

Reading

Local System Review findings

Health and Wellbeing Board

Date of review visit:
29 October to 2 November 2018

Summary of findings

What are older people's experiences of care in Reading?

- Older people usually experienced a timely and person-centred approach to care and treatment. Multi-disciplinary teams were providing effective support to people in the community when they experienced a health crisis and were effective in preventing people from needing to attend hospital. When admitted to hospital, people had access to high-quality, compassionate care and support.
- When people were admitted to hospital, they were treated with dignity and were encouraged to stay active during their stay. People with dementia received one-to-one support from dedicated staff who had been specially trained to care for people with high-level needs.
- When older people attended A&E at the Royal Berkshire Hospital, whether as a walk-in or via ambulance, there was effective streaming to ensure that people were triaged to the unit best suited to their needs or to prevent them from being admitted unnecessarily.
- Although people received high-quality care and support in hospital, people aged 65+ were more likely to attend hospital in an emergency when compared to the national average; there was also a higher chance than the England average that they would be admitted.
- People were less likely to experience a delayed transfer of care when compared with England and comparator area averages. System partners had done a significant amount of

work to improve pathways and people's experiences of transfers of care, we found a 'home-first' culture to be embedded throughout the system.

- People living in care homes were well supported to have their needs met, preventing them from needing to access hospital care unnecessarily. The Care Home Support Team and Rapid Response and Treatment Team provided timely support at a point of crisis and worked with care homes to provide training and support in preventative care.
- While there was extensive support for people living in care homes, the support offer in the wider community was less developed. Schemes such as the Falls and Frailty Service and the Rapid Response Service were in place to meet people's needs at a point of crisis, but there was not an effective system risk stratification to identify people at high risk of deterioration in their condition which meant that early targeted interventions could not be put in place.
- People had access to a wide range of voluntary, community and social enterprise (VCSE) services in Reading, however people told us that they were not always aware of what services were available which meant that people could reach crisis point before accessing support.
- People told us how important the Readibus (dial-a-ride transport service) was to allow them to remain active and independent, and they were concerned that if this was reduced this would increase chances of social isolation.
- Carers had varying experiences of accessing support in Reading. Statutory services were not always well-linked to voluntary, community and social enterprise (VCSE) sector services that could provide support to carers. The Reading Carers Hub provided information and advice for unpaid carers, but carers felt that they were not always well supported to access services and many felt they had to reach crisis point before they were offered support.
- Carers we spoke with were concerned about the availability of respite care, while people who did not fund their own care had limited choice and control over what respite services were available. Carers felt that carers issues were not well understood and more could be done to join services together and promote common issues.

Is there a clear shared vision and common purpose, underpinned by a credible strategy to deliver high-quality care which is understood across the system?

- The vision for the delivery of health and care services in Reading was set out in the Health and Wellbeing Strategy. However, we did not find this had strong engagement and agreement by all system partners. The Health and Wellbeing Strategy had a strong public health focus but was not driving the future direction of health and care for the area. The

delivery of health and care services in Reading was influenced by the work of a collaboration of organisations, known as the Berkshire West 10 (BW10).

- The strategic direction of the Berkshire West 10 was set out by Chief Officers representing the member organisations. There were strong relationships between the Chief Officers, but the strategic vision for the Berkshire West area, including Reading, had not yet been articulated into a credible strategy that was agreed by, and understood by, all partners. As a result, it was not clear to people who use services (or staff) how the strategy for the delivery of health and care services in Reading was aligned to the vision for the Berkshire West area.
- Health partners had led the development of the Berkshire West Integrated Care System (ICS) in 2016 and were in support of merging the work of the BW10 into the ICS. Historically there had been reluctance from some local authority partners for this direction of travel, but opportunities for alignment were being explored and supported through recent meetings between the Chairs of the Health and Wellbeing Boards in the three unitary authorities.

Are there clear governance arrangements and accountability structures for how organisations contribute to the overall performance of the system?

- There was not a clear governance structure for Reading as a system. While the vision and strategy for Reading was articulated in the Health and Wellbeing Strategy, we did not find the Health and Wellbeing Board to be calling leaders to account for system performance. Work was happening in parallel to the Health and Wellbeing Board. The Berkshire West 10, through the strategic direction of the Chief Officers Groups, was overseeing the work of the Reading Integration Board, however this was not aligned to the Health and Wellbeing Board. It was not always clear to staff and people who use services who was driving the improvement of health and care services in Reading.
- Reading did not have an effective scrutiny function. The Adult Social Care, Children's Services and Education Committee did not always engage and challenge health and care decisions that would affect people locally, and it rarely called health partners to attend committee meetings. This meant that there was limited engagement and scrutiny on wider system planning, including plans to merge the work of the Berkshire West 10 and the Berkshire West Integrated Care System.
- Reading had made significant progress with information governance and record-sharing through the Connected Care programme, which would allow health and care partners using different electronic record systems to share information over the Connected Care platform. Over 120 organisations had signed up to an information sharing agreement as part of this programme. It was well-established across health organisations and plans were in place to roll out across social care.

Are there arrangements for the joint funding, commissioning and delivery of services to meet the needs of older people?

- There was not a joint commissioning strategy in place at the time of our review. Using funding through the Better Care Fund (BCF), the Reading Integration Board oversaw the joint commissioning of health and care services designed to meet local needs. These schemes had a positive impact on multi-disciplinary working and a more person-centred approach to care. Outside of the BCF, local authority and CCG joint commissioning was limited to two Voluntary Community Sector Enterprise services – a social prescribing service and a mental health peer support service. The Reading Integration Board had a commissioning function, but this was not being fully utilised outside of the BCF.
- It was not clear how population needs assessment tools were being used to inform commissioning intentions. At the time of our review the Joint Strategic Needs Assessment was being redeveloped, led by the local authority, with proposals for a new model taken to the HWB. At the same time the CCG was focusing attention on an ICS Population Health Management approach – it was not clear how the local authority and CCG were working together to develop a joint understanding of population needs.
- Market management was undertaken by the local authority and the CCG separately, although system leaders stated an intention to move towards a more joined up approach. The local authority had a robust market position statement and were undertaking work to update this during the time of our review.

Are people who work in the system encouraged to collaborate and work across organisational boundaries to meet the needs of older people?

- Frontline staff told us that good relationships were the foundation of their joint working, which they used to circumvent the practical barriers they faced. We saw excellent practice from staff who were committed to putting the person at the centre of their care, working together across health and social care to achieve the best outcomes for people. However, staff told us that a lack of understanding of the strategic delivery of services made it difficult to plan for the future.
- Although frontline staff were not always clear on the vision for the delivery of health and care services in Reading, they were given the freedom to develop services and innovative solutions. Innovation was recognised and encouraged, but not aligned to strategic objectives. This presented a risk of duplication across the system with projects running concurrently and resources potentially being used ineffectively.
- We saw examples of effective multi-disciplinary working which supported people to receive care from the right people in the right place at the right time. Schemes funded through the

BCF, such as the Care Home Support Team and the Community Reablement Team, were ensuring that people could receive support in their usual place of residence to prevent hospital admission. The Integrated Discharge Team was another example of a multi-disciplinary team that worked together to facilitate smooth and timely discharges of care.

- Connected Care, an information sharing platform, was already improving connectivity between services - ambulance and A&E staff were accessing GP summary care records, enabling them to make more informed decisions about people's care. Connected Care had been rolled out within the acute and community trusts but was yet to be established in social care – plans were in place for a phased roll out. Social care staff told us that this will make a big difference for them as they will be able to see the conversations that have taken place with a person before the point that they make contact, saving time and informing better assessments.

Key areas for improvement

- In developing the next Health and Wellbeing Strategy, due for publication in 2020, the local authority should engage system partners and ensure greater alignment with the wider Berkshire West Integrated Care System's strategic intentions and those of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership.
- Health and care commissioners should work together to develop the new Joint Strategic Needs Assessment and ensure that in its development it is aligned with the Integrated Care System's Population Health Management approach.
- Health and care commissioners should develop a joint commissioning strategy. Health and care commissioners should agree on commissioning intentions across health and social care and work together to develop a joint market position statement.
- System leaders should focus on developing prevention and early intervention services that increase the support offer in the community. A system approach to risk stratification and active case management should be developed to identify people at the highest risk of hospital admission.
- While relationships between system leaders were strong, improvements in relationships between health and local authority partners could be improved. As the system moves towards greater integration at a Berkshire West level, system leaders should ensure that staff are engaged in the process and that health partners are working with colleagues in the local authority to progress plans.
- System leaders should evaluate governance boards and processes to ensure that there is not duplication. System leaders should also ensure that people working in the system are clear on where decisions are taken, and where accountability lies for system performance.

