SLOUGH WELLBEING BOARD - WEDNESDAY, 28TH MARCH, 2018

SUPPLEMENTARY PAPERS

The following Papers were tabled at the meeting.

AGENDA ITEM	REPORT TITLE	PAGE	WARD
5.	Frimley Health and Care Sustainability and Transformation Partnership – Presentation Slides	1 - 20	All
6.	Homelessness - The Current State of Play – Presentation Slides	21 - 42	All

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Slough Wellbeing Board

28 March 2018

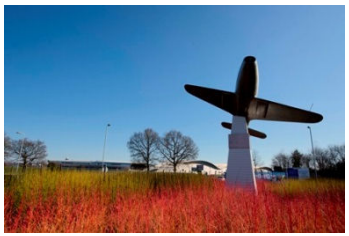
Sir Andrew Morris

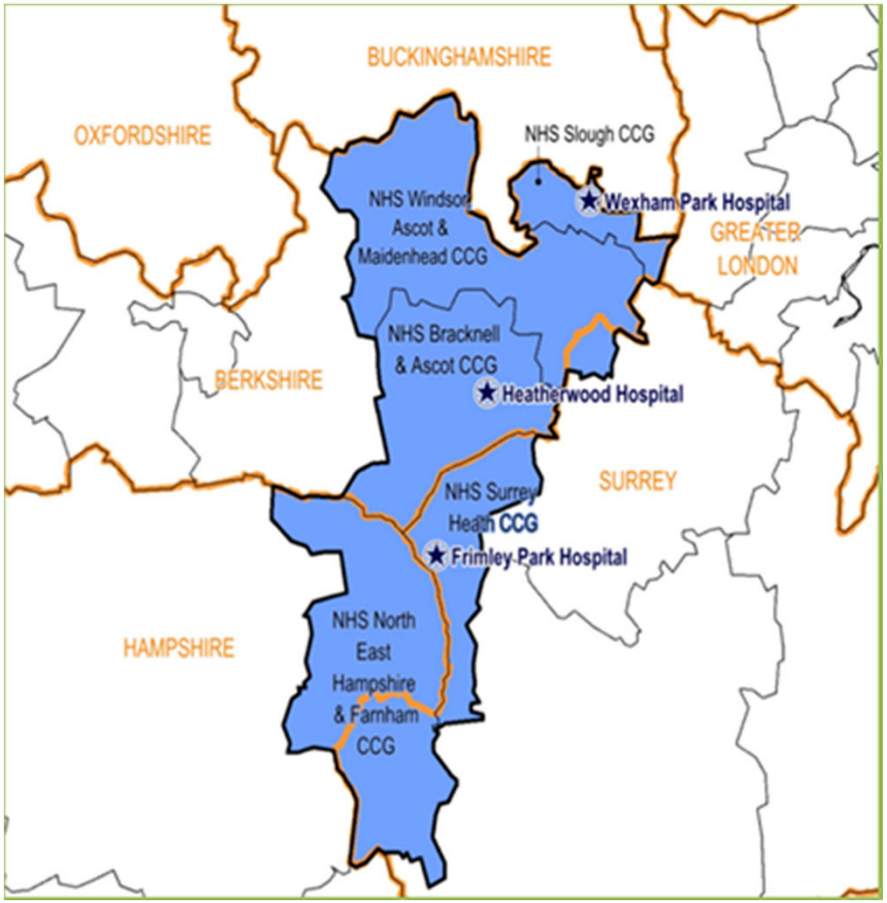
ICS Lead

Frimley Health & Care ICS

- Health & Wellbeing
- Care & Quality
- Finance & Efficiency
- Effective Workforce

