READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**7th OCTOBER 2022**		
REPORT TITLE:	**INTEGRATION PROGRAMME UPDATE**		
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ORGANISATION:	**READING BOROUGH COUNCIL / INTEGRATED CARE BOARD (ICB)**		

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 of Reading, against the national Better Care Fund (BCF) targets covering the period April to June 2022 (Quarter 1 of 2022/23 reporting period).

1.2 The BCF metrics were updated in the planning guidance for 2022/23 and the targets against the revised metrics were agreed with system partners during the BCF Planning process. The Length of Stay target, related to length of stay in an acute hospital bed, was removed for 2022/23. Outcomes as at the end of June 2022 for the remaining metrics are outlined below:

a) The number of avoidable admissions (unplanned hospitalisation for chronic ambulatory care) **(Met)**
b) An increase in the proportion of people discharged home using data on discharge to their usual place of residence **(Met)**
c) The number of older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population **(Met)**
d) 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 alongside the performance of the local schemes and demonstrates the effectiveness of the collaborative work with system partners.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board note the Quarter 1 (2022/23) 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

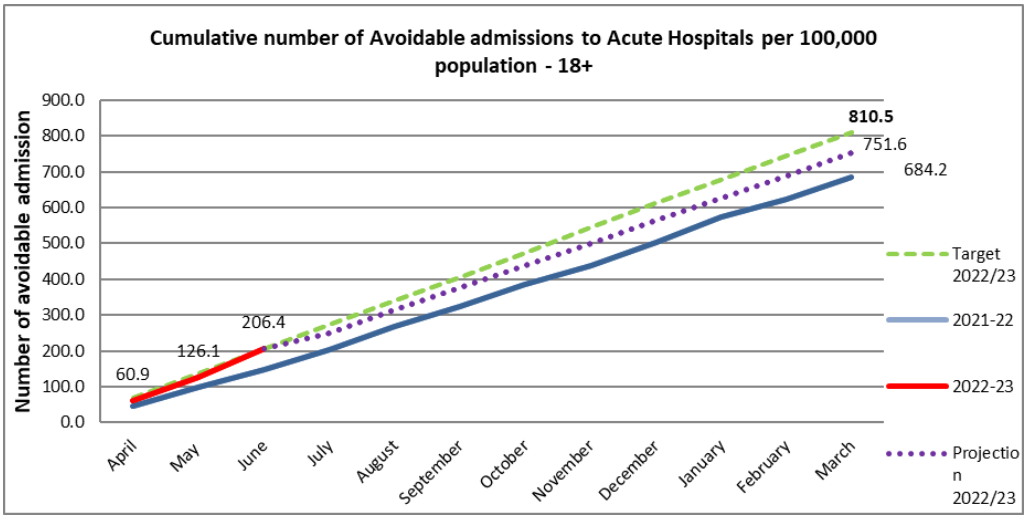
3.1 The Reading Integration Board (RIB) is responsible for leading and overseeing system working with Local Authority Adult Social Care and Housing, Acute and Community health providers, Primary Care, Integrated Care Board (ICB) Commissioners, Voluntary Sector partners and Healthwatch, across Reading. 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 2022/23)*

4.1 **Admission Avoidance:** Reduction in avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions), no more than 810, per 100,000 population, for the year. This metric was adjusted to a more realistic target based on previous performance and projections for 2022/23. It measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and high blood pressure.

