READING HEALTH AND WELLBEING BOARD

Date of Meeting	12 July 2024
Title	BCF Integration Update
Purpose of the report	To note the report for information
Report author	Beverley Nicholson
Job title	Integration Programme Manager
Organisation	RBC – Adult Social Care / BOB Integrated Care Board
Recommendations	1. That the Health and Wellbeing Board note the Quarter BCF End of Year (2023/24) return, formally submitted by the due date of 23rd May 2024. 2. To note the contents of the BCF Refresh plan for 2024/25, formally submitted by the due date 10th June 2024 3. To note that both submissions were made following delegated authority sign-off by the Executive Director for Communities and Adult Social Care in consultation with the Lead Member for Public Health in order to comply with the national deadlines which fall outside the cycle of these Board meetings.

1. 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. This report will show the position as at the end of March 2024, and also outlines the spend against the BCF Plan, including the Discharge Fund to support hospital discharges in 2023/24.

1.2 The BCF metrics were agreed with system partners during the BCF Planning process. These will be refreshed for the 2024-25 Plan where appropriate. Outcomes shown here are for Q4 (January to March) 2023/24.

- **a)** The number of avoidable admissions (unplanned hospitalisation for chronic ambulatory care) **Not Met for quarter 4, overall Met for the year.**
- **b)** The number of emergency hospital admissions due to falls in people aged 65 and over, per 100,000 population. **Met**
- **c)** An increase in the proportion of people discharged home using data on discharge to their usual place of residence **Not Met**
- **d)** The number of older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population **Not Met**
- **e)** The effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation) **Met**

Details against each of these targets is outlined in Section 3 of this report and demonstrates the effectiveness of the collaborative work with system partners.

The report also covers the Better Care Fund (BCF) End of Year report for 2023/24 and the refreshed BCF Plan for 2024/25 which is a light touch update, recommending that we only change the target for the metric in relation to long term admissions to residential/nursing

care. Both the End of Year return and the refreshed plan were signed off through the Delegated Authority process in advance of submission by 23rd May and 10th June respectively. We continue to meet the National Conditions and the submissions are attached at Appendices 1 and 2.

2. Policy Context

2.1. The Better Care Fund Policy Framework[1] sets the principles 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 3.0 of this paper.

3. Performance Update for Better Care Fund and Integration Programme

3.1. Performance as at the end of Quarter 4, 2023/24

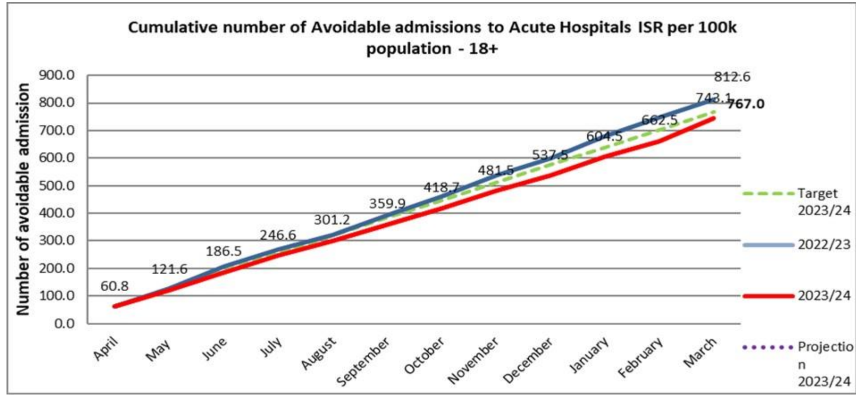
Admission Avoidance

This aims to reduce avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions), and have no more than 767 admissions, per 100,000 population, for the year. This metric was adjusted to a more realistic target based on previous performance and projections for 2023/24. It measures how many people with specific long-term conditions, which should not normally require hospitalisation if their conditions were well managed, who were admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and high blood pressure.

Whilst we did not achieve the target in Quarter 4, due to a 13% increase in admissions, compared to the average over the previous 3 quarters, we have achieved the overall target as at the end of the 2023/24. In review with the Integrated Care Board, we are reducing the target by 1%, after accounting for actuals and the health service projected increases in Non-Elective admissions of 2.3%, as well as population growth. We have also adjusted the quarterly targets to reflect the pattern of seasonal variations. Factors that support this positive outcome included 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. Other activity to support the promotion of healthy living is delivered through a variety of Public Health and Wellbeing services, working with Carers and Dementia groups, as well as our Voluntary Care Sector and Community partners.