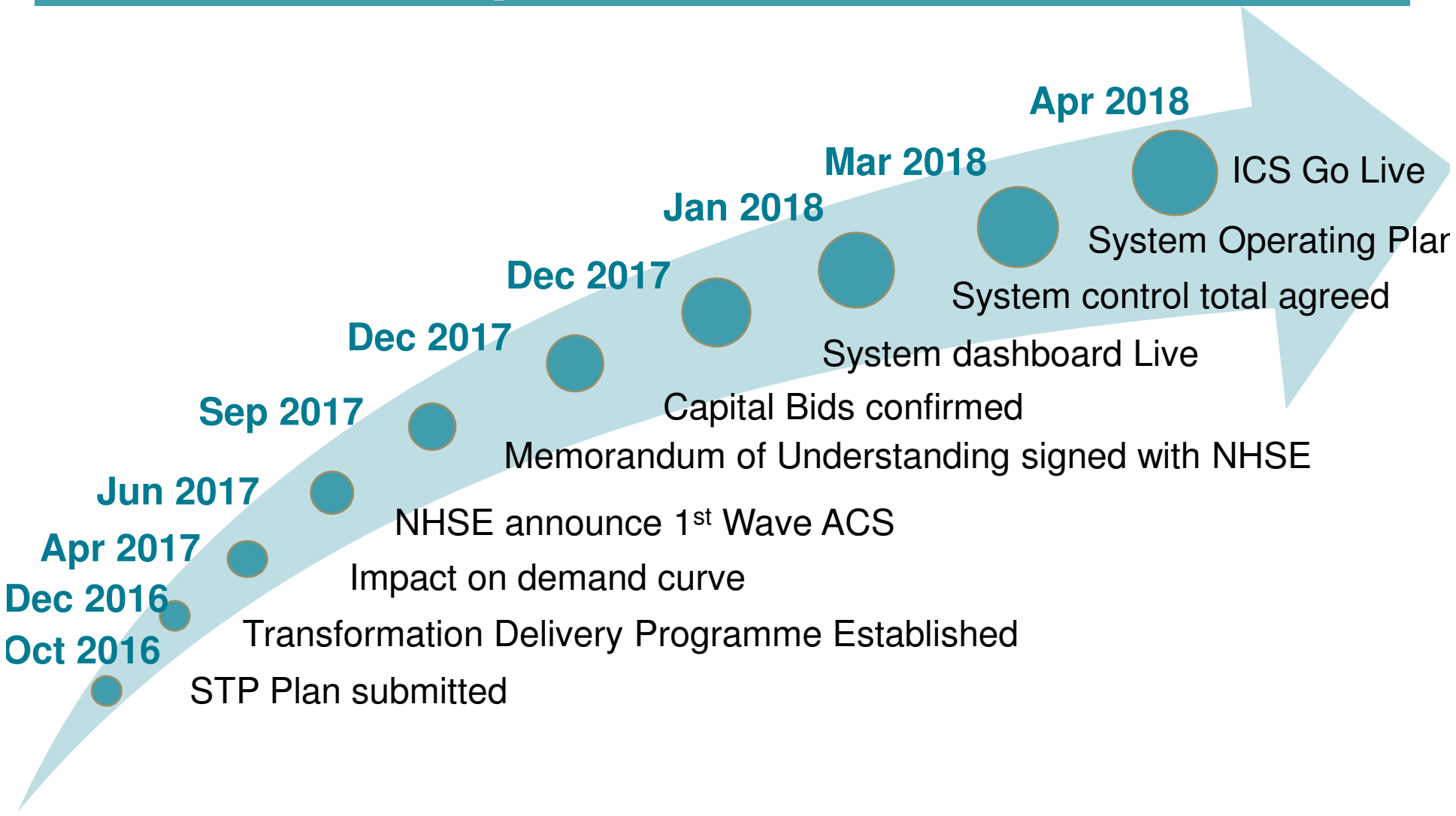
The Frimley geography





Frimley STP population of 800,000 people in East Berkshire, NEH&F and Surrey Heath CCGs. Involves 30 statutory bodies.

Our ICS Journey - Developing our system and relationships



Our System Ambition

Our collective ambition is that the people living in the Frimley system have the best possible health and wellbeing, keeping them healthy and in their homes for longer.

The changes required across our health and care system cannot be addressed by individual organisations; they are a collective challenge and require a collective response. Our success will be judged by the strength of our system, not the individual organisations.

Our system is inclusive and brings together the providers and commissioners of all health services, social care, public health, council services and the voluntary sector.

Primary Care constitutes one of our key partners in successful transformational change. We are working with GP leaders to ensure resilience and increased capacity to support our local residents

Main mechanisms for ICS 2018/19

Mechanisms:

- A single ICS leader
- A system-wide board with delegated decision-making
- A system operating plan for 2018/19
- A system-level accountability framework
- Transformational funding to support priority schemes
- A system control total mechanism for health
- A blend of system level governance and local structures to meet all performance, quality and financial standards required at system and organisational levels.

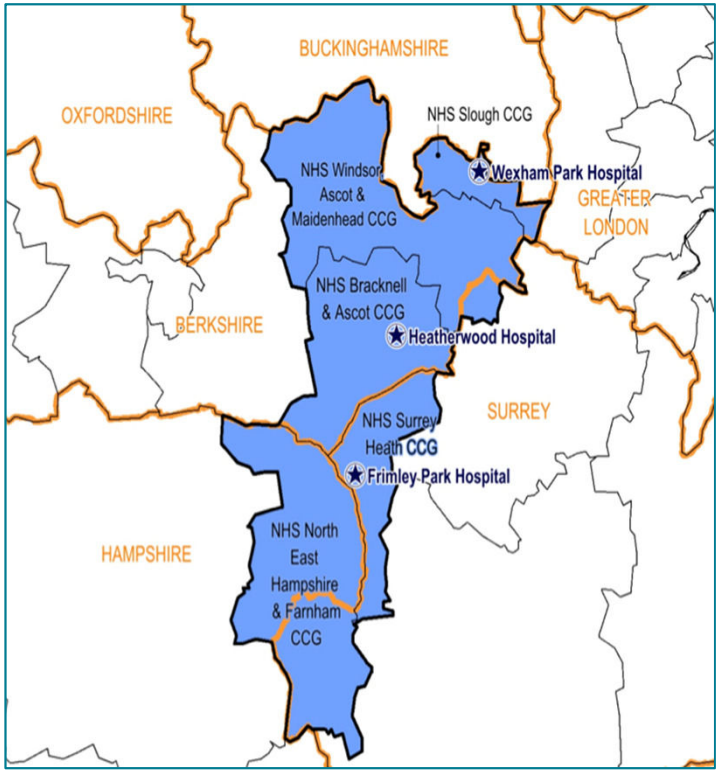
STP to ICS

One System

One Budget

One Vision

ICS



Our system on a page:

Five Year Priorities

National

National 'must do's':
Primary Care,
Urgent and Emergency Care,
Referral to treatment times,
Cancer,
Improving quality
Financial sustainability
Development of high quality STP

Local

Priority 1: Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection

Priority 2: Action to improve long term condition outcomes including greater self management & proactive management across all providers for people with single long term conditions

Priority 3: Frailty Management: Proactive management of frail patients with multiple complex physical & mental health long term conditions, reducing crises and prolonged hospital stays

Priority 4: Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place

Priority 5: Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence

Transformation Initiatives

1.Prevention & Self-care: Ensure people have the skills, confidence and support **to take responsibility for their own health and wellbeing**

2.Integrated care decision-making: Develop **integrated decision making hubs** to provide single points of access to services such as rapid response and re-ablement

3.GP Transformation: Lay foundations for a new model of **general practice provided at scale**, including development of GP federations to improve resilience and capacity.

4.Support Workforce: Design a **support workforce** that is fit for purpose across the system

5.Care and Support: Transform **the social care support market** including a comprehensive capacity and demand analysis and market management

6.Reducing clinical variation: Reduce **clinical variation** to improve outcomes and maximise value for individuals across the population.

7.Shared Care record: Implement a **shared care record** that is accessible to professionals across the STP footprint.

