READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**17th MARCH 2023**		
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 October to December 2022 (Quarter 3 of 2022/23 reporting period), and to outline the spend against the BCF Plan and the Adult Social Care Discharge Fund Plan (2022/23), an additional fund provided by NHS England to be used to support hospital discharge over the Winter 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, although we have been asked to continue monitoring at a local level. Outcomes shown here are as at the end of December 2022 covering the Quarter 3 period:

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. Spend against the BCF Plan and the ASC Discharge Fund are outlined in Section 10.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board note the Quarter 3 (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 spend against the Adult Social Care (ASC) Hospital Discharge Fund Plan for 2022/23 which is subject to fortnightly reporting to NHS England until the end of March 2023.

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

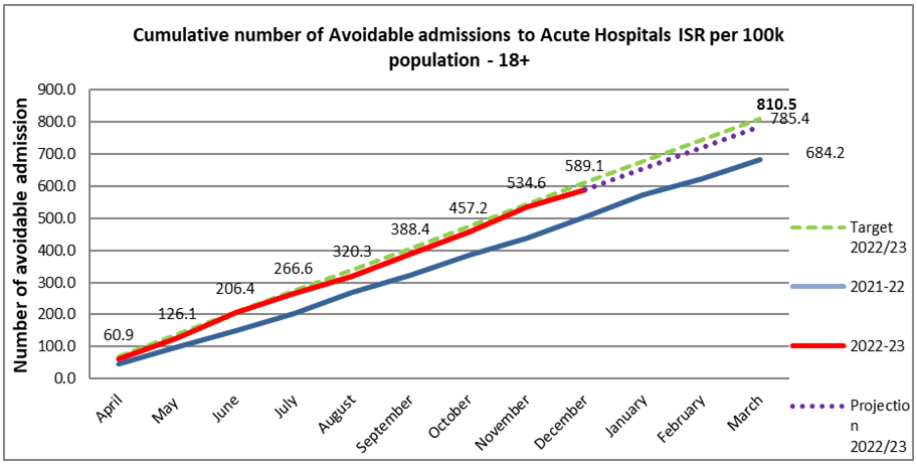
This aims to reduce avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions), and have no more than 811, per 100,000 population, for the year. This metric was adjusted to a more realistic target based on previous performance and projections for 2022/23. It measures 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 continue to 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	589
Average projected performance for the current period	785

[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



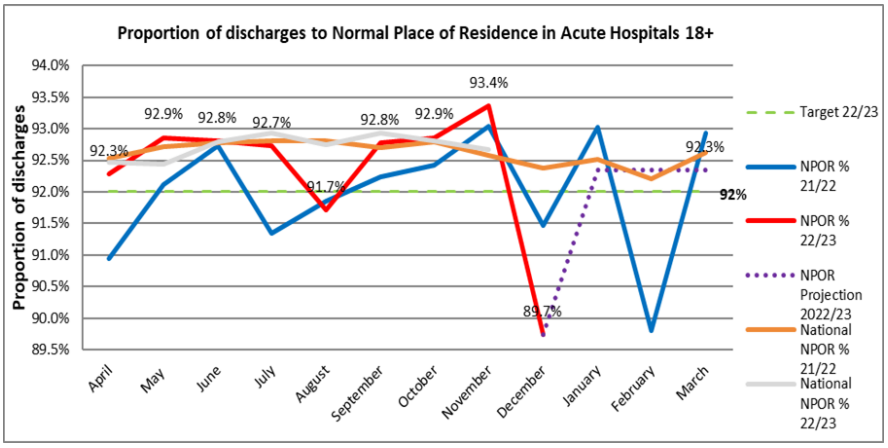
4.2 Discharge to Normal Place of Residence

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".

Although performance in December dropped slightly below the target, at 89.7%, the overall performance for Quarter 3 was 92.3%. The reasons for a drop in performance for the month of December was the high referral rate of complex needs, which meant that these patients were referred into Discharge to Assess beds. In some cases, due to a need for bariatric care and a lack of bariatric capacity within community hospitals, this has meant we have needed to use a block bed in a nursing home while rehab, and adaptations to their home environment where necessary, takes place.

