READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	20th JANUARY 2023		
REPORT TITLE:	INTEGRATION PROGRAMME UPDATE		
REPORT AUTHOR:	BEV NICHOLSON	TEL:	07812 461464
JOB TITLE:	INTEGRATION PROGRAMME MANAGER	E-MAIL:	Beverley.nicholson@reading.gov.uk
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 July to September 2022 (Quarter 2 of 2022/23 reporting period), and to outline the plan for additional funds provided by NHS England to be used to support hospital discharge over the Winter period, the Adult Social Care (ASC) Discharge Fund.

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, although we have been asked to continue monitoring at a local level. Outcomes shown here are as at the end of September 2022 (Quarter 2):

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 2 (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.

2.2 The Health & Wellbeing Board to note the Adult Social Care (ASC) Hospital Discharge Fund Plan and Narrative for 2022/23 which has been formally submitted by the due date of 16th December 2022 to NHS England utilising delegated authority of the Executive Director for Adult Social Care in consultation with the Lead Member for Public Health in order to comply with national deadlines outside of the Board meeting cycle.

DRAFT

3. POLICY CONTEXT

3.1 The Better Care Fund Framework[1], and Better Care Fund Policy Framework[2] sets the guidance for the pooling of funds to support integrated working across health and social care, to ensure the right care is available to people at the right time. 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 the Better Care Fund (BCF) planning guidance 2022/23)*

4.1 Admission Avoidance

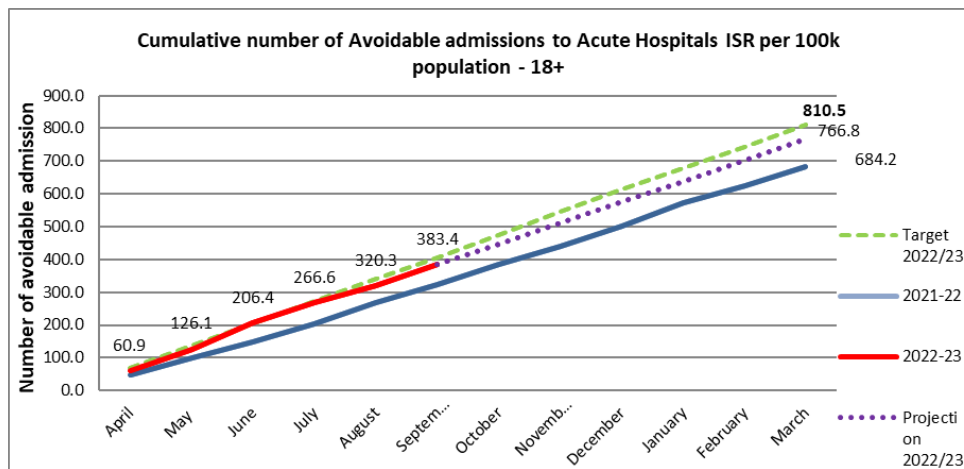
This aims to reduce avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions), and have no more than 811, per 100,000 population, for the year. This metric was adjusted to a more realistic target based on previous performance and projections for 2022/23. It measures 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.

In terms of performance we remain on track to achieve this target by the end of the year and have additional planned interventions to further avoid hospital admissions. These include engaging with the Berkshire West Ageing Well programme for rapid and emergency responses by intermediate care services to support people to stay well at home with a short-term care package, where appropriate. We also have Technology Enabled Care equipment that can be installed/worn to build confidence and ensure early alerts for people at risk of falls or to address other safety concerns. 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.