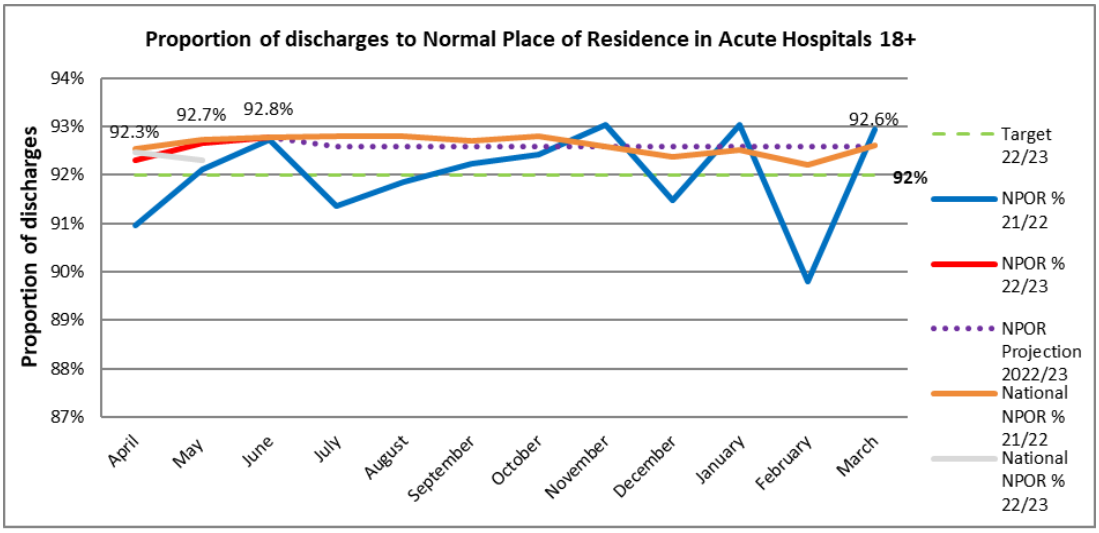
We are currently on track to achieve this target by the end of the year and have additional planned support to avoid hospital admissions, such as having a Social Worker based at A&E front door to signpost and enable alternative intermediate care to be arranged, where appropriate. The Reading Integration Board have a priority project to support the delivery of Health Checks, working with our partners in health to promote and enable people to receive these important checks to flag any issues at an early stage. **NB:** NHS England have changed the method of measuring against this target from a previously "crude" rate to an "Indirectly Standardised Rate" (ISR) and when the new method was applied, this adjusted all the rates up by approx. 20%. This does not indicate poorer performance, but just the improved method of reporting.

Cumulative number of Unplanned hospitalisations for chronic ambulatory care sensitive conditions per 100,000 population - 18+, Acute hospitals	
Target performance per annum (no more than)	810
Actual performance to date	206
Average projected performance for the current period	751



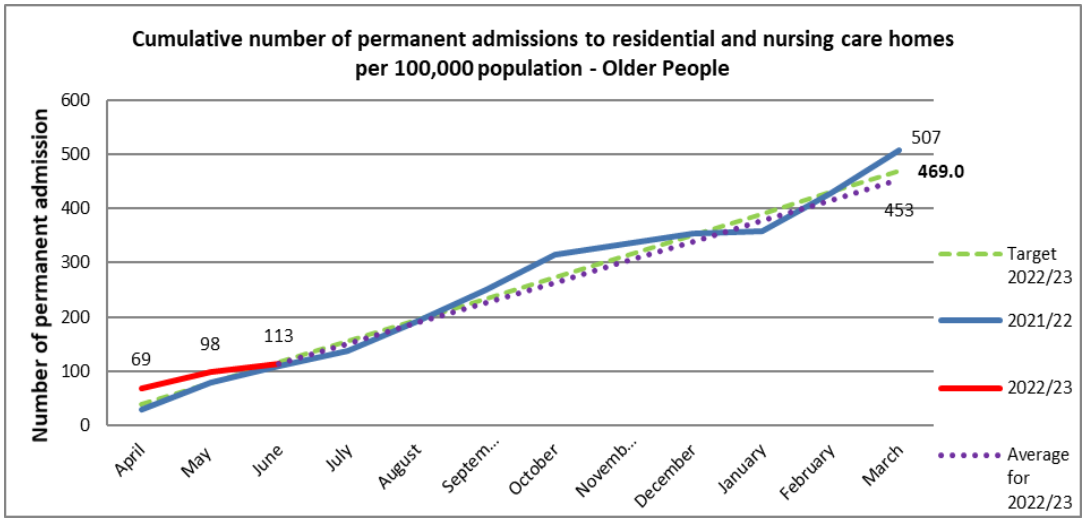
4.2 **Discharge to Normal Place of Residence:** An increase in the proportion of people who are discharged directly home, from acute hospitals is the aim of this measure, with a target of not less than 92%. This is based on hospital data for people "discharged to their normal place of residence". We exceeded the minimum target for quarter 1, due to effective discharge processes, working with the multi-disciplinary team in the hospital and following the ethos of "Home First", in line with the Hospital Discharge Policy, 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)	92.0%
Actual performance this month	92.8%
Average performance for the current period	92.6%
Status	Green