We continue to work 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.

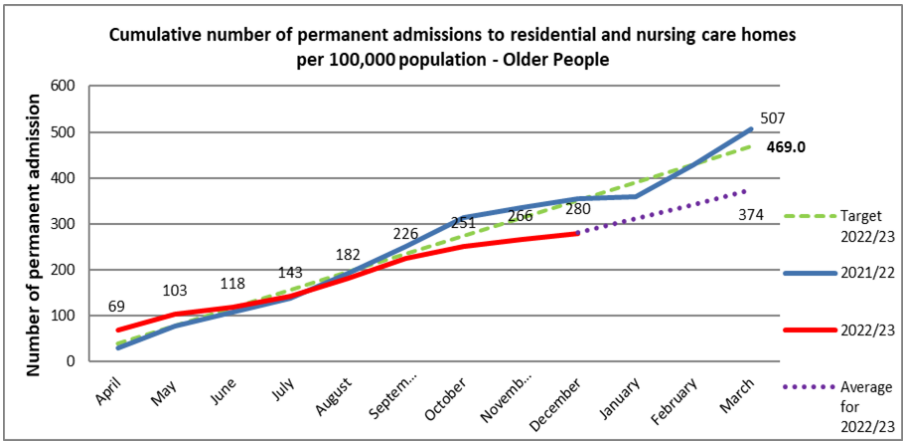
Proportion of discharges to Normal Place of Residence in Acute Hospitals 18+, per month	
Target performance per month (not less than)	92.0%
Actual performance this month (December)	89.7%
Average performance for the current period	92.3%
Status	Green



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.

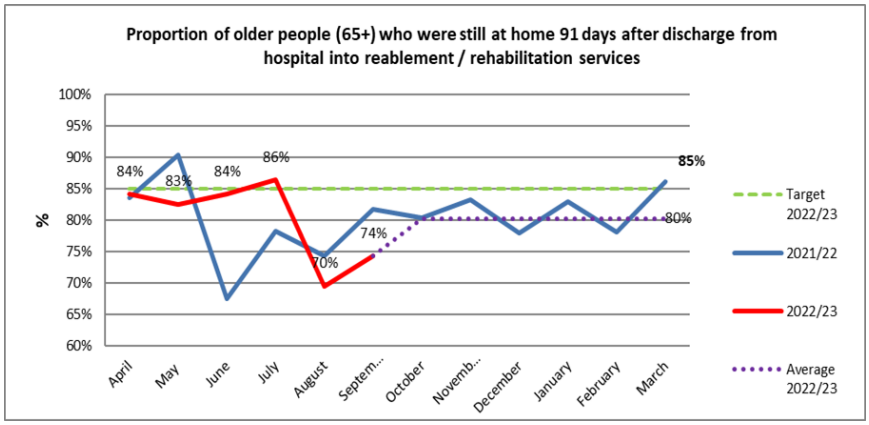
Cumulative number of permanent admissions to residential and nursing care homes per 100,000 population - Older People	
Target performance per annum (no more than)	469
Actual performance to date	280
Average projected performance for the current period (based on performance to date)	374
Status	Green



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 were 11% below the minimum target. NHS England reporting requirements are 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 83%, had we excluded those that had unfortunately passed away during that 91-day period, and still short of the target due to hospital readmissions.

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 hospital into reablement 91 days ago (numerical)	39
Of those, no. at home 91 days later (numerical) this month	29
Actual performance (%) this month	74%
Status of Monthly performance	Amber