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)	811
Actual performance to date	383
Average projected performance for the current period	767

[1] https://www.gov.uk/government/news/better-care-fund-framework-2022-23-published

[2] https://www.gov.uk/government/publications/better-care-fund-policy-framework-2022-to-2023

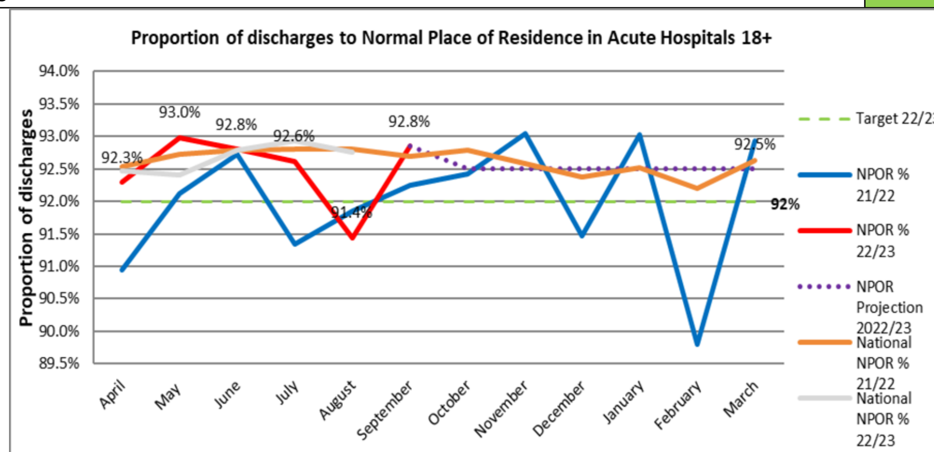


4.2 **Discharge to Normal Place of Residence**

This aims to increase the proportion of people who are discharged directly home, from acute hospitals with a target of not less than 92%. This is based on hospital data for people "discharged to their normal place of residence".

In terms of performance we continue to exceed the minimum target for quarter 2, 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.

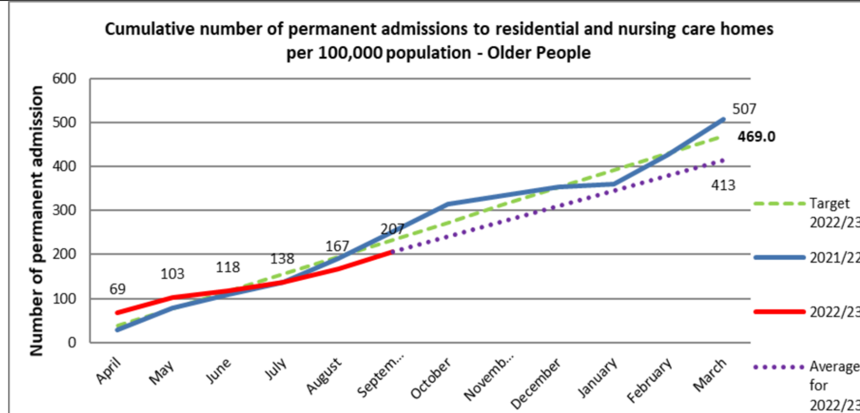
Proportion of discharges to Normal Place of Residence in Acute Hospitals 18+, per month	
Target performance per month (not less than)	92.0%
Actual performance this month	92.8%
Average performance for the current period	92.5%
Status	Green



4.3 **Permanent Admissions to Residential/Care Homes**

This aims to reduce the number of older adults (65+) whose long-term care needs are met by admission to residential or nursing care per 100,000 population with a 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 more challenging behaviours and we continue to work with our system partners to address these gaps.

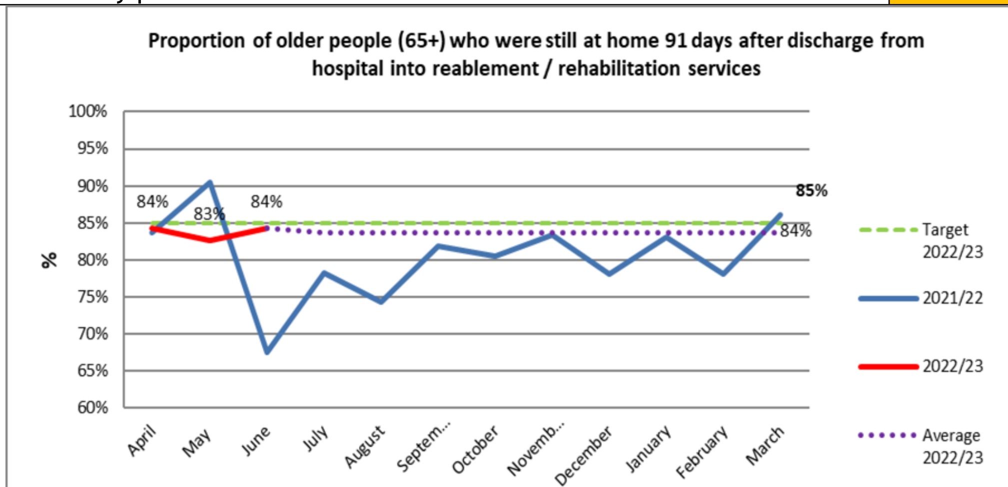
Cumulative number of permanent admissions to residential and nursing care homes per 100,000 population - Older People	
Target performance per annum (no more than)	469
Actual performance to date	207
Average projected performance for the current period (based on performance to date)	413
Status	Green



