READING HEALTH AND WELLBEING BOARD

Date of Meeting	14 March 2025
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 performance in Quarter 3 against BCF Metrics 2024/25 is noted. 2. That the Health and Wellbeing Board note the BCF Quarter 3 return (2024/25) was formally submitted by the due date of 14th February 2025, following the Delegated Authority procedure.

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 December 2024 (Quarter 3), and also outline the spend against the BCF Plan, including the Discharge Fund to support hospital discharges in 2024/25.

1.2 The BCF metrics were agreed with system partners during the BCF Refresh Planning process for 2024-25.

a) The number of avoidable admissions (unplanned hospitalisation for chronic ambulatory care) The target for Q3 was no more than 176, per 100,000 population, **Met**
b) The number of emergency hospital admissions due to falls in people aged 65 and over, per 100,000 population. The target for Q3 was no more than 456, **Met**
c) An increase in the proportion of people discharged home using data on discharge to their usual place of residence. The target for Q3 was not less than 92.2% **Met** *(Note: this was met for the Quarter but not on track for the year. The current forecast is 91.9%)*
d) The number of older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population. The target for Q3 was no more than 140. **Not Met**

Details against each of these targets are outlined in Section 3 of this report along with examples of the collaborative work with system partners.

The report also covers the Better Care Fund (BCF) Quarter 3 return for 2024/25, attached at Appendix 1. The Quarter 3 return was signed off through the Delegated Authority process in advance of submission by the due date of 14th February 2025.

2. Policy Context

2.1. The Better Care Fund Policy Framework[1] and the Addendum to this policy for refreshed plans in 2024/25[2] set out 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 and Community Sector partners and Healthwatch, across Reading. The aim of the board is to facilitate partners and other interested stakeholders to agree and deliver 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 the Integration Programme

3.1. Performance as at the end of Quarter 3, 2024/25

3.1.1 Admission Avoidance

This measure aims to show a reduction in avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions). This measures how many people with specific long-term conditions, which should not normally require hospitalisation if their conditions were well managed, were admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and hypertension.

Our target for 2024/25 is to have no more than 753 admissions, per 100,000 population, for the year. The target for Q3 was no more than 176, per 100,000 population. The actual performance was 156.9 Targets for 2024/25 were set by reviewing the performance in 2023/24, when we met the target for that year by a small margin and our Urgent and Emergency Care Board, in their health capacity and demand planning, predicted a 2.3% increase in non-elective admissions for 2024/25 which we applied to our actuals from last year. We then applied a 1% reduction to set this target, as the BCF Planning Guidance requires a "stretching target" for plans to be agreed. We believe this is a stretching target given the increasing complexity we are seeing in hospital discharges.

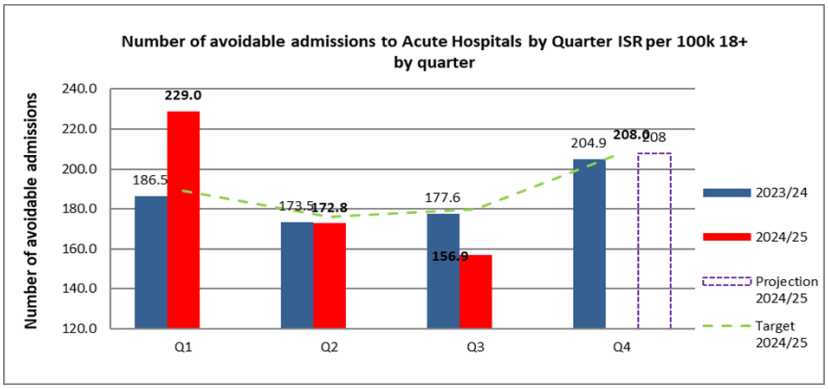
Analysis of the reported data shows that the top three conditions that people are admitted for are Chronic Obstructive Pulmonary Disease (COPD), Asthma and Heart Failure. We have a working group actively reviewing communications over the Winter period to ensure people are reminded to have their annual reviews with their GP and know what to look for in the early stages of their condition worsening, and take early action. The ICB have also issued risk stratification guidelines to GPs to enable early identification of any worsening COPD symptoms.