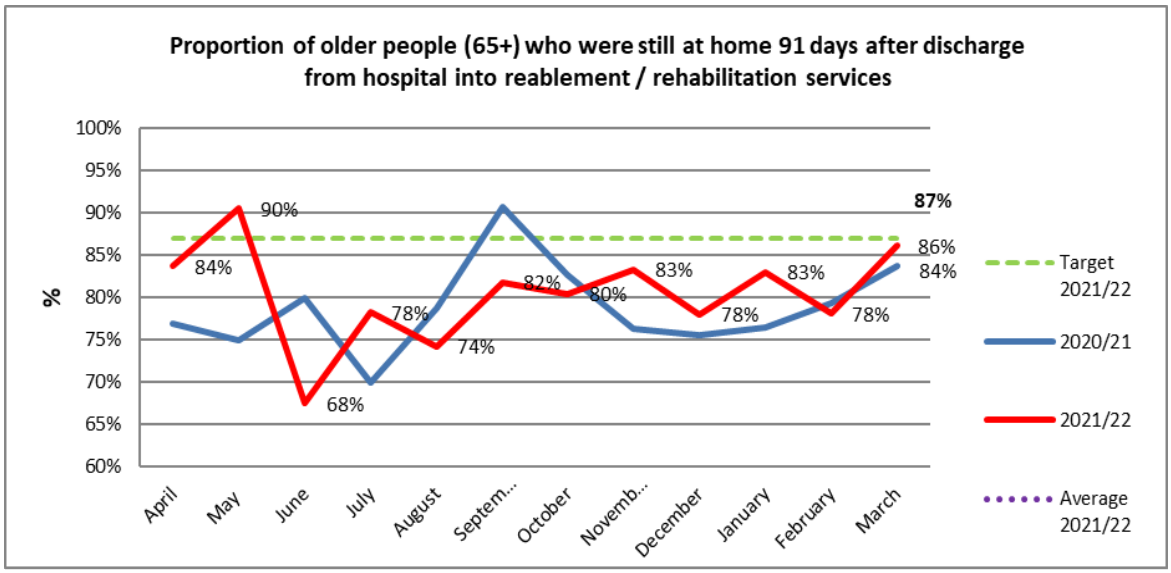
4.3 **Permanent Admissions to Residential/Care Homes:** The number of older adults (65+) whose long-term care needs are met by admission to residential or nursing care per 100,000 population, the maximum target of 469 for 2022/23. Whilst we are meeting the target we remain mindful of the current limited capacity in the care market for complex cases, such as people with dementia or extreme behaviours and we continue to work with our system partners to address these gaps.

Cumulative number of permanent admissions to residential and nursing care homes per 100,000 population - Older People	
Target performance per annum (no more than)	469
Actual performance to date	113
Average projected performance for the current period (based on performance to date)	453
Status	Green



4.4 **91 Day Rehabilitation:** The effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation). The target was adjusted for 2022/23 from 87%, which was not consistently achievable due to the requirement from NHS England to include the number of people who had been referred into reablement but had passed away within that 91 day period. The target of 85% has been agreed at Place level across the Berkshire West region for 2022/23, however the data reported here is for the March 2022 cohort of people discharged, and therefore still falls under the 2021/22 target of 87%, which we just missed by 1%. The report in the next quarter will show the new target of 85%.

Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	
Target performance	87%
Total no. of people departing reablement 91 days ago (numerical)	36
Of those, no. at home 91 days later (numerical) this month	31
Actual performance (%) this month	86%
Status of Monthly performance	Amber



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

4.5 **Length of Wait for Discharge from Acute Hospital:** Whilst the Length of Stay metric for Acute hospital stays of longer than 14 and 21 days has been removed from the BCF reporting, we continue to monitor the position. The Rapid Community Discharge dashboard, developed by the Royal Berkshire Hospital, captures data on the Length of Wait (LoW) for discharge after a person has been declared Medically Optimised for Discharge on Pathway 1 (home with some support) and Pathway 3 (complex care needs requiring 24/7 nursing/care). We are just above the 2 day target for Pathway 1 discharges at 3.1 days, having reduced this wait down from 4 days in April. Whilst Pathway 3 discharges often take a longer period to arrange appropriate levels of care, we have significantly reduced the length of wait from 32.9 days in April to 8.2 days as at the end of June 2022. This is as a result of good relationships with providers and effective early discharge planning and acknowledgement of some extremely complex case management. We are continuing to work with our care market to ensure the most appropriate care is provided based on need.

LA / Pathway	LOW Target	202204	202205	202206
Wokingham P1	2.0	3.0	2.8	2.4
Wokingham P3	6.5	9.4	11.1	13.1
Reading P1	2.0	4.0	3.3	3.1
Reading P3	6.5	32.9	12.0	8.2
West Berks P1	2.0	5.1	4.9	4.0
West Berks P3	6.5	19.3	16.8	19.0
Berkshire West P2	1.7	3.1	2.4	1.8

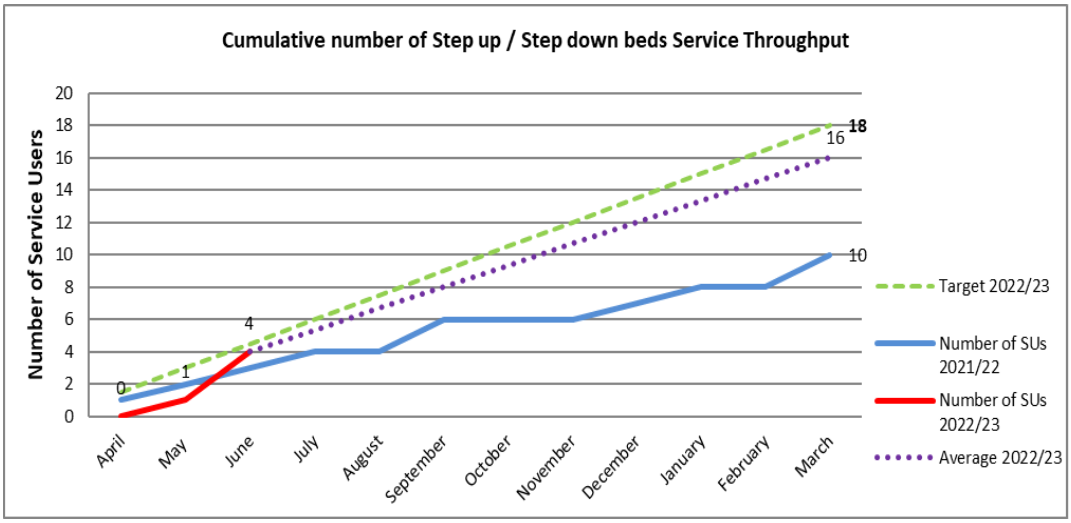
4.6 Local Schemes funded through BCF

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

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 was met, due to improvements in reducing the length of stay, moving on more complex cases to appropriate care settings or directly home with package of care, where required.

A key factor in the improved performance is the introduction of a therapy led service, following the positive learning from the Huntley Place model that was implemented during the winter pressures period (2021/22).