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)	767
Actual cumulative performance to date	743
Status	Green

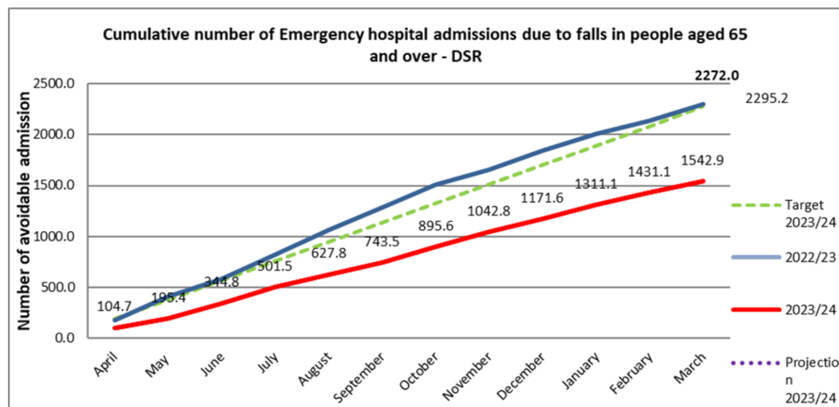
[1] https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025



Falls

This metric was introduced for 2023/24 in relation to emergency hospital admissions due to falls in people aged 65 and over. The target for 2023/24 is to have no more than 2,722 people per 100,000 (given the population of Reading for this age group this equates to no more than 500 people) and represents a 2% improvement on the average performance in the previous two years. We also continue to provide Technology Enabled Care equipment that could be installed/worn to build confidence and ensure early alerts for people who are frail or at risk of falls. Performance is positive, being significantly better than the plan and in discussion with ICB colleagues it has been agreed to apply a 2% reduction on actual numbers achieved in 2022/23 for the 2024/25 plan, allowing for increases in population and the Urgent & Emergency Care Board (UEC) predicted increase in non-elective admissions of 2.3%.

Cumulative number of Directly Standardised Rate (DSR) of Emergency hospital admissions due to falls in people aged 65+	
Target performance per annum (no more than)	2272
Actual performance to date	1543
Status	Green



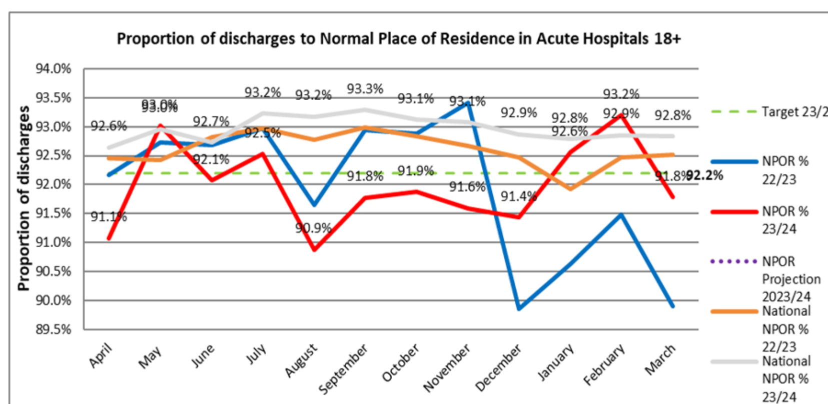
Reading Local Authority has agreed with the Integrated Care Board to carry out a Diagnostic review and map existing pathways and support across Berkshire West. The review will help understand the underlying causes that may support the development of future pathways and support. We have recruited a lead for the diagnostic review and this work has started with a view to completing this phase by the end of July 2024. The diagnostic review will inform the next steps in developing our falls and frailty service.

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 92.2% per month. This is based on hospital data for people “discharged to their normal place of residence”.

There has been some improvement in Quarter 4, and performance in March was 91.8, which brought the overall performance for the year up to 92%, just short of the target by 0.2%. Whilst there is an impact on this metric of the numbers of people being admitted to long term care there are more people returning directly home rather than into Pathway 2, which is community bedded care. This has improved outcomes against this metric. 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. We are not proposing any changes to this target for 2024/25.