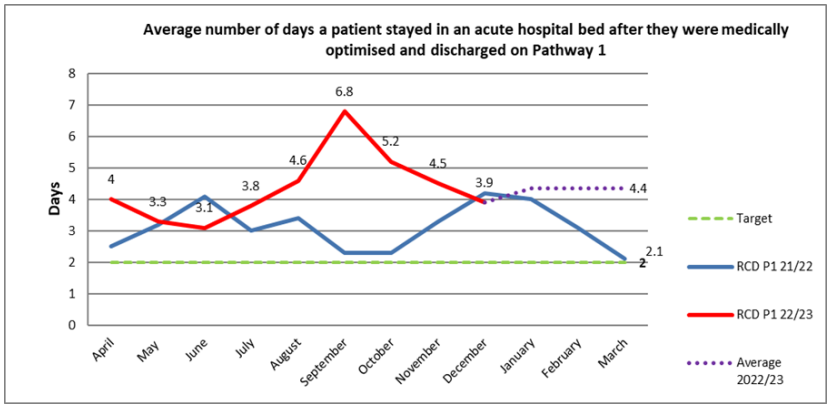


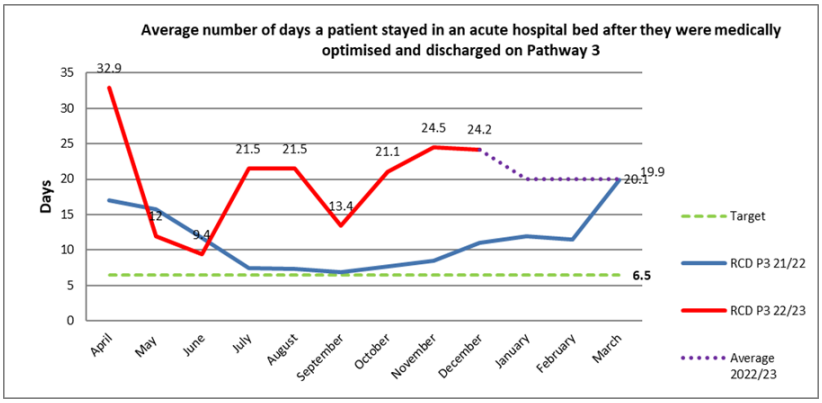
(based on people discharged in September 2022, who were still at home in December 2022 – the December cohort)

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 December, Pathway 1 discharge waits have continued to reduce to 3.9 days but are still outside of the 2 day max. target. The wait on Pathway 3 has reduced slightly but is still high due to complex care needs and awaiting agreement from health partners for funding specialist elements of care. There was also a Court of Protection case, where the patient became medically unfit on several occasions. Through the Adult Social Care Discharge Fund we have commissioned block beds, which has improved capacity for December, and there have been no restrictions in care homes which meant the flow has improved.



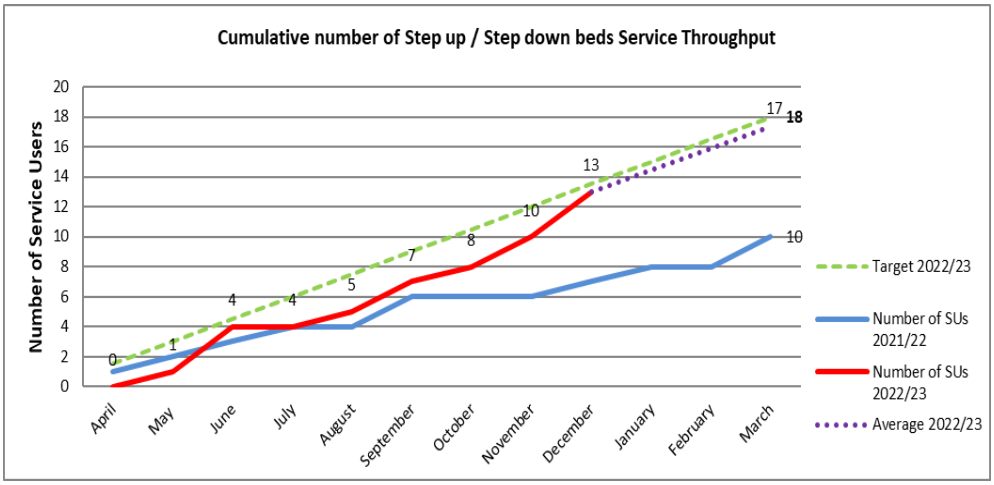


4.6 Local Schemes funded through BCF

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. Whilst the projected performance for the year is still slightly below the minimum required number of referrals there is a marked improvement. To support the flow through this service, it will continue to be therapy led, following the learning from the Huntley Place model that was implemented during the winter pressures period (2021/22). We have also commissioned an additional 4 D2A beds at Riverview, through the ASC Discharge Fund, to support flow out of hospital, which were all occupied as at the end of December.