We continue to work with our public health, system partners and operational teams to reduce the number of admissions, and have the Community Wellness Outreach project running which provides Health Checks, with a particular focus on people who are at risk of poor health outcomes, and ensuring follow up with GPs where there are particular concerns raised during the check, that need to be addressed urgently.

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

[2] Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements - GOV.UK (www.gov.uk)

Number of Unplanned hospitalisations for chronic ambulatory care sensitive conditions per 100,000 population - 18+, Acute hospitals	
Annual Target for 2024/25 (no more than)	753
Target performance for Quarter 3 (2024/25) (no more than)	176
Actual performance in Quarter 3 (2024/25)	156.9
Actual annual performance to date (2024/25)	559
Status	Green



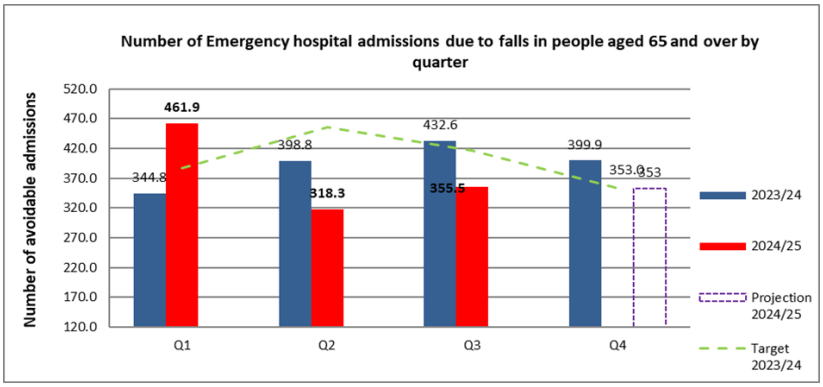
Note: *As data is refreshed retrospectively, i.e. reported admissions are flagged at discharge date, the position reported here may change as some people are admitted but not discharged within the quarter, and for this reason we are using data one month after the end of the quarter to calculate the position for the risk share claims from the BCF.*

3.1.2 Falls

This metric is in relation to emergency hospital admissions due to falls in people aged 65 and over. The target for 2024/25 is to have no more than 1,612 per 100,000. The performance as at the end of December 2024 was 1,136, and this is still significantly lower than performance in the same period in the previous year. We performed well against this target in 2023/24, and significantly below the average 3 year maximum that had been set. It was noted that the 65+ population figure being used on the planning template was not using ONS datasets and had been static since 2021/22 and yet our 65+ population has been increasing, so we changed the population figure to match the 65+ population used for Long Term Admissions to Residential/Nursing care which also focuses on this group. This change showed a 4% increase in the population of 65+ from the original figure that had been used as a denominator (i.e., 21,100). The target equates to a 2% reduction on actual performance in 2023/24 accounting for the adjustment in population figures.

We 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. A diagnostic review of falls was undertaken and the findings presented to the Reading Integration Board in November to inform further development of the falls service in Reading. An addendum will be included in the report for Health and Wellbeing Board in March to share the highlights of the review.

Number of Emergency hospital admissions due to falls in people aged 65+ per 100,000 population. Directly Standardised Rate (DSR)	
Annual Target for 2024/25 (no more than)	1,612
Target performance quarter 3 (no more than)	456
Actual performance in Quarter 3 (2024/25)	356
Actual annual performance to date (2024/25)	1,136
Status	Green



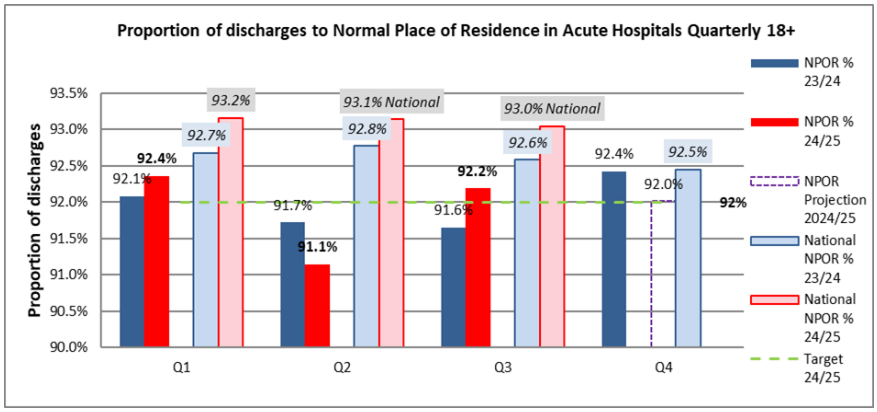
***Note**: This data is subject to change because updates are made to the dataset retrospectively when people are discharged from hospital, not on admission and this can span over two quarters.*