- The Health and Wellbeing Board should play a greater role in scrutinising health and care decisions taken at an ICS and BW10 level to ensure that plans are aligned with Reading's Health and Wellbeing Strategy. The Health and Wellbeing Board should also review its membership and ensure greater representation of health and social care providers, including independent providers.
- The Adults, Children and Education (ACE) Committee should better embed its scrutiny function and play a more significant role in holding partners to account for common goals and scrutinising future strategic plans. The ACE Committee should call health leaders to account for decisions that impact on the delivery of health and care services to people in Reading.
- The role of the Reading Integration Board should be further developed to enable joint commissioning outside of the Better Care Fund and be more closely aligned to the Health and Wellbeing Board.
- The modelling work undertaken by ICS workforce leads should be developed into a system workforce strategy and they should ensure that the local authority and the VCSE sector are involved in its development as partners and not just as providers.
- There were opportunities to make better use of the VCSE sector services market. Health and care commissioners should work with VCSE sector providers to support in the development joined up service offers.
- In the establishment of pathways of care, operational leads should ensure they are understood, and signed up to, by staff across the system, and that they are clearly communicated to people so that they understand what options are available to them when they are discharged from hospital.
- Strategic provider forums which bring together staff from across health and social care providers should be established to enable staff to discuss operational processes and overcome barriers to joint working.

Background to the review

Introduction and context

This review has been carried out following a request from the Secretary of State for Health and Social Care and the Secretary of State for Housing, Communities and Local Government for the Care Quality Commission (CQC) to undertake a programme of targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system in Reading, with a focus on the interfaces between services.

This review was carried out under Section 48 of the Health and Social Care Act 2008. This gives CQC the ability to explore issues that are wider than the regulations that underpin its regulatory activity. By exploring local area commissioning arrangements and how organisations are working together to meet the needs of people who use services, their families and carers, we can understand people's experience of care and what improvements can be made.

This report follows a programme of 20 reviews carried out between August 2017 and July 2018. The reports from these reviews and the end of programme report, [Beyond barriers: how older people move between health and social care in England](#), can be found on our [website](#).

How we carried out the review

Our review team was led by:

- Ann Ford, Local System Review Programme Delivery Lead, CQC
- Rich Brady, Lead Reviewer, CQC

The review team included: one other CQC Reviewer, four CQC Analysts, one CQC Expert by Experience; and three Specialist Advisers with backgrounds in health and local government leadership.

The local system review considered system performance along a number of pressure points on a typical pathway of care with a focus on **older people aged 65 and over**.

We looked at the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system was functioning within and across three key areas:

- Supporting people to maintain their health and wellbeing in their usual place of residence
- Care and support when people experience a crisis
- Supporting people to return to their usual place of residence and/ or admission to a new place of residence following a period in hospital

Across these three areas, detailed in the report, we asked the questions:

- Do people experience care that is safe?
- Do people experience care that is effective?
- Do people experience care that is caring?
- Do people experience care that is responsive to their needs?

We then looked across the system to understand whether the system was well led.

Prior to visiting the area we developed a local data profile containing analysis of a range of information available from national data collections, as well as CQC's own data. We requested the local system provide an overview of their health and social care system in a System Overview Information Return (SOIR) and asked local stakeholder organisations for information.

We used two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from hospital into adult social care.

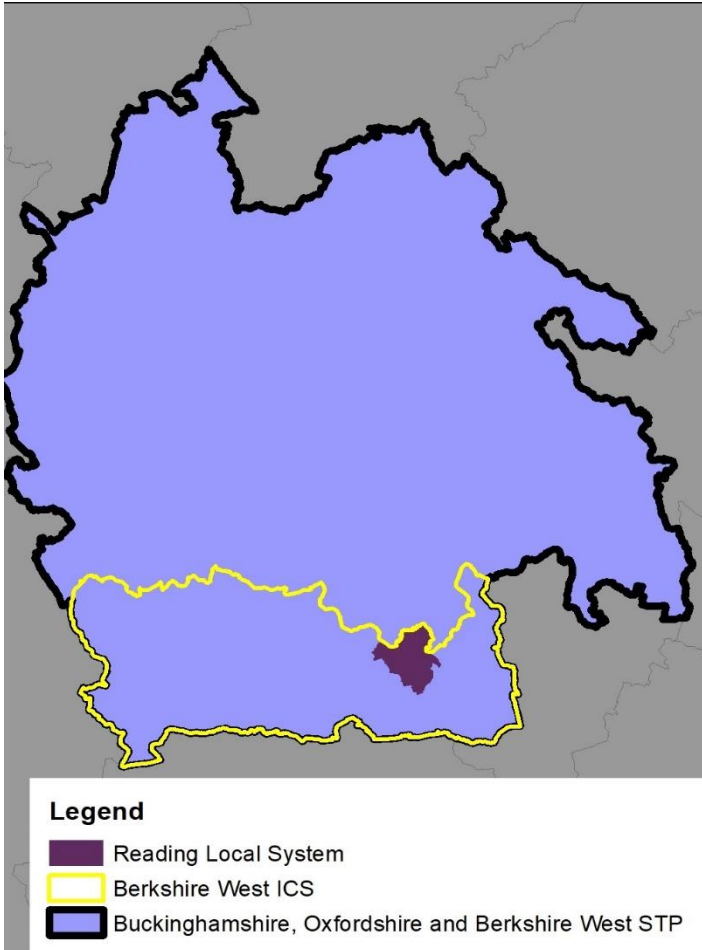
During our visit to the local area we sought feedback from people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Reading Borough Council (RBC), Berkshire West Clinical Commissioning Group (CCG), Royal Berkshire NHS Foundation Trust (RBH), Berkshire Healthcare NHS Foundation Trust (BHFT), South Central Ambulance Service (SCAS) and members of Reading's Health and Wellbeing Board (HWB)
- Staff members including GPs, social workers, occupational therapists, medical staff, nursing staff, care workers and allied healthcare professionals
- Local Healthwatch, voluntary, community and social enterprise (VCSE) services
- Provider representatives

- People who use services, their families and carers

We reviewed 16 individual people's care and treatment records and visited 10 services including the acute hospital, care homes, extra care housing, a GP practice, reablement services, a social work single point of access service, voluntary, community and social enterprise services and an out-of-hours service.

Reading Context



Map 1: Geographical map highlighting the Reading area.

Overall a lower proportion of older people lived in the Reading area compared to the England average.

As of 1 April 2018, NHS England approved the merger of the 4 previously existing CCGs in the Berkshire West area, two of which covered the Reading area. The merged CCGs now operate as the Berkshire West CCG.

Locally, people requiring acute a hospital admission were predominantly treated by the Royal Berkshire Hospital, rated by CQC as outstanding. The Community provider, Berkshire Healthcare Foundation Trust was rated as good.

Further information can be found in the [local area data profile](#) on the CQC website.

The Reading local system was part of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership covering a population of 1.8 million and was also positioned within the boundary of the Berkshire West Integrated Care System covering 528,000 people in Reading, Wokingham and Berkshire West. The population of the Reading local system was 155,698 people.

Detailed findings

Are services in Reading well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high-quality care and support?

We looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system and the involvement of people who use services, their families and carers.

The vision for the delivery of health and care services in Reading was set out in the Health and Wellbeing Strategy. However, we did not find this had strong engagement and agreement by all system partners. The Health and Wellbeing Strategy had a strong public health focus but was not driving the future direction of health and care for the area. The delivery of health and care services in Reading was influenced by the work of a collaboration of organisations, known as the Berkshire West 10 (BW10).

The strategic direction of the Berkshire West 10 was set out by Chief Officers representing the member organisations. There were strong relationships between the Chief Officers, but the strategic vision for the Berkshire West area, including Reading, had not yet been articulated into a credible strategy that was agreed by, and understood by, all partners. As a result, it was not clear to people who use services (or staff) how the strategy for the delivery of health and care services in Reading was aligned to the vision for the Berkshire West area.

Health partners had led the development of the Berkshire West Integrated Care System (ICS) in 2016 and were in support of merging the work of the BW10 into the ICS. Historically there had been reluctance from some local authority partners for this direction of travel, but opportunities for alignment were being explored and supported through recent meetings between the Chairs of the Health and Wellbeing Boards in the three unitary authorities.

- Reading was part of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Partnership (STP) covering a population of 1.8 million people. Engagement with the STP was undertaken at a Berkshire West level through the

Berkshire West ICS covering a population of 528,000, which, at the time of our review, did not include Reading Borough Council (the local authority). While there was not a conflict in vision, Reading was not as closely engaged with the STP as other local systems, who were a greater focus for the STP under its transformation agenda. As a result, we did not find the STP to be driving the future direction for the Reading.