Cumulative number of Step up / Step down beds Throughput	
Target performance per year (not less than)	18
Actual performance this month (December)	3
Status of Monthly performance	Green
Cumulative cases financial year to date	13

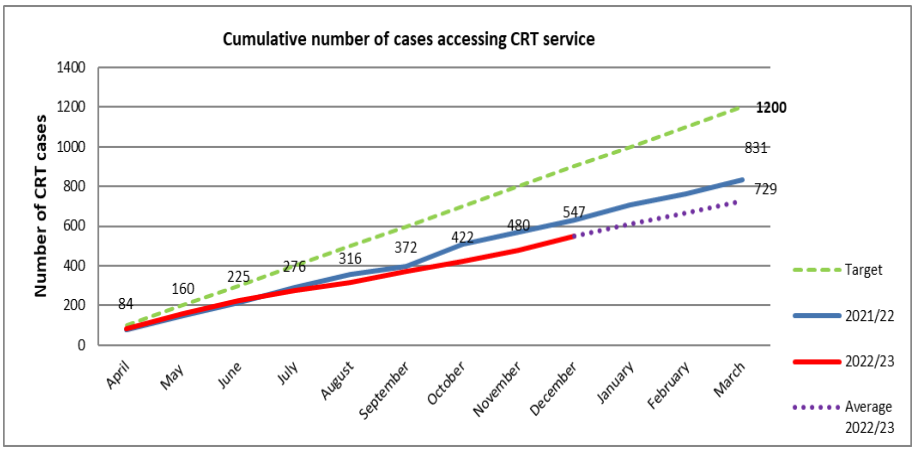


4.6.2 Impact of Community Reablement Service

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 543 as at the end of Quarter 3. 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. A manual solution was implemented and 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

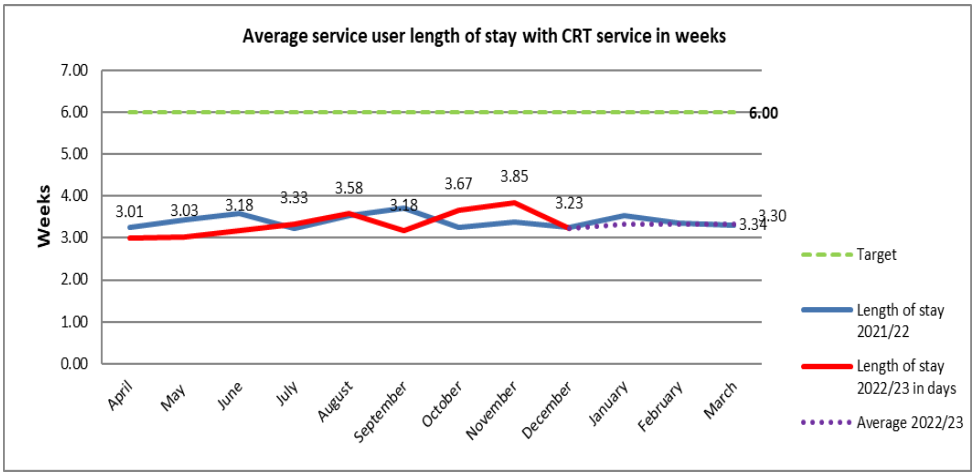
discharges on Pathway 1, where the primary support is provided by the reablement team. The Reading Integration Board have agreed that a Task and Finish Group will be set up to review factors impacting on performance, where the BCF targets are not being met, and agree an improvement plan.

Cumulative number of cases accessing CRT service	
Target performance per year (not less than)	1200
Actual performance December 2022	67
Cumulative number of cases FY to date	547
Projected number of cases based on performance to date	729
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 3.23 weeks, as at the end of December 2022. This indicates that people receiving reablement services are being effectively supported and enabled to regain their independence.