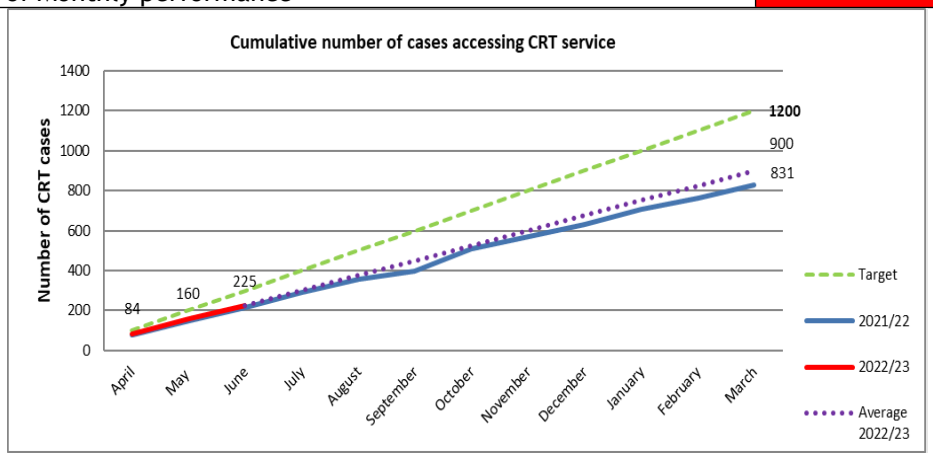
Cumulative number of Step up / Step down beds Throughput	
Target performance per year (not less than)	18
Actual performance this month	3
Status of Monthly performance	Green
Cumulative cases financial year to date	4



4.6.2 Impact of Community Reablement Service

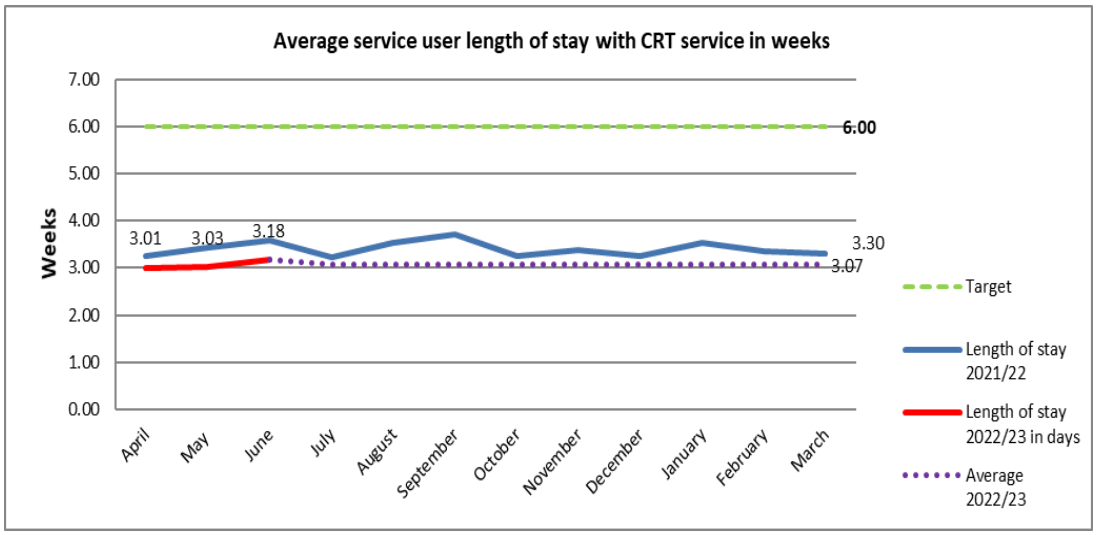
Numbers accessing the service: The number of people accessing support through the Community Reablement Team (CRT) service continues to be significantly below the expected level to achieve the target of 1,200 per year, with an intake of 225 as at the end of quarter 1. The majority of referrals are made 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 refuse reablement although capacity was allocated for the referral. Reviews of the reablement services both locally, and in the wider Berkshire West area, with system partners across intermediate care, are ongoing. Reporting has also been significantly affected by a system outage in relation to the Advanced Healthcare - Staff Plan Roster Provider. Work is ongoing to address the issues and we have been advised that due to the complexity of the issues this may take several months. In the meantime, our reablement team have been managing rostering manually and are able to meet the needs of all our existing referrals. Due to the additional time taken in relation to allocating referrals manually, this also has an impact on the length of wait for hospital discharges on Pathway 1.