4.4 **91 Day Rehabilitation**

This aims to measure the effectiveness of reablement by looking at the proportion of older people who are still at home 91 days after discharge from hospital into reablement or rehabilitation. The target for 2022/23 is a minimum of 85%. We just missed the minimum target by 1% however this uses the NHS England reporting requirement to include the number of people who had been referred into reablement but had passed away within that 91-day period. Our performance would have been 94% had we excluded those that had unfortunately passed away during that 91-day period.

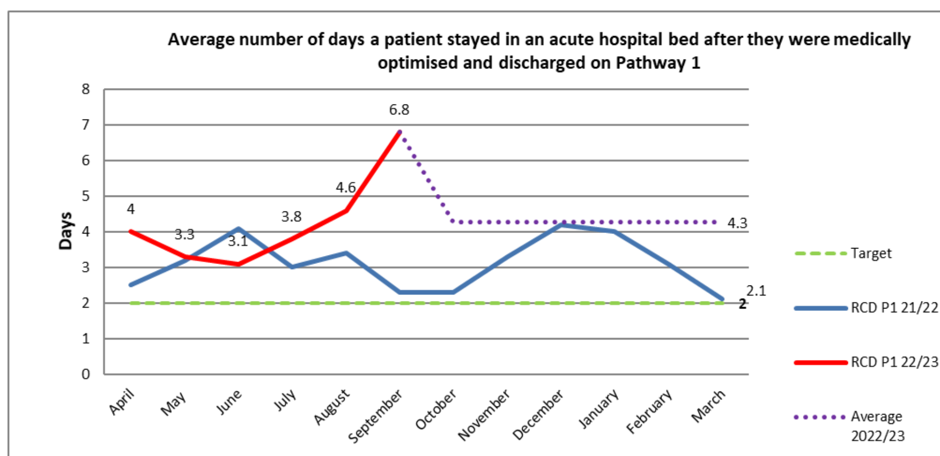
Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	
Target performance	85%
Total no. of people departing reablement 91 days ago (numerical)	38
Of those, no. at home 91 days later (numerical) this month	32
Actual performance (%) this month	84%
Status of Monthly performance	Amber

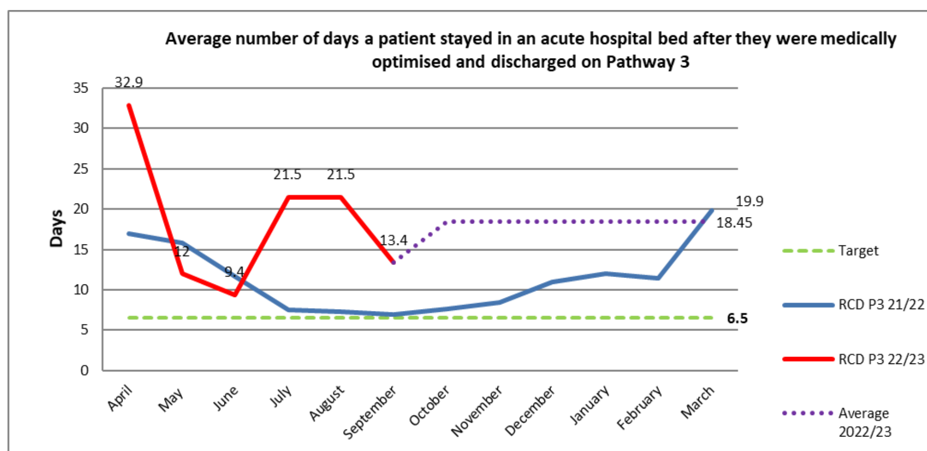


(based on people discharged in April 2022, who were still at home in July 2022 - the April cohort)