Cross cutting Programmes

Cross cutting Programmes

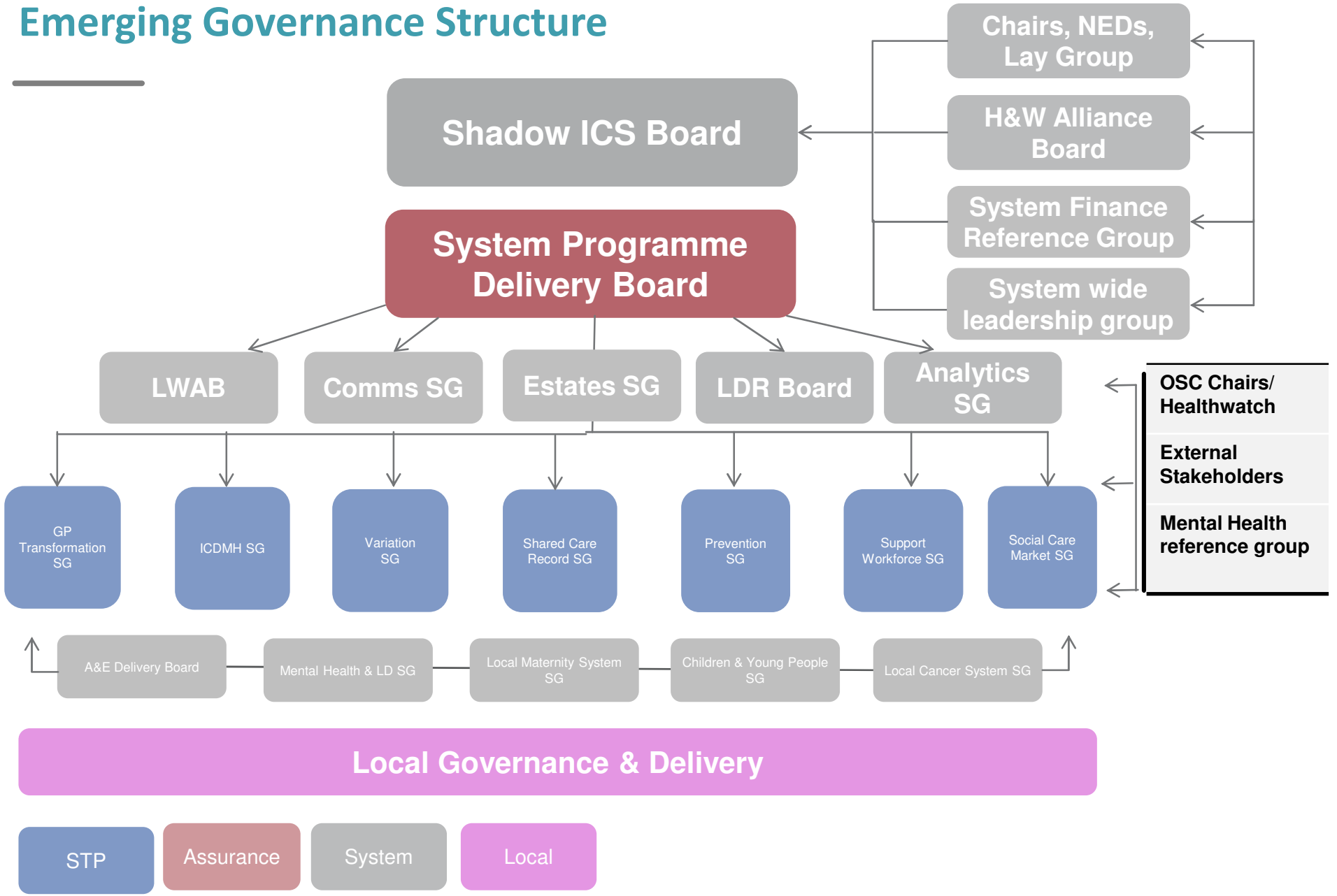
- Urgent & Emergency Care
- Mental Health & Learning Disabilities
- Maternity
- Children & Young People
- Cancer

Enablers

Enablers

- Workforce
- Analytics
- Communications & Engagement
- Estates
- Digital & Technology

Emerging Governance Structure



Mental Health

The three priority areas for the ICS for 18/19 include:

- **Out of Area Placements –** aiming to reduce OAPs for non-specialist inpatient care - has a significant impact on the experience and quality of care for people and their families.
- **24/7 Urgent MH Work -** Ensure we have easily accessible support and to commission 24/7 urgent and emergency mental health services for children & adults.
- **Perinatal Mental Health - Increase access to evidence-based specialist perinatal mental health care**

Plans and Aspirations for 18/19

- Having more Mental Health staff working within primary care
- East Berkshire to transform the front door for mental health services in primary care
- Working towards CORE 24 service in Wexham Park
- We plan on co producing an ICS crisis pathway for all ages and develop plans to ensure all areas have an improved crisis pathway
- Develop a multi agency Out of Area Placement strategy with clear actions and deliverables
- East Berkshire to review all current 117 funded placements alongside the local authority and BHFT to improve quality and reducing spending in this area to enable reinvestment in community provision and support
- We want people to be supported at the earliest opportunity so people can be signposted to the right care at the right time to a crisis we will reduce the need for crisis pathways in the future.

Children & Young People

MH 5YFV Targets

- 32% increase in children and young people accessing mental health services in 18/19
- 95% of children receive urgent treatment (within one week) or routine treatment (within four weeks) when they are referred to children's eating disorder services
- Closer to home specialist children inpatient beds (known as Tier 4)

Plans for 18/19

- Commission more services together with the local authorities and education
- Work with local authorities to support children with special educational needs
- All areas have a Children & Young Peoples Eating Disorder Service
- Develop a place based CYP Services for mental health at Frimley Park Hospital
- All areas are signed up to the national quality programme
- All areas commission voluntary sector organisations and preventative support

Key Work streams

Prevention

The Frimley system footprint already contains many examples of key asset-based work streams run by members of our population for our population. Transformation seed funding has already been allocated to strengthen this work.

- **Community Asset Toolkits & Maps**

Extensive collaboration across agencies and resident groups will take place to generate a set of online tools aimed at guiding asset based work.

- **Social Prescribing**

Helps residents find and access community based health improvement opportunities. Link workers now in place

- **Hospital Based Alcohol Services**

An additional 4 alcohol liaison nurses will enable the extension of the service at Frimley Park Hospital and introduce a new service at Wexham Park Hospital, enabling the service to run 7 days a week between 8am and 8pm.

- **Physical Activity Initiatives**

A range of accessible opportunities for activity will be developed and promoted through Community Sports Partnerships. Pilot scheme using patient facing wearable technology to encourage activity.

Shared Care record

Residents will only have to tell their story once and will experience more joined up care experience. Professionals will have more time to deliver that care and improve decision making.

- Supports improved patient safety by providing critical patient information at the point of care
- Improved efficiency for health and social care staff by having access to information or having signposts to who holds the information
- Releasing time to care at the point of delivery by reducing the need for telephone calls to ascertain recent care history
- Developing a patient portal in order that our population can collaborate in their own plan

Workstreams

GP Transformation

Aims to develop a sustainable clinical, career and business model for general practice which will deliver improved access and outcomes for our patients by:

- Reducing variation in care, offering an enhanced urgent care access 7 days a week,
- offering an enhanced urgent care access 7 days a week,
- making full use of competencies within the practice multi-disciplinary team
- recruiting and retaining high quality GPs by offering portfolio career options,
- improved use of technology and IT
- care provided at scale, when appropriate, through better use of general practice estate for clinical services.

Support Workforce

The aim is to design a support workforce that is fit for purpose across the ICS system by developing the capability and capacity of the support workforce in the independent sector, local authorities and health.