- The vision for the delivery of health and care services in Reading was set out in the Health and Wellbeing Strategy (2017-20) with a mission statement to ‘improve and protect Reading’s health and wellbeing, improving the health of the poorest fastest’ – we did not find strong engagement from all system partners in this strategy. The Health and Wellbeing Strategy had a strong public health focus but was not driving the future direction of health and care for the area. The delivery of health and care services in Reading was influenced by the work of a collaboration of organisations, known as the Berkshire West 10 (BW10).
- Reading was part of the BW10, a collaborative of seven organisations across Reading, Wokingham and West Berkshire local authority areas, established in 2013. It comprised: the three unitary authorities; NHS Berkshire West CCG; South Central Ambulance Service NHS Foundation Trust; Berkshire Health Foundation Trust; and Royal Berkshire NHS Foundation Trust. Prior to the merger of the four Clinical Commissioning Groups in the Berkshire West area in April 2018, the Berkshire West 10 comprised ten organisations.
- The vision for the BW10 was set out by the Chief Officers of these organisations which set the workstreams of a Berkshire West 10 Integration Programme Delivery Group (BWDG). The BWDG was established to provide system leadership for health and social care integration and oversaw the delivery of integration programmes in the Berkshire West area.
- While there was a shared vision between the Chief Officers Group, this was not underpinned by a strategy which set out the strategic direction for the Berkshire West area. This meant that there were multiple operational integration programmes which reported into the BWDG without a strategy that set out how these programmes were contributing towards the vision for the delivery of health and care services. It was not always clear to staff who and what was driving decision making at a local level and what was being driven by the BW10. We heard examples of work being undertaken at a local level only for this to be discontinued by the Chief Officers Group.
- Without a formal strategy that articulated the vision and strategic direction for the BW10 it was not clear how the Health and Wellbeing Strategy for Reading was aligned to the strategic priorities of the wider BW10 system. System leaders found it hard to articulate what the strategy for integration was in Reading. System leaders described the vision as being that set out in the BCF plans. There is no guarantee of BCF funding in the long term, and it was not clear if, outside of the BCF, there was a strategy for integration in Reading that could be delivered independently of this funding.

- There was a recognition from leaders and frontline staff that relationships between system partners had been a long-standing obstacle to system working and that instability of leadership within the local authority had affected continuity and the subsequent delivery of a strategic plan. However, more recently there had been a number of key permanent appointments within the local authority including the Chief Executive Officer and Director of Adult Care and Health Services – following these appointments there was consensus amongst system partners that relationships between health and local authority partners had improved considerably which was leading to improved engagement and a renewed appetite for system working.
- System partners invested resource into bringing leaders together in person to collaborate on system issues. In recent months leaders from across the NHS acute and community providers, the CCG and local authorities have come together in a weekly 8am meeting to discuss individual cases of delayed transfers of care. This had improved understanding between system partners and had also had a positive impact on performance.
- Frontline staff told us that good relationships were the foundation of their joint-working, which they used to circumvent the practical barriers they faced. We saw excellent practice from staff who were committed to putting the person at the centre of their care, working together across health and social care to achieve the best outcomes for people. However, staff told us that a lack of understanding of the strategic delivery of services made it difficult to plan for the future.
- Although frontline staff were not always clear on the vision for the delivery of health and care services in Reading they were given the freedom to develop services and innovative solutions. Innovation was recognised and encouraged, but not aligned to strategic objectives. This presented a risk of duplication across the system with projects run concurrently and resources potentially being used ineffectively.
- People who use services, their families and carers did not always feel they had opportunities to influence the delivery of care in Reading. Healthwatch Reading and Reading Voluntary Action (a representative organisation of Reading’s voluntary and community sector) were represented on various strategic boards, but people who use services did not feel that there were sufficient engagement opportunities outside of these organisations. System leaders acknowledged that more could be done to involve people who use services, their families and carers in the development of strategy, at both the Reading and wider BW10 and ICS levels.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

There was not a clear governance structure for Reading as a system. While the vision and strategy for Reading was articulated in the Health and Wellbeing Strategy, we did not find the Health and Wellbeing Board to be calling leaders to account for system performance. Work was happening in parallel to the Health and Wellbeing Board. The Berkshire West 10, through the strategic direction of the Chief Officers Groups, was overseeing the work of the Reading Integration Board, however this was not aligned to the Health and Wellbeing Board. It was not always clear to staff and people who use services who was driving the improvement of health and care services in Reading.

Reading did not have an effective scrutiny function. The Adult Social Care, Children's Services and Education Committee did not always engage and challenge health and care decisions that would affect people locally, and it rarely called health partners to attend committee meetings. This meant that there was limited engagement and scrutiny on wider system planning, including plans to merge the work of the Berkshire West 10 and the Berkshire West Integrated Care System.

Reading had made significant progress with information governance and record-sharing through the Connected Care programme, which would allow health and care partners using different electronic record systems to share information over the Connected Care platform. Over 120 organisations had signed up to an information sharing agreement as part of this programme. It was well-established across health organisations and plans were in place to roll out across social care.

- The Reading local system was part of the Buckinghamshire, Oxfordshire and Berkshire (BOB) West Sustainability and Transformation Partnership (STP) covering a population of 1.8 million and was also positioned within the boundary of the Berkshire West Integrated Care System covering 528,000 people in Reading, Wokingham and Berkshire West. The population of the Reading local system was 155,698 people.
- In April 2018, Berkshire West CCG was formed, bringing together South Reading CCG, North & West Reading CCG, Wokingham CCG and Newbury and District CCG. Berkshire

West CCG maintained the Locality structure and still commissions within the four Localities due to the diverse needs across the CCG footprint.

- As a small system that was situated within an ICS and a large, three county-wide STP footprint, Reading had a complex set of governance arrangements – as a result, it was not always clear where leaders were called to account for system performance. While the Health and Wellbeing Board held statutory responsibility for oversight of health and care in Reading, decisions impacting on the delivery of health and care in Reading were driven by the Chief Officers Group, with projects delivered through the Berkshire West 10 Integration Programme, which was linked to the Berkshire West ICS.
- As a system, Reading was not as closely engaged with the BOB STP as other local systems in the STP footprint. STP engagement took place through the Berkshire West ICS (which Reading Borough Council was not part of) and through the Chief Officers Group, where the three unitary authorities in Berkshire West area were represented by the Chief Executive of West Berkshire Council. Reading's understanding of the STP agenda was therefore dependent on Reading's interaction with the ICS and two unitary authorities.
- Without clear alignment between multiple governance groups this meant that decisions were taken in different levels and made it difficult for people to understand where accountability was held in the system and who was driving the future direction of health and care.
- The A&E Delivery Board (AEDB) had effective leadership, giving it a strong grasp on the performance of the acute system and was well regarded across the system as being effective in holding partners to account. The AEDB had good representation across the system, with increased engagement with social care (through the three unitary authorities) and work had been undertaken to align the AEDB with the Berkshire West ICS so that the AEDB could be held to account at ICS level.
- The BWDG was responsible for co-ordinating the work of the BW10 Integration Programme and brought together a significant portfolio of work, including the BCF and through this had oversight of the work of the three separate integration boards within Reading, Wokingham and West Berkshire.
- The Reading Integration Board (RIB) was established to oversee projects funded through the BCF. The Health and Wellbeing Board did not play a role in setting the agenda for the Reading Integration Board. Without links between the HWB and the RIB, outside of the BCF the RIB governance and assurance was limited. The scale of the work that the BWDG was responsible for overseeing was vast, which meant that there was limited opportunity for Reading, as a local system, outside of the deliverables of the BCF, to have its voice heard within the partnership.
- In 2016 the Berkshire West Integrated Care System (ICS) was formed by health partners in the Berkshire West area. This included the Berkshire West CCG, the Royal Berkshire

Hospital and Berkshire Healthcare Foundation Trusts and providers of GP services. At the time of our review the three unitary authorities were not formal members of the ICS but were linked through the BW10.