4.5 Length of Wait for Discharge from Acute Hospital

This is a local measure in relation to the Length of Wait (LoW) for discharge after a person has been declared Medically Optimised for Discharge (MOFD) on Pathway 1 (home with some support) and Pathway 3 (complex care needs requiring 24/7 nursing/care). The maximum threshold for the hospital flow is 2 days on Pathway 1, and 7 days on Pathway 3. As at the end of quarter 2, there had been a steady increase in the wait times on Pathway 1 due to reduced care capacity through the Community Reablement Team (CRT) due to their referrals and allocation system being compromised and limited capacity in the wider market to pick up referrals. The CRT service now have their system up and running and the position has improved significantly since September and will be reported in March 2023. The wait on Pathway 3 is reducing as we have commissioned block beds, which has improved capacity, and there have been no restrictions in care homes which meant the flow has improved.





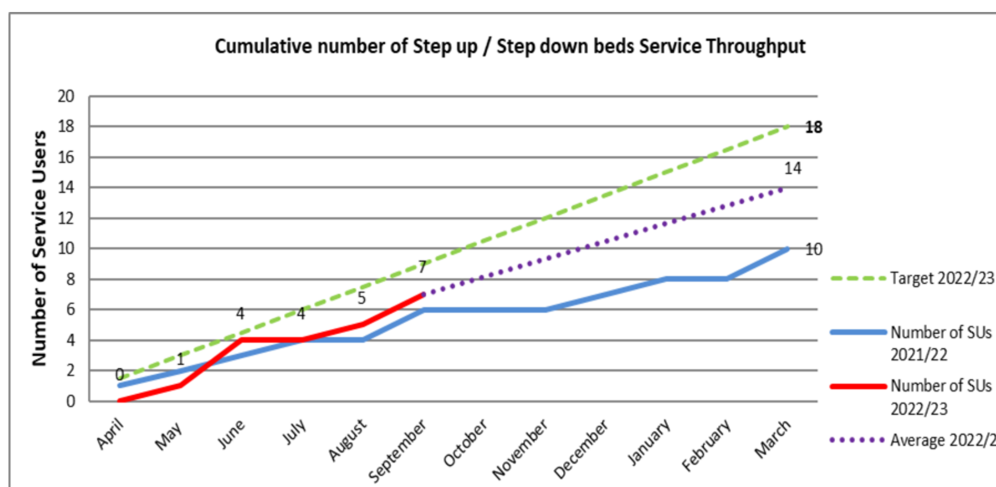
4.6 Local Schemes funded through BCF

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

There are four independent living D2A flats, within a wider complex of extra care flats. These D2A flats have carer support for people who are not able to return directly home after a period in hospital (Step down), or for people who require some additional support to avoid a hospital admission (Step up). The minimum number of people placed in the commissioned Discharge to Assess beds at Charles Clore Court was again 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.

However, the projected performance for the year is still below the minimum required number of referrals. To support the flow through this service, the service will continue to be therapy led, following the learning from the Huntley Place model that was implemented during the winter pressures period (2021/22).

