Reading BCF narrative plan
2023-25
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 Alliance 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 2023/25, 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 the Integrated Care Board, Berkshire West Place level Unified Executive and Integrated Care Services (ICS) which cover Buckinghamshire, Oxfordshire and Berkshire West (BOB) areas, representatives from the Integration Board also attend key

meetings at ICB and ICS level, and share local priorities with other 'place based' integration boards.

Governance

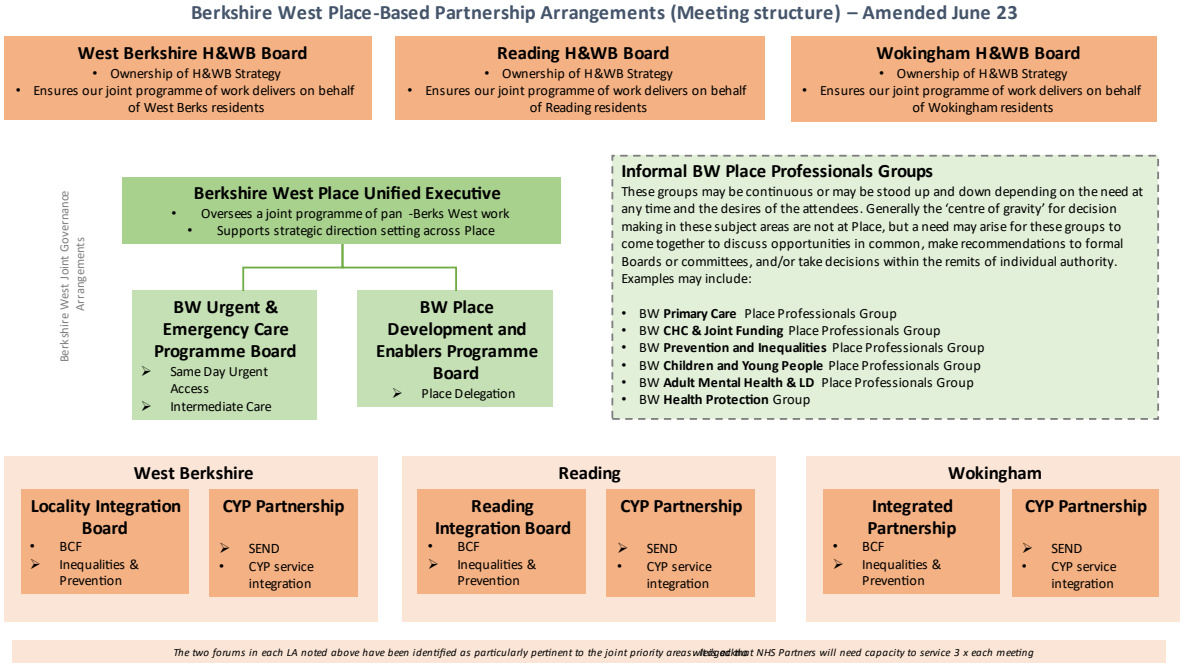
The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Service (BOB ICS) takes strategic decisions at scale for the benefit of its 1.8 million population, and the newly formed Integrated Care Board (ICB) at BOB level is responsible for commissioning system wide services.

The Berkshire West Place Unified Executive brings together the Berkshire West Urgent & Emergency Care Board and Place Development and Enablers Boards to identify opportunities to work at scale across both the BOB and ICB Place region. These boards have members from system partners in NHS foundation trusts, ambulance service and Local Authorities which serve the 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.

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*).*

The recent changes in primary care has led to the development of Primary Care Network Alliances and we have representation from this network across Reading as an active member of 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 graphic below shows the reporting lines of the Local Integration Boards into the Place based Unified Executive and up to the Health and Wellbeing Boards across the Berkshire West Place.



Executive summary

The Reading Health and Wellbeing Board, Better Care Fund (BCF) Plan for 2023-25 shows a continuation of the schemes that were funded in 2022-23. In collaboration and agreement with the Integrated Care Board (ICB), we have continued a Project Fund, setup last year, to support the Reading Integration Board (RIB) priority projects and to support us in meeting the Better Care Fund Objectives and the BCF Metrics. These were agreed with system partners representing health (Acute and Community), social care and voluntary sector services across Reading.

