Appendix 1: Reading BCF Quarterly Return (Q1)

HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

		Complete:
Health and Wellbeing Board:	Reading	Yes
Completed by:	Beverley Nicholson	Yes
E-mail:	beverley.nicholson@reading.gov.uk	Yes
Contact number:	0118 937 3643	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Reading

Has the section 75 agreement for your BCF plan been finalised and signed off?	No
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	17/11/2023

Confirmation of National Conditions

National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:	Checklist Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Reading

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information – Your planned performance as reported in 2023-24 planning				For information – actual performance for Q1	Assessment of progress against the metric plan for	Challenges and any Support Needs	Achievements – including where BCF funding is supporting improvements.	Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	197.0	174.0	198.0	198.0	187.8	On track to meet target	There are no challenges or support needs in relation to us meeting this target at the present time.	Effective support in the community to manage long term conditions and co-morbidities through Primary Care MDT meetings, Intermediate Care, rapid response pathways and use of	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.6%	92.1%	92.2%	92.0%	92.07%	On track to meet target	Whilst we were slightly below the quarterly target (by less than half a percent) we do not expect any significant challenges in meeting this target throughout the year.	We continue to work with the Voluntary Care Sector who deliver a Hospital to Home service, and settling in to support hospital discharge flows in a timely way.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,272.0	334.9	On track to meet target	Our Falls and Frailty project has been delayed, pending a diagnostic review across the Berkshire West Place.	We have engaged with our Voluntary Care Sector and Community providers to support people with frailty, as well as provision of Technology Enabled Care, and housing adaptations to	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				433		On track to meet target	Performance for Q1 was a cumulative figure of 127 admissions, per 100,000 population (65+). We had a higher than average number of admissions in Q1. Historically the trend has been that	We are working with our health and voluntary care sector providers, alongside our Technology Enabled Care services to ensure that only those people that need admission are	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				82.5%		On track to meet target	As at the end of Q1 we had met the target (Performance 91% in June - March discharges). The new target of 82.5% is applicable to discharges from April 2023 >.	Our triage processes for Community Reablement have recently been updated, to ensure people are getting the right care, in the right place, at the right time.	Yes

Expanded sections of text:

There are no challenges or support needs in relation to us meeting this target at the present time.	Effective support in the community to manage long term conditions and co-morbidities through Primary Care MDT meetings, Intermediate Care, rapid response pathways and use of Technology Enabled Care to support wellbeing and safety in the home environment.

Whilst we were slightly below the quarterly target (by less than half a percent) we do not expect any significant challenges in meeting this target throughout the year.	We continue to work with the Voluntary Care Sector who deliver a Hospital to Home service, and settling in to support hospital discharge flows in a timely way.
Our Falls and Frailty project has been delayed, pending a diagnostic review across the Berkshire West Place.	We have engaged with our Voluntary Care Sector and Community providers to support people with frailty, as well as provision of Technology Enabled Care, and housing adaptations to address risks and reduce likelihood of falls.
Performance for Q1 was a cumulative figure of 127 admissions, per 100,000 population (65+). We have had a higher than average number of admissions in Q1. Historically the trend has been that the number of discharges reduce from September for the remainder of the year, with admissions in the last 6 months representing 35% to 40% of total admissions for the year.	We are working with our health and voluntary care sector providers, alongside our Technology Enabled Care services to ensure that only those people that need admission are admitted.
As at the end of Q1 we had met the target (Performance 91% in June - March discharges). The new target of 82.5% is applicable to discharges from April 2023.	Our triage processes for Community Reablement have recently been updated, to ensure people are getting the right care, in the right place, at the right time.

