programme Plan objectives are mapped to both the Health and Wellbeing Board strategic priorities, as listed in 5.1 above, and the Berkshire West Integrated Care Partnership (ICP) priorities, listed below, to ensure alignment and effective reporting:

Berkshire West Integrated Care Partnership (ICP) Strategic Objectives

- Promote and improve health and wellbeing for Berkshire West residents
- Create a financially sustainable health and social care system
- Create partnerships and integrate services that deliver high quality and accessible Health and Social Care
- Create a sustainable workforce that supports new ways of working

Planning for 2022/23 has commenced and system partners have submitted their respective priorities, which have been collated. Discussions are ongoing to agree the top 4 priorities for the Programme Plan for 2022/23.

6. ENVIRONMENTAL AND CLIMATE IMPLICATIONS

6.1 The Council declared a Climate Emergency at its meeting on 26 February 2019 (Minute 48 refers).

6.2 Not applicable as this report summarises the performance of the Better Care Fund and Integration Programme. No new services are being proposed or implemented that would

impact on the climate or environment, however climate implications are being considered in relation to the Health and Wellbeing Board Strategic Priority Action Plans.

7. COMMUNITY & STAKEHOLDER ENGAGEMENT

7.1 Section 138 of the Local Government and Public Involvement in Health Act 2007 places a duty on local authorities to involve local representatives when carrying out "any of its functions" by providing information, consulting or "involving in another way".

7.2 Engagement in relation to specific services takes place as referenced in the Reablement service above. Stakeholder engagement continues to be a key factor to effective integrated models of care, and engagement with all system partners is important to the Reading Integration Board.

8. EQUALITY IMPACT ASSESSMENT

8.1 Not applicable as there are no new proposals or services recommended or requested.

9. LEGAL IMPLICATIONS

9.1 A Section 75 document was agreed between Reading Borough Council and Berkshire West Clinical Commissioning Group, for the management of the Better Care Fund pooled and non-pooled funds.

10. FINANCIAL IMPLICATIONS

10.1 The Better Care Fund (BCF) plan for 2021/22 was approved by NHS England on 11th January 2022. This was late due to the delayed release of the BCF policy and guidance. The Year End report against the Better Care Fund (BCF) plan for 2021/22 is being completed, which will include the detail of expenditure against the plan and inform planning for 2022/23. The BCF underpins vital services and plays an important part in supporting integrated health and social care services to Reading residents.

11. BACKGROUND PAPERS

11.1 The BCF performance data included in this report is drawn from the *Reading Integration Board Dashboard -April 2022(Reporting up to 31st March 2022)*

11.2 Reading Integration Board (RIB) Programme Plan (Mar) 2021-22 (Q4)