Cumulative number of cases accessing CRT service	
Target performance per year (not less than)	1200
Actual performance this month	65
Cumulative number of cases FY to date	225
Projected number of cases based on performance to date	900
Status of Monthly performance	Red



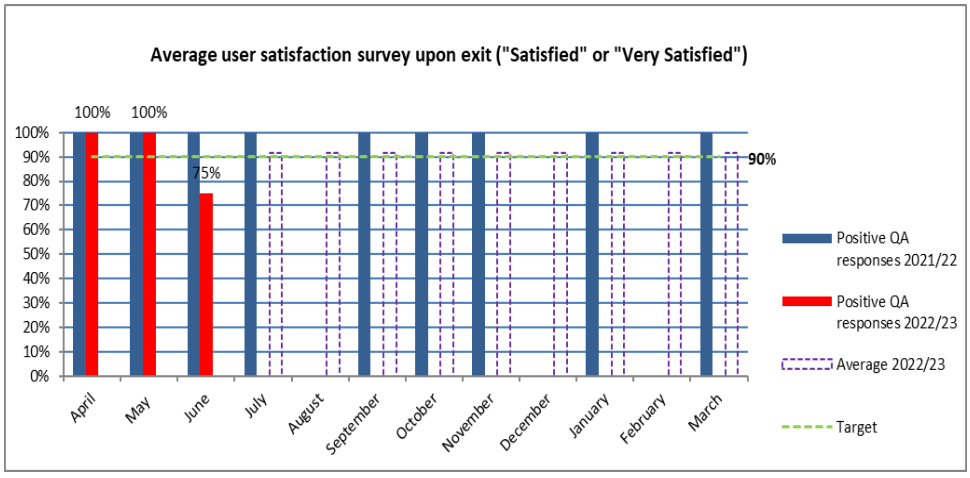
Average length of stay: The average length of stay with the reablement service continues to be well below the 6 week maximum target, at 3.18 weeks, as at the end of June 2022. This indicates that people receiving reablement services are being effectively supported and enabled to regain their independence.

Average service user length of stay with CRT service in weeks	
Target performance per month (no more than)	6.00
Actual performance this month	3.18
Status of Monthly performance	Green



Level of satisfaction: The satisfaction levels of service users with the reablement service has dipped below the target of 90% in June but has remained just above the target for the quarter, at 91%. The service lead is looking into the reasons for the drop in customer satisfaction in the last month of the quarter, to address any areas of concern.