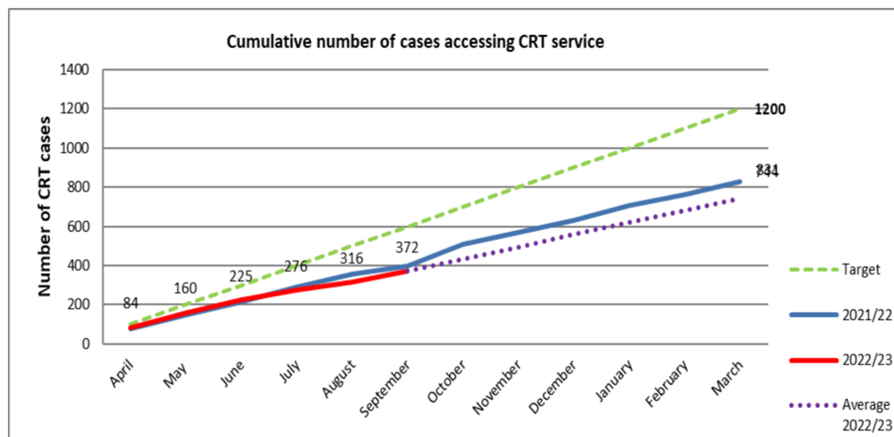
Cumulative number of Step up / Step down beds Throughput	
Target performance per year (not less than)	18
Actual performance this month	2
Status of Monthly performance	Green
Cumulative cases financial year to date	7



4.6.2 **Impact of Community Reablement Service**

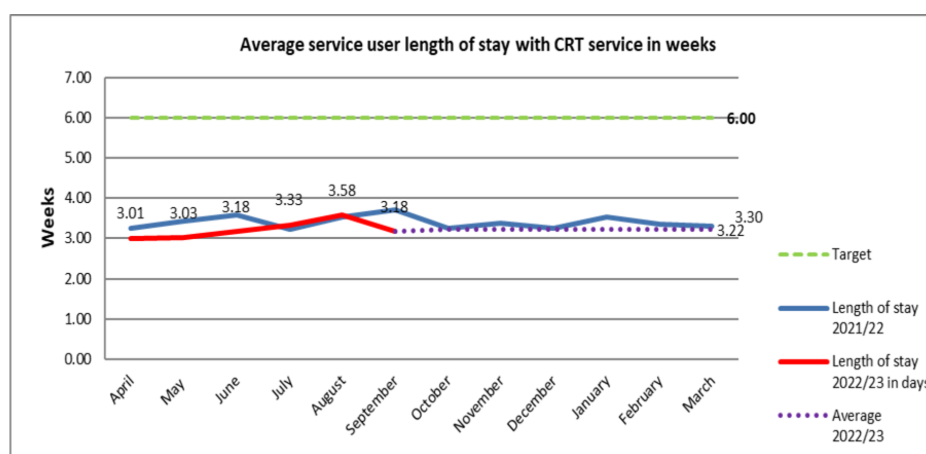
Numbers accessing the service: The number of people accessing support through the Community Reablement Team (CRT) service continues to be significantly below the expected level to achieve the target of 1,200 per year, with an intake of 225 as at the end of quarter 2. The majority of referrals are made following discharge from hospital but not all of these people have reablement potential, some are not well enough to start reablement, and some refuse reablement support. Reviews of the reablement services both locally, and in the wider Berkshire West area, with system partners across intermediate care, are ongoing and are seeking to address challenges and improve performance. Reporting has also been significantly affected by a system outage in relation to the rostering system used. Work has been ongoing to address the issues which were complex, taking several months to resolve. Due to the additional time taken in relation to allocating referrals manually, there had been 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 September 2022	56
Cumulative number of cases FY to date	372
Projected number of cases based on performance to date	744
Status of 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 September 2022. This indicates that people receiving reablement services are being effectively supported and enabled to regain their independence.