Priorities for 2023-25 – 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 Local Authority have developed a series of new projects that will support admission avoidance and improve discharge pathways including a new partnership with the Voluntary Sector to help people to find care and support within their communities. 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 continuing the work started in 2022-23 to review our Discharge Pathways and Discharge to Assess service, to continue a shift 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. We are developing an End-of-Life pathway, and specific pathways such as Bariatric and Delirium to support the complex needs of our local population. We are also going to provide reablement focused training to domiciliary care staff to increase recruitment and retention opportunities and to better support residents to remain as healthy and independent has possible at home.

3. Service User Engagement and Feedback

To ensure the voice of Reading residents drives the continuous improvement of integrated ways of working we are developing a coproduction charter that will include an intention to fundamentally change the relationship between Reading and its residents. A new Expert Citizens group will help us to codesign and develop new services and new ways of working that reflect the views of service users, carers and families. A consultation has commenced with carers across Reading to better understand their needs and shape services to support them.

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 continuation of the Social Prescribing Platform JOY which services are encouraged to register with to enable referral or self-referral onto a range of services provided by the voluntary and health care sectors.

5. Falls Prevention

A new Falls prevention and postural equipment service using specialist OT and musculoskeletal physiotherapist is being developed to offer help and advice to older people avoid falls and regain confidence if they have fallen. The emphasis will be on assessment, addressing risk factors, rehabilitation and exercise. The service will also make recommendations about medications, exercise, equipment and home adaptations. A diagnostic review will help identify the type of service and support needed and those most at risk.

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 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 Board, both Place based and 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.

National Condition 1: Overall BCF plan and approach to integration

To determine the Joint Priorities for Reading for 23-25 a reflection and associated learning through the integration board 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 were asked to pro-actively propose projects that address inequalities and support people to stay healthy and well at home. There is currently a large consultation taking place with Carers in our region, to better understand what they need to support them best and this is due to conclude in July 2023.

The providers that are funded through our BCF Plan, providing commissioned services, are actively encouraged to contribute to the 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 and Carers forums, Dementia Friendly Reading, Voluntary Care Sector and Carers and representatives who attend these groups are actively engaged in suggesting activities that could be funded to support our residents and the aims and objectives of the BCF. We had some really positive outcomes from the project bids that were approved with local community services last year and we will offer the opportunity again to our community providers to submit project bids to support us in delivery against our BCF objectives and meeting the metrics. One of the projects was to enable improved digital literacy in an area of deprivation with a voluntary care sector provider mainly supporting ethnic communities to build confidence in using digital applications and supporting online training to improve employment opportunities as well as community providers being able to use the space for hotdesking and training of the people using the community space:

- 40 individuals were trained in computer basics
  20 elderly participants and talks and conversation with 100 individuals on digital training
  5 Community groups used the hotdesking facilities
- 10 individuals received computer aided design (CAD) training.

Another project funded through the Better Care Fund, was to implement the JOY social prescribing platform across all the GPs within Reading and the Social Prescribing teams. There were over 400 referrals in the first two months of implementation and over 146 services signed up to the platform already. Once the two-year pilot is completed, we would look to enabling the self-referral options on the site as well. Our mental health services at Berkshire Health

Foundation Trust have also signed up to the platform to enable easy referrals into their Talking Therapies.

We have also supported the Reading project for Physical Activity for Mental Health (PAMH) through the Mental Health and Wellbeing Group and the graphic below gives an overview of that service for people with low level mental health:

We worked with our Dementia Friendly Reading Group and funded the production of a guide to dementia friendly activities and a dedicated website in Reading, both launched in May 2023.

We continue to work pro-actively with our voluntary care sector and community services to meet the needs of our local community and where possible we look to scale up to work at a Place level across Berkshire West.

The Reading Integration Board (RIB) Priorities 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)
- Berkshire West Unified Executive priorities that could be influenced or supported by the Integration Board

We remain committed to delivering against the national BCF metrics (outlined below), and the proposed targets for 2023/25. 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 2023/25. Of the £485k 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

- £240k to support project bids from voluntary care sector, community and council providers. The project bid fund will be topped up to using part of the underspend from 2022/23.