- System leaders told us that the ICS and BW10 shared the same objectives and by running both in parallel this was causing duplication. Plans had been developed to merge the work of the BW10 with the ICS however it was not clear if this aim was shared across all local government and health partners in the system. Historically, there had not been universal support to align all partners in the BW10 with the ICS. To strengthen links with the ICS, the Chairs of the Health and Wellbeing Boards in the three unitary authorities had begun to meet to discuss opportunities for alignment.
- The Health and Wellbeing Board (HWB) was established to provide collective leadership and oversee the health improvement and wellbeing of people living in Reading. However, we did not find the HWB to be effective in bringing together health and care partners across the system to discuss and scrutinise performance and plans – health providers did not regularly attend HWB meetings. While performance against a Health and Wellbeing Dashboard (relating to the Board's strategic priorities) was reported to the HWB, it was acknowledged by some members of the HWB that performance was not always challenged. As a result, not all partners were fully engaged and included.
- The Health and Wellbeing Board was not seen as the driver for health and social care strategy and functioned as a place where papers were taken to be reviewed rather than a decision-making body. It was viewed as being dominated by the local authority and as such health partners were not well engaged. However, improved relationships between the local authority and health partners had helped to increase engagement in the work of HWB.
- At a Health and Wellbeing Board meeting that we attended, a proposed new model for Reading's Joint Strategic Needs Assessment (JSNA) was brought to the meeting with a request for agreement on a proposed model, and how this would be funded. At the meeting, it was acknowledged that health partners were not present for the discussion and were therefore also unable to provide feedback on how this would impact on the development of the ICS's Population Health Management tool. As a result, discussions were limited, and it became difficult to come to a decision on a preferred model.
- Healthwatch Reading and Reading Voluntary Action were both members of the Health and Wellbeing Board and the Reading Integration Board, representing the voices of people who use services, families and carers, as well as other voluntary, community, and social enterprise (VCSE) organisations which represent them. Healthwatch Reading were also members of the A&E Delivery Board.
- While Healthwatch Reading and Reading Voluntary Action were invited to attend boards and had the opportunity to present findings, it was felt that with the exception of the A&E Delivery Board, there was limited challenge and also a limit to the impact that they were able

to have as system partners. Despite a commitment from the Health and Wellbeing Board over recent years to include outcome measures for people who use services in the Health and Wellbeing Dashboard, this had yet to materialise.

- There was not an effective scrutiny function for the Reading system. The Adult Social Care, Children's Services and Education (ACE) Committee was responsible for the statutory and non-statutory functions relating to Adult Social Care, Children's Services and Education. It was acknowledged that ACE had a broad remit and that matters relating to Children's services had been prioritised at previous committee meetings and ACE was therefore not providing an effective scrutiny function to hold health and social care partners to account. Scrutiny did not always engage and challenge health and care decisions that would affect people locally and rarely called health partners to attend committee meetings.
- Two primary care alliances had recently formed – the Reading Primary Care Alliance (covering practices in South Reading) and the North & West Reading Primary Care Alliance. The formation of the two alliances covered 25 GP practices in Reading and would allow for a more cohesive and collaborative approach to workforce planning and would contribute towards a strategy for primary care within the Integrated Care System. It was expected that through the alliances, GP practices would work closer together in the development of a system risk stratification tool that would identify people at highest risk of hospital admission.

Information governance

- Reading was on the cusp of significant developments in the ability to gather and share information across health and care organisations. 'Connected Care', a powerful tool that would facilitate information sharing across different electronic systems, was being rolled out at the time of our review. The full implementation and expansion of Connected Care was highly anticipated by people working across the system.
- At the frontline, it would allow health and social care staff to view corresponding health and care records. We saw examples of how Connected Care was already improving connectivity between services, with ambulance and A&E staff accessing GP summary care records, enabling them to make more informed decisions about a person's care and treatment. Connected Care had been rolled out within the acute and community trusts but was yet to be established in social care – at the time of our review the Connected Care project was two years into a five-year programme and plans were in place for a phased roll out across partners. Social care staff told us that this will make a big difference for them as they will be able to see the conversations that have taken place with a person before the point that they make contact, saving time and informing better assessments.
- At the strategic level, it was anticipated that Connected Care would provide the CCG and local authority with detailed intelligence around the populations needs. This information could inform the developing Population Health Management approach and be used to develop place-based commissioning strategies.

How is the system working together to develop a health and social care workforce that will meet the needs of its population now and in the future?

We looked at how the system is working together to develop its health and social care workforce, including workforce planning and effective use of the current workforce.

There was not a system wide approach in Reading to recruitment and retention of staff. Workforce challenges were being addressed at an organisational level, and while work had been undertaken in the STP and ICS to gain a collective understanding of workforce challenges the local authority were not prominent partners, as a result this work had not yet been articulated into a joint workforce strategy for Reading.

- Reading had challenges in recruiting and retaining a skilled workforce across health and social care. The area was highly populated compared to other parts of the wider Berkshire West 10 system and had a relatively high cost of living. Reading's location meant that some NHS organisations did not attract NHS fringe payments which could mean that staff could earn as much as an additional £2,000 per annum in neighbouring areas. Workforce leads believed that this contributed to a shortfall in qualified nursing staff, especially for elderly care. Skills for Care estimated that adult social care vacancy rates in 2017/18 were significantly higher in Reading (15.8%) than the England average (8.0%).
- Reading was experiencing high turnover in social workers which was impacting on the timeliness of assessments in the community and on relationships with social care providers. Data provided by the system showed that between November 2017 and October 2018 there was a 33.3% turnover in social workers. Care providers told us that it was a challenge to be able to contact a named social worker and because of high staff turnover they were unable to build relationships with individuals who were familiar with and understood the needs of the people they cared for.
- To address shortages of social workers, locality teams were working with Buckinghamshire New University to attract newly qualified social workers to Reading. We also heard about a local college running work experience days in care homes to promote elderly care to students. To address shortages in the community nursing workforce the community trust was looking beyond traditional roles and investing in nursing associates.
- There were also examples of schemes that were making the best use of the existing workforce by deploying the skills of professionals flexibly. For example, some GPs were contracting paramedics to undertake home visits, social care staff were working as part of integrated community health teams, and in the out of hours service, an advanced nurse

practitioner was working with a clinical pharmacist who specialised in diabetes. Such approaches were enhancing GP capacity and their ability to focus on complex cases.

- While work was being undertaken by different organisations to address specific workforce issues, this was not part of a joint strategic approach to workforce planning across Reading. Strategic workforce planning was more developed at an STP level and this was being supported by the Local Workforce Action Board, however, due to the wide footprint of the STP this did not translate to a detailed strategy for the workforce needs of the Reading local system. The local authority were not prominent partners in system workforce planning.
- Workforce leads in the Berkshire West ICS had led some work to gain an understanding of workforce challenges across the Berkshire West area with organisations using the same workforce models to understand the issues in each sector. Good working relationships were established between health partners, but it was not clear how the local authority had been able to input into this work as they were not formal members of the ICS workforce group. The VCSE sector did not have representation in workforce development groups and were viewed as providers and not partners.
- Although a shared understanding of current workforce issues had been established by system partners this has yet to be articulated into a joint workforce strategy. The importance and value of a strategy was acknowledged by workforce leads but there were no plans outside of the STP to develop a system-wide workforce strategy that incorporated the health and care workforce needs of the Reading system.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

There was not a joint commissioning strategy in place at the time of our review. Using funding through the Better Care Fund (BCF), the Reading Integration Board oversaw the joint commissioning of health and care services designed to meet local needs. These schemes had a positive impact on multi-disciplinary working and a more person-centred approach to care. Outside of the BCF, local authority and CCG joint commissioning was limited to two Voluntary Community Sector Enterprise services – a social prescribing service and a mental health peer support service. The Reading Integration Board had a commissioning function, but this was not being fully utilised outside of the BCF.

It was not clear how population needs assessment tools were being used to inform commissioning intentions. At the time of our review the Joint Strategic Needs Assessment was being redeveloped, led by the local authority, with proposals for a new model taken to the HWB. At the same time the CCG was focusing attention on an ICS Population Health Management approach – it was not clear how the local authority and CCG were working together to develop a joint understanding of population needs.

Market management was undertaken by the local authority and the CCG separately, although system leaders stated an intention to move towards a more joined up approach. The local authority had a robust market position statement and were undertaking work to update this during the time of our review

- The Health and Wellbeing Board's Joint Strategic Needs Assessment (JSNA) for Reading was a comprehensive document with over 70 profiles for different population groups that were used to inform commissioning decisions. However, it was not clear how often the profiles were updated and if they were articulating current assessment of need – it was acknowledged that the current approach to the JSNA was not effective in engaging health partners.
- At the time of our review work was underway to develop a new model for the JSNA that would provide a more interactive, cohesive, up-to-date assessment of need. While the local authority was leading on the development of the JSNA, the CCG was focusing on the ICS Population Health Management approach – it was not clear how the local authority and CCG were working together to develop a joint understanding of population needs. It is a statutory responsibility for local authorities and CCGs to develop JSNAs in partnership.
- Historical financial challenges in the local authority had been a barrier to joint commissioning – at the time of our review there was not a well-developed joint commissioning approach across the local authority and CCG. Commissioning functions were not aligned and there was not a joint commissioning strategy in place. At the time of our review the commissioning leads in the local authority and the CCG were both interim appointments and it was not clear how strategic intentions would be brought together. A commissioning strategy was being developed by the local authority at the time of our review however this was in draft form and not due to be published until early in 2019.
- Outside of the BCF local authority and CCG joint commissioning was limited to two Voluntary Community Sector Enterprise services - a social prescribing service and a mental health peer support service. The Reading Integration Board had a commissioning function, but this was not being fully utilised outside of the BCF.