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Reading

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
On our original plan, Reablement in a bedded setting and Rehabilitation in a bedded setting for Pathway 2, were two separate lines. On this template these two have been combined and therefore our capacity has been adjusted to combine both elements to meet the demand.	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
Our Length of Wait for discharge from hospital on Pathway 1 is currently 3 days on average against a 2 day target and an average of 8 days for Pathway 3 (local data) against a target of 6.5 days. We are increasing home care hours through the winter using the Discharge Fund, as well as commissioning additional Pathway 3 short term beds to enable assessment of ongoing care, particularly for people with complex needs. There are several scheduled meetings including Acute, Community hospitals and Adult Social Care to review and resolve any flow issues and alerts from our Acute	Yes
Capacity:	
Our commissioned capacity baseline has remained the same and we have the option to spot purchase addiitonal resource to meet demand bearing in mind that some needs will be complex and each case has to be dealt with based on the needs of the individual, which are often multiple. We continue to work closely with our care market providers and the Market Sustainability Improvement Fund (MSIF) has supported our market for care providers. The issues arise when care is arranged and then patients become medically unfit whilst waiting for discharge.	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
The data has remained largely unchanged from our submitted plan as projections are based on data over recent years, although we can never really know what the demand will look like, we are confident that our current projections are as accurate as they can be. We have capacity to spot purchase care where needed and have trained domiciliary care providers in rehabilitation to provide an extra level of reablement support if required. We work closely with our Voluntary and Community Sector partners, and have increased the support provided for hospital	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
We are currently managing waiting lists of referrals waiting for assessments and have a dedicated resource in place to reduce the waiting lists. There are some issues in relation to the percentage of patients who are put on the "ready to Go" discharge list but then become medically unfit again. Latest data shows 37% of failed discharges were due to the patient becoming medically unfit and 18% due to Transport issues. Only 2.2% of discharges were delayed due to the Social Care Services. When the discharge teams have started planning for discharge and	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
Data is not routinely retained where services are at capacity and unable to accept any more referrals which leaves a gap in our knowledge in terms of the true demand. We continue to work with our Acute and Community hospital partners to improve the quality of data received in relation to discharges and intermediate care in the community. We do not have one "single source of truth" in relation to our discharge data (although an attempt was made to bring in a digital platform to manage this, our hospital partners would not buy into this option). There is	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
The Council has block contracts in place with 3 providers for the provision of 38 nursing care beds and 27 nursing dementia beds (15 beds are out of borough). Broadly, the Council has sufficient provision to meet nursing care needs using in borough, out of borough, block and spot. The block commissioned provision is supplemented with spot purchased provision as required – taking into account affordability and choice. The most significant capacity challenges arise when meeting very complex needs – this can include people with significant mental health difficulties, or cognitive issues which lead to aggressive and challenging behaviours; but also, for people with needs around physical environment (e.g. a small number of people with bariatric needs). We also work closely with our Commnity Intermediate Care Rapid Response and Urgent Care providers, Berkshire Health Foundation Trust, who respond within the required 2 hours for rapids and 2 days for urgent to avoid hospital admissions wherever possible. The Acute hospital operates a "Virtual Ward" which is a joint initiative between the hospital and the community nursing teams to effectively	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

Expanded Text (from sections that overrun on template):

Section 2. Discharge Demand: Our Length of Wait for discharge from hospital on Pathway 1 is currently 3 days on average against a 2 day target and an average of 8 days for Pathway 3 (local data) against a target of 6.5 days. We are increasing home care hours through the winter using the Discharge Fund, as well as commissioning additional Pathway 3 short term beds to enable assessment of ongoing care, particularly for people with complex needs. There are several scheduled meetings including Acute, Community hospitals and Adult Social Care to review and resolve any flow issues and alerts from our Acute hospitals in relation to their OPEL status.
Section 2. Discharge Capacity: Our commissioned capacity baseline has remained the same and we have the option to spot purchase additional resource to meet demand bearing in mind that some needs will be complex and each case has to be dealt with based on the needs of the individual, which are often multiple. We continue to work closely with our care market providers and the Market Sustainability Improvement Fund (MSIF) has supported our market for care providers. The issues arise when care is arranged and then patients become medically unfit whilst waiting for discharge. This is capacity that has been held and not used and we are working with our Acute providers to enable timely updates to our brokerage and discharge teams. We have also embedded a Triage step for our referrals to reablement to ensure appropriate provisioning of care.
Section 3. Impact of Planned Interventions on C&D Planning and refreshed figures: The data has remained largely unchanged from our submitted plan as projections are based on data over recent years, although we can never really know what the demand will look like, we are confident that our current projections are as accurate as they can be with the data we have available to us. We have capacity to spot purchase care where needed and have trained domiciliary care providers in rehabilitation to provide an extra level of reablement support if required. We work closely with our Voluntary and Community Sector partners, and have increased the support provided for hospital discharges "Hospital to Home" offer, particularly to support people living alone.
Section 4. Discharge Capacity Concerns: We are currently managing waiting lists of referrals waiting for assessments and have a dedicated resource in place to reduce the waiting lists. There are some issues in relation to the percentage of patients who are put on the "Ready to Go" discharge list but then become medically unfit again. Latest data shows 37% of failed discharges were due to the patient becoming medically unfit and 18% due to Transport issues. Only 2.2% of discharges were delayed due to the Social Care Services. When the discharge teams have started planning for discharge and allocated appropriate care, this capacity is then not utilised when someone becomes unwell and this requires several checks with the hospital (or on the 3 x daily updates from the hospital) to continually check the status of patients which is not an effective use of time. Staff Sickness/Absence is always a concern in relation to potential impact on patient flow and our Public Health team have issued advice and guidance to all staff on staying well this Winter.
Section 5. Data Quality Issues: Data is not routinely retained where services are at capacity and unable to accept any more referrals which leaves a gap in our knowledge in terms of the true demand. We continue to work with our Acute and Community hospital partners to improve the quality of data received in relation to discharges and intermediate care in the community. We do not have one single source of our discharge data. There is no current way of tracking

a patient through their journey at each stage to assess impact. Therefore audits/satisfaction surveys are undertaken with random selections of patients in relation to their discharge experience and we await the collation of this data to inform service delivery.