Reportable performance	Key Metrics	Performance 2022/23	Proposed Target 2023/25
BCF Monitoring	Admission Avoidance (per 100,000 pop)	774.5	767
	Falls	510*	500
	Reduce number of long-term admissions to Residential / Nursing Homes (65+), (per 100,000 pop)	408	432.8**
	Effective Reablement Service *(Increase the number of people still at home 91 days after being discharged from hospital into reablement services)*	79%	82.5%

*Actual count based on 2021/22
** Based on average actual performance across 2021/22 and 2022/23

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 been reduced based on the actual performance 2022/23. This is still a stretch given the potential impact of increased frailty of residents, post pandemic including long COVID systems, the cost-of-living crisis, energy price increases and winter flu.

We are supporting the Health and Wellbeing Board, the Berkshire West Unified Executive, and the BOB Integrated Care Board to deliver priorities for a number of local and national initiatives through the priority programmes they have outlined:

UE Project	UE Sponsor	SRO	Housed within Governance Structure
Same Day Urgent Access	Andy Statham	Adrian Chamberlain	BW UEC Joint Programme Board
Intermediate Care Review	Matt Pope	Lisa Shoubridge	BW UEC Joint Programme Board
Reducing preventable premature deaths	TBC (Sarah Webster in interim)	Belinda Seston	BW Prevention & Inequalities Working Group / Locality Integration Boards
CHC & Joint Funding	Sarah Webster	Liz Hodgkinson	BW CHC & Joint Commissioning Place Engagement Group

Special Educational Needs and Disability	Susan Parsonage	Paul Coe	LA CYP Partnerships / BW CYP Programme Board (TBC)
CYP Mental Health	Nigel Lynn	Tehmeena Ajmal	LA CYP Partnerships / BW CYP Programme Board (TBC)
High Complexity High Cost Placements	Julian Emms	Tehmeena Ajmal	BW MH & LD Place Engagement Group
Place Delegation Development	Sarah Webster	Belinda Seston	BW Place Development and Enablers Programme Board

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
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 last year was to support the avoidance of admissions and increase capacity through, Anticipatory Care, Virtual Wards and Virtual Care, and we are working with system partners at a Berkshire West "Place" level to review and further improve capacity.

Winter Discharge Funding received in 2022/23 enabled a range of additional capacity including more staffing and four additional D2A beds as well as additional reablement and home care hours in the community and a range of new support to improve discharge pathways. We propose a continuation of existing services into 2023/24 using new allocations confirmed for the next 12 months and we are in the planning stage of implementing a new plan of support and services to support winter pressures and enable timely hospital discharge, as well as admission avoidance, which will support the Better Care Fund metrics for 2023/25. Whilst the additional staffing capacity was beneficial, we identified specific gaps in the care market such as for complex cases (e.g. Bariatric) where specialist support was required. We are working towards addressing this in order to better meet the needs of people being discharged from hospital in a timelier way.

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.

National Condition 2: How we will meet the BCF 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 continuing to use a Population Health Management approach (PHM) 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, within the Primary Care Network Alliance, using criteria agreed with the Primary Care Clinical Lead representatives, 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 a number of those localities, which has been successful in promoting awareness within the communities.

Our Multi-Disciplinary Teams project has been successful and is now business as usual. This is delivered through the Primary Care Network Alliance, 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.

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.

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 over 1000 people now having used the service. This service provides cost savings and more flexible person-centred care for individuals. This service is being expanded in 2023/24 following the completion of a pilot for a 12 Week TEC provision to help people at risk. Once they are stable, they have the opportunity to continue with the TEC. This will also form part of the wider Falls Prevention strategy being developed and will be OT led.

- **Independent Living Pilots (Continuing)**

Having successfully completed a procurement exercise the Local Authority is working with two providers 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)

Under the Independent Living project is a new project in 2024/25 being run with 15 people with a learning disability to use the Auto-no-Me smart phone app that helps with everyday living and can provide tailored content including useful prompts and many how to guides including video tutorials such as food preparation. The Local Authority is also piloting the use of Brain-in-Hand a digital self-management support system for people who are autistic, who have learning disabilities or who are managing mental health difficulties.

