# Reading BCF narrative plan-2022-23

**Health and Wellbeing Board(s)**

Reading Health and Wellbeing Board

**Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)**

- Reading Borough Council (RBC) including the following services:
  - Adult Social Care Services
  - Public Health and Wellbeing Team
  - Adult Social Care Commissioning & Transformation Services
  - Housing Services
- Reading Integration Board (RIB)
- Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB
- Berkshire West Integrated Care Partnership (ICP)
- Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Service (BOB ICS)
- South-East Commissioning Support Unit (CSU) and RBC Data & Performance Teams
- Royal Berkshire NHS Foundation Trust (RBFT)
- Reading Primary Care Network representatives
- Berkshire Mental Health Foundation Trust (BHFT) and Berkshire West Community Nursing
- Reading Voluntary Action (RVA), Alliance for Cohesion and Racial Equality (ACRE) and other Voluntary Care Sector partners
- Ageing Well Programme representatives
- Healthwatch Reading and neighbouring Local Authorities in West Berkshire and Wokingham (covering the Berkshire West “Place”)
- Urgent & Emergency Care Board
- Rapid Community Discharge (RCD) delivery group

**Engagement and involvement of Stakeholders:**

Consultation through the Reading Integration Board (RIB), programme delivery groups and voluntary care sector forums, as well as close liaison with neighbouring Local Authorities through weekly review and progress meetings at a Place based level, Berkshire West.

Our system partners are regularly engaged through our monthly Integration Board and were jointly responsible for developing the Reading Integration Board (RIB) Programme Plan for 2022/23, identifying a range of projects, including health inequalities focussed schemes. The Integration Board is also responsible for delivery of the Joint Health and Wellbeing Strategy Action Plans for Priorities 1: Reduce the differences in health between different groups of people, and 2: Support individuals at high risk of bad health outcomes to live healthy lives.

To ensure alignment with Integrated Care Partnerships (ICP) and Integrated Care Services (ICS)/Integration Care Boards (ICB) – which cover Buckinghamshire, Oxfordshire and Berkshire West (BOB) areas, representatives from the Integration Board also attend key meetings at ICP and ICS level, and share local priorities with other ‘place based’ integration boards.

## Executive summary

The Reading Health and Wellbeing Board, Better Care Fund (BCF) Plan for 2022-23 shows a continuation of the schemes that were funded in 2021-22. This is primarily due to the delayed release of the BCF Planning Guidance for 2022-23. In collaboration and agreement with the Integrated Care Board (ICB), we have created a Project Fund to support the Reading Integration Board (RIB) priority projects in this financial year, that were agreed with system partners representing health (Acute and Community), social care and voluntary sector services across Reading.

### Priorities for 2022-23 – Reading Integration Board (RIB)

**1. Tackling Health Inequalities**

*To identify and deliver projects that result in improved outcomes for the most disadvantaged communities in Reading. The new projects are supporting and promoting health checks and developing a Self-Neglect pathway, and we are continuing with our Multi-Disciplinary Team programme within the Primary Care Networks, which has seen significant successes, such as reducing Acute attendances by 82%. We are continuing delivery against the Joint Health and Wellbeing Board Strategic Priorities for reducing the differences in health and supporting people at high risk of bad health outcomes.*

**2. Creative Solutions to meet emerging need**

*To identify and deliver integrated projects to, more effectively, meet the emerging needs of Reading. This will include continued further development of our Discharge to Assess service, building on learning from the temporary service, implemented in the winter period of 2021/22, moving to a therapy led model, and our review of reablement services also continues with a view to meet the demand in the most effective and efficient way.*

**3. Service User Engagement and Feedback**

*To ensure the voice of Reading residents drives the continuous improvement of integrated ways of working. We will engage with our service user groups and forums as well as our system partners, learning from what methods are working well, identifying what engagement and feedback methods we already have across the system and to draw together a multi-disciplinary Service User Strategic Framework for engagement and feedback.*

**4. Care Navigation and Education**

*To facilitate improved access to information and services for Reading residents that ensures the right support is accessible and resources are used effectively. This will include a focus on digital inclusion, enabling disadvantaged people within our communities to learn how to use digital devises and gain access to them within community settings, with appropriate support and training to enable people to access services to support their health and wellbeing needs.*

The existing support available to the people of Reading, through our Disabled Facilities Grants, Social Prescribing, Adult Social Care services, Voluntary Care Sector, Primary Care Networks and acute and community health care providers offers a solid foundation to continue building a safer and more inclusive support network. Some of the great work being undertaken by our services across Reading is outlined in this supporting narrative for our BCF Plan, such as the increased use of Technology Enabled Care (TEC) to enable people to stay safe and well at home and prevent crisis, by providing the right care, in the right place, at the right time. We are engaged in supporting the wider health and social care initiatives that are aligned with the Berkshire West Integrated Care Partnership (ICP) and Integrated Care Board (ICB) across Buckinghamshire, Oxfordshire and Berkshire West (BOB) and continue to develop joint commissioning opportunities where this offers the best value and improved care for our residents.

## Governance

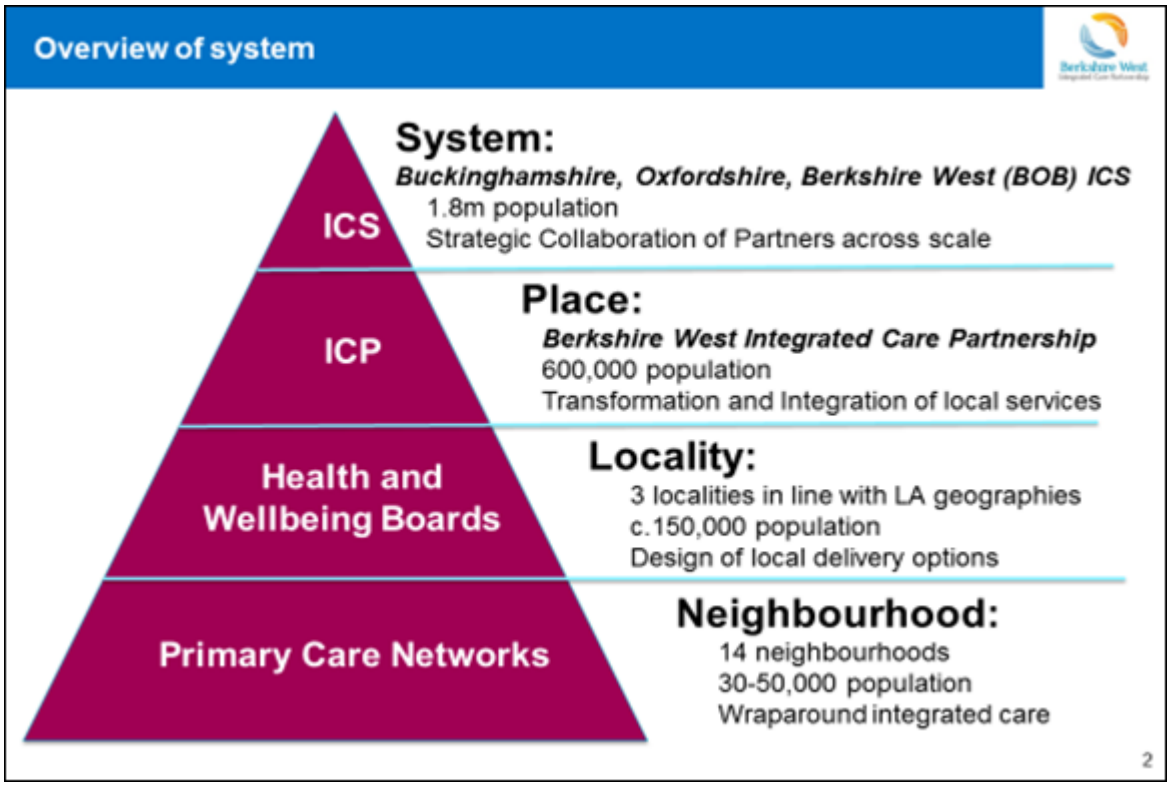
The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Service (BOB ICS) takes strategic decisions at scale for the benefit of its 1.8 million population, and the newly formed Integrated Care Board (ICB) at BOB level is responsible for commissioning system wide services.

The Berkshire West Integrated Care Partnership (ICP) brings together the CCG, NHS foundation trusts, ambulance service and Local Authorities which serve the 600,000 residents of Reading, West Berkshire and Wokingham. The partnership works on a '**Place'** basis to transform and integrate local services, so patients receive the best possible care.