- An agreed process for cross sector secondments to build capacity in the adult social care sector
- An integrated apprenticeship which promotes recruitment and retention by offering career development pathways
- A learning and development passport which enables movement between sectors and promotes an integrated approach to training
- An enhanced care worker role to enable improved community provision for the frail elderly and those with complex needs
- A joint health and social care recruitment strategy to build capacity across the system and emphasis the benefits of a career in health and care within the Frimley ICS
- The development of tools, workforce models and employment approaches to support and enable partner organisations across the NHS, Local Authorities, Independent and voluntary sector to manage, recruit and develop their workforce

Workstreams

Care & Support Market

Focused on the independent care and support market by working together to co-design a sustainable model of care and support which enables people to continue living at home for as long as possible,.

- A comprehensive market review and development plan with a blueprint for our co-designed future model of care and support
- An agreed strategy and implementation plan for enhancing quality of care within the independent sector
- An agreed joint approach on the review and commissioning of high cost placements
- An ICS wide strategy on future investment in accommodation with care options
- 30 care home worker delegates in the leadership coaching course
- 50 care home worker delegates taken part in the introduction to coaching course
- Red bag Scheme in care homes

Clinical Variation

Aimed at improving health outcomes and maximise value for our patient population through the reduction of variation in clinical practice across the ICS.

- Standardised integrated treatment pathways and patients supported to self-manage resulting in less clinical appointments
- Patients receive optimised treatment resulting in improved health outcomes
- Patients are able to live a healthier life for longer
- Improved continuity of care and clearer information about care choices through standardised pathways
- Accessible, local community care which is closer to home
- Reduction in elective and non-elective care spend with improved demand management
- A more patient focused approach enabling earlier access into proactive integrated services for individuals

Key Work streams

Integrated Care Decision Making

We will be focused on developing a common approach to managing individuals living with frailty and multi-morbidities. The model is underpinned by strong partnerships including social care, general practice and the voluntary sector.

All localities will implement the following elements of the model:

- **A Single Point of Access (SPA)** to enable timely access to integrated interventions, triage and case management
- **Community Integrated Multi Disciplinary Care Teams** co-located with Primary Care services and staffed with an appropriate skill mix to effectively manage people at high risk of hospital admission or re-admission
- **Multi-disciplinary Assessment and Rehabilitation Centres (ARC)**: Co-located teams who will undertake a comprehensive assessment resulting in a structured individual care plan
- **Hospital In-Reach**: pro-active movement of individuals out of hospital back home or into the most appropriate care setting
- **GP Led Anticipatory Care**: Proactive case finding to identify patients who are at high risk of admission and enable proactive interventions to avoid unnecessary hospital admissions

Potential Locations

- **Ascot Hub: Heatherwood Hospital**
- **Bracknell Hub: Skimped Hill**
- **Slough Central Hub: The Centre**
- **Maidenhead Hub: St Marks Hospital**
- **Windsor Hub: King Edward VII Hospital**
- **Fleet Hub: Fleet Hospital**
- **Surrey Heath Hub: Surrey Heath Office and Hub Surgeries**
- **Heathlands – Care Home Development**

What Does this mean for our local populations

- Focused programmes aimed at helping people find the right support at the right time
- Support available 7 days per week enabling them to better manage their own physical and mental health and wellbeing
- Access to seamless holistic services that meet the needs at the earliest possible opportunity.
- Improved access to primary care team from 8-8 Mon – Fri and enhanced urgent care access 7 days a week,
- Less out of area placements
- Residents only having to tell their story once and will have access to their medical records online
- Improved quality of care and support provided in care homes
- Reduce variation in clinical practice across the system so no matter where they live they can expect the same service and support.

Engaging local people and professionals

Public meetings - ensuring resident and patient views are integral to how we develop care and support offers and shaping our engagement activity

Clinical and professional leads co-design all service changes and developments

Frimley Health and Care is being developed as a **Communications and Engagement Exemplar.**

Working closely with the **Health & Wellbeing Alliance** to develop key messages and communicate better with our local population

Developing our workforce through leadership & empowerment

1. Developing teams

- Ensuring our teams and those in the wider system are prepared and able to deliver
- Encouraging staff to work differently to provide more seamless care and support for the people we look after.
- Improving workplace wellbeing
- Our shared workforce plan increases opportunities for rotation across organisations

2. Supporting key developments and new models of care

- 20:20 leadership programme supports people from all geographies, disciplines and professions, to work together.
- Organisational Development programme for general practice
- Working closely with Medical School at Surrey University to help with the challenge of recruiting of consultants and GPs and retaining them within the system.
- We are developing an Improvement Faculty to equip the wider workforce with the support and skills required to take on new or extended roles and to understand how to drive collective change.

3. Leading system development

- Building trust and strong relationships along with sharing and co-developing the direction of travel
- The ICS Board development sessions are helping to build on the trust and shared responsibility
- A local Memorandum of Understanding (MOU) demonstrates the commitment from organisations across the ICS
- The All Boards session took place which allowed all organisations to discuss the MOU and what that means for us moving forward as an Integrated Care System.

It's starting to work

	SH	NEHF	WAM	B&A	Slo
A&E attendances	↓1%	↑1%	↓4%	↑1%	↓3%
Non-E admissions	↓3%	↓2%	↓1%	↓3%	↑2%
GP referrals	↓10%	↓3%	↑1%	↓2%	↑5%

- Sharing models and successes
- Evaluation to test outcomes and value for money
- Working with national teams and other areas
- All priority areas under review for impact over time
- Expectation using evidence that demand can continue to be controlled in 2018/19
- Planning underway for capital investments in out of hospital care, including Slough sites

Conclusions

We have been through a period of significant change but progressed a long way from our STP plan

It has given us a unique opportunity to locally redesign our system and develop new ways of working

Encouraged by early signs that its working but still a long way to go

System working is about relationships and facilitating the reaching of consensus

Financial challenges are significant but we're healthier than some other systems

Empowering and developing staff is fundamental

Learn how to achieve results through consultation, engagement, persuasion and influence

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Public Health England

Protecting and improving the nation's health

Homelessness Workshop Slough Wellbeing Board – 28th March 2018

Emma Seria-Walker, Consultant in Public Health, PHE South East Centre

Introduction and outline of the session

Main purpose:

- To explore some of the issues around homelessness, with a specific focus on health and wellbeing

Aims:

- To understand the scale of the issue nationally and locally
- To understand some of the reasons why people become homeless
- To explore some of evidence around what works to prevent homelessness

Objective:

- To agree two or three key actions to take forward in Slough

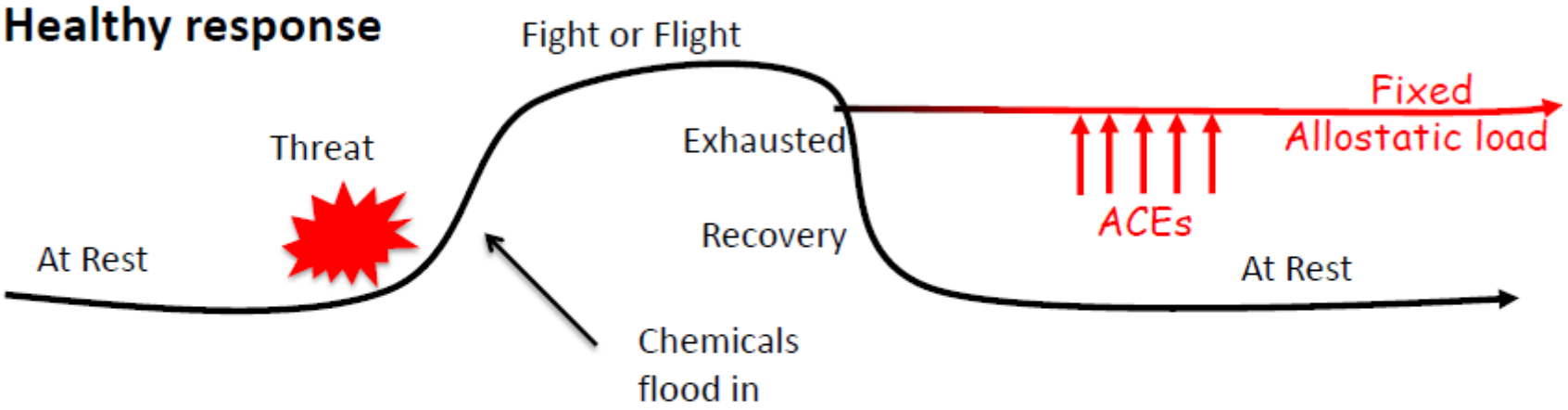
What's the scale of the issue?

Summary of Homelessness Statistics	2009/10	2014/15	2015/16	% change 2014-15 - 2015-16	% change 2009/10 - 2015/16
Rough sleeping in England – snapshot[a]	1,768	3,569	4,134	16%	134%
Rough sleeping in London - annual[b]	3,673	7,581	8,096	7%	120%
Local authority statutory homelessness cases - annual[c]	89,120	112,350	114,780	2%	29%
Local authority homelessness acceptances - annual[d]	40,020	54,430	57,740	6%	44%
Local authority homelessness prevention and relief cases[e]	165,200	220,800	213,300	-3%	29%
Total local authority homelessness case actions	205,220	275,230	271,050	-2%	32%

Source: Taken from the Homeless Monitor: England 2017.

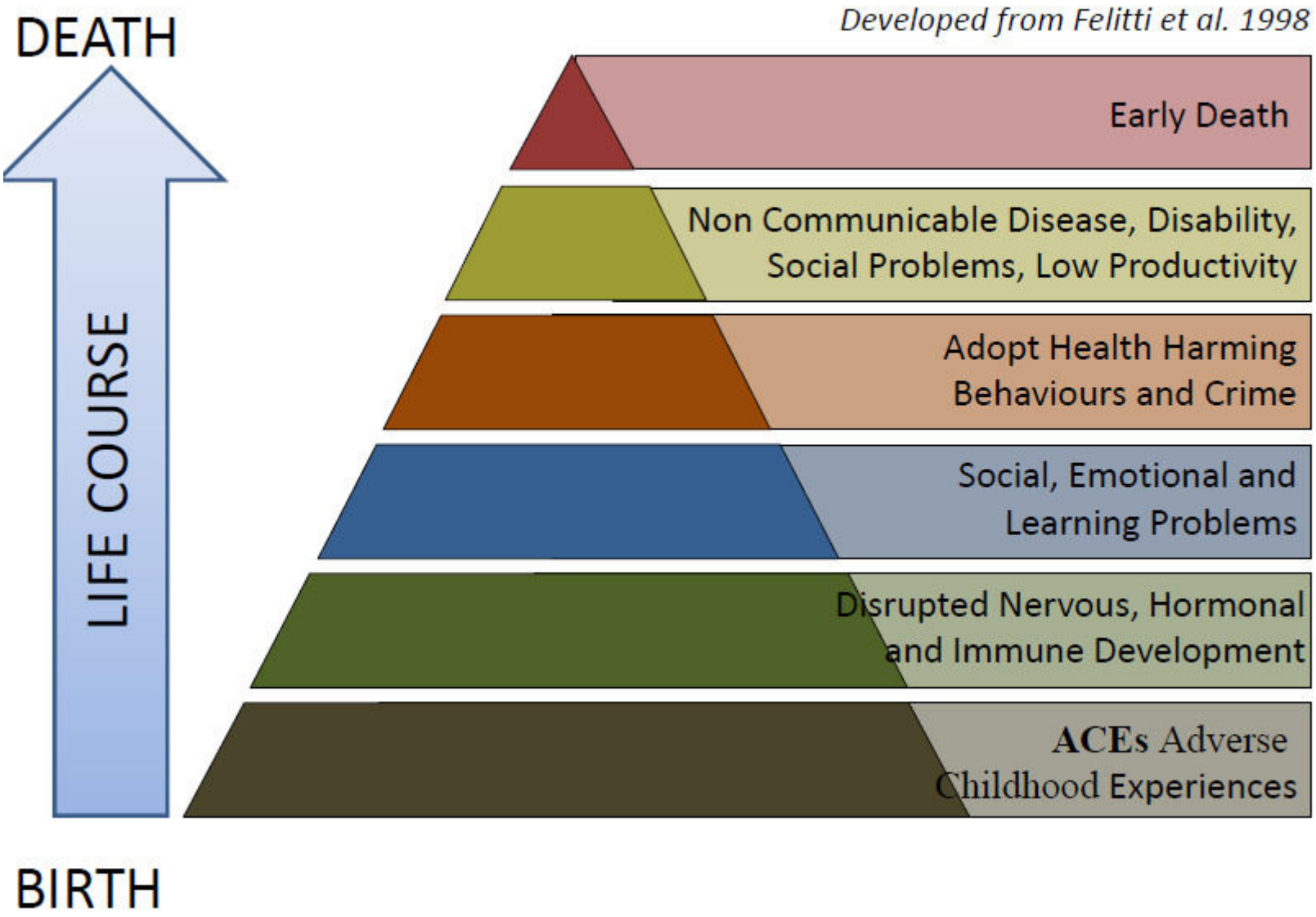
Why do people become homeless?