- Reading had a substantial VCSE sector, however VCSE organisations were not seen as system partners in the design, delivery and commissioning of services. This important partner could be better included – there were opportunities to make better use of VCSE services and working with the VCSE sector to developing joint service offers.
- Shaping of the health and care market was not addressed as a joint responsibility in Reading. The local authority took responsibility for shaping the adult social care market, while the CCG focused on the health market. The local authority had developed a market position statement (2016-19) that detailed clear commissioning intentions to providers – this was being updated at the time of our review. Following the merge of the four CCGs a single commissioning intentions document had not yet been published – there was an opportunity for collaboration between local authority and CCG to work together in the development of these two documents. System leaders confirmed that one of the future objectives for the system was to move towards a joint market management approach.
- Local authority commissioners were shaping the adult social care market away from bed-based provision towards services that better supported people to remain independent. Extra care provision was being expanded across the area with two new schemes due to open in 2019. At the time of our review the local authority was reviewing its reablement service to improve its ability to promote independence. There was a consultation in progress to close a residential care home which also provided a bed-based reablement service. The local authority was proposing to move the reablement service to a location providing extra care housing facility as it was felt the environment would better promote recovery and independence.
- There was clear direction from the local authority to commission services that supported older people to live independently, where possible – the system was meeting its BCF target to reduce admissions into care homes. Between April 2015 and April 2018, there was a reduction of residential care beds by 7.9%, compared to a national reduction of 0.4%. During the same period the number of nursing care beds had remained the same.
- While adult social care commissioners and providers had good communication channels, strategic provider forums had not been maintained. There was not a forum for health and social care providers to come together to discuss and overcome challenges faced. Commissioners informed us that these forums had ceased due to poor attendance and they were now engaging with providers on an individual basis.

How do system partners assure themselves that resources to support the interface of health and social care are achieving sustainable high-quality care?

We looked at how systems assure themselves that resources are being used to achieve sustainable high-quality care and promote people's independence.

Through the Berkshire West 10 Integration Programme Delivery Group and the Reading Integration Board there was good oversight of resources used to commission health and care services, using effective monitoring and evaluation. There was a good understanding of the value for money (VFM) schemes funded through the BCF. VFM reports were used to set key performance indicators (KPIs) and revised service targets, however, the sustainability of these services was not clear should the BCF be discontinued. The lack of joint commissioning across the local authority and CCG was a missed opportunity to make the best use of resources to invest in sustainable services that delivered shared positive outcomes for local people.

- As a health and care system, Reading had a relatively stable financial position. In recent years the local authority had experienced financial challenges, however under new leadership a significant amount of work had been done to reduce overspend, enabling the local authority to move to a healthier financial position.
- Health partners had been in a financially sound position over recent years and through the ICS, the CCG and health providers had brought funds together into a shared system control total. This enabled resources to be deployed flexibly across the system. At the time of our review finance leads did not signal an intention to bring the local authority on board with this. While finances were being managed well within organisations, health and local authority finance leads were not investing in pooled budgets that would share financial risk. Significant work had been done in the local authority to improve its financial position – this has provided an opportunity for the system's position to re-evaluate its collective financial position.
- Through the Berkshire West 10 Integration Programme Delivery Group and the Reading Integration Board there was good oversight of resources used to commission health and care services, using effective monitoring and evaluation. There was a good understand of the VFM schemes funded through the BCF and VFM reports were used to set KPIs and revised service targets.
- Schemes funded through the BCF, including the Community Reablement Team and the Discharge to Assess, were shown to be having a positive impact on people who use services, families and carers, and were exceeding targets in some areas. However, the stability of these services was not clear if BCF funding was to be removed and we were not

made aware of any plans to move these schemes into business as usual. The lack of joint commissioning across the local authority and CCG was a missed opportunity to make the best use of resources to invest in sustainable services that delivered shared positive outcomes for local people.

How are people supported to stay well in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how safe, effective, caring and responsive the system is in the area: maintaining the wellbeing of a person in usual place of residence.

People were supported to stay well in their usual place of residence. Effective joint working between ambulance and hospital staff was enabling people to receive support in the community however, system-wide risk stratification for people at high risk of deterioration in their condition was underdeveloped which meant that people could not receive targeted support. A comparatively high rate of people aged 65 and over in the community were attending A&E instead of accessing care and support in the community.

For people living in care homes there was comprehensive support available to prevent hospital admission and this meant that people living in care homes did not rely on hospital care unnecessarily. This was reflected in the consistently lower rate of people living in care homes who attended A&E, compared to the England average.

- There was a strong focus on supporting people to stay well in their usual place of residence and improvements were being made in developing primary care support as well as increasing the availability of services in the community. However, there were no formal arrangements in primary care for population risk stratification to identify and the support people at the greatest risk of health deterioration. This meant that people could not be proactively provided with support which may prevent them from accessing hospital care.
- There was good access to GP services in Reading. The system told us that from 1 October 2018, 100% of the Reading population had access to pre-bookable GP appointments on Saturdays, Sundays, and on each weekday until 8pm. In Reading there were 492 appointments per week available at these times; this equates to an average capacity of 31.2 minutes per 1,000 weighted population per week compared to a national target of 30 minutes. Plans were in place to increase capacity to 45 minutes per 1,000 weighted population per week from 1 April 2019.
- System leaders acknowledged the absence of formal risk stratification and expected this to be addressed through the development of GP hubs that were bringing together practices in locality areas. There was an expectation that GPs would work together to develop a risk

stratification approach, supported through the two recently formed GP alliances, which aimed to shape general practice to work more collaboratively.

- The lack of risk stratification meant that there could be an overreliance on services such as the Rapid Response (RR) service. The RR service - made up of occupational therapists, physiotherapists and community nurses - provided support to people in their own homes who were at risk of hospital admission. It also provided end of life support. It was accessible via referrals from GPs, other healthcare professionals and through the Berkshire Integrated Hub – a single point of access for health services. This service was having a positive impact on preventing people experiencing a health crisis from potentially being admitted to hospital, however with a more systemised approach to monitoring and identifying people at risk of hospital admission could mean that pro-active support could be provided before people reach crisis point.
- Reading had an ethnically diverse population and the local authority was working to ensure that people had access to services that met their needs. The Indian Community Centre was well-attended and supported people with meals, exercise and reducing social isolation. Many people we met there had attended for years – one person described it as a “lifeline” and another told us that without the centre, they would not get any exercise. Staff signposted people to other services and support them with accessing services such as completing carers assessments.
- People had access to a wide range of voluntary, community and social enterprise (VCSE) services in Reading, however people told us that they were not always aware of what services were available which meant that people could reach crisis point before accessing support. Reading Voluntary Action (RVA) provided the link between the VCSE sector and statutory services, however VCSE providers we met with acknowledged that more could be done to join up the offer.
- People told us how important the Readibus (dial-a-ride transport service) was to help them remain active and independent. The Readibus provided people with mobility issues and those who couldn't make use of public buses with transport to social groups, medical appointments and to the supermarket. People told us that the service had recently been reduced and that they were concerned that without the Readibus they would struggle to remain independent. VCSE sector representatives told us that reductions in support for people to access transport would increase social isolation.
- There were two points of access for health and social care services – one for health and one for social care. The single point of access for health, the Berkshire Integrated Hub was based in Wokingham covering the Berkshire area and could only be accessed by people if they had been referred by their GP or another health professional. ‘The Avenue’ contact centre provided a single point of access for social care services and was accessible to people, carers and professionals who could then be signposted and referred to appropriate

services. This created some duplication with both services running in parallel, however it had been decided to not embed the contact centre within the Berkshire Integrated Hub as the contact centre was Reading focused and was able to maintain closer links with local services.