3.1.3 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 quarter. This is based on hospital data for people "discharged to their normal place of residence". Performance in Quarter 3 has improved, with the quarterly target being met but the annual performance to date is slightly below the annual target and remains below the national average by 0.8% for this metric. The target for this metric was maintained at the same rate as last year, as we did not meet the target in 2023/24 missing it by just 0.2%. Given the increasing complexities we have seen in hospital discharges it was agreed that we should maintain this target at the same level as in the original 2023/25 plan, which would constitute a stretching target.

There is an impact on this metric of the numbers of people being admitted to residential/nursing homes (see 3.1.4) for their long term care. We continue to work with the multi-disciplinary team and the hospital discharge hub, to follow the ethos of "Home First", in line with the Hospital Discharge Policy with support from domiciliary care and, if needed, through the use of TEC / equipment that can be installed to support independent living, and reablement.

Proportion of discharges to Normal Place of Residence in Acute Hospitals 18+, per month	
Annual Target for 2024/25 (no less than)	92.2%
Target performance per quarter (not less than)	92.2%
Actual performance in Quarter 3 (2024/25)	92.2%
Actual annual performance to date (2024/25)	91.9%
Status	Green



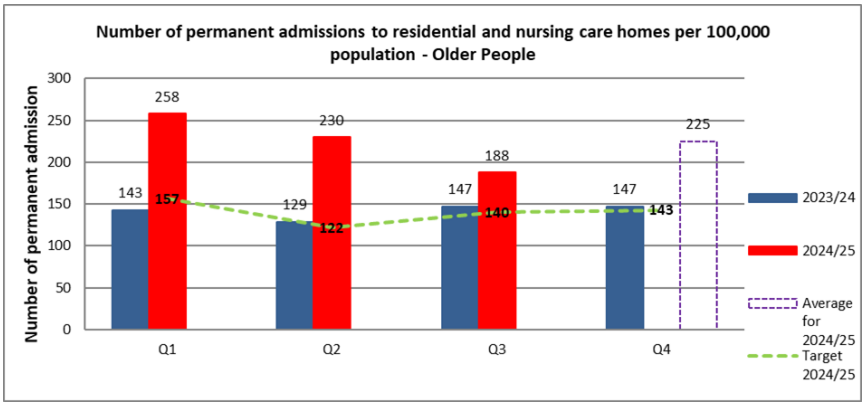
3.1.4 Permanent Admissions to Residential/Care Homes

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 562 admissions for the year. We had a 31% increase in permanent admissions in 2023/24, compared to the plan with over 66% of those admissions being into Dementia Care beds. We have taken our actuals for 2023/24, applied the population increase from 2023/24 to 2024/25, and then applied a 1% reduction to reach the target for 2024/25, which was a challenging target, given the rising population of over 65s with increasing complexity of needs.

The target for quarter 3 was no more than 140 people per 100,000 and the actual rate for the quarter was 188, 34% higher than the target for the quarter.

We know that 49% of admissions were primarily for dementia beds, which is significantly lower than in 2023/24 (66%). We continue to work with our system partners to identify appropriate care for people to meet their needs and are aware of the work being undertaken by Buckinghamshire, Oxfordshire, Berkshire West (BOB) to develop a Dementia Strategy, which will also inform our specialist discharge pathways. We have a multi-disciplinary working group looking at the admissions to care homes and identifying any actions that can be taken to improve outcomes.