Proportion of discharges to Normal Place of Residence in Acute Hospitals 18+, per month	
Target performance per month (not less than)	92.2%
Performance in March 2024	91.8%
Annual performance to date	92.0%
Status	Amber

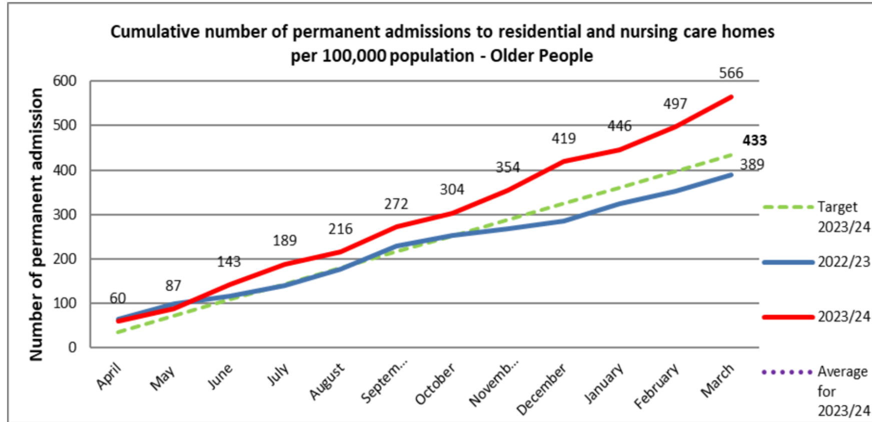


Permanent Admissions to Residential/Care Homes

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 433 admissions for the year. The quarterly target is no more than 108 people per 100,000 and for Quarter 4 there were 147 admissions per 100k. Across the year there has continued to be a steep increase in the number of admissions and this is primarily due to increased complexity, particularly for people with Dementia. Over 66% of admissions were to dementia care beds. We continue to work with our system partners to identify appropriate care for people to meet their needs and are aware of the Buckinghamshire, Oxfordshire, Berkshire West (BOB) Dementia Strategy draft, which will also inform our specialist discharge pathways.

We are proposing an adjustment to this target for 2024/25 based on 566 (which was the actual rate per 100k, for 2023/24), accounting for population growth in 65+, of a 1% decrease, which gives an amended target of 561.6 per 100k (124 people) for 2024/25.

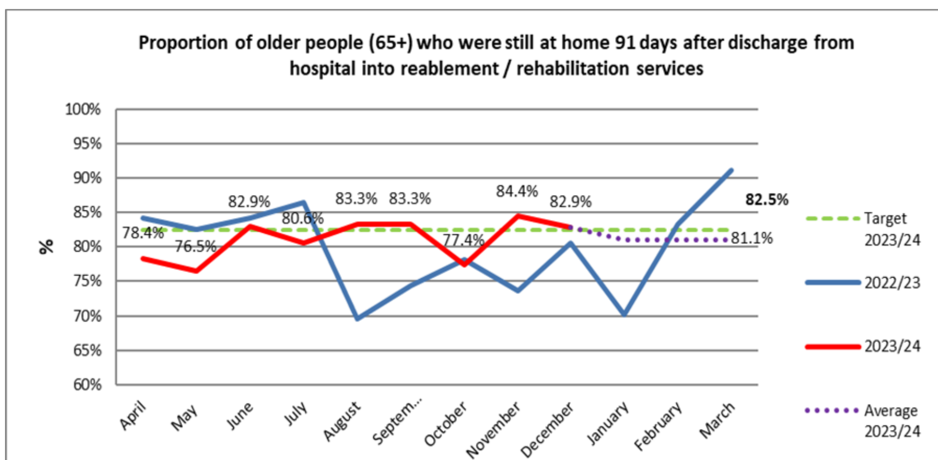
Cumulative number of permanent admissions to residential and nursing care homes per 100,000 population - Older People	
Target performance per annum (no more than)	433
Actual performance in Quarter 4 *(Target no more than 108)*	147
Annual Performance as end of March 2024	566
Current Status	Red



91 Day Rehabilitation (discharged June to September)

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 2023/24 is a minimum of 82.5%. and we have been able to meet the target at the end of December. There is a new Triage process in place for reablement, to ensure that referrals are only made where there is a true potential for reablement. We are currently in the process of scoping a specialist discharge pathway for a Hospice at Home, End of Life pathway to ensure people receive the right care in the right place at the right time. This metric has been removed from the 2024/25 planning template and will no longer be required.

Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	
Target performance (2023/24)	82.5%
Total no. of people departing hospital into reablement 91 days ago (numerical)	35
Of those, no. at home 91 days later (numerical)	29
Actual performance (%)	82.9%
Status of Monthly performance	Green



(based on people discharged December 2023, who were still at home in March 2024- the December cohort)

4. Contribution to Reading's Health and Wellbeing Strategic Aims

4.1. Our contribution to the overall direction of the Berkshire West Joint Health & Wellbeing Strategy 2021-30. Priority areas:

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

4.2. 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, Primary Care and Voluntary and Community Sector. Delivery against the action plans involves a collaborative approach, supported by the membership of the Integration Board. Action plans are in the process of being reviewed by the RIB membership, against the 10-year strategy and as a result of good progress since the implementation of the strategy.

4.3. In working to address priorities 1 and 2, grant funding is provided through the Better Care Fund to Voluntary and Community sector organisations for projects that support us in addressing these priorities. We are spotlighting the projects at each RIB meeting and have seen some great outcomes, such as the Parish Nurse project that we helped to seed fund from the Better Care Fund last year and funding this year to add more capacity. From January 2023 to December 2023 they had helped 914 people. They have a regular chair exercise group led by the Band 6 Nurse they were able to recruit with 32 people per week attending. The Nurse also provides mini health screening for people, which includes blood pressure and diabetes risk, and gives advice on health and wellbeing also signposting people to the right services. She also provides a lot of advice on disability aids and equipment. They have set up a men's breakfast group, craft and other meets and greets with the funding. They also helped people on end of life offering spiritual and health & wellbeing support until their passing. The Parish Nurse also goes out into the parish to provide support and works closely with Whitley CDA. They have had 406 referrals from other agencies and work closely with social prescribers, and have registered on the JOY marketplace so that referrals can be made through that platform, which is now being widely used across Reading. The team have also been able to recruit an additional 700 hours of volunteers to support the work and are developing a Community Garden at St. Pauls to help Mental Health as well as at St. Agnes (Whitley).

4.4. We also funded Compass Recovery College outreach service who run a Coffee & Chat group session, which we have linked into another project, which was managed by our Transformation Team, for a 12 week Reablement offer for Mental Health patients in Prospect Park Hospital. The two project leads were asked to review how these could provide some consistency for people leaving the reablement service and it was agreed that people in the reablement programme would be encouraged to engage in the Coffee & Chat groups in the last phase of their 12 week reablement to enable a social support network to be developed in the community before they finish the reablement.

4.5. Supporting People with Dementia: The Better Care Fund contributes to contracts commissioned by the Integrated Care Board from a place-based perspective across Berkshire West:

- Dementia Care Advice through Alzheimer's UK. The Dementia Care Advisers help the person with a diagnosis, carers, and family members by providing support as their point of contact throughout the dementia journey. The Dementia Care Adviser service funds 2 x 28 hour Dementia Care Advisers who provide information; give guidance around the dementia pathway and the caring role; refer to local services which promote independence; facilitate engagement with specialist services and encourage planning to help prevent crisis.

- Young Onset Dementia (YOD). The Young People with Dementia charity's model is integrated with local healthcare provision meaning that there is a seamless service from diagnosis to post-diagnostic support within the charity, to Admiral Nurse and Dementia Care Advisor. This model reflects several key needs that The Angela Project highlighted for people with YOD, including access to young onset specific advice, information and support to remain independent, supported age-appropriate activity and support to maintain physical and mental health. Key recommendations from The Angela Project relating to service design and development cited both the need to build capacity and ownership of young onset dementia services within, and between, organisations and to provide specialist or shared care, rather than care from a GP alone (3). The charity, with its integration with health care, has demonstrated cost-savings through supporting people at a time of crises by early monitoring and active engagement, thus reducing the burden on healthcare. It has also been shown to delay younger people with dementia's entry into 24-hour care.