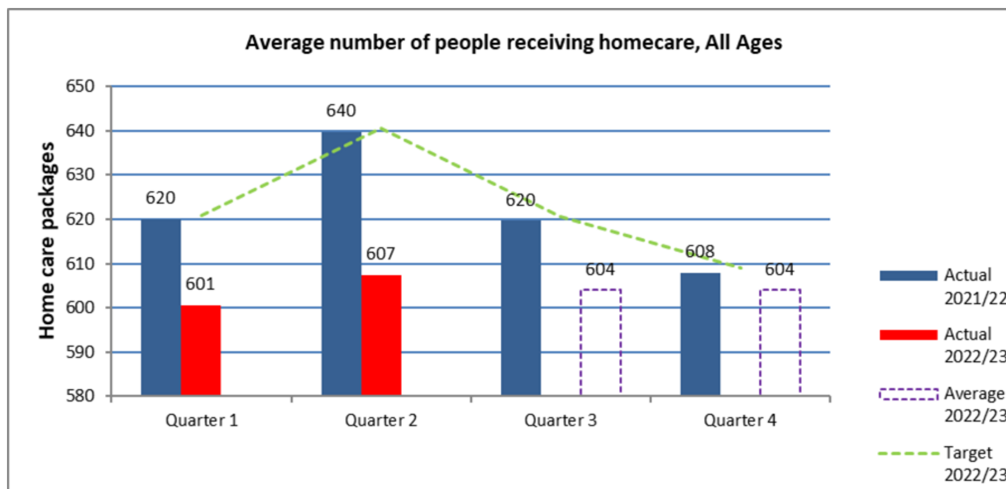
Average service user length of stay with CRT service in weeks	
Target performance per month (no more than)	6.00
Actual performance this month	3.18
Status of Monthly performance	Green



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 reduction (n33) of the number of care packages in quarter 2, 2022/23, compared to the same period 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 always be met through reablement. We also supported "self-funders" in 2021/22 as the hospital discharge funding enabled us to do that across the year, which meant the numbers were much higher.

Marginal increase in home care packages	
Average Annual Target performance	623
Average Annual performance (based on performance FY to date)	604
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 are outlined below:

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)**
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)

We are providing progress information here in relation to the MDT meetings, as this was a continuing project that is showing really effective outcomes that we wish to share with the Board. The MDTs are Multi-Disciplinary meetings that are held within groups of GP Surgeries that make up a Primary Care Network (PCN). There are several members of the health and care services in attendance at a Multi-Disciplinary Team meeting, including GPs, District Nursing, Mental Health, Social Work and Social Prescribers, that can review cases from all aspects of the care required to support that person to stay well. There are three MDT Clusters established:

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

Case finding for the MDT meetings continues to be via a Population Health Management approach, using our Shared Care Record system, “Connected Care”, to identify those most at risk and who are high users of health services. The criteria agreed with the PCN Clinical Leads. There were 66 people whose cases were reviewed by an MDT between July and September 2022 (Quarter 2). The impact of the MDT interventions for each of the cohorts is assessed at both 3 and 6 monthly intervals,

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.

A review of 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
Mental Health referrals	43% decrease	12% decrease
Acute Admissions	73% decrease	59% decrease
A&E attendances	61% decrease	32% decrease
SCAS	24% decrease	14% decrease
111	53% decrease	73% decrease
GP	41% decrease	No change

(Table 1)

Since the project went live in January 22, 220 patients have been brought to MDTs and Two examples of cases discussed are shown below.

MDT Case Studies:

Patient A - This patient was a high intensity user. He had a large Package of Care (POC) and 2-night warden visits, weekly Nomad boxes for his medication and was having his leg ulcers dressed by District Nurses. Prior to the MDT review, he was a high daily user of the ambulance service and made daily calls to the GP surgery. The patient agreed to move from his home and Adult Social Care (ASC) were investigating the most appropriate options. Following discharge from hospital the patient was moved into ‘warden controlled’ accommodation to meet his needs. Contacts with the system have reduced by more than 50%.

Patient B - GP referral as they felt that she should be rehoused because of mental and physical capacity issues and general health concerns. Social worker completed a Mental Capacity Act (MCA) Assessment around accommodation and had a Best Interest meeting around her capacity. It was decided that it would be in the patient's best interest that she would be re housed. This has now been arranged resulting in the patient being much happier, and addressing concerns raised by the GP.

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. Action plans have been developed in collaboration with the members of RIB, which includes representation from system partners, including Acute hospital, Community care providers, Primary Care and Voluntary Care Sector. Delivery against the action plans will be a collaborative approach, 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 in the short-term. Action plans will be regularly reviewed against the 10 year strategy. A Launch event for the Join Strategy and Action Plans was held on 12th December, to engage the wider community providers who were encouraged to pledge support.