While the ICS, ICB and ICP are committed to strong joint working at place level, they recognise that there remains a need to design local delivery options to meet the local strategic objectives.

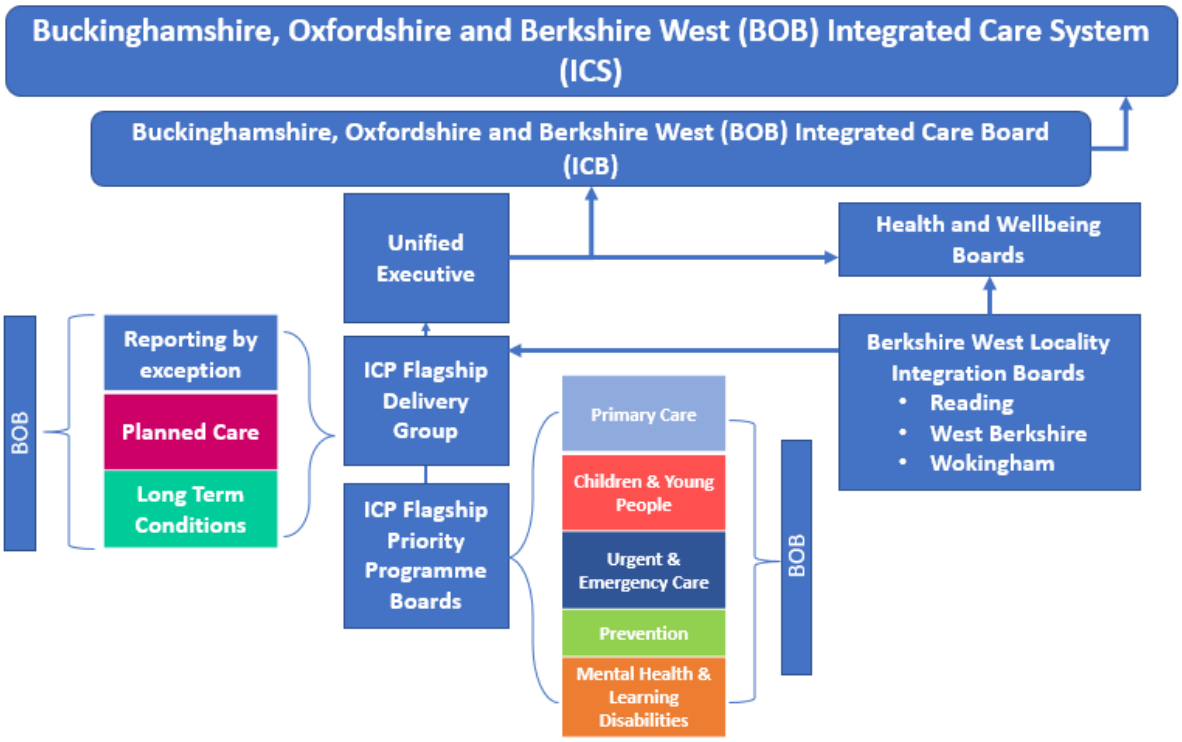
The Reading **Locality** Integration Board (RIB) fulfils this function for the circa 161,000 residents of Reading *(Population data source: ONS 2020 mid-year estimates – which were used by NHSE in developing the BCF Plan Template).*

Primary Care Networks (PCNs) are clusters of GP practices who serve **neighbourhoods** of up to 50,000 patients. We have 7 PCNs in Reading: Tilehurst, Whitley, Reading Central, University, Caversham, Reading West and New Reading. Community services will wrap around these networks to deliver care closer to patients and representatives of the PCNs sit on the Reading Integration Board.




The Reading Integration Board (RIB) is an operational delivery group that reports to the Reading Health and Wellbeing Board. Its main responsibility is overseeing the Better Care Fund Plan and implementing a programme of work to develop integrated Health and Social Care Services for Reading at a locality and neighbourhood level. The Reading Integration Board also provides regular updates to the Integrated Care Partnership Delivery Group and the Integrated Care Board.

The graphic below shows the reporting lines of the Local Integration Boards into the Health and Wellbeing Boards and the Integrated Care Partnership Delivery Group up to Integrated Care Boards.




**Updated graphic agreed with ICS / ICB / Local Authority leads (Aug 2022)**

## Overall BCF plan and approach to integration

To determine the Joint Priorities for Reading for 22/23 a reflection and associated learning was undertaken from the previous year to ensure continuous improvement. The priorities outlined below were reached in agreement with system partners represented at the Integration Board.

To ensure input from a range of partners we have opened up the membership of the Integration Board to include representatives from Housing and the wider voluntary care sector with particular focus on ethnically diverse and disadvantaged community groups, to ensure we also have a focus on priority groups and those most at risk of poor social and health outcomes. The representatives from our system partners at Reading Integration Board have opportunities to contribute to the Programme Plan and update on progress, as well as comment on activities and engage in supporting integrated working, e.g. the Multi-Disciplinary Team project to prevent crisis / admission.

Other than the support of projects through the Better Care Fund, in relation to the Reading Integration Board (RIB) priorities, we have been unable to make any significant changes to the BCF funded schemes within Reading and contributions to the Berkshire West commissioned schemes. This is because the BCF planning guidance was released late, and we have therefore maintained the schemes being provided in 2021/22 in 2022/23,

The providers that are funded through our BCF Plan, providing commissioned services, are aware of our plan and we continue to work with them to capture key priorities across our area, engaging in local and Berkshire West wide projects. Provider forums, such as the Dementia Friendly Reading Group, Voluntary Care Sector and Carers are made aware of the BCF Plan and offered the opportunity for engagement with RIB Projects and Priorities.

Providers have been given an opportunity to bid for funding from the Reading Integration Board (RIB) BCF Project Fund, to deliver projects that support us to meet our priorities for 2022/23.

The Reading Integration Board (RIB) Priorities are outlines in the table below and are aligned with the wider priorities for:

- The Joint Health and Wellbeing Strategy (Berkshire West)
- The Integrated Care Board (ICB), Buckinghamshire, Oxfordshire, Berkshire West (BOB)
- The Integrated Care Partnership (ICP), Berkshire West System partner priorities that could be influenced or supported by the Integration Board

| RIB Priority | Key Projects (2022/23) |
|---|---|
| **1. Tackling Health Inequalities**<br>*To identify and deliver projects that result in improved outcomes for the most disadvantaged communities in Reading.*<br>***H&WB Priority 1:** Reduce the differences in health between different groups of people*<br><br>***H&WB Priority 2**: Support individuals at high risk of bad health outcomes to live healthy live* | 1.1 Multi-Disciplinary Teams (MDT) within Primary Care Network (PCN) Clusters **(Continuing)** |
| | 1.2 Develop Self-Neglect Pathway **(New)** |
| | 1.3 Support Programmes of preventative Health Checks for vulnerable groups **(New)** |
| **2. Creative Solutions to meet emerging need**<br>*To identify and deliver integrated projects to, more effectively, meet the emerging needs of Reading.* | 2.1 Discharge to Assess (D2A) / Admission Avoidance **(Continuing)** |
| | 2.2 Strengthening support for those with low level mental health needs **(New)** |
| **3. Service User Engagement and Feedback**<br>*To ensure the voice of Reading residents drives the continuous improvement of integrated ways of working.* | 3.1 Develop a Multi-Disciplinary Service User Engagement Strategic Framework and deliver a method of gaining system wide feedback from Service Users **(New)** |
| **4. Care Navigation and Education**<br>*To facilitate improved access to information and services for Reading residents that ensures the right support is accessible and resources are used effectively.* | 4.1 Improve access to and awareness of services available **(New)** |
| | 4.2 Co-ordinate the Making Every Contact Count (MECC) Programme in Reading **(New)** |
| | 4.3 Digital Inclusion – Ensuring people are enabled to use digital technologies **(New)** |

We remain committed to delivering against the national BCF metrics (outlined below), and the proposed targets for 2022/23. The 91 Day reablement target has been agreed at Berkshire West "Place" level for 2022/23. We have also allocated funding for increased staffing for Discharge to Assess stepdown, and local projects to support delivery against the Better Care Objectives and our Integration Priorities for 2022/23. Of the £400k project fund we will use:

- £80k on 2 OT's (Discharge to Assess posts to ensure a continued Therapy Led service)
- £200k per annum to fund the front door VCS project
- £120k to support project bids from voluntary care sector, community and council providers. The project bid fund will be topped up to £150k using part of the underspend from 2021/22.

| Reportable performance | Key Metrics | Performance 2021/22 | Proposed Target 2022/23 |
|---|---|---|---|
| **BCF Monitoring** | Admission Avoidance (per 100,000 pop) | 775.4* | 810 |
| | Discharge to Normal Place of Residence | 92% | 92% |
| | Reduce number of long-term admissions to Residential / Nursing Homes (65+), (per 100,000 pop) | 507 | 469 |
| | Effective Reablement Service *(Increase the number of people still at home 91 days after being discharged from hospital into reablement services)* | 80% | 85%** |

*NHS England method of measuring changed from using "crude rate" to "Indirectly Standardised Rate (ISR) of admissions (per 100,000 population), which adjusted the previously reported totals for 2021/22.
** Berkshire West wide target agreed at Place level with Acute Hospital provider and Integrated Care Board.