Trauma response and the impact of ACEs on brain development

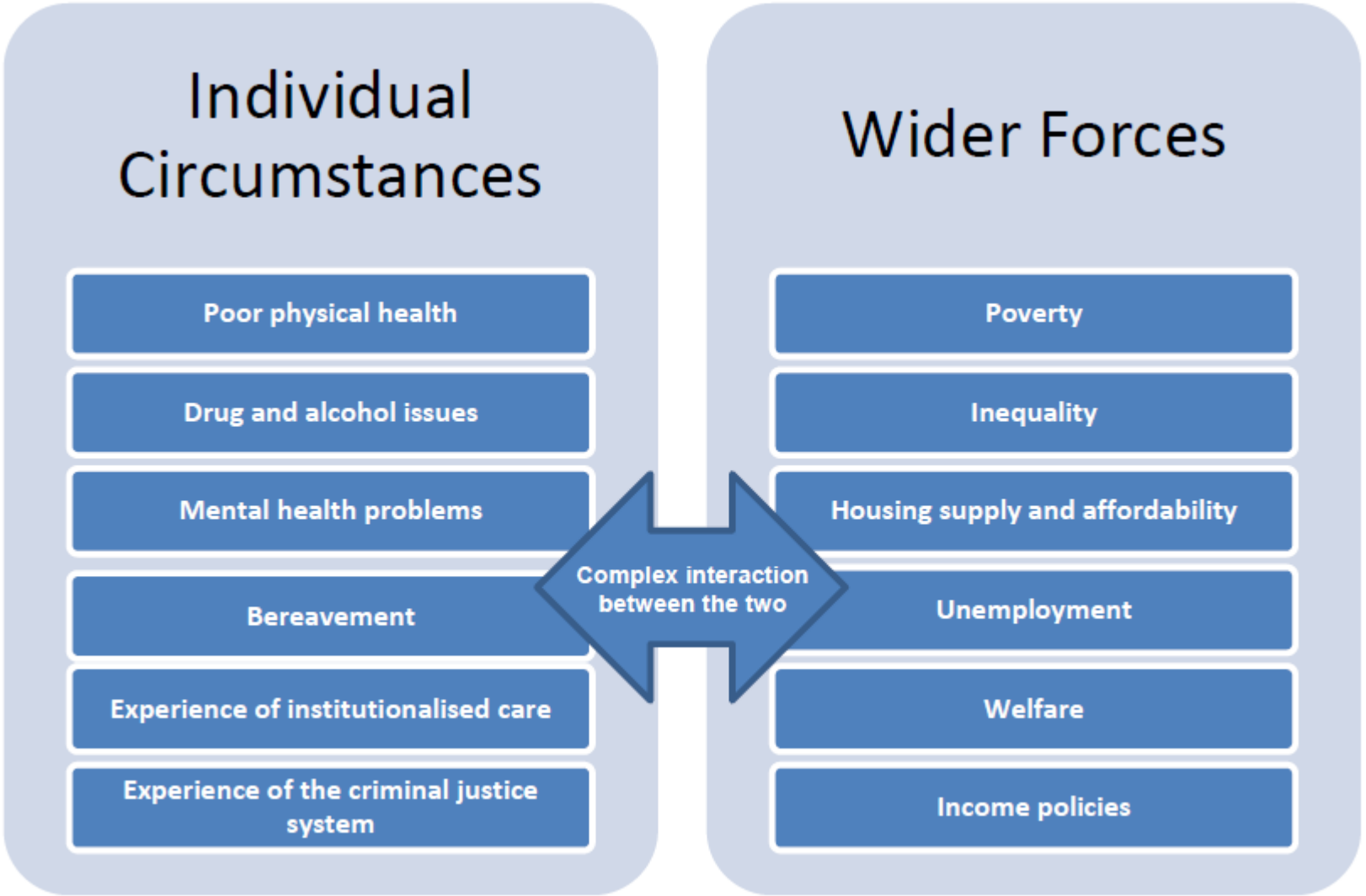


Chronic Stress from ACEs over-develop 'life-preserving' part of the brain.

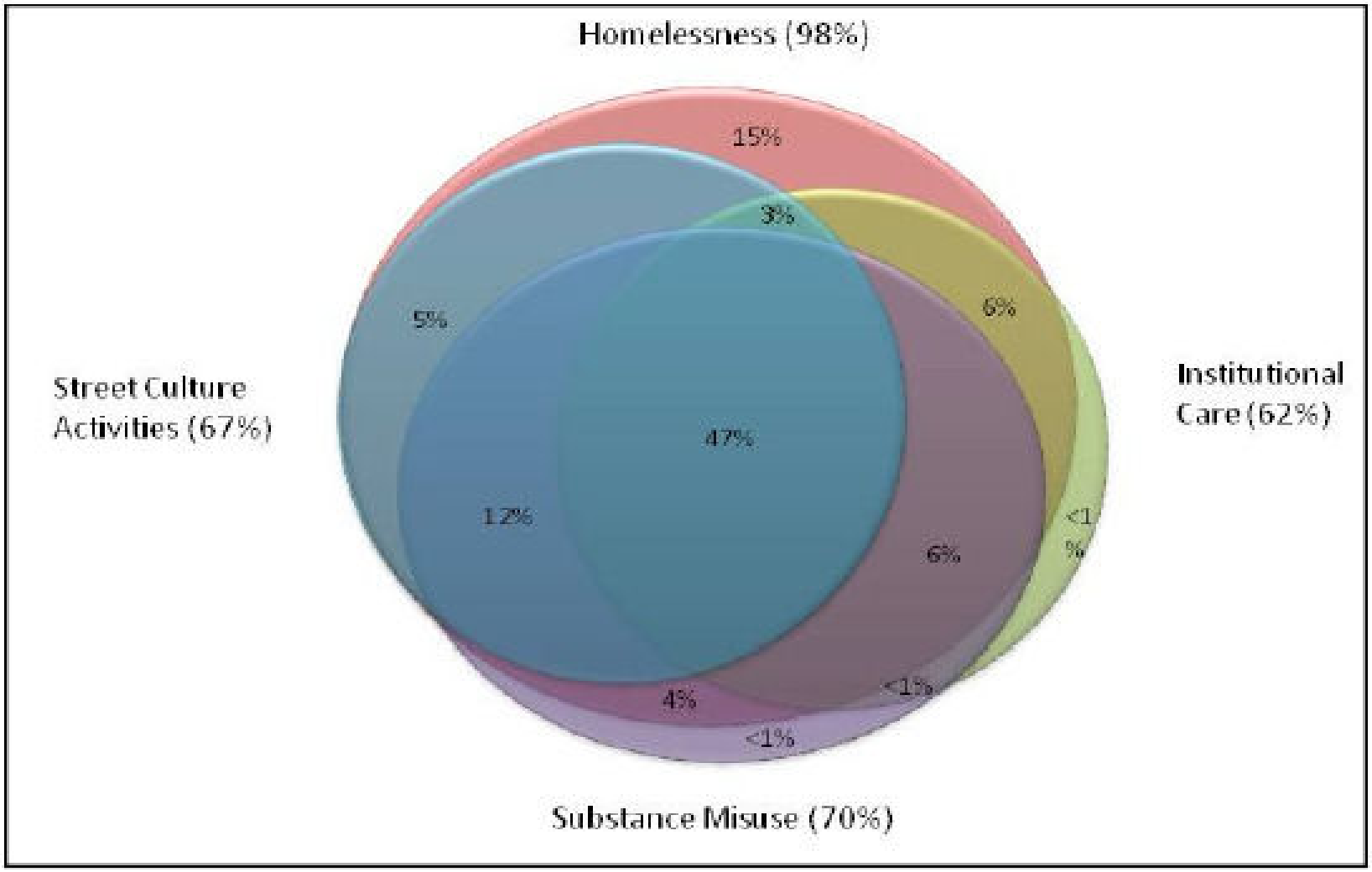
Adverse Childhood Experiences ACEs - The Life Course