- The single point of access (SPA) for social care had recently been remodelled and expanded. The team that took referrals used a ‘three conversations’ model so that people’s first interactions with the system started from an assets-based approach to meeting their needs. This team had a dedicated coordinator role to connect people into the wide range of low level community services available in Reading – at the time of our review a networking event with community providers had been set up to provide people with access to a wider range of VCSE services. The SPA team also had strong links with the resource centre which could provide equipment to help with mobility and increase independence. Trusted assessments between the SPA team and resource centre teams meant that delays in accessing equipment were reduced.
- People’s social care needs were generally assessed and reviewed in a timely way. The local authority had invested resources into reducing a backlog of assessments. The new social care single point of access at The Avenue contact centre was responding to people in the same day, and the new model was allowing the team to spend more time providing personalised signposting and support. We heard about a self-funder who had contacted the service because they needed respite care. The team rang around providers on their behalf and arranged a placement for them in the same day.
- Staff positively anticipated the arrival of Connected Care as this would allow staff from the Berkshire Integrated Hub and the Avenue contact centre to know what services people had already accessed, which would save time and lead to better assessments.
- VCSE sector representatives felt that there was a disconnect between primary care and VCSE services. While some GPs were actively signposting and prescribing services to people, VCSE sector representatives told us that most referrals came through social care services. This meant that people could be missing out on support services that would help to maintain their health and wellbeing at home.
- Carers had varying experiences of accessing support in Reading. Statutory services were not always well linked to VCSE sector services that could provide support. The Reading Carers Hub provided information and advice for unpaid carers. VCSE representatives told us that carers who were self-funders were not well supported to access services, they were provided with a care directory and expected to navigate their way through services themselves. This meant that carers felt they needed to be at crisis point before they were offered support.
- Carers we spoke with were concerned about the availability of respite care and that those who did not fund their own care had limited choice and control over what respite services

were available. Carers felt that carers issues are not well understood and more could be done to join services together and promote common issues.

- The local authority was making greater use of aids and assistive technology such as medication prompts, falls monitors and bed sensors which were helping to keep people safe at home. We heard how a person living with advanced dementia and who was prone to falls had a sensor in her room which enabled her to be monitored safely while her privacy was maintained. The local authority had increased expenditure on equipment from £354,455 in 2014/15 to £481,190 in 2017/18.
- Support for people living in their own homes was underdeveloped compared to support provided to people living in care homes. Between April 2014 and March 2018, A&E attendance rates per 100,000 population (aged 65+) were consistently higher in Reading compared to England and comparator areas. For example, in Q4 2017/18 rates were 13,760 compared to England (11,025) and comparator areas (11,354).
- People who lived in care homes were well supported by secondary and community health services. As part of the Berkshire West 10, Reading had an established Care Home Support Programme (CHSP) which provided a range of multi-disciplinary support to care homes across West Berkshire, Wokingham and Reading. This was having a positive impact on people in care homes being able to access therapeutic support and preventing people from needing to attend hospital in an emergency. During 2017/18, A&E attendance rates from care homes per 100,000 population (aged 65+) were lower in Reading, at 2,710 compared to 3,894 in England. Emergency admissions from care homes were also lower in Reading, at 2,235 compared to 2,794 per 100,000 population (aged 65+) nationally.
- Through the CHSP the Rapid Response and Treatment Team (RRAT) and Care Home Support Team (CHST) were well embedded in the system. In addition, a pharmacist led a medication review services provided support to 52 care homes in the Berkshire West area, conducting medication reviews, providing a medicines management service, as well as guidance and training for staff. These services were valued by care homes and were regarded as having made significant contributions to preventing the need for people to be admitted to hospital by responding quickly and providing effective support at a time of crisis. This was reflected in our analysis of Hospital Episode Statistics data which showed that between April 2014 to March 2018 the rate of A&E attendances from people aged 65+ who live in care homes in Reading was consistently lower than England and comparator area averages.
- The CHST operated 9am to 5pm, five days a week. This was a multi-disciplinary team, comprising a registered general nurse and registered mental health nurse, an occupational therapist, physiotherapist and a speech and language therapist. The CHST worked closely with care homes to identify support needs, including providing training to care home staff to build knowledge, skills and confidence. We heard about positive examples of training

regarding nutrition as well as helping staff identify early signs of conditions such as urinary tract infections. The CHST also provided direct support to people living in care homes with more complex needs.

- The RRAT was established to respond to people living in care homes at a point of crisis and operated 8am-7pm, seven days a week. The team was made up of a staff nurse, an advance nurse practitioner, a community geriatrician and could call upon occupational therapists and physiotherapist if required. Care homes could refer directly to the RRAT who aimed to respond within two hours, provide assessments in the home, as well as urgent care, such as intravenous antibiotics and could arrange extra care if needed. Staff working in care homes told us how they valued this service and that it prevented people from needing to access hospital care, and that the desire to expand the RRAT service further had been discussed in provider forums.
- Care home staff told us that people living in care homes were more likely to be admitted to hospital out of hours when the RRAT was not available. Care home staff also felt that the RRAT team facilitated stronger links with other services and were more likely to arrange additional support service through the 111 services than if the care home called 111 direct.

How are people supported during a crisis?

Using specially developed key lines of enquiry, we reviewed how safe, effective, caring and responsive the system is in the area: support to a person in a crisis.

To address the comparatively high rates of people aged 65+ attending A&E, system partners were working well together to provide services to support people when they reached crisis point, in their usual place of residence as well as in the A&E department in the hospital. The Rapid Response and Falls and Frailty services were proven to be effective in preventing people from needing to access hospital care unnecessarily by providing support to people in their usual place of residence.

When people attended A&E they were seen by appropriate personnel in accordance with their clinical need. Comprehensive triage and streaming services for both walk-in and ambulance arrivals were in place to ensure that people were seen by the right person in the right place at the right time.

People had access to high-quality, person-centred care and support in hospital – people were treated with dignity and were encouraged to stay active during their stay in hospital. Specially trained staff supported people with high level health and care needs. The hospital had a good system for bed and flow management, and as a result people were less likely to experience multiple moves while in hospital.

- A&E attendance rates per 100,000 population (aged 65+) were consistently higher in Reading compared to England and comparator areas. People aged 65+ also experienced higher rates of emergency admissions compared to England and comparator areas (analysis of 2017/18 hospital admissions for people aged 65+). To address this, system partners were working together to provide services to people in their own homes, as well as in the A&E department in the hospital to prevent people from being admitted to hospital unnecessarily.
- The South Central Ambulance Service (SCAS) was working with health partners in the Reading area to implement initiatives to prevent people attending and being admitted to hospital. Some GP practices contracted SCAS to undertake home visits and were providing paramedics with access to GP patient records, so they could make better informed decisions. A pilot was also in progress to upskill paramedics as independent prescribers which would increase the number of prescribable appointments for local people.

- Using funding secured through the A&E Delivery Board, proactive work was being undertaken by RBFT and SCAS to provide a Falls and Frailty Service. A paramedic and occupational therapist were responding to calls in people's homes, carrying out joint assessments, and identifying additional support. The service was linked to clinics, services in the hospital and the community, such as the rapid access clinic, falls clinic, movement disorder clinic and the rapid response team, enabling people to be referred and receive appropriate support to meet their needs. Links to the equipment services meant that equipment requests could be made without delay.
- Funded to run three days a week from 7am to 7pm, between October 2017 and April 2018, 76% of people referred to the Falls and Frailty Service were kept at home. At the time of our review an application for funding had been submitted to extend the service to run seven days a week during the winter months. The service had been identified as best practice and was being trialled in systems outside of Berkshire.
- In addition, SCAS were training their staff in how to recognise frailty. Paramedics were undertaking frailty scoring as part of their assessments. This meant that when a person attended hospital their frailty was immediately identified, streamlining their assessment process and reducing the likelihood of them spending time in a setting inappropriate for their needs.
- There was a hospital geriatrician that paramedics could call if they were not sure whether to take a person to hospital, however this service was limited to specialist paramedics who had advanced training in urgent care. There was a perception from staff we spoke with that the service was underutilised and building awareness and confidence among specialist paramedics was needed to make consistent best use of this resource.
- When older people attended A&E at the Royal Berkshire Hospital, whether as a walk-in or via ambulance, there was effective streaming to ensure that people were triaged to the unit best suited to their needs or to prevent them from being admitted unnecessarily.
- The Frailty Friendly Front Door Team, an occupational therapist and nurse-led service, was successful in identifying people with frailty and only admitting them when they needed to be. They greeted people when they arrived at A&E and conducted initial cognitive and mobility assessments. The service ran from 8am to 8pm, seven days a week. An evaluation of the scheme showed that 60% of people seen by the team were not admitted into hospital.
- For people who attended A&E and did not have urgent care needs the Primary Care Centre (PCC) was open 11am to 11pm, seven days a week for them to be seen by a GP. This was effective in ensuring that older people who did not have urgent care needs could be seen in a timely way – over 50% of people using this service were aged 65 and over. At the time of our review the PCC was seeing between 30-40 people a day, however it had capacity to see more and work was underway to understand how this service could be better utilised.