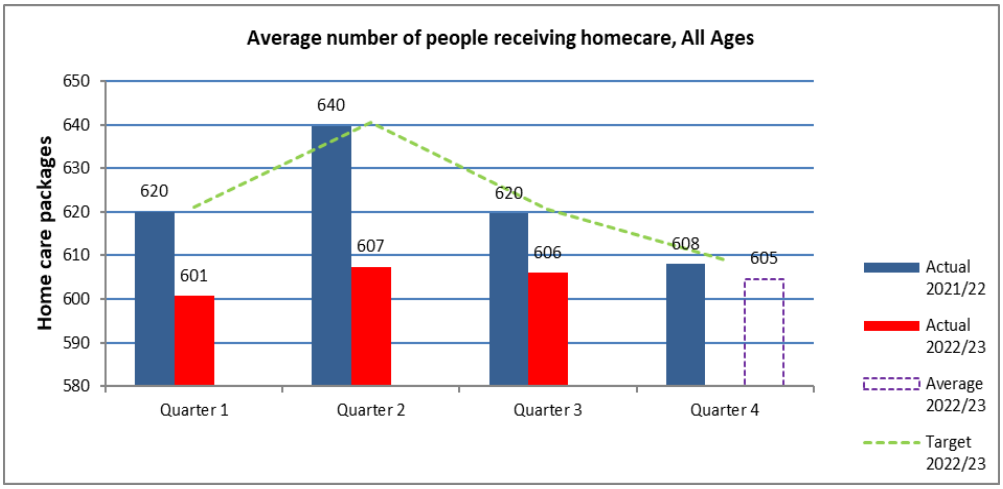
Average service user length of stay with CRT service in weeks	
Target performance per month (no more than)	6.00
Actual performance this month (December)	3.23
Status of Monthly performance	Green



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 (n14) of the number of care packages in Quarter 3, 2022/23, compared to the same period last year. We are continuing to see higher levels 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)	605
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,*	2.1 Discharge to Assess (D2A) / Admission Avoidance **(Continuing)**

RIB Priority	Key Projects (2022/23)
more effectively, meet the emerging needs of Reading.	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 **(New)**

We have outlined below, a few project outcomes and updates. A full programme update will be provided for the Health and Wellbeing Board in July.

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. 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 1 was a GP referral. They are an ex intravenous drug user patient. They are a high user of all services with anger management issues. They find it difficult to engage with formal support and safeguarding is in place due to self-neglect. The service user is waiting to have an allocated social worker and food parcels have been arranged for them. The ED Liaison service at the RBH have put a care plan in place for repeated ED attendances.

Patient 2 was found via case finding using Connected Care and is a high intensity user. They have been seen by the Community Matron and referrals have been made for a care needs assessment and to Domiciliary Physio to help improve movement. A pendant alarm and a key safe have been put in place. Adult Social Care will investigate some adaptations to the property. The Community matron will teach the patient good inhaler technique and to do a bladder scan to check for incontinence and will refer if needed. Communicare have helped with grants, Personal Independence Payments (PIP) and community support groups that speak Urdu.

4.8.2 **Self-Neglect Pathway**

Phase 1 of the pathway development for Self-Neglect, focused on Hoarding. An assessment and referral pathway has been developed in conjunction with the West of Berkshire Safeguarding Adults Board (WBSAB) and was presented to the Reading Integration Board members in February 2023.