The BCF plan metrics have been developed in consultation with system partners, including key representatives from our acute hospital trust and Urgent & Emergency Care Board. Targets were set based on a combination of forecast data and agreed Berkshire West performance metrics. The Admission Avoidance target has increased because of a variety of factors, and an actual increase in our Q1 admissions compared to Q1 in 2021/22 of 21%. It is of note that 30% of the admissions in Q1 were for the 65+ age group and due to COPD. Historically admissions in Q3 and Q4 have been higher than the admission rates in the first two quarters of the year, and we have therefore not applied any reduction percentage to the remaining three quarters in our plan and have maintained these at the same level as 2021/22, which will be a stretch given the potential impact of the cost of living crisis, energy price increases and the winter flu (Public Health England predicting death rates 3 to 5 times higher than in previous years related to Flu). These targets have been shared in a series of meetings with colleagues from across the West of Berkshire (including the Royal Berkshire Hospital and the Integrated Care Board (ICB).

We are supporting the Health and Wellbeing Board, the Integrated Care Partnership and the BOB Integrated Care Board to deliver priorities for a number of local and national initiatives through the ICP flagship priority programmes:

- Heart Failure Integrated Service **(Continuing)**
  Integrated Service model for Heart Failure wrapped around the need of the patient and carers. This will embrace proactive, anticipatory approaches for:
  - Earlier detection, diagnosis and improved management (including optimisation of treatments)
  - Proactive personalised care, recognising that patients live with co-morbidities
  - Use of digital/technology as enablers including supporting self-management, education

- MDT working focused on 'low level' Mental Health and reducing Health Inequalities **(New)**
  - Improved outcomes for patients/ service users
  - Reduced admission and readmissions

- Reducing health inequalities measure

**NB:** Case finding for people with low level mental health issues can be incorporated into our existing structure of MDT meetings across the Reading Primary Care Networks, as there is a mental health professional assigned to each MDT.

- The Additional Roles Reimbursement Scheme (ARRS) Workforce **(Continuing)**
  ARRS funding is made available to PCNs to diversify the primary care workforce by employing clinical pharmacists, paramedics, physician's associates, first contact physiotherapists, social prescribers and others

- Children & Young People (CYP) Mental Health and Emotional Wellbeing Transformation **(Continuing)**
  - CYP mental health is efficiently and effectively met by agreeing options for aligning commissioning strategies to facilitate easier access and improve the experience of CYP, families and professionals who have identified a need for help and support.
  - Reduce stigma and promote CYP mental health is everybody's business and skilling up the wider CYP workforce
  - Improved waiting times for both core CAMHs and early intervention services as well as even better support whilst CYP are waiting for their intervention to start.

## Joint/Collaborative Commissioning

**System Level:**

The Integrated Care Board (ICB) for Buckinghamshire, Oxfordshire and Berkshire West, alongside the Local Authority jointly commission services, some locally for Reading and others across the Berkshire West footprint, which neighbouring Local Authorities also contribute to (e.g. Intermediate Care Services). A Section 75 Framework Agreement is signed off each year that outlines how the pooled funds will be managed, both for local and jointly commissioned services. Please see examples of the cross Berkshire West commissioned services, to which contributions are made through Reading's Better Care Fund:

| | |
|---|---|
| BHFT Reablement Contract | Reablement & Rehabilitation Services. |
| SCAS Falls Service & Frailty | Partnership with SCAS to reduce NEAs due to falls. |
| Carers Funding CCG | Support for Young People with Dementia (YPWD), Alzheimers Dementia Advisor & Stroke Association. |
| Connected Care | Data Integration between Health & Social Care |
| Care Homes / RRaT | Intermediate Care Services |
| Out Of Hospital Speech & Language Therapy | Eating & drinking referral service. |
| Out of Hospital Care Home in-reach | HICM for Managing Transfer of Care |
| Out Of Hospital - Community Geriatrician | Provide Community Geriatrician Service - urgent referrals seen within 2 days. |

| | |
|---|---|
| Out Of Hospital - Intermediate Care (including integrated discharge, discharge to assess service) | Rapid response services delivered for patients discharged from A&E or AMU, preventing a hospital admission. |
| Out Of Hospital Health Hub | Acute Single Point of Access to Community Health Services. |
| Out Of Hospital - Intermediate Care night sitting, rapid response, reablement and falls | Rapid response services delivered to patients in their own homes, avoiding hospital admission within 2hours. |
| Street Triage | To reduce the number of S136's applied by Thames Valley Police (TVP) across Berkshire West. |

At Integrated Care Service level across Buckinghamshire, Oxfordshire and Berkshire West (BOB), a gap analysis was carried out in June 2022, of the new national Hospital Discharge Policy, to help shape the direction of travel and joint working between Health and Social Care. A key priority identified was to support the avoidance of admissions and increase bed capacity through, Anticipatory Care, Virtual Wards and Virtual Care, and we are working with system partners at a Berkshire West "Place" level to improve capacity. We have recently been advised that the funding has been awarded through the "Discharge Front Runner" programme to the BOB Integrated Care System (ICS) and we are in the planning stage of implementing the required services to support winter pressures and enable timely hospital discharge, as well as admission avoidance, which will support the Better Care Fund metrics for 2022/23.

**Place Level:**
Reading Borough Council (RBC) have commissioned services, including services that support vulnerable people such as those who are homeless, or are unpaid carers. We have locally commissioned services with place based Local Authority partners to deliver carers breaks (respite) and information, advice and guidance to support carers on behalf of place partners.

Within Reading Borough Council (RBC), Adult Social Care (ASC) Advice and Wellbeing Hub and Housing are working together to narrow the gap with rough sleepers and create a joint approach to address health, wellbeing and housing needs. Our Housing Service is a member of the Reading Homelessness Partnership (HoP). This is a partnership of charities and statutory organisations working together to end rough sleeping and homelessness in Reading. The Reading HoP is facilitated by the charity Street Support Network and meet every two months to plan and action projects and strategies for preventing and relieving homelessness in the borough. This includes developing a delivery plan and providing governance for Reading's Rough Sleeping Strategy 2019 – 2024. A proportion of our Better Care Fund continues to support the Street Triage services.

Working with the Rough Sleeping Interventions Team we have a jointly funded post for an experienced social worker to support our residents who have experience of rough sleeping, rough sleeping lifestyles and homelessness, and will enable us to support the government's Rough Sleeping Strategy to end rough sleeping by 2027.

There are a range of commissioned services across Reading to support rough sleepers, and here is a list of the "Rough Sleeping Interventions" funded projects:

- A Rough Sleeping Interventions Co-ordinator within RBC to facilitate all rough sleeping interventions
- Additional outreach capacity within the St Mungo's Team to respond to increased numbers and enable more flexible and assertive work patterns
- A Housing Led model managed by St Mungo's to quickly accommodate up to 15 people verified rough sleeping, within paid nightly accommodation, for up to six months providing intensive support whilst suitable housing options are explored and facilitated
- Extension of Reading's winter shelter in partnership with Faith Christian Group; a winter month only night shelter (Jan-Mar) that operated with RSI funding contributions in 2018 and 2019 prior to Covid restrictions and subsequent best practice guidance regarding communal night shelters
- An additional move-on worker role with Launchpad to work intensively with a small group of individuals who are finding their move-on options particularly limited or challenging
- An out of hours tenancy sustainment service provided by the Salvation Army for those with rough sleeping histories moving into independent living
- Funds to provide an off the streets offer into emergency, paid nightly accommodation

The Disabled Facilities Grants (DFG) team are also working closely with other Housing providers in our locality to ensure that they are involved in funding adaptations to their own housing stock.

## Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to enable people to stay well, safe and independent at home for longer and to provide the right care in the right place at the right time. Our plans to support these objectives are set out below:

### Objective 1: Enable people to stay well, safe and independent at home for longer

A Berkshire West interactive "Inequalities Report" has been developed, to enable population health analysis within the Reading locality and the wider Berkshire West place. There is more detail about this project within the Health Inequalities section of this narrative.

We are using a Population Health Management Approach to support the delivery of anticipatory care, through our Multi-Disciplinary Team meetings, identifying people who are at risk of poor health outcomes and who are frequent users of primary and secondary care services. The case finding process, using Connected Care (single care record system) for our Multi-Disciplinary Team meetings, at Primary Care Network (PCN) level using criteria agreed with the PCN Clinical Leads, is also highlighting where there is a greater need for people within areas of deprivation and has led to an initiative to set up "pop-up" health check clinics in one of those localities as a trial.

Our Multi-Disciplinary Teams project is continuing into 2022/23, and is delivered through the Primary Care Networks (PCNs) each month across 3 clusters of PCN's to make the best use of resources across the Reading, and wider Berkshire West region. They include input from GPs, District Nursing, Social Work, Therapy services, Voluntary Care Sector, Mental Health Services, Ambulance Services and other key partners (on a 'case by case' basis) in relation to the care of that person. A Care Plan is either reviewed, or put in place and a further review, where needed, is scheduled to ensure expected outcomes are being achieved. There were 78 people whose cases were reviewed by an MDT between April and June 2022.

Anticipatory Care is an NHS Long Term Plan commitment that aims to provide proactive and personalised health and care for individuals living with multiple long-term conditions (MLTC), delivered through multidisciplinary teams in local communities. The care model aims to optimise use of the health and care system for individuals with MLTC by intervening earlier, proactively and more holistically while the patient is at home. The model will initially target individuals with MLTC who are at greatest risk of using unplanned care, including people living with frailty, populations experiencing health inequalities, and people reliant on unplanned care for routine care needs. We are already following this model in Reading as our case finding is based on conditions that are most prevalent within each cluster of Primary Care Networks, where there is a greater risk or evident increased use of primary and secondary care services.

A review of the outcomes for the cohorts that had been discussed by an MDT within the previous 6 month period showed the following positive impacts (see Table 1) on both primary and secondary care services:

| Contacts | Month 3 | Month 6 | Estimated Cost saving |
|---|---|---|---|
| Mental Health referrals | 7% decrease | 25% increase | |
| Acute Admissions | 86% decrease | 82% decrease | £8.8K |
| A&E attendances | 64% decrease | 42% decrease | £5.6K |
| SCAS | 72% decrease | 55% decrease | £7.9K |
| 111 | 60% decrease | 50% decrease | |
| GP | 60% decrease | 25% decrease | £5.9K |

Table 1

**MDT Case Studies:**

***Patient A*** *Housebound patient is very frail and stays in bed most of the day. Lives with 2 sons and it is not clear how much care they provide. This has been raised as a safeguarding issue. The patient is on daily Insulin which is administered by a DN. Adult social care are now involved and have completed an assessment. An increased care package is now in place. The community Diabetes nurse is now involved in the patient's diabetes management.*

***Patient B*** *This patient has a Learning Disability with complex needs. The focus of the meeting was to discuss bringing other professionals together as to how his needs can be managed in the community. The learning and disability team are now involved along with an OT. Adult social care have been able to sort some respite out for his family who care for the patient.*

***Patient C*** *is struggling with depression and alcohol misuse and has reduced mobility. English is not their first language and it is not clear if she understands her treatment as she has little translation support. The patient has financial issues and is not able to afford to buy food. She has been referred to the MHT which have made contact to assess her cognitive ability and decisions around care. A Social worker will support her with care, shopping, cleaning and filling out forms. Another MDT meeting has been set up due to her complexities for further support and to put a care plan In place.*

We have the following initiatives in place to support better outcomes and enable people to remain safe and well in their homes for longer:

- **Technology Enabled Care (TEC)**

We have a TEC Service which continues to have high usage, with 114 assessments between April and June 2022, and increasing the number of users from 184 in May 2021 to 455 in June 2022, which

provide cost savings and more flexible person-centred care for individuals. The number of GPS users has increased from 0 to 47 in March 2022. GPS being used to support positive risk taking with dementia and LD pathways.

- **Independent Living Pilots**

Having successfully completed a procurement exercise we are now awarding two contracts with Providers who have successfully demonstrated that they have strengths and experience to work with different cohorts of service users to help them live independently with the use of TEC. These two Providers will work with 2 service user groups each and will test with around 10 service users in the following categories:

  - Sheltered Housing (non-emergency cord pulls and check-in calls)
  - Young People In Transition
  - Discharge to Assess
  - Mental Health
  - Community Reablement (2 cohorts one with each supplier)

**What next:** Having completed engagement with Adult Social Care colleagues we will now be completing planning workshops, where we will need to identify service users to take part with the selected Providers. Identifying service users, obtaining consent and arranging installations of the sensors are our next steps.

- **Front Door Voluntary Care Services (VCS) project**

This project is in very early stages, working towards the VCS being our front door to ensure that people are connected to the VCS – taking an asset-based approach. Where appropriate people will then be passed to the social care teams for further assessment. Our early research of other systems has demonstrated that successful transformation of front door services must happen in collaboration with the community and the local support organisations and health. With the introduction of the Social Care Reform taking effect October 2023, we estimate a 30% increase in assessments (200) within the first year. A substantial proportion of the current referrals are requests for support that is available in the community, which the Hub signposts out, so there is a clear need to:

  - Bring in the Voluntary Community Sector at a much earlier point on the customer journey
  - Ensure outcomes are met in a timelier manner
  - Ensuring best use of care co-ordinator and social workers skills by removing the current high need for signposting
  - Ensuring best use of the skills and expertise available in the VCS by involving them more closely in triaging

- **Personal Assistant Market**

Personal Assistants (PA) Market: We are supporting development of a Personal Assistants market, to enable people to employ their own PAs. This allows people to have greater choice and control over their care needs and how they are met.

## Objective 2: Provide the right care in the right place at the right time

Funding was agreed in August, following a bid submitted for Expansion of the Transfer of Care hub and Discharge improvement, via the Integrated Care Board (Buckinghamshire, Oxfordshire and Berkshire West – BOB):

Developing the current discharge infrastructure to create a fully functioning discharge hub - expanding both the capacity and capability within the hub and widening the focus to include admission avoidance. The enhanced offer will enable triaging at the front door signposting patients onto the most appropriate pathway and support a reduction in LOS across all pathways (including P0). Services will operate extended hours and 7 days a week supporting an increase in weekend discharge rates. Scheme to include: streaming practitioner and social worker in ED to support admission avoidance (signposting into alternative pathways both NHS and social care), opening the Discharge Lounge 7 days a week supporting both week-end discharges and promoting earlier on the day discharges, support to SFs who have an above average length of wait particularly for P3, P0 safety net team supporting a reduction in re-admissions, enhanced Early Supported Discharge Team providing a bridging role for those needing support at home, additional Patient Flow Co-ordinators to support P0 which make up 60% of the bed days and Care Home liaison practitioner. Costings based on 14 Band 4, 10 Bands 6-8 and social workers at locum rates with extended hours and 7 day coverage. Expected bed occupancy across medical and elderly care wards 94% for this winter. Scheme aims to reduce this to 90% releasing 2,800 bed days over 6 months.

**D2A bedded facility to support Pathway 1 discharges: Discharge improvement**
Building on the successful pilot run by Reading Borough Council during covid and winter pressures period, commissioning a D2A bedded facility to move patients promptly out of hospital. A team approach with strong therapy leadership enabled over 80% of patients after a short stay to return home independently, commissioning 10-11 beds for a 6 month period for use by any Berkshire West patient.

We have created a new Physiotherapy post, funded through the Better Care Fund, to work alongside Community Reablement (CRT) and Discharge to Assess (D2A) service, to support with fast-track access to services for people being discharged from hospital and to prevent readmission / admission.