- We saw examples of how staff in A&E were accessing information about the people they saw provided by other health and care services. They could access primary care records using Connected Care, although this had only been recently implemented. The 'red bag' scheme had been introduced in February 2018 – staff in A&E told us that by having access to a person's information and medical records this was supporting them to make safe and effective decisions in a timelier way.
- For people that arrived at hospital via an ambulance it was not automatically assumed that A&E was the best place for them. The STAT (See, Treat, Access, Transfer) section of the A&E department triaged ambulance arrivals and was staffed by an A&E consultant who could decide if people should go through to A&E. This system was effective in preventing some people attending A&E who did not need to, but it could also cause some delays as GPs and ambulance staff could not always refer straight through to a specialty department.
- A Patient Transport Service Hospital Ambulance Liaison Officer (HALO) was working in A&E, liaising between ambulance staff and staff working in A&E. The HALO was hugely appreciated by A&E staff and was effective in facilitating faster discharges, but there was only one working officer in the hospital at any one time which meant that there were concerns about resilience planning during surges in demand, such as during winter.
- The Royal Berkshire Hospital performed well for A&E waiting times, better than the average across England. Between May and August 2018, A&E staff met the national target to see, treat and admit or discharge 95% of A&E attendances within four hours. The hospital also performed well for bed occupancy – in 2017/18 bed occupancy was always below the 85% national target and the England average of 90%.
- Effective triage was in place in A&E – there were alternative services available for people not to be admitted unnecessarily. A 21-bed short stay unit, staffed by a multi-disciplinary team, including occupational therapists would care and treat people for up to 72 hours so they could return home safely and quickly. There had been a 25% increase in people using this service in the year prior to our visit and there were plans to increase capacity to better meet demand. The Acute Medical Unit received regular referrals from A&E and aimed to provide assessments within four to six hours. An elderly care consultant was part of a multi-disciplinary team that focused on early intervention and getting people home as quickly as possible.
- The hospital had a good system for bed and flow management, as a result people were less likely to experience multiple moves while in hospital. We saw evidence that planning for discharge commenced when a person was admitted, and a provisional discharge date established. This enabled discharge arrangements with health and care partners to be made in advance of a person's discharge and help avoid unnecessary delays.

- People who were admitted to hospital received person-centred care and support. We saw people with dementia receiving one-to-one support from dedicated health care assistants who were part of the 'care crew' and had been specially trained to care for people with high level needs. The care crew used specialist resources and stimulus to aid people with dementia during recovery.
- We saw numerous examples of people receiving person-centred and dignified care that was also supporting them to return home as soon as they were ready. People staying on the older people's ward were encouraged to be mobile to maintain their independence – there was a dedicated enhanced recovery facilitator working to promote this across the ward. 'Dress for dignity' was a scheme where people staying on the rehabilitation ward were encouraged to get up and dressed whenever possible, using clothing donated by volunteers, to promote their dignity and feeling of wellness.
- We found that staff across health and social care had a good understanding of the Mental Capacity Act. Where people did not have the capacity to make decisions about their care, staff understood where to make decisions in their best interests with a strong focus on engaging family and carers in the decision-making process.
- VCSE providers had good links into the hospital so they could support people to return home. The British Red Cross had a strong presence across the hospital and their 'Home from Hospital' transport and support service was well publicised among staff. VCSE providers were present in the hospital to signpost people to services which better meet their needs. Hospital staff met with VCSE provider staff to increase their knowledge and understanding of services in the community, so that they could signpost people to support after they are discharged.

How are people supported to return home or to a new place following an admission to hospital?

Using specially developed key lines of enquiry, we reviewed how safe, effective, caring and responsive the system is in the area: support to a person returning home or to a new place of residence.

Whether people were returning home or moving to a new place of residence they were usually supported to move to a place best suited to their needs and that would enable them to be as independent as possible. We found a significant emphasis on ‘home first’ throughout the hospital and saw evidence of discharge planning at the point of admission onto wards.

Good social care capacity in the community meant that people did not experience delays due to a lack of availability of services. The home first principle was established across health and social care and understood by staff – where there was a good understanding of systems and process between staff, people generally had good experiences of being discharged. However, where there was a less well-developed understanding between staff, including of pathways of care and funding arrangement for continuing healthcare, people could experience delays.

- People in Reading were less likely to experience a delayed transfer of care when compared to other areas in the country. In October 2016, Reading’s rate of delayed transfers of care (DTOC) for all adults was significantly higher than the England average. By July 2018 the rate of people experiencing a delayed transfer of care was lower than both the England average and that of comparator areas.
- The improvements were due to a significant drive from senior leaders across the system to improve performance in relation to DTOC. Through the Berkshire West 10, system leaders had commissioned a peer review from the Local Government Association (LGA) to assess the system’s performance and processes. Following this review, we found that the system had developed good oversight of delays at both operational and strategic levels – system leaders had established a weekly DTOC meeting, which brought together leads from the three unitary authorities, NHS trusts and the CCG to discuss individual cases and address delays, as a system. Through this meeting, leads were also able to identify common themes in the reasons for delays which were fed into the Berkshire West 10 Integration Delivery Group.
- The system had gone a long way to develop a ‘home first’ culture, which we found to be well understood across the system. We found a significant emphasis on home first, the

prioritisation of getting people home from hospital as soon as they are ready, throughout the hospital and staff wore lanyards emphasising this. At the local authority we saw a drive to ensure that care homes were only seen as an option for a person who was unable to be remain independent even with support. There had been a decrease in the proportion of older people being admitted into care homes in recent years, reducing from 834 per 100,000 population (aged 65+) in 2015/16 to 597 per 100,000 population in 2017/18, lower than that of comparator area averages.

- Reading did not have significant challenges with its care home and home care capacity. The local authority did not pay retainers to domiciliary care providers which meant that when a person who was in receipt of a package of care in their own home was admitted to hospital, the local authority ceased payment to the care provider. As social care capacity was good this meant that the local authority was not challenged in securing care packages in the community and people would rarely experience delays when being discharged. This could however make it difficult for people to receive continuity of care as they might not be seen by the same care worker(s) or the same care agency as before their admission.
- While the system had been successful in reducing DTOCs, some people with complex mental health needs were experiencing significant delays because of a lack of specialist capacity in the community. We had an example of a person who had been waiting over 90 days for a placement in the community and was now being considered for placement outside of area.
- Operational leads acknowledged that the lack of capacity in the community for people with a high level of dementia needs was having a significant impact on people being discharged to a place appropriate for their needs.
- As highlighted in the LGA review, the system had not been successful in establishing the high impact changes for managing transfers of care. Following the LGA review, the system had developed an action plan to implement the high impact changes – while progress had been made to implement some elements of the model, there was still need for significant development needed for others, including implementation of seven-day services and the trusted assessor model – this was acknowledged in performance reports.
- The high impact changes had been used in the development of a Getting Home Project, overseen by the Berkshire West 10 Integration Delivery Group. We found good examples of multi-disciplinary working to support people who moved between health and care settings. The integrated discharge service, located in the Royal Berkshire Hospital (RBH) comprised of staff from RBH and Berkshire Healthcare NHS Foundation Trust working alongside a social care team. The team focused on established pathways of care, reducing time taken to commence multiple assessments, especially for people with complex needs.
- Discharge to Assess pathways out of hospital had been reviewed and simplified, however we found that these were not well understood across the system which could cause

confusion among staff and people using services. This was recognised by staff as an area for improvement and plans were in place to better embed pathways through the 'Getting Home Project'.

- System partners had improved the support provided at the point of discharge from hospital to people who fund their own care. An external company, Care Home Selection (CHS) was commissioned to work with people funding their own care who required care home packages. Staff utilised Berkshire West's Patient Choice Policy: 'Supporting Patients' Choices to Avoid Long Hospital Stays'. CHS helped people to understand the options available to them post-discharge and supported them in making those decisions. Hospital staff told us that this had enabled better support to people who fund their own care and that conversations about discharge had begun much earlier – messages regarding a person's choices were much clearer as a result. The impact of the service could be seen in the reduction of delayed discharges among this group of people.
- The system had been encouraging people to use direct payments as a way of giving people more choice and control over the service they use. While the percentage of people in receipt of direct payments for adult social care had increased to 11.1% in 2017/18, this was still lower than the comparator (14.8%) and England (17.5%) averages.
- A lack of communication between health and care professionals and an underdeveloped understanding of different roles could cause delays in transfers of care. Hospital staff expressed frustration at some care home providers not being able to undertake assessments at weekends, while some social care providers felt that hospital staff did not fully understand the distinction between nursing and residential care. There were not any established forums for health and social care providers to come together and discuss such issues. This was a missed opportunity for system partners to come together to address this and jointly improve people's experiences.
- People could experience delays due to the timeliness of assessments. Registered managers of care home and home care services told us of a reluctance to trust the assessments of people's needs undertaken by hospital staff. They would usually always conduct their own assessments as they did not feel that staff working in the hospital had an accurate understanding of the services they could provide. A lack of trust and established relationships between health and care staff was having an impact on the ability for the system to establish the trusted assessor model. This was acknowledged by the system as was being addressed through the High Impact Change Model action plan developed following the LGA review.
- Care home and home care providers told us that the quality of information on discharge was not always comprehensive and that staff would sometimes have to follow up with the hospital for information such as changes to medication. Initiatives such as the 'red bag' scheme were in place to improve information flow between health and care services and a

'Discharge Envelope' was used for people to collect and store useful information ahead of their discharge. One registered manager told us that a recently introduced two-sided discharge form had improved information flow but it was not uncommon for important information to be missing.