4.6. The Reading Integration Board (RIB) Programme Plan objectives are mapped to both the Health and Wellbeing Board strategic priorities, as listed in 4.1 above, and the Integrated Care Board (ICB) priorities, listed below, to ensure alignment and effective reporting:

ICB key priorities are as follows:

- Same day access
- Intermediate care
- Community wellness
- CHC/Joint Funding
- SEND
- High complexity / high-cost placements
- Children and Young People's Mental Health

5. Environmental and Climate Implications

5.1. The Council declared a Climate Emergency at its meeting on 26 February 2019 (Minute 48 refers).

5.2. No new services are being proposed or implemented that would impact 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.

6. Community Engagement

6.1. 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 in 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 were 100%, with an average to date of 98%, against a minimum target of 90%. Service Users being discharged from hospital have been given an opportunity to provide feedback on their experience to enable us to shape our services.

6.2. Reading Adult Social Care have recruited a co-production lead and setup a Working Together Group of service users, carers and self-funders. This will help ensure that services are co-designed with service users, carers and families as much as possible, and feedback on user experiences will be gathered.

6.3. The Community Wellness Outreach Project is progressing well. This involves the provision of NHS Health Checks, delivered by qualified Nurses from the Royal Berkshire Hospital, within communities that are more at risk of poor health outcomes, with a focus on Whitley and Church wards and ethnic diversities within our communities in the first instance. There are also holistic wrap-around services to support people with mental health advice, housing, food poverty and debt advice and a range of other information and support which

is shaped based on what communities are indicating they need. The Social Prescribers and Community Champions are key partners to reach into these areas, and to ensure appropriate referrals and support is provided. The programme started delivery of the checks in December and as at the end of April there had been 471 people seen and the team are in the process of identifying options for more capacity. There has continued to be very effective collaboration across the system. Primary Care are working with us and messages were sent out to people within the core 20 Plus 5 group; in deprivation deciles 1 to 4, and after one surgery had sent the message out, over 200 bookings were made. The sessions at the moment remain 50/50 drop in and booked. We have also been approached by colleagues in Public Health, Community Health Champions, with a view to adding screening facilities into the offer at the Community settings, for TB, Sickle Cell and Prostate Cancer, as the model is working well, engaging the wider ethnically diverse groups in Reading.

7. Equality Implications

7.1. Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2. There are no new proposals or services recommended in this report that would impact negatively on anyone with protected characteristics.

8. Other Relevant Considerations

8.1 The Better Care Fund Planning and Performance reporting included in this report requires us to adhere to the Better Care Fund Framework 2023/25 four National Conditions and the Better Care Fund Objectives:

- National Condition 1: Plans to be jointly agreed.
- National Condition 2: Enabling people to stay well, safe and independent at home for longer.
- National condition 3: Provide the right care in the right place at the right time.
- National Condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

BCF Objective 1: Enabling people to stay well, safe and independent at home for longer.
BCF Objective 2: Provide the right care in the right place at the right time.

9. Legal Implications

9.1. Compliance with the Better Care Fund (BCF) 2023/25 National Conditions: The report sets out the National Conditions in Section 8. A Section 75 Framework Partnership Agreement (2023/24) was agreed between the Integrated Care Board (ICB) and Reading Borough Council (RBC) in relation to the pooled funds, in accordance with the Planning

Requirements[2], and the Addendum for 2024/25[3] and remains in line with National Conditions 1 and 4.

10. Financial Implications

10.1. BCF 2023/24 Expenditure to date against the Plan

This overview of the BCF budget shows the end of year variance of £450.9k. There are projects for which funding was committed that have been slow to start, so only a small spend, along with a shift in timelines agreed at the Reading Integration Board and Directorate Management Team meetings. These projects include the Front Door project for which funding has been increased for 2024/25, with an expectation for this to start in June 2024. The Falls and Frailty project was dependent on recruitment to undertake the Berkshire West wide diagnostic review has now commenced to inform the development of a Falls & Frailty service in Reading. This will build on, and bring together elements of falls prevention that are already showing positive results. There is an additional c/fwd BCF reserve from 2022/23 which was allocated to specific projects to support admission avoidance and support effective discharge. There is £713k of this fund being c/fwd into 2024/25, which has been allocated to these schemes. The Specialist Discharge Pathways have been dependent on audits and the wider strategic work within the Integrated Care Board (ICB) and BOB Integrated Care System, to ensure alignment. It has been agreed between the Council and the ICB that the committed funding of £1,163k will be carried forward to support these projects into 2024/25 and this will continue to be reviewed at the Integration Board each month.