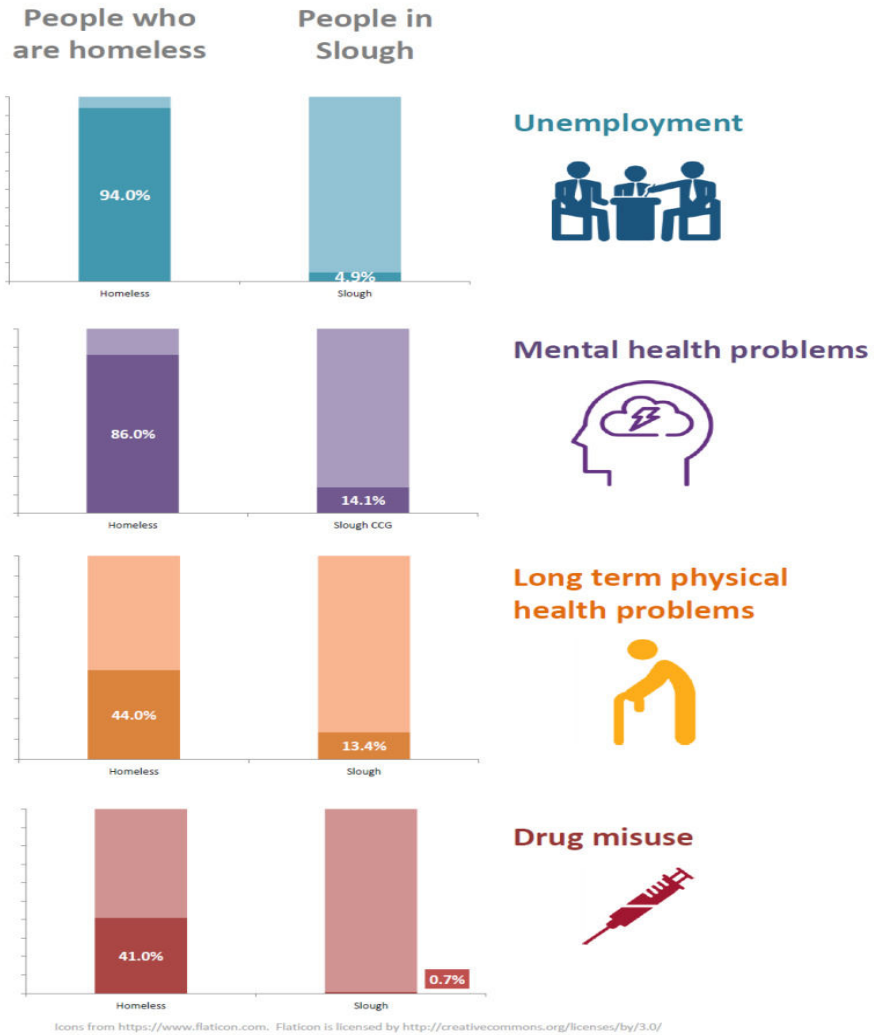
Factors Impacting on the Likelihood of Becoming Homeless



Multiple Exclusion Homelessness



Impact of homeless on individuals



- Co-morbidity amongst the longer-term homeless population is not unusual
- The average age of death of a homeless person is 47 (and is lower for women at 43)

Craig’s story

Discussion

- What opportunities might there be locally to look at how you use the knowledge and understanding of some of the risk factors for homelessness, particularly across the life course to inform policy, strategy and service development?
- How can we respond from a strategic perspective?
- How can we respond from an operational perspective?

Recommended Actions

1. Early intervention – ACEs:

- Children and young people are a key priority for the council and early intervention there is already a lot of work going on in relation to this area, but how could this be strengthened in the context of ACEs and what we know about the risk factors for homelessness?
- Consider the Welsh approach to breaking the cycle of ACEs in housing, is this something that Slough could develop?
- First step could be to invite someone from Wales to come and talk about this project and how you could then embed this type of approach locally

2. MEAM approach:

- Consider using the MEAM approach locally
- First step might be to engage in the South East workshop due to take place in June / July which will include learning from Basingstoke and Deane – scope out next steps for Slough following this

Recommended Actions

3. Whole systems approaches / integration:

- Consider how housing and health could be better integrated into the STP / ICS agenda
- First steps could be as outlined in the King's Fund report:
  - Health and housing sector system leaders should explore whether a 'Housing and Health Alliance' model may be appropriate to strengthen policy and practice links between them to support stronger local working
  - STP workstreams should designate a lead on housing whose role is to co-ordinate and share knowledge on housing and health from within the footprint and from beyond (local)
  - STPs should implement the new national memorandum on improving health and care through the home (Public Health England 2018) …….and assess themselves against its indicators of success (local)