- Connected Care was having a positive impact in enabling health professionals to access people's information, but this had not yet been established across health and social care providers to support the transfer of information between health and social care at the point of discharge.
- The Royal Berkshire Hospital had recently introduced an Electronic Prescribing and Administration system to improve the accuracy and timeliness of medication summaries at the point of discharge. This had only been recently implemented at the time of our review and was not yet fully embedded.
- There was a high level of demand for the patient transport service and demand had increased further over the last two years. As a result, some people experienced delays in returning home due to availability of transport. Delays could also occur due to ambulance crew members needing to undertake risk assessments before transporting people home and these could sometimes take up to 48 hours to complete. This process could be improved by ambulance crew members being given more notice of a person's discharge to undertake assessments earlier.
- The British Red Cross was commissioned to provide a 'Home from Hospital' service which provided transport and a settle at home service following discharge from hospital. This service was hugely valued by the people that used it and volunteers were also able to provide links to other services.
- The decision process for continuing healthcare (CHC) funding was not timely or widely understood by staff. Consequently, staff found the process of applying for funding lengthy and complex – decisions about funding were also having a negative impact on relationships between staff.
- System leaders told us that processes for CHC had been reviewed and extra training had been provided for frontline staff. Despite this frontline staff still did not feel processes were clear and consequently this was continuing to cause delays. We heard how this was impacting on people being able to die in their preferred place and were given examples of people dying in hospital before the funding was approved. A progress report given to the Berkshire West 10 Integration Delivery Group on the CHC Quality Premium in March 2018 showed that the CCG had not reached the terms of the Quality Premium.
- Reablement services in Reading were effective. In 2017/18 91% of people aged 65+ who were discharged home with reablement were still at home after 91 days, compared to an

England average of 83%. However, the percentage of people aged 65+ who were accessing reablement services dropped from 4% in 2015/16 to 3% in 2017/18.

- People had access to good reablement care in the community through the Community Reablement Team (CRT). The multi-disciplinary team provide reablement care to people in their own homes to help them recover from an illness or injury and help to promote independence. The BCF report from May 2018 showed that of the proportion of people accessing support from the CRT, 98% of people were still at home 91 days after discharge.
- Recognising the reduction in demand for bed-based reablement care and taking into account the availability of the CRT, at the time of our review the local authority was consulting to close the Willows, a residential care home which also provided bed-based reablement. The local authority was proposing to move the reablement service to Charles Clore Court, an extra care facility, where it was anticipated that the environment would better promote recovery and independence. There was an intention that staff at Charles Clore Court would receive extra training to support people with their reablement and recovery needs.
- The high levels of support provided to people living in care homes through the care home support programme was reflected in the proportion of emergency readmissions for people living in care homes. Across two quarters of 2017/18 Reading had significantly lower rates of emergency readmissions from people over 65 living in care homes within 30 days of discharge, compared to the England average. In the same period, Reading's rate of emergency readmissions within 30 days of discharge, for the general over 65 population, was slightly higher than England average.

Maturity of the system

What is the maturity of the system (direction of travel) to secure improvement for the people of Reading?

- Strong relationships had developed between system leaders and it was clear that there was an increased appetite for system working to meet the needs of people in Reading. While there was a desire between health colleagues to increase the pace of integration and merge the work of the BW10 with the ICS it is important that this is agreed as the system direction of travel amongst all system partners, including elected members in the three unitary local authorities. Recent meetings between the Chairs of the three Health and Wellbeing Boards signalled progress in this area. The maturity of relational working between health and social care will be key to the achievement of the ICS vision, if this is the agreed direction of travel.
- Improved relationships between system leaders had generated a focus on system working and a shared vision for health and care was held by system leaders in the Chief Officers Group. While relationships have improved between the local authority and health partners at a system leader level, it is important that others, working at different levels, are encouraged and enabled to develop closer working relationships.
- Not all system partners were engaged with the Health and Wellbeing Strategy for Reading, and it was not driving the future direction of health and care for the area. In developing the next Health and Wellbeing Strategy, due for publication in 2020, there is an opportunity for co-production between system partners, and to ensure alignment with the wider Berkshire West ICS strategic intentions and those of the STP.
- Governance and accountability in Reading could be strengthened to better hold system partners to account. The Health and Wellbeing Board was not effective in bringing together health and care partners across the system and the Adult Social Care, Children's Services and Education (ACE) Committee providing was not providing an effective scrutiny function across health and social care. Officers across health and social care organisations working with elected members can help to strengthen the HWB and ACE in providing system accountability. It was not clear where the Chief Officers in the Berkshire West area were held to account, and if there were significant changes in leadership, how leaders would maintain strategic consistency. Arrangements for holding the Chief Officers Group to account should be developed.
- The Berkshire West 10 Integration Delivery Group was overseeing many operational programmes under the direction of the Chief Officers Group. This work was not underpinned by a strategy that set out how these programmes were contributing to a strategy for how the needs of people in Reading and the wider Berkshire West area were going to be met in the

future. A strategy should be developed in alignment with the future Health and Wellbeing Strategy

- Joint commissioning was underdeveloped, and the commissioning leads in the local authority and the CCG were both interim appointments. The Reading Integration Board provided the governance structure to undertake joint commissioning and could be better used to support joint commissioning arrangements outside of the BCF.

Areas for improvement

We suggest the following areas for improvement

- In developing the next Health and Wellbeing Strategy, due for publication in 2020, the local authority should engage system partners and ensure greater alignment with the wider Berkshire West ICS strategic intentions and those of the Buckinghamshire, Oxfordshire and Berkshire West STP.
- Health and care commissioners should work together to develop the new Joint Strategic Needs Assessment and ensure that in its development it is aligned with the Integrated Care System's Population Health Management approach.
- Health and care commissioners should develop a joint commissioning strategy. Health and care commissioners should agree on commissioning intentions across health and social care and work together to develop a joint market position statement.
- System leaders should focus on developing prevention and early intervention services that increase the support offer in the community. A system approach to risk stratification and active case management should be developed to identify people at the highest risk of hospital admission.
- While relationships between system leaders were strong, improvements in relationships between health and local authority partners could be improved. As the system moves towards greater integration at a Berkshire West level, system leaders should ensure that staff are engaged in the process and that health partners are working with colleagues in the local authority to progress plans.
- System leaders should evaluate governance boards and processes to ensure that there is not duplication. System leaders should also ensure that people working in the system are clear on where decisions are taken, and where accountability lies for system performance.
- The Health and Wellbeing Board should play a greater role in scrutinising health and care decisions taken at an ICS and BW10 level to ensure that plans are aligned with Reading's

Health and Wellbeing Strategy. The Health and Wellbeing Board should also review its membership and ensure greater representation of health and social care providers, including independent providers.

- The Adults, Children and Education (ACE) Committee should better embed its scrutiny function and play a more significant role in holding partners to account for common goals and scrutinising future strategic plans. The ACE Committee should call health leaders to account for decisions that impact on the delivery of health and care services to people in Reading.
- The role of the Reading Integration Board should be further developed to enable joint commissioning outside of the Better Care Fund and be more closely aligned to the Health and Wellbeing Board.
- The modelling work undertaken by ICS workforce leads should be developed into a system workforce strategy and that the local authority and the VCSE sector are involved in its development as partners and not just as providers.
- There were opportunities to make better use of the VCSE sector services market. Health and care commissioners should work with VCSE sector providers to support in the development joined up service offers.
- In the establishment of pathways of care, operational leads should ensure they are understood, and signed up to, by staff across the system, and that they are clearly communicated to people so that they understand what options are available to them when they are discharged from hospital.
- Strategic provider forums which bring together staff from across health and social care providers should be established to enable staff to discuss operational processes and overcome barriers to joint working.