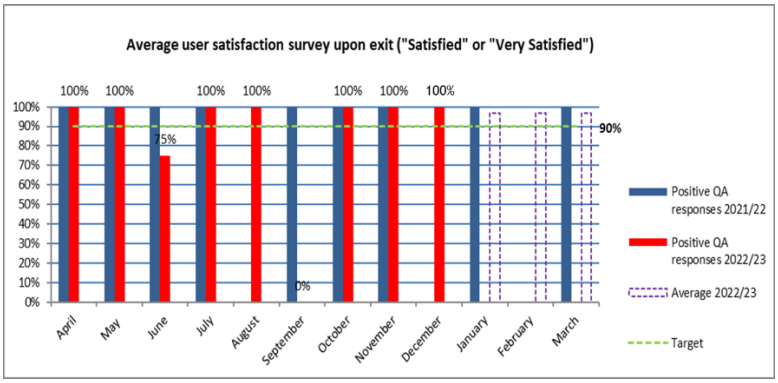
- The project has commissioned 15 Understanding Hoarding courses. And one level 2/3 course for staff who work more closely with these individuals. 2 Mental Capacity Act and Self-Neglect courses have also taken place. These courses are all going to continue to be available throughout this year (2023).
- Summary of feedback from the training – *'excellent piece of training should be compulsory'' very informative training, interactive and with lots of practical examples and shared experiences, This will help me in my role' 'a good use of my time'.*
- A Hoarding and Self-Neglect Protocol and Pathway are about to be launched, integrating the West of Berkshire Safeguarding Adult Board (WBSAB) risk assessment – this aims to provide clarity and consistency for all colleagues when making risk assessments. Brief training events in the use of the risk assessment tool for both external and RBC staff are planned for March 2023.

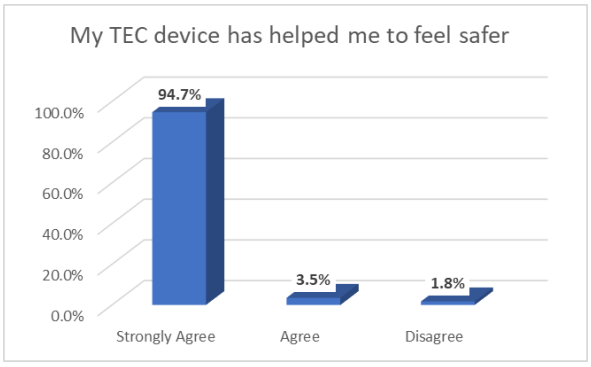
4.8.3 **Improve access to and awareness of services available**

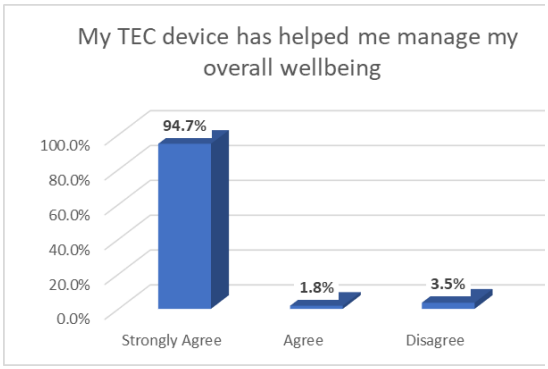
A funding bid was approved for Reading Voluntary Action (RVA) to procure a Social Prescribing platform that enabled easy access for referral to services, either through Social Prescribers, self-referral or via GPs, and to provide reporting that gives insight into the timeliness between referral and access to the service. The report function also enables clear data driven insights into any potential commissioning gaps. Following a procurement process, RVA have commissioned the JOY platform which is already being used within the Berkshire West "Place" in Wokingham and is shortly to come online in West Berkshire, providing the opportunity for a consistent person-centred approach across Berkshire West.

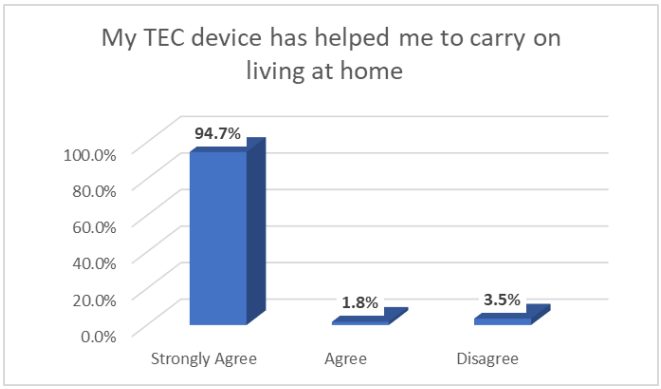
4.8.4 **Service User Feedback**

We have feedback from the users of our Community Reablement Team services, indicating a 100% satisfaction rate, and also very positive feedback from the Technology Enabled Care (TEC) service users (see charts below) and have worked with our Business Support Team to develop a survey that our ASC teams can undertake with our Service Users to ascertain their experience of integrated care, and will be able to share this feedback following the formal launch in March 2023.