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

This project is still in the development stages as we co-design a new service in partnership with Reading Voluntary and Community organisation. The aim of the programme is to co-work with people with the VCS working as part of 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. 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: Last year we supported the 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. This programme has recruited more than 31 PAs and development of a new PA Portal.

We continue to review the capacity in the care market and where we have identified gaps in specialist care we are working with our system partners to address those gaps e.g. Bariatric pathways. We have invested in our hospital discharge service to increase capacity to effectively manage discharges in a timely way and have agreed additional care hours capacity in the market to meet the demand.

Training: Royal Berkshire Fire & Rescue

Since 9th March 2023, the care quality team have been working closely with Royal Berkshire Fire & Rescue Service to promote the importance of both safe & well visits within people's own homes and to encourage care providers to attend training sessions led by the fire service in relation to fire safety within the home. To date 166 people have attended training sessions, this included 82 staff members from Reading Borough Council's adult social care. Bespoke training sessions have also been provided for carers who may have a visual or hearing impairment. This training has been instrumental in enabling carers to have a better awareness of fire safety within people's homes, especially for residents who are less mobile or rely heavily on carers on a daily

basis. Carers now have a better insight in how they can support the people of Reading with fire safety by assisting with basic tasks such as:

- Closing doors at night to stop fire/ smoke spread
- Not over charging batteries
- Not putting things in front of electrical and gas heaters
- Taking the fluff out of tumble driers etc.,
- Checking smoke alarms

Further joint working continues in relation to promoting the fire services safe & well visits with care providers, and since March 2023 the fire service have seen an increase in referrals by care providers. Whilst the fire service is unable to provide us with accurate data in relation to the exact number of safe & well referrals they have seen from providers, they have reported that overall, the referrals from the Reading area have increased. One of our domiciliary care providers have also referred a considerable number of service users for consideration to a home visit.

National Condition 3: How we will meet BCF Objective 2 - provide the right care in the right place at the right time

Funding was agreed in 2022/23, 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 enables triaging at the front door signposting patients onto the most appropriate pathway and support a reduction in LOS across all pathways (including P0). Services operate extended hours and 7 days a week supporting an increase in weekend discharge rates. Scheme includes: 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.

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. We are commissioning 4 additional Discharge to Assess beds as part of the Discharge Funding planning and additional staffing capacity to support us through the high demand period.

A Physiotherapy post, funded through the Better Care Fund, works 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 beds. Working with deterioration and deconditioning associated with ageing and dementia, hospital acquired functional decline, frailty, and other long-term conditions within Adult Social Care. Our Improved Better Care Fund (IBCF) is allocated to support reablement across the locality and to ensure appropriate support to maintain wellbeing at point of need.

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.

A new Hospital Discharge pilot programme has commenced with funding via the BCF to discharge people with TEC free for 12 weeks.

Mental Health Reablement

The pilot Mental Health Rehabilitation service has been a great success helping people to stay out of Hospital and living independently without the need for a care package. 12 people have so far been through the pilot with up to 12 weeks rehabilitation support. 11 out of the 12 users have left the programme and now have no care package and have not been admitted to hospital in the 9 months the pilot has been running. People that had previously gone into Hospital almost monthly have not had an episode of Hospital intervention. The success and learning of the pilot has led to an expansion of the support to people with Learning Disabilities. We hope to see the same results that have helped people regain their independence.

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	**Developing independent living skills**	**Supporting contact** with friends and family.