Quarterly Number of permanent admissions to residential and nursing care homes per 100,000 population - Older People	
Annual Target for 2024/25 (no more than)	562
Quarterly Target for Quarter 3 (not more than)	140
Actual performance in Quarter 3 (2024/25)	188
Actual annual performance to date (2024/25)	675
Status	Red



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. The action plans were reviewed by the RIB membership in June 2024/25, against the 10-year strategy and have been updated, reflecting the positive progress to date in reducing difference in health and supporting people at risk of poor health outcomes.

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. One of the projects presented to RIB for Quarter 3 was the Parish Nurse Project with Reading Gateway Church, a service which combats loneliness, improving the health and wellbeing of individuals, supporting those with mental health issues by providing health advice, signposting to additional assistance and combatting hoarding. The demand for this service has been increasing, and referrals to the Parish Nurse Service have a two week wait for the first contact at this time.The team shared these case studies showing the difference made by having this support.

4.3.1 **Case Study 1:**

X is a gentleman, who lives alone . He has support from his family. X was referred through a family friend. X was very poorly on initial assessment he didn't like to bother his GP or any services . He was having constant falls and was suffering from other un-diagnosed ailments. On initial assessment X was very suspicious and unwilling to engage. With further follow up visits and being able to build up trust we were able to put measures in place to help X remain in his own home. A personal alarm was fitted , joint visits with the OT were undertaken and referrals were made to his GP and conditions treated. The welfare unit at the fire service were also contacted to arrange a welfare and fire assessment visit. Support was given to the family with advice and choices made available . Ongoing support continues with this gentleman, and he has been able to remain in his own home with the appropriate support in place.

4.3.2 **Case Study 2:**

K is an elderly gentleman who lives on his own and was referred to us from the social prescribing team . K has multiple physical problems and was attending his GP on numerous occasions. At an Initial home visit K was a wary and wasn't too keen . With further follow ups we began to establish a relationship and trust was formed . K was very lonely but had social anxiety so found it very difficult to access any groups or social events. We were able to encourage him to attend the coffee morning initially as it was quiet, and I met him at the door making him feel welcome . K then expressed an interest in our therapy garden and came along to do a bit of weeding! He enjoyed the company of other males and the provision of a hot free lunch . We continue to support K.

4.3.3 **Case Study 3:**

Z Was referred to our services from RBC Social workers. This lady lived alone in assisted living accommodation . She had a terminal illness and her daughter thought that she needed support and wasn't happy with the current engagement . On initial visit the lady was very sceptical of us and didn't want to engage . During the visit we were able to break down the barriers and the stigma of health services and the church. We were able to ascertain that she needed spiritual health intervention as well as physical and emotional help. She was referred for a home visit to the GP and we were able to pray with this lady and her daughter. Both were extremely grateful and felt they were being listened to and cared for in a holistic way. On subsequent visits with a PN assistant I was able to support the patient whilst the assistant was able to take the daughter/ carer for a coffee and spend time with her, offering support and a chance to chat .We continued to support these 2 lovely ladies until sadly Z passed away . On Her final days she was able to say how the peace she had received from our visits had enabled her to enjoy the last few weeks and she was no longer in turmoil . We still continue to support the daughter.

4.4. We are also delivering against Priority 2: identifying people at risk of poor health outcomes, through our Community Wellness Outreach project, which is reaching into communities where there are higher levels of deprivation, and where there are larger numbers of people from ethnically diverse backgrounds that are more at risk of developing conditions that can lead to cardiovascular disease, such as hypertension and diabetes. The project is funded from the Integrated Care Board (ICB) Inequalities Fund, which has been pooled into our Section 75 Framework Agreement for the Better Care Fund, and is funded to the end of June 2025. The service is being delivered by the Meet PEET Nurses from the Royal Berkshire hospital and supported by Reading Voluntary Action to co-ordinate venues, enable appointments to be booked and provide social prescribing services. A separate presentation on outcomes from these checks to date has been provided for the Board.

4.5. 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. Links with the strategic priorities of the Berkshire West Health and Care Partnership are also identified and a number of joint programmes of work are underway. The ICB provides a monthly update report including information on partnership priorities which are currently as follows:

- Future models of care (with links to RBFT New Hospital Programme)
- Integrated neighbourhood team development
- Same day access
- Community wellness outreach programme
- SEND
- Therapies Review
- Children and Young People's Mental Health – Mental Health Support Teams in schools

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, and the potential impact on avoidable admissions, particularly those related to respiratory conditions as we move into the Winter period.