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 Joint Strategy and Action Plans was held on 12th December, to engage the wider community providers who were encouraged to pledge support. Progress and successes are reported through the Health and Wellbeing Strategy Updates provided by the Public Health and Wellbeing Team.

5.2 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 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. Service User satisfaction rates for our Community Reablement Team remain high at 100%.

Average user satisfaction survey upon exit ("Satisfied" or "Very Satisfied")	
Target performance (not less than)	90%
Actual performance this month (December)	100%
Status of Monthly performance	Green
Projected average performance (based on performance to date)	97%

One of the 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. A number of partner organisations are 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 agreement has been drafted and will be agreed between Reading Borough Council and the Integrated Care Board (ICB), in respect of 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, released by NHS England in two tranches; December 2022 and January 2023.

10. FINANCIAL IMPLICATIONS

10.1 The Better Care Fund (BCF) plan for 2022/23 was submitted 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 Section 10.2) was submitted to NHS England 16th December, following delegated authority 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 was also agreed on 6th January 2023, subject to an adjustment to remove risk/contingency items and allocate all funds. An adjusted plan was resubmitted on 23rd 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 Total spend against the Better Care Fund as at the end of December 2022 (M10) is:
£ 13.211m

10.2 The Adult Social Care Discharge Fund, is additional funding provided by NHS England through the Better Care Fund, covering the period form 1st December 2022 to 31st March 2023:

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**

The high-level plan submitted is outlined in the table below. Fortnightly reporting is required to NHS England and the reported spend to date is indicated to provide assurance that the allocated funding is being used.

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	82,000
Increased social care staff capacity - Care hours	100,000
Workforce development and retention	20,000
Sub-Total:	**462,785**
Care Home Capacity	
Mental Health placements	90,000
Additional D2A beds	124,800
Additional residential/nursing bed capacity	322,496
Sub-Total:	**537,296**
Home Care Capacity	
Increased Home Care capacity (200hrs pw)	129,700
Sub-Total:	**129,700**
Additional Services	
Equipment (incl. Technology Enabled Care (TEC)	110,000
Additional Advocacy capacity	10,000
Ensuring safe home environment on discharge	35,000
Sub-Total:	**155,000**
TOTAL	**1,284,781**

10.2.1 The Reporting Templates were issued 20th December 2022 for the first return due by 6th January 2023, and we have reported fortnightly since that date, in line with the conditions of the grant. Information from the returns is presented here as a summary of activity reported covering the period 1st December 2022 to 26th February 2023 as at reporting date 3rd March:

Discharge Setting	Unit	Activity Totals
Home or domiciliary care	Hours	7,275.00
Reablement in a person's own home	Hours	502.75
Residential care	Number of Beds	65.00
Nursing care	Number of Beds	41.00
Intermediate care	Number of Beds	20.00

Service type	03/03/2023 Return (Spend 01/12/2022 to 26/02/23)
Home care or domiciliary care (long term)	£0.00
Home care or domiciliary care (short term - up to 6 weeks)	£75,000.00
Bed based intermediate care services	£70,200.00
Reablement in a person's own home	£21,768.52
Care home placements (residential - short term - up to 6 weeks)	£376,348.18
Care home placements (residential - long term)	£0.00
Residential placements (complex/nursing)	£32,399.57
Workforce recruitment and retention	£261,636.82
Assistive technology and equipment	£51,750.00
Spend on any other areas (e.g. admin, contingency etc. Outline any spend here in notes section)	£80,786.00
Total	**£969,889.09**

11. BACKGROUND PAPERS

11.1 The BCF performance data included in this report is drawn from the *Reading Integration Board Dashboard – January 2023(Reporting up to 30th December 2022)*.

11.2 Adult Social Care Discharge Fund Plan and ASC Discharge Fund Fortnightly returns as at 03/03/2023.