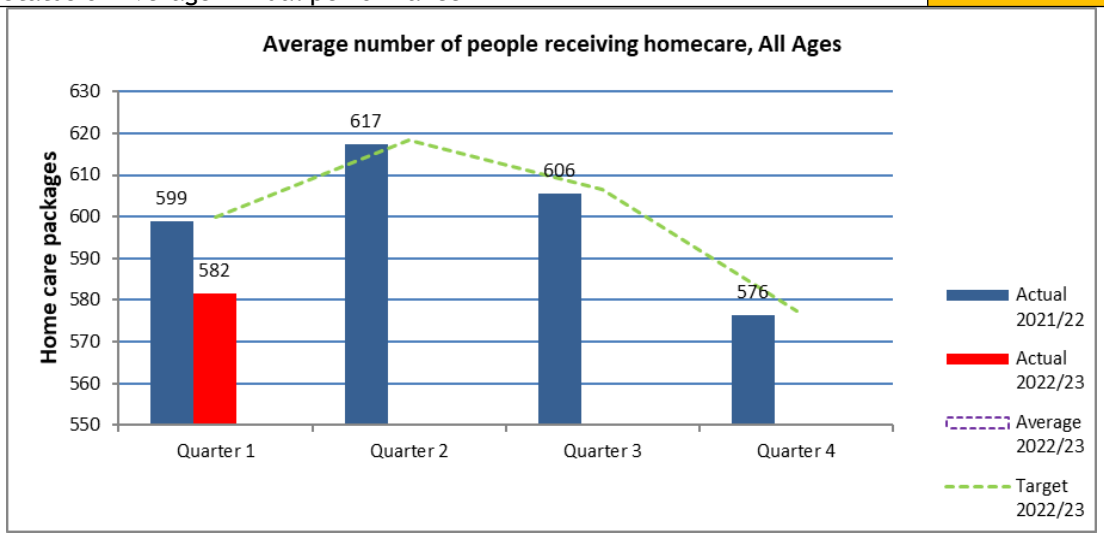
Average user satisfaction survey upon exit ("Satisfied" or "Very Satisfied")	
Target performance (not less than)	90%
Actual performance in Quarter 1 (April to June)	91%
Status of Monthly performance	Green



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. It is noted that there has been a slight reduction (17) of the number of care packages in Quarter 1 2022/23 compared to last year. We are seeing a higher level of complexity in this quarter with our hospital discharges, and therefore their needs are higher and cannot be met through reablement.

Marginal increase in home care packages	
Average Annual Target performance	600
Average Annual performance (based on performance FY to date)	582
Status of Average Annual performance	Amber



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 priorities and key projects for 2022/23 have been identified as:

RIB Priority	Key Projects (2022/23)
1. Tackling Health Inequalities *To identify and deliver projects that result in improved outcomes for the most disadvantaged communities in Reading.* ***H&WB Priority 1:*** *Reduce the differences in health between different groups of people* ***H&WB Priority 2****: Support individuals at high risk of bad health outcomes to live healthy lives*	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 *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)**

RIB Priority	Key Projects (2022/23)
3. Service User Engagement and Feedback *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 *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

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. The Board have continued with this project due to the positive outcomes achieved towards the end of 2021/22. There are three MDT Clusters established:

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

Case finding for the MDT meetings is through the use of a Population Health Management approach, using our Shared Care Record "Connected Care" to identify those most at risk and using criteria agreed with the PCN Clinical Leads. There were 78 people whose cases were reviewed by an MDT between April and June 2022. We will be able to show the outcomes for each of the cohorts at 6 monthly intervals, and the next update will be shared at the January Health and Wellbeing Board.

The case finding process 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.

An outcomes review of 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 services:-

Contacts	Month 3	Month 6
Mental Health referrals	7% decrease	25% increase
Acute Admissions	86% decrease	82% decrease
A&E attendances	64% decrease	42% decrease
SCAS	72% decrease	55% decrease
111	60% decrease	50% decrease
GP	60% decrease	25% decrease

(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.*

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

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

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. One of the key priorities of the Board is Project 3.1 Develop a Multi-Disciplinary Service User Engagement Strategic Framework and deliver a method of gaining system wide feedback from Service Users. We are aware of multiple sources of receiving information from service users/people of Reading and this project will look for ways of aligning that feedback for a system wide strategic overview and a driver for change.

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 will be agreed between Reading Borough Council and the Integrated Care Board (ICB) 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 2022/23 was submitted by 26th September 2022 and approval is awaited from NHS England, at the time of writing this report. The BCF policy and guidance was released late for 2022/23 (due for release in February and released at the end of July 2022). The budgets have been agreed with Integrated Care Board (ICB) and Adult Social Care service and finance leads.

11. BACKGROUND PAPERS

11.1 The BCF performance data included in this report is drawn from the *Reading Integration Board Dashboard –July 2022(Reporting up to 30th June 2022)*