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

Routine	Environment	Motivation for Occupation
Sleep hygiene. **Developing full and productive routine** Considering weekly planners, identifying what needs to be done (domestic etc.), organising appointments. **Balancing activities** e.g. Self-care, productivity, leisure. **Supporting people to engage** with organisations to find employment /engage in productive occupations. **Developing regular patterns** of activities (e.g. brushing teeth twice daily, washing (not everyone showers/baths every day), eating, cleaning etc).	**Maintaining a safe and appropriate environment** • Supporting people to liaise with housing providers for maintenance issues etc; • Support with decluttering (if hoarding an issue); • Minor adaptation and equipment practice; • Safe use of the home.	**Support to identify and pursue interests** Interest checklists, trying new activities, finding out what activities are available locally. **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 Berkshire West Discharge group, which has a focus on acute hospital discharge into the community. The group meets fortnightly to discuss and address challenges to timely discharge of patients and improve patient flow. Ongoing projects being handled by the group are:

- 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 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 has been reviewed and amended to share with the discharge 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:

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. 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) Review of Multi-Disciplinary Triage process for CRT. 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. Weekly Directors meeting to discuss barriers and capacity within the system. 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 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. MDT working is in place across all our	Further improvement in documentation and reporting planned alongside reviews of Ward Round Etiquette in some areas.

	Trusts and embedded in local policies. 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.	
Change 4: Home first	We have 48-hour OT follow up, Review within 2 weeks post discharge for people on Pathway 1. We have 4 assessment flats for discharge to assess with a reablement focus, All system partners are committed to a Home First approach. Clear processes in place and pathways mapped at a LA level. 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) Additional capacity commissioned for peak periods based on learning from 2022/23. (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 restricted services and general staffing levels within Trusts are lower at the present time.	Financial investment required to enable RBC Hospital Discharge Team to provide a 7 day a week service. Additional staffing recruited through ASC Discharge Fund. (IN PROGRESS)
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. 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. 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. 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. 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) Joint working/funding between Health and Social Care. CHC – dedicated worker (through Winter funding - tbc). Dedicated care home contact in place.

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. Link with homeless services to ensure regular contact with people who prefer not to reside in a settled habitat. (COMPLETED) Raise discussion in Berkshire West Discharge group about support for homeless people on discharge. (COMPLETED)

We are continuing to invest in ways of enabling people to live as independently as possible. We have an ongoing local review of the Reading Borough Council Reablement services using external independent specialist and are also involved in a review of Intermediate Care service delivery at Berkshire West "Place" level. We believe the reablement target is currently not realistic as the intake model includes patients that should be on an 'End of Life' pathway, which we are looking at commissioning a service to support Hospice at Home. We have also worked closely with our voluntary care sector partners to support people who are vulnerable, and have commissioned a "Hospital to Home" service, that complements 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 of capacity 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 voluntary care sector information. We are working with specialists in the field of reporting and data analysis in order to improve our ability to report on capacity and demand more effectively and to meet the reporting requirements of the ASC Discharge Fund. All the funding was spent in 2022/23, with the main outcomes increasing staffing capacity to support timely discharge over the peak periods. We are looking to extend this and other schemes into this year and have submitted our plan which effectively supported discharges in the peak period of 2022/23.

Supporting unpaid carers.

We commissioned a new Carers support offer in 2022/23 including Carers Information, Advice and Guidance (IAG), for Reading and West Berks together.

The specification for the Information, advice and guidance service being delivered 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 promotes or protects 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 accommodation the individual's contribution to society

A new joint Carers Strategy is currently in development for Reading.

Carer's grants are provided to Carer's in the form of Direct Payments to help them maintain their caring role.

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. Once the person has been assessed the recommendations and specifications are usually completed within two weeks.

***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. These services are essential in enabling early return from hospital and preventing long stays and a home first ethos.

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, such as low-level mental health outreach, 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.

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.

The **Public Mental Health Dashboard** was 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. This data is accessed 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 successful projects in 2022/23 within that priority was the development of a Self-Neglect pathway for Hoarding.

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.
- 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.
- Developed a Hoarding Protocol shared across Berkshire West, including the core assessment toolkit: https://intranet.reading.gov.uk/page/hoarding-protocol

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.

We are also working with our Public Health team to identify additional activities to address inequalities and the proposals will be discussed at our Integration Board in July 2023 in order that a plan can be submitted to the Integrated Care Board as to how the additional Inequalities funding will be spent. This will be driven by local inequalities data, which was also referenced in the process of scoring the projects that the Integration Board will be taking forward over 2023/25.