The remit of the role is to provide fast track physiotherapy input within the D2A and wider Adult Social Care (ASC) reablement services. To be responsible for the clinical diagnosis, assessment, and ongoing physiotherapeutic management of adults with varied physical rehabilitative needs in their own homes or D2A Step down/Step up flats at Charles Clore Court. Working with deterioration and deconditioning associated with ageing and dementia, hospital acquired functional decline, frailty, and other long-term conditions within Adult Social Care.

Outcomes to be achieved to support individuals who use services, and their carers', to maintain their health, wellbeing, and independence and reduce reliance on funded care. Types of interventions to include:

- Undertake home assessment and set up reablement goals and treatment plans to improve such areas as mobility, posture, trunk control, balance and transfers
- Contribute to Care Act assessments for future need
- Right size packages of care on discharge
- Work alongside OT/ ASC / CRT staff with complex manual handling, falls prevention
- Support with a positive risk-taking approach
- Work closely with D2A OTs on complex discharges home to prevent admission to care homes

- Work closely with D2A OTS on discharge pathways and reablement gaols setting for plus size individuals with care and support needs

**Technology to support people to remain at home**
We are working with the voluntary care sector to bring about digital inclusion and address social isolation and the TEC team are now able to refer Service Users to 'AbilityNet' for support with online shopping, e-mails and video calls with family and friends using their computer, laptop, tablet or smartphones.

Options are being explored for BCF funding for additional TEC to trial further innovative TEC solutions (e.g. 'AutonoMe' to aid with life skills and independence and 'YourMeds' to support medication adherence).

**Mental Health Reablement**

We are piloting a Mental Health Rehabilitation Service with a dedicated workforce of Enablers that have received reablement specific training to provide the most effective reablement for service users. Some examples of reablement activities are listed below, however this list is not exhaustive and the Enablement work will focus on the goals set by the service-user according to what is meaningful to them:

| Self-Care | Productivity | Leisure |
|---|---|---|
| Encouraging good **daily routine** to establish structure in their lives<br><br>**Personal care**<br>Planning and organising e.g:<br>• Dressing / undressing (upper/lower)<br>• Washing;<br>• Brushing teeth;<br>• Grooming (combing hair/shaving).<br><br>**Medication**<br>Encouraging medication compliance via:<br>• Prompting;<br>• Checking dosette boxes;<br>• Attending clinic for depot or clozapine;<br>• Use of TEC to prompt.<br><br>**Eating/Drinking** Supporting adequate and heathy dietary intake.<br><br>Dressing for the weather.<br>Access to clothing – support to access charities etc. | **Developing independent living skills**<br>e.g. Teaching task skills, role modelling, encouraging/motivating, supporting task performance by providing verbal assistance or doing together.<br><br>Tasks may include:<br>• Hoovering<br>• Cleaning<br>• Laundry<br>• Shopping - determining what items are required, essential items shopping lists, budgeting, access to local shop and shopping; online shopping<br>• Meal preparation – simple preparation and cooking heating<br>• Correspondence – dealing with letters and other correspondence appropriately | **Supporting contact** with friends and family.<br><br>**Referrals** to, and connecting with, community groups/organisations.<br><br>**Providing support to access** community activities.<br><br>**Developing confidence** with social skills and communication. |

| Routine | Environment | Motivation for Occupation |
|---|---|---|
| Sleep hygiene.<br><br>**Developing full and productive routine** Considering weekly | **Maintaining a safe and appropriate environment**<br>• Supporting people to liaise with housing | **Support to identify and pursue interests**<br>Interest checklists, trying new activities, finding out |

| | | |
|---|---|---|
| planners, identifying what needs to be done (domestic etc.), organising appointments.<br><br>**Balancing activities** e.g. Self-care, productivity, leisure.<br><br>**Supporting people to engage** with organisations to find employment /engage in productive occupations.<br><br>**Developing regular patterns** of activities (e.g. brushing teeth twice daily, washing (not everyone showers/baths every day), eating, cleaning etc). | providers for maintenance issues etc;<br>• Support with decluttering (if hoarding an issue);<br>• Minor adaptation and equipment practice;<br>• Safe use of the home. | what activities are available locally.<br><br>**Grading support** as people become more engaged in doing tasks. |

### Supporting people at Discharge to go home

There is joint system wide membership of the Rapid Community Discharge group, which has a focus on acute hospital discharge into the community. The current projects being handled by the group are:

- Promotion of Single-handed Care (SHC): project coming to an end in August, and plans for Early Supported Discharge (ESD) and SHC assistant to continue to work together. A bid has been submitted for further development of this programme through Community Hospitals.
- Transport - complex booking guidance: rolled out to all wards now leading to fewer errors, which are demonstrated by the Medically Optimised for Discharge (MofD) data collection. Updated guidelines being cascaded.
- Improving Communication with care Homes: dedicated phone helpline for Care Homes to contact the acute hospital following a hospital discharge if there are any concerns or queries. Designated number to a single point of contact to support the communication if the wards aren't able to respond. A list of e-mail addresses for Care Homes is being compiled for sharing information about the contact details.
- Patient information: rewriting patient information leaflets and discharge letters in line with guidance. Pathway information for Pathways 1 and 3 is being reviewed and amended to share with the RCD group, and then wider dissemination.
- Bariatric/Plus Size Forum and systemwide approach: developing pathways and a Standard Operating Procedure
- Enhanced care Needs: reviewed referral forms to capture this additional information to improve discharge planning and ensure people have the right care in place on discharge.

## Confirmation that our area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

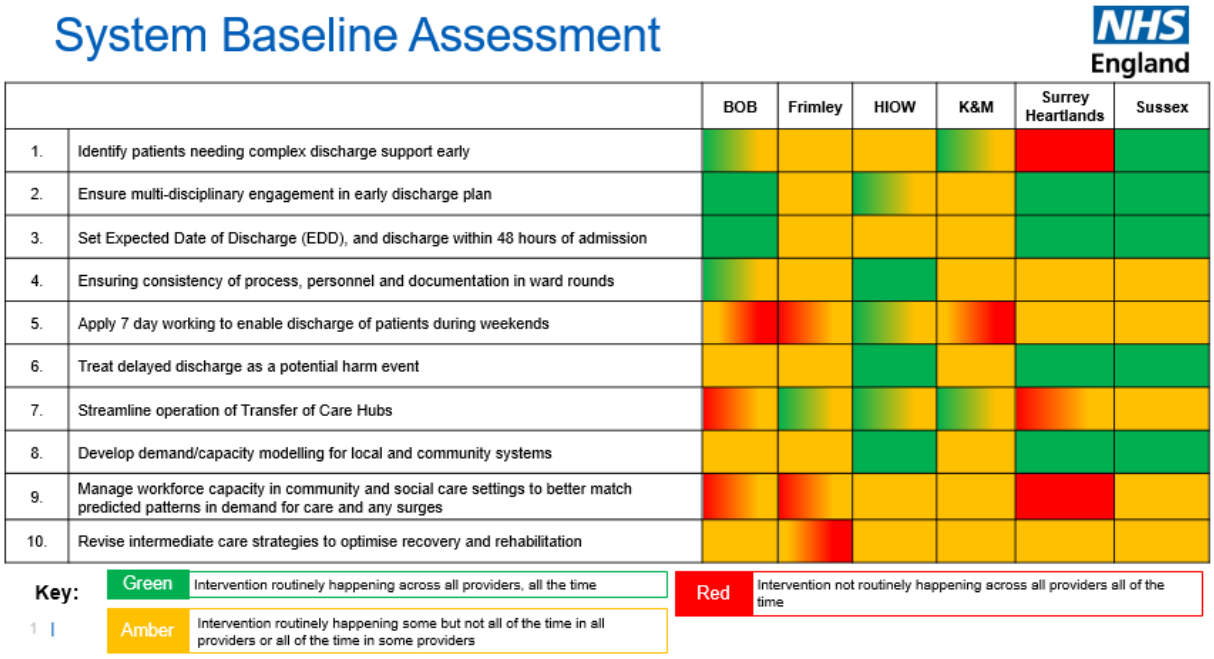
A review of hospital discharge process was undertaken locally in Reading and expanded into the Berkshire West system review, mapping the 100 Day Challenge review outcomes to the HICM Action Plan template as outlined below:

| Impact change | Where are you now? | What do you need to do? |
|---|---|---|
| Change 1: Early discharge planning | High intense cases are flagged early by the OT, in the acute hospital for early discussion and allocation of a social worker.<br>Weekly discharge operational meeting to discuss length of stays and any patients on the ward where early discharge planning may be required. | Expected Date of Discharge, set at date of admission, to be shared with wider hospital discharge team, including Adult Social Care. (COMPLETED)<br>Review of Multi-Disciplinary Triage process for CRT.<br>Co-located members of the Triage team. |
| Change 2: Monitoring and responding to system demand and capacity | Daily sitrep calls twice a day (reduced to once a day for whole system, twice a day for community hospitals) with the trust to look at discharge detail, to have an overview of the demand on the system.<br>Weekly Directors meeting to discuss barriers and capacity within the system.<br>All Trusts have modelling capability, but this is limited in its scope. Across the ICB we are working to develop a more consistent approach using the Lightfoot model (Consultancy recommended model) | Undertake a review of capacity for Rapid Response and Reablement. (Intermediate Care Review) – IN PROGRESS<br><br>Manage workforce capacity in Community and Social Care settings to better match predicted patterns in demand in care and any surges. (RECRUITMENT ISSUES REPORTED) |
| Change 3: Multi-disciplinary working | Rapid Community Discharge Working Project Group to address barriers and to promote a collaborative approach to improving system flow.<br>MDT working is in place across all our Trusts and embedded in local policies.<br>All out Trusts have elements of the transfer of care hubs and plans to expand both the operating time of these and the functional areas. Most of these plans are dependent on the demand and capacity bids and/or internal business cases to resource. | Further improvement in documentation and reporting planned alongside reviews of Ward Round Etiquette in some areas. |
| Change 4: Home first | We have 48-hour OT follow up,<br>Review within 2 weeks post discharge for people on Pathway 1.<br>We have 4 assessment flats for discharge to assess with a reablement focus,<br>All system partners are committed to a Home First approach. Clear processes in place and pathways mapped at a LA level.<br>Technology Enhanced Care (TEC) and equipment available to enable people to be at home with support where needed. | Voluntary Care Sector - Home from Hospital service to be extended (tendering process currently underway) (IN PROGRESS)<br><br>Potential to implement Huntley Place model across Berkshire West – or similar model based on feedback from Local Authorities. (IN PROGRESS) |
| Change 5: Flexible working patterns | RBC have agreement for 6 days working (Mon to Sat). All Acute Trusts have teams focusing on discharge 7 day a week with some having explicit improvement plans focusing on P0 discharges at the weekend. Partners operate more | Financial investment required to enable RBC Hospital Discharge Team to provide a 7 day a week service.<br>(IN PROGRESS) |

| | | |
|---|---|---|
| | restricted services and general staffing levels within Trusts are lower at the present time. | |
| Change 6: Trusted assessment | We have a trusted assessor policy in place for Pathway 1's and Pathway 3 from the trust. The Trusted Assessor will send a referral to Adult Social Care for Pathway 3. | Issues with over prescription of care at ward level.<br>Promote attendance at OT delivered training for care package prescription. (IN PROGRESS) |
| Change 7: Engagement and choice | Majority of discharges to a care home would be via the Discharge to Assess pathway. Choice is considered for long-term care wherever possible.<br>New leaflets available at ward level to share with patients/service users about discharge planning and choice. | New Discharge leaflets introduced following Covid funding coming to an end. (COMPLETED) |
| Change 8: Improved discharge to care homes | We have provision of block contract within care homes.<br>Care Home single point of contact with the Acute hospital to ensure any queries or issues can be resolved for hospital discharges to a Care Home.<br>We run a care home forum for a small group of professionals close to the discharge program and a Care Home Clinic – where anyone running or working in a care Home can join. Both are very successful | Increased capacity in the care market, particularly for complex care (e.g. Dementia, challenging behaviours). – Dedicated Care Home Practitioner / Admin support – recruitment supported by the Winter funding. (IN PROGRESS)<br>Joint working/funding between Health and Social Care. CHC – dedicated worker (through Winter funding - tbc). |
| Change 9: Housing and related services | We have connections in housing and there is a housing pathway for hospital discharges – Duty to refer. | We do not have an agreed pathway for people who have no recourse to public funds, particularly if they do not have a care need.<br>Link with homeless services to ensure regular contact with people who prefer not to reside in a settled habitat. (COMPLETED)<br>Raise discussion in Rapid Community Discharge group about support for homeless people on discharge. (COMPLETED) |

The following baselines (see graphic below) were identified through the '100 day' challenge and actions are identified in the HICM Action Plan above.

## System Baseline Assessment




A System Flow Improvement Plan was drawn up across Buckinghamshire, Oxfordshire and Berkshire West (BOB) in May 2022, to improve hospital discharge flow. Berkshire West "Place" had the lowest average length of stay across the three "Places" within the Integrated Care Service (ICS). The key areas of focus identified were in relation to discharges to Care Homes. We have referenced the Rapid Community Discharge (RCD) project group initiatives in the previous section and expand on these further here, taken from the System Flow Improvement Plan to address this:

1. The predominant issue to address is the delay in discharges to Care Homes.
2. RCD Project -aims to improve liaison and communication with Care Homes in order to streamline transfers and repatriation.
3. Care Home Forum -A monthly forum in which concerns and processes needing improvement can be raised. This has recently been expanded to include key Nursing leads in Berkshire West who are linked to Care Homes. Community Hospital leads are also included in the expansion.
4. Transfer documentation revised -In response to Care Homes concerns around the level (lack of) of information being transferred with the patient to a care Home, the transfer documentation has been revised and simplified -from a 5 page document to a 2 page document. More work is needed to roll this out across the Trust.
5. Format of 72 hour 'diaries' review -The current 72 hour diary is old and not well formatted –a new format has been produced and is being trialled in Elderly Care
6. Care Home Help-Line -In January a dedicated telephone line was introduced to enable any Care Home to call should they be unable to get through to a ward to discuss a patient. The qualified nurse at the end of the help-line will facilitate the ward liaison or will use EPR to answer the query directly
7. Revitalise the Red Bag Project-The initial Red Bag project was seen as a success but has fallen down during Covid times. Plans are in progress to revitalise it.
8. Business Case for a dedicated Care Home Liaison Practitioner -The success of the Care Home Help-line has demonstrated the benefits of dedicated liaison. A dedicated practitioner would support Care Home Assessment, placement of self-funders and set up of meetings such as 'Best Interest Meetings' as well as general liaison on a day to day basis.
9. Introduction of care Home 'Clinic' in May 2022 -A new concept in which key Care Homes are invited to join the Care Home Forum attendees to share concerns, good news stories and learning in general. It is felt that any unmet training needs can be picked up and addressed in this forum.

10. Training Sessions instigated for Care Homes -In order to facilitate transfer to a care Home RBFT has set up simulated training in the Sim Lab in order for Care Home staff to be trained when training is vital for the transfer. This has been provided by acute clinical experts free of charge. Further training will be provided as required
11. Visits to key care Homes -The System Lead Co-ordinator and Lead for Complex DC have a series of visits underway to key Care Homes to build a system of trust and liaison. This includes follow-up of complex patients who are accepted into Care Homes and where the care Home wishes to develop admission-avoidance plans for the future.

We are investing in a direction of travel to enable people to live as independently as possible. We are in the process of a local (Reading) review of our Reablement services and are also involved in a review of Intermediate Care service delivery at Berkshire West "Place" level. We believe the reablement target is realistic based on previous performance and is a stretch, in consideration of the context. We continue to work closely with our voluntary care sector partners to support people who are vulnerable, and we are currently in the process of commissioning a "Home from Hospital" service, that will complement our reablement and intermediate care services in Reading.

Ensuring the availability of specialist accommodation for adults with additional needs, who are unable to remain in the own home, continues to be a priority for the Council and specifically Adult Social Care. There is no one option that fits all residents with a disability or those requiring additional support; the options required within the town include, but are not limited to, the following:

- Nursing Care – high level support including medical interventions.
- Residential Care – 24 hours support, including personal care, without individual tenancies.
- Extra Care Housing – Residents have individual properties and tenancies, support provided on site.
- Supported Living - residents live independently with support purchased separately.
- Shared Lives – Individuals live with approved carers.

In order to ensure that the right provision is available for the residents of Reading when they require it, a detailed needs analysis, gap analysis and market review is currently underway.