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. The Service User feedback forms submitted by people using the Community Reablement Team, indicate 100% satisfaction rates with the service. We have also held co-production sessions with Carer's to support us in shaping a Carer's breaks and respite service, funded through the Accelerating Reform Fund, and feedback from people engaged has been very positive.

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.

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. We continue to monitor equality data to ensure people are not adversely affected.

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.

8.2. Confirmation was received from the National Better Care Fund Team on 21st August 2024, that our refreshed BCF Plan for 2024/25 was accepted.

9. Legal Implications

9.1. Compliance with the Better Care Fund (BCF) 2023/25 National Conditions has been confirmed in the BCF Quarter 3 return.

10. Financial Implications

10.1. **BCF 2024/25 Expenditure to date against the Plan**
Budgets are aligned to the refreshed Better Care Fund plan for 2024/25. Whilst there is an underspend currently showing against 2024/25, this funding has been committed to projects that are continuing into 2025/26. The budgets are reviewed on a monthly basis at the Reading Integration Board, to ensure we report any slippage in schemes. **Note:** The budget sheet as at end December reported spend as £15,628,509 *(see table below)* 76%, with projects that will be running in 2025/26 carrying forward funding as agreed with the ICB at the Reading Integration Board.

RIB Summary Report at P9	Original Budget £k	YTD Budget as at 31/12 £k	YTD as at 31/12 (Actuals) £k	Forecast to 31/03/25 £k	Variance £k
Reading Borough Council Hosted Schemes	12,177,724	9,133,293	9,031,928	12,077,503	-100,221
BOB Integrated Care Board	1,795,924	1,346,943	1,346,943	1,795,924	0
Cross BOB ICB Hosted Schemes	3,483,173	2,612,380	2,612,380	3,483,174	0
ICB Portion of Adult Social Care Discharge Fund passported to Reading (Qtr3 data)	629,170	314,585	490,336	629,170	0
LA Adult Social Care Discharge Fund (Qtr3 data)	1,473,618	736,809	1,313,063	1,473,618	0
23/24 Under Spend	1,572,812		833,859	1,111,812	-461,000
Total	**21,132,421**	**14,144,010**	**15,628,509**	**20,571,201**	**-561,221**

10.2. **BCF Return Q3 - Expenditure**
2024/25 is the second year of a two-year Better Care Fund (BCF) plan and expenditure in is as per our original submission with minor adjustments to increase the allocation in areas of greatest need and reduce in other areas based on actual spend in the previous year. The Quarter 3 BCF return (Appendix 1) shows expenditure as at the end of December 2024.

10.3. **Section 75 Framework Agreement**
The Section 75 Framework Agreement, covering the BCF planned expenditure from the Integrated Care Board (ICB) and Reading Borough Council, was signed and sealed on 8th January 2025.

11. Timetable for BCF Reporting

11.1. The Quarter 3 BCF return, covering the period from 1st October 2024 to 31st December 2024, was submitted on 14th February 2025, following the Delegated Authority procedure and ICB agreement. The final End of Year (EOY) return will be prepared for submission in line with the updated BCF reporting schedule:

Task/Activity/Milestone description	Start Date	End Date	Submission Dates
Q1 Report Template completion period	29/07/24	29/08/24	
Q1 Report Submission			**29/08/24**
Q1 National and Regional Assurance Period	01/09/24	30/09/24	
Q2 Reporting Template Completion Period	16/09/24	31/10/24	
Q2 Report Submission			**31/10/24**
Q2 National and Regional Assurance Period	01/11/24	30/11/24	
Q3 Reporting Template Completion Period	16/12/24	14/02/25	
Q3 Report Submission			**14/02/25**
Q3 National and Regional Assurance Period	01/02/25	28/02/25	
Q4 EOY Return Completion Period	04/04/25	30/05/25	
Q4 EOY Submission			**30/05/25**

Background Papers

The BCF performance data included in this report is drawn from the Reading Integration Board Dashboard – January 2025 *(Reporting up to 31st December 2024).*

Appendices

1. Reading BCF Quarter 3 Return (2024/25)