Section 6. Approach for any projected Demand and Capacity Gaps: The Council has block contracts in place with 3 providers for the provision of 38 nursing care beds and 27 nursing dementia beds (15 beds are out of borough). Broadly, the Council has sufficient provision to meet nursing care needs using in borough, out of borough, block and spot. The block commissioned provision is supplemented with spot purchased provision as required – taking into account affordability and choice. The most significant capacity challenges arise when meeting very complex needs – this can include people with significant mental health difficulties, or cognitive issues which lead to aggressive and challenging behaviours; but also, for people with needs around physical environment (e.g. a small number of people with bariatric needs). We also work closely with our Community Intermediate Care Rapid Response and Urgent Care providers, Berkshire Health Foundation Trust, who respond within the required 2 hours for rapids and 2 days for urgent to avoid hospital admissions wherever possible. The Acute hospital operates a "Virtual Ward" which is a joint initiative between the hospital and the community nursing teams to effectively support someone and manage their needs in their own home.

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Reading

Hospital Discharge	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Reablement & Rehabilitation at home (pathway 1)	32	33	33	46	42	-5	-4	-2	-2	-3	0	1	3	3	2
Short term domiciliary care (pathway 1)	0	0	0	0	0	-9	-5	-8	-10	-9	1	5	2	0	1
Reablement & Rehabilitation in a bedded setting (pathway 2)	116	116	116	116	116	8	1	9	7	5	8	1	9	7	5
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	2	1	1	2	3	5

Capacity - Hospital Discharge		Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing				
Ser	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Soci	Monthly capacity. Number of new clients.	70	70	70	70	70	70	70	70	70	70	0	0	0	0	0
Real	Monthly capacity. Number of new clients.	61	64	63	65	66	61	64	63	65	66	5	5	5	5	5
Shor	Monthly capacity. Number of new clients.	25	25	25	25	25	25	25	25	25	25	10	10	10	10	10
Real hway 2)	Monthly capacity. Number of new clients.	119	119	119	119	119	119	119	119	119	119	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	4	4	5	10	12	4	4	5	10	12	1	1	2	3	3

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes

Demand - Hospital Discharge		Prepopulated from plan:					Please enter refreshed expected no. of referrals:				
Pathway	Trust Referral Source	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	Total	69	69	69	69	69	69	69	69	69	69
	ROYAL BERKSHIRE NHS FOUNDATION TRUST	69	69	69	69	69	69	69	69	69	69
Reablement & Rehabilitation at home (pathway 1)	Total	29	31	30	19	24	66	68	65	67	69
	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	29	31	30	19	24	66	68	65	67	69
	(blank)										
Short term domiciliary care (pathway 1)	Total	25	25	25	25	25	34	30	33	35	34
	ROYAL BERKSHIRE NHS FOUNDATION TRUST	25	25	25	25	25	34	30	33	35	34
	(blank)										
Reablement & Rehabilitation in a bedded setting (pathway 3)	ROYAL BERKSHIRE NHS FOUNDATION TRUST	3	3	3	3	3	111	118	110	115	114
	Total	3	3	3	3	3	111	118	110	115	114
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	4	4	5	10	12	4	4	5	10	10
	ROYAL BERKSHIRE NHS FOUNDATION TRUST	4	4	5	10	12	4	4	5	10	10

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Reading

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	39	83	61	24	50	39	83	61	24	50
Reablement & Rehabilitation at home	-42	-62	-67	-53	-53	10	7	1	2	2
Reablement & Rehabilitation in a bedded setting	1	0	1	0	1	1	0	1	0	1
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:					Checklist Complete:
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	Monthly capacity. Number of new clients.	69	69	69	69	69	69	69	69	69	69	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	177	221	199	162	188	177	221	199	162	188	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	168	127	157	152	137	168	127	157	152	137	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	4	2	4	2	4	4	2	4	2	4	Yes
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	Yes

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	69	69	69	69	69	69	69	69	69	69	Yes
Urgent Community Response	138	138	138	138	138	177	221	199	162	188	Yes
Reablement & Rehabilitation at home	210	189	224	205	190	168	127	157	152	137	Yes
Reablement & Rehabilitation in a bedded setting	3	2	3	2	3	3	2	3	2	3	Yes
Other short-term social care	0	0	0	0	0	0	0	0	0	0	Yes