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 wider context of 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, such as feedback on customer satisfaction for services such as Reablement. 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 Framework document will be agreed between Reading Borough Council and the Integrated Care Board (ICB), by the end of January 2023, for the management of the Better Care Fund pooled and non-pooled funds. The Section 75 document will encompass the additional Adult Social Care Discharge funding, to be released by NHS England in two tranches; December 2022 and January 2023, and therefore the deadline for completion of the Section 75 Framework document has been moved from 31st December to 31st January 2023.

10. FINANCIAL IMPLICATIONS

10.1 The Better Care Fund (BCF) plan for 2022/23 was submitted by 26th September 2022 and approved by NHS England on 6th January 2022. 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 the Integrated Care Board (ICB) and Adult Social Care service and finance leads from both organisations. An additional plan specifically for the Adult Social Care Discharge Funding (see Appendix 1) was submitted to NHS England by 16th December, following delegated sign-off by the Director of Adult Social Care in consultation with the Chair of the Health and Wellbeing Board, due to the submission dates falling outside the Health and Wellbeing Board meeting dates. Our plan for the ASC Discharge Fund has also been agreed on 6th January 2023.

This is a summary of Better Care Fund budget for 2022/23:

Running Balances	Income	Planned Expenditure
DFG	£1,197,341	£1,197,341
Minimum NHS Contribution	£11,781,757	£11,781,757
iBCF	£2,692,624	£2,692,624
Additional LA Contribution	£270,400	£270,400
Additional NHS Contribution	£0	£0
Total	**£15,942,122**	**£15,942,122**

The high level scheme types against which the funds are allocated are set out below:

Scheme Type	Expenditure	% of Total Fund
Assistive Technologies and Equipment	£184,500	1.2%
Care Act Implementation Related Duties	£2,079,046	13.0%
Carers Services	£529,423	3.3%
Community Based Schemes	£421,324	2.6%
Disabled Facilities Grant (DFG) related schemes	1,197,341	7.5%
Enablers for Integration	£970,808	6.1%
High Impact Change Model (HICM) for Managing Transfers of Care	£173,640	1.1%
Integrated Care Planning and Navigation	£1,118,623	7.0%
Bed based Intermediate Care Services	£1,761,265	11.0%
Reablement in a persons own home	£6,181,661	38.8%
Personalised Care at home	£1,279,491	8.0%
Prevention/Early Intervention	45,000	0.3%
Total:	**£15,942,122**	

The Adult Social Care Discharge Fund, is additional funding provided by NHS England:

ICB Portion of Adult Social Care Discharge Fund passported to Reading	Adult Social Care Discharge Fund	Total Adult Social Care (ASC) Discharge Funding for Reading
£810,196	£474,585	**1,284,781**

Category	Amount
Staff	
Agency capacity within Social Care; 6 x SW, 3 x OT	223,000
Operational Commissioning capacity	25,000
Contract Management and Administration	£12,785
Healthcare capacity	52,000
Increased social care staff capacity	70,000
Workforce development and retention	20,000
Sub-Total:	**402,785**
Care Home Capacity	
Mental Health placements	60,000
Additional D2A beds	124,800
Additional residential/nursing bed capacity	242,000
Contingency for high-cost placements	70,000
Risk pool: risk associated with discharge to assess, surrounding unresolved CHC or self-funding clients	130,196
Sub-Total:	**626,996**
Home Care Capacity	
Increased capacity (200hrs pw)	100,000

Sub-Total:	**100,000**
Additional Services	
Equipment (incl. additional TEC)	110,000
Additional Advocacy capacity	10,000
Ensuring safe home environment on discharge	35,000
Sub-Total:	**155,000**
TOTAL	**1,284,781**

Appendix 1 shows the planned spend for the ASC Discharge Fund.

11. BACKGROUND PAPERS

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

Appendix 1: Adult Social Care Discharge Funding Plan (December 2022)