Our ‘Demand and Capacity’ template has been populated with data from our community reablement and intermediate care services, the acute hospital and limited voluntary care sector information. We have not been able to break the data down by age group and pathway for hospital discharge, and therefore cannot map this to our planning template in relation to long term care needs met by residential/nursing care for people aged 65 and over. This exercise has been useful in terms of identifying where our data gaps are and we will work towards improving on this model to better inform our planning for our winter period and for the BCF plan in 2023/24. It should also be noted that the BCF template is based on population estimates that are not matched to the 2021 Census data and targets are per 100,000 population, whereas the Capacity and Demand template shows actual numbers. We are also conscious that the Ageing Well programme funds intermediate care services but we do not have the breakdown of that budget at Local Authority/Health and Wellbeing Board level, so an estimated proportion of that total cost is factored into the “total spend” BCF and non-BCF on the template.

## Supporting unpaid carers.

We are currently in the process of commissioning a new Carers support offer under two separate procurements; Carers Information, Advice and Guidance (IAG), for Reading and West Berks together, and Carers Breaks.

The specification for the Information, advice and guidance service is:

**User group:** People who are providing unpaid/informal care to friends, relatives or neighbours with support needs because of a disability or long-term health condition.
**Service:** The service will promote or protect carer wellbeing across the wellbeing domains specified in the Care Act (2014) statutory guidance, i.e:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal life
- suitability of living accommodationthe individual's contribution to society

The specification for the Carers Breaks service is:

**User group:** This service will focus on Reading residents who are providing unpaid/informal care to friends, relatives or neighbours with support needs because of a disability or long-term health condition.
**Service*:*** The aim of this service is to ease the strain of unpaid caring by enabling carers to take breaks and to participate in activities which may ordinarily be difficult because of their caring role. The service is intended to complement and not to take the place of replacement care (respite) services which may be arranged as part of a support package for people eligible for Adult Social Care.

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The new contracts will be in place from 1st November 2022.

Initial work is ongoing in relation to the development of a Carers Strategy for Reading as the Carers Steering Group (CSG) is really keen to see this developed, and we are pulling together a subgroup from CSG to undertake a deep dive into the data and the provision for Carers in Reading as a building block towards developing a strategy.

Consideration is being given for support from the Better Care Fund for a "Dementia Friendly Reading Coordinator" that would sit within the voluntary sector, a service which is currently funded by our neighbouring Local Authorities in Wokingham and West Berkshire, to coordinate the Dementia Friendly Reading (DFR) programme bringing together all the partners currently on the DFR Steering Group and look at things like non-clinical pathways, supporting those suffering with Dementia and their carers. Carer's grants are provided to Carer's in the form of Direct Payments to help them maintain their caring role. In 2021/22 48 Direct Payments were granted, representing 9% of our overall number of Carers.

## Disabled Facilities Grant (DFG) and wider services

Within Reading Borough Council (RBC), Adult Social Care (ASC) Advice and Wellbeing Hub, Hospital Discharge Services and Housing are working together to ensure a joined-up approach to address health, wellbeing and housing needs. Schemes funded through the Better Care Fund to support the BCF priorities include Disabled Facilities Grants, Housing, Minor Adaptions, and Equipment and Wellbeing Grants to enable individuals to return home after a hospital admission and ongoing enablement to maximise independence and stay safe in their own homes. Our Housing Department manage the Disabled Facilities Grant and this is supported by an Occupational Therapy led assessment of needs.

In line with recent guidance Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England - GOV.UK (www.gov.uk) Reading Adult Social Care (ASC), Housing and DFG Teams are working closely to ensure the Reading adaptations offer is in line with the outcomes and expectations laid down in the new guidance. Outcomes enabling individuals to sustain their independence, remain at home, avoid hospital admission and long hospital stays are met through these services. The Disabled Facilities Grant (DFG) Team are now based in RBC Housing and are leading a review of all our adaptation policies and procedures in line with this guidance. The Housing Occupational Therapists (OTs), DFG Team, Principle Occupational Therapist and Brighter Futures for Children OTs have been meeting to scrutinise the new guidance and review existing policies and procedures to ensure compliance. This is an ongoing piece of work and a number of areas have been identified for review some of which are outlined below:

- Broadening the criteria for the Wellbeing Grant to enable more people to remain at home under 5K adaptations and repairs
- Reviewing the upper limit of the minor works grant to enable more flexible use and fast track of minor adaptations to reduce risks of falls and increased independent use of environments.
- Ensure the outcomes are compliant with Better Care Fund outcomes.
- Improve information on the RBC website with regards to DFGs and new discretionary grants.
- Review time scales for assessment and implementation of the grant and completion of the work in line with the new guidance.

All DFG referrals are RAG rated, all referrals are triaged within five working days of receiving the referral, urgent cases are accessed within four weeks or sooner. The longest wait for assessment is 10 weeks. Once the person has been assessed the recommendations and specifications are usually completed within two weeks. There have been 36 accepted DFG referrals since April with an average number of 10 new referrals a month, 19 DFG have been completed providing such solutions as level access showers, stairlifts, wheelchair access, washer dryer toilet, environmental controls. An analysis of 7 of those DFGs has led to a yearly cost avoidance of £33,280 or an average weekly cost saving of £640.

The average amount of time taken to complete low cost DFG works, those under 5k, is a week, and from grant approval to completion of the work is 3 weeks.

There has been an improvement in completion time for complex DFGs over £15K which has moved from 73 weeks in 2021 to 29 weeks in 2022. Demonstrating the impact that COVID had on the ability to deliver DFGs during the pandemic. There has been an increase in the use of discretionary grants, with three DFG top up grants and two accommodation grants to support completion of complex adaptations.

***Case Study**: Provision of a level access shower through a DFG. Following her stroke Mrs M found she was losing her independence and confidence, and she is now carrying out her personal care tasks independently and the time to carry out these tasks has reduced by more than half the time it originally took, and with much less effort and level of anxiety due to risk of injury. "The change to my bathroom has been life changing, this has made life a lot easier, my daughter does not have to come and support me, I live on my own and can shower independently and without worry. I cannot fault Reading Borough Council"*

The Discharge To Assess OTs work very closely with the DFG Team and RBC Minor Works team to jointly ensure safe discharge from hospital. There have been 6 Wellbeing Grants to ensure the property is safe to return to providing services such as: managing deep clears, removal of waste, moving furniture to enable equipment such as hoisted and profiling beds to be delivered, creating downstairs living, removing hoarded environments and cleaning unsanitary properties so that care agencies can deliver care. These services are essential in enabling early return from hospital and preventing long stays and a home first ethos.

Over 364 individuals have been supported by our RBC Minor Works Teams in private and rented accommodation, of these 203 where to enable safe discharge home from hospital through the provision of rail, keys safes and small adaptations. The NRS equipment service has supported 322 individuals with equipment since April 22, with 9 ceiling track hoists installed, 32 hospital discharges, 69 for falls prevention, 18 to support carers, 105 to maintain independence at home, 55 to promote client safety, 105 Assistive Technology Assessments.

The Discharge To Assess In Reach OTs have supported 86 individuals with their discharge from hospital and carried out a follow up home visit within 24 hours in their own homes this enable the service to manage complex needs on discharge and manage family anxiety. Some examples of input, training family to use equipment, ensuring property is safe for discharge, complex manual handling, specialist seating assessments, setting up the environment for discharge, TEC to prevent wandering and referring for Wellbeing Grants to manage hoarded properties

Our Brighter Futures for Children (BFfC) Service completes all of our assessments holistically, looking at the impact of the young person's disability not only on them but the whole family unit. We have monthly meetings with Health colleagues and bi-monthly meeting with housing, as well as 6 weekly meetings with the Social worker, parent/ guardian and education provider as part of the Child in need process. This ensures that any recommendations we make for intervention is an inclusive approach, taking into account current and predictive future needs whilst still keeping the young person at the centre of all discussion.

## Equality and health inequalities

The Reading Integration Board (RIB) is responsible for delivery against two strategic action plans within the Joint Health and Wellbeing Strategy for 2021-2031.

Priority 1: Reduce the differences in health between different groups of people

Priority 2: Support individuals at high risk of bad health outcomes to live healthy lives

Progress against these plans is reported quarterly through the Reading Health and Wellbeing Board.