RIB Summary Report at P12	Original Budget £k	YTD Budget as at 31/03 £k	YTD as at 31/03 (Actuals) £k	Forecast to 31/03/24 £k	Variance £k
Summary					
Reading Borough Council Hosted Schemes	11,751.0	11,750.6	11,308.1	11,299.8	(450.9)
BOB Integrated Care Board	1,699.7	1,699.6	1,699.6	1,699.7	0.0
Cross BOB ICB Hosted Schemes	3,296.5	3,296.1	3,296.1	3,296.6	0.0
Total	**16,747.2**	**16,746.3**	**16,303.8**	**16,296.1**	**(450.9)**

10.2. Hospital Discharge Fund

Returns were submitted in line with the required reporting schedule. As at the last return submitted for expenditure up to 31st March, £1,820,073 (see table below) had been spent against the total fund of £1,211,427. The main contributor to this overspend was the high costs of complex care beds to support Pathway 3 discharges, which indicates the increasing complexity of needs. Over 66% of beds required were dementia care.

Scheme Type	Planned Spend	Total spend to date
Home care or domiciliary care (Pathway 1)	£150,000	**£123,949**
Home-based intermediate cae services (Pathway 1)	£40,000	**£36,001**
Bed based intermediate care services (Pathway 2)	£270,400	**£161,880**
Residential placements (Pathway 3)	£249,925	**£881,940**
Workforce recruitment and retention	£264,000	**£344,601**
Assistive technologies and equipment	£100,000	**£100,000**
Voluntary and community support	£37,982	**£37,982**
All other spend	£99,120	**£133,720**
Total	**£1,211,427**	**£1,820,073**

[2] https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

[3] https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements#:~:text=The%20Better%20Care%20Fund%20(%20BCF,place%20at%20the%20right%20time

The total overspend against this fund was £608,646. We continued to report the overspend on the monthly returns, in order to demonstrate the cost pressures on adult social care. **Note:** on the BCF End of Year template we are only able to report 100% of the discharge fund having been spent, but have noted that there has been an adjustment to planned spend in 2024/25 based on this shift in trends across 2023/24.

The planned income for the Discharge Fund is significantly increased in 2024/25 at £2,102,788.The funding is split across two income streams; Local Authority £629,170 and ICB £1,473,618. We have maintained the areas of spend for this fund but increased the allocation in areas of greatest need and reduced in other areas based on actual spend in the previous year.

11. Timetable for BCF Planning and Implementation

11.1. The Better Care Fund (BCF) plan covers the period 1st April 2023 to 31st March 2025 and the refresh for 2023/24 is to enable us to update capacity and demand plans as well as the planned expenditure and any changes to the plan from the initial submission. We are working with our system partners to develop the Demand and Capacity reporting, based on actuals in 2023/24. In agreement with the Urgent and Emergency Care Board (UEC) and the Integrated Care Board (ICB), we have included an expected growth in non-elective admissions of 2.3%, as advised by the Urgent and Emergency Care Board, and also a 2% increase in our over 65 year population figures. The Metrics have also been updated in agreement with system partners and our neighbouring Local Authorities in the Berkshire West area are applying the same method to setting the BCF Performance Targets for 2024/25.

11.2. The BCF End of Year Return submission date was 23rd May 2024 and the BCF 2024/25 Refresh of the Plan submission date is 10th June 2024. The draft refresh plan has been submitted for regional BCF Scrutiny from subject matter experts and the Integrated Care Board for Berkshire West Place leads to review. Final adjustments are to be made based on feedback, ahead of a planned delegated sign off process on 3rd June, before formal submission to the Better Care Fund Team at NHS England. A refreshed Section 75 Framework Agreement outlining the pooled funds and Risk Share, is to be agreed between the Council and the Integrated Care Board, and is required to be in place by 30th September. The proposal is to complete a Deed of Variation on the full Section 75 completed for 2023/24, outlining changes made as part of the refreshed plan submitted for 2024/25 and our legal team are supporting with this work.

12. Background Papers

The BCF performance data included in this report is drawn from the Reading Integration Board Dashboard – April 2024 (Reporting up to 31st March 2024*).*

Appendices *(available on request as these are large documents)*

1. Reading BCF End of Year Return 2023/24
2. Reading BCF Plan Refresh 2024/25