Analysis of data based on the Core20Plus5 conditions being monitored across the Berkshire West region in partnership with our Health Colleagues, e.g. Cardiovascular Disease, Diabetes, Respiratory conditions (COPD), indicated that in Reading there are no particular outliers within areas of deprivation (Deciles 1 to 4) compared to National data. However, the area identified as highest risk was in relation to low level Mental Health, particularly in areas of deprivation where there are larger populations of ethnic minorities, which were more adversely affected by COVID, not just physically but mentally, due to isolation. This led to the priority project around Low-Level Mental Health. We are engaged in a Berkshire West project, developing an Inequalities Report to identify further areas and groups who have been adversely affected. Our Priority 1 and 2 of the Health and Wellbeing Strategy is focusing on at risk groups such as people with dementia, learning difficulties, at risk of domestic abuse and those who are unpaid carers or homeless.

The BCF Plan supports projects and continuing services funded through the BCF, to support carers and other 'at risk' groups, particularly where exacerbated by the COVID 19 Pandemic, such as low level mental health, which is a priority for the Integration Board. We work with our Voluntary Care Sector to provide social prescribing services and support to all our residents, and to develop and strengthen community connections in those most deprived areas, where vaccine hesitancy was high. Our Public Health team are represented on the Integration Board and provide regular updates in relation to Covid and the vaccine programme, including the introduction of Covid champions. The Covid Vaccine Champion (CVC) programme is in the delivery phase, with 16 Community Champions recruited and training being delivered. Contracts have been awarded to Reading Voluntary Action (RVA), Alliance for Cohesion and Racial Equality (ACRE) and 7 other providers, to support vaccine promotion, and particularly within harder to reach communities,

We are supporting PCN projects to reduce inequalities by improving the take up of LD and SMI health checks. People living with a learning disability (LD) and or serious mental illness (SMI) often have poorer physical health and a shorter life expectancy than other people. Annual health checks offer general practice an opportunity to provide appropriate health and lifestyle advice to patients and to help identify preventable illnesses early (this is also sits in the HWB action plan).

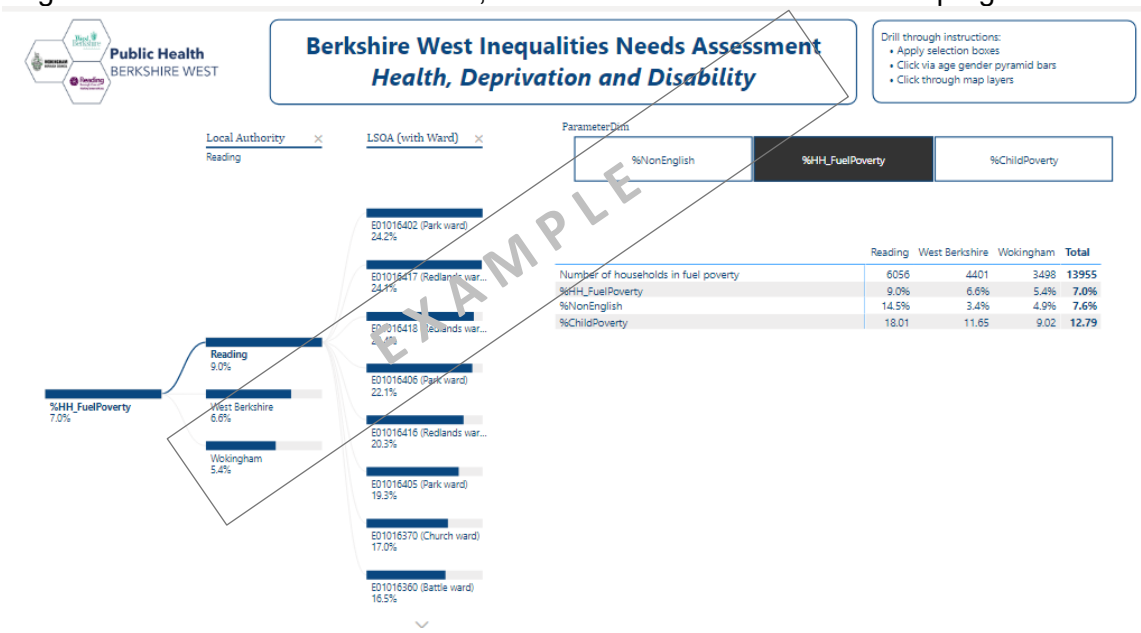
The covid pandemic effected many clinical work areas and health checks have been no exception. The system wide and, indeed, local emphasis on inequalities, plus the requirement of the network contract have converged to renew efforts to ensure high levels of take up of health checks. This focus on health checks has also been drawn through to our Health and Wellbeing Strategic Priority action plans to ensure a cohesive and collaborative approach.

The Berkshire West Inequalities Report includes data in such areas as Population composition, in order to identify particular inequalities by protected characteristics, Access to Healthy Assets & Hazards (AHAH) Deciles, Environment, Transport, Life Expectancy & Mortality, Housing, Crime, Digital Exclusion and Health, Deprivation & Disability.

Each chapter of the Equalities Report will address each domain in turn, looking at how they impact on the health and wellbeing of people living in Reading in relation to:

- The wider determinants of health (e.g., quality of housing)
- Behavioural risks to health (e.g., alcohol use)
- Life expectancy
- Health status (physical and mental)
- Access and experience of care (including digital accessibility)
- The impact of COVID-19

This report is in the developmental stage (see one example below) and the plan is to access this report to show baseline needs, broken down by a number of protected characteristics within the Reading and wider Berkshire West areas, and use this data to drive the RIB programme of work.




The **Public Mental Health Dashboard** has recently been developed by OHID for use by local authority Public Health teams and others to prepare mental health needs assessments. It complements the mental health and wellbeing Joint Strategic Needs Assessment (JSNA) toolkit . We plan to access this data and use this to inform our service developments for people with low level mental health support needs within Reading.

One of the key Integration Board Priorities is tackling health inequalities, and one of the new projects within that priority is to develop a Self-Neglect pathway. This project was identified as a result of analysis of the Safeguarding Adult data over two years from 2020 to 2022.

| | |
|---|---|
| Self-neglect (as a percentage of all safeguarding figures) for Reading April 2020 – March 2022 | April – June 20 15.3% |
| | July – Sep 20 16.4% |
| | Oct - Dec 20 19.4 % |
| | Jan - March 21 17.0% |
| | April – June 21 23.9% |
| | Jul - Sep 21 13.7% |
| | Oct - Dec 21 9.8% |
| | Jan – March 22 20.0% |

Further analysis of the safeguarding concerns that were related to Self-Neglect, indicated that just over 26% were related to hoarding. Phase 1 of the Self-Neglect Pathway project will build on work that has already been undertaken during a pilot to manage hoarding within the Reading area:

**The Overall aim of the pilot project:**

To understand the extent and impact of hoarding on individuals and on the agencies working with those individuals.

- To establish how best to support people with self-neglect or hoarding tendencies in Reading and to make recommendations on prevention and future support.
- Raise awareness of Hoarding Disorder and the impact on wellbeing
- To work with multi-agency partners to provide a collaborative approach.
- To establish an integrated pathway to support with risk management interventions
- Provide training and support to statutory and voluntary agencies on hoarding and self-neglect

**Main actions completed as part of the Project:**

- Raised awareness, the Project has met with colleagues in many roles across Reading (i.e., Housing, Environmental Health, Mental Health Teams) Berkshire Health Foundation Trust (MH and Intermediate Care Services), Integrated Care Board (formerly Berkshire West CCG), fire service, police, ambulance, voluntary sector colleagues, Public Health and other LA areas.
- Delivered updates and awareness presentations to a number of groups including the Adult Care and Education (ACE) Committee Lead Councillors, West Berkshire Safeguarding Board, Team meetings, Learning Lunches, Reading Integration Board
- Investigated other Local Authority approaches to Hoarding and self-neglect.
- Commissioned ongoing Understanding Hoarding training sessions open to all sectors within Reading who work or who may in their work come across people who hoard. 14 sessions commissioned more to be delivered in the Autumn.
- Commissioned Level 2 and 3 Hoarding training for staff whose roles involve direct work with individuals with a Hoarding Disorder.
- Draft Hoarding Protocol shared for feedback
- Gathered new and scrutinised existing data, including safeguarding figures for self-neglect Jan 21-Dec 21, data from commissioned ’blitz cleans’ from April 2020- March 22, individuals using D2A beds at Huntley Place (Jan 2022 – April 2022) and anecdotal case studies from colleagues in Adult Social Care.

**Outcomes:** we now have a better understanding of the health and wellbeing for those people who Hoard and lack of impact from existing services who only respond to crisis. Further work is being done to review existing services and a grant application is being made for additional resources to create an early intervention Hoarding Service.