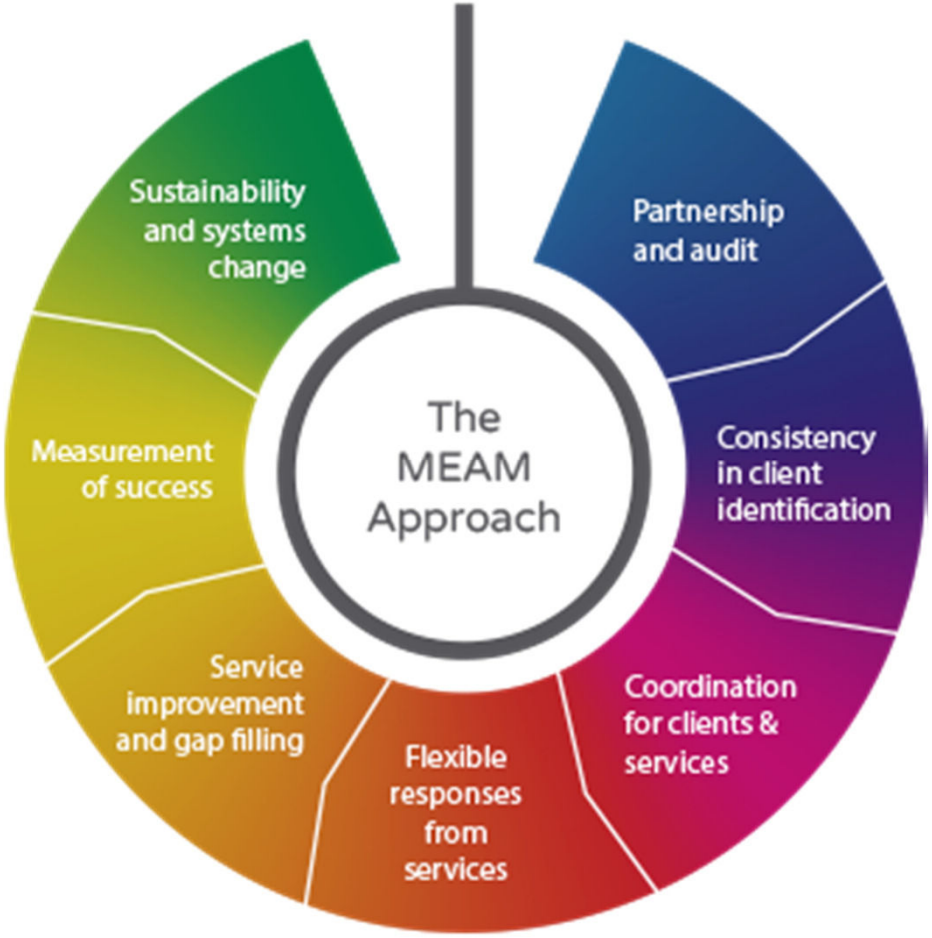
What can we do about it?

- The evidence around interventions to prevent or reduce homeless found related to:
  - Homelessness in its broadest sense
  - Particular aspects of homelessness e.g. homeless veterans or institutional homelessness
  - Specific issues e.g. drugs and alcohol or mental health
- There were 3 key themes that emerged throughout:
  - Early intervention (in the context of homelessness)
  - Integrated working and whole system approaches
  - Interventionist approaches Vs non-interventionist approaches

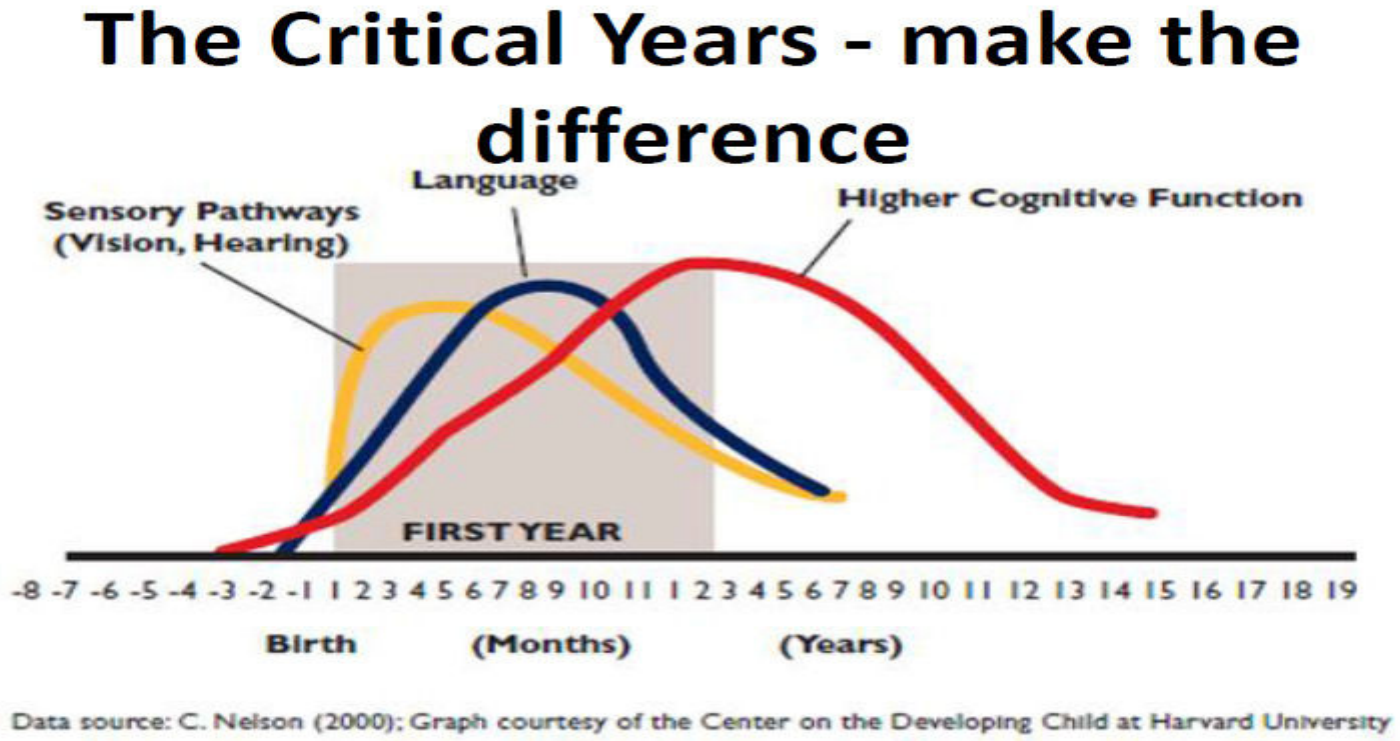
Promising Interventions

- No Second Night Out – focuses on rough sleepers
- Housing First – primarily aimed at rough sleepers, but covers homelessness in general
- **Psychologically Informed Environments** – focuses on the need to tackle the psychological aspects of early trauma / adverse events in order to support changes in behaviour
- Personalised Services – looks at emerging work around personal budgets etc with rough sleepers
- **MEAM** – Making Every Adult Matter – Basingstoke and Deane example

MEAM approach – Basingstoke and Deane example



Early Intervention



Data source: C. Nelson (2000); Graph courtesy of the Center on the Developing Child at Harvard University

- In the first 2 years a baby's brain grows from 25% to 80% of its adult size
- Development continues in childhood learning empathy, trust and community

Protective Factors
The building blocks of resilience

Welsh example – Breaking the cycle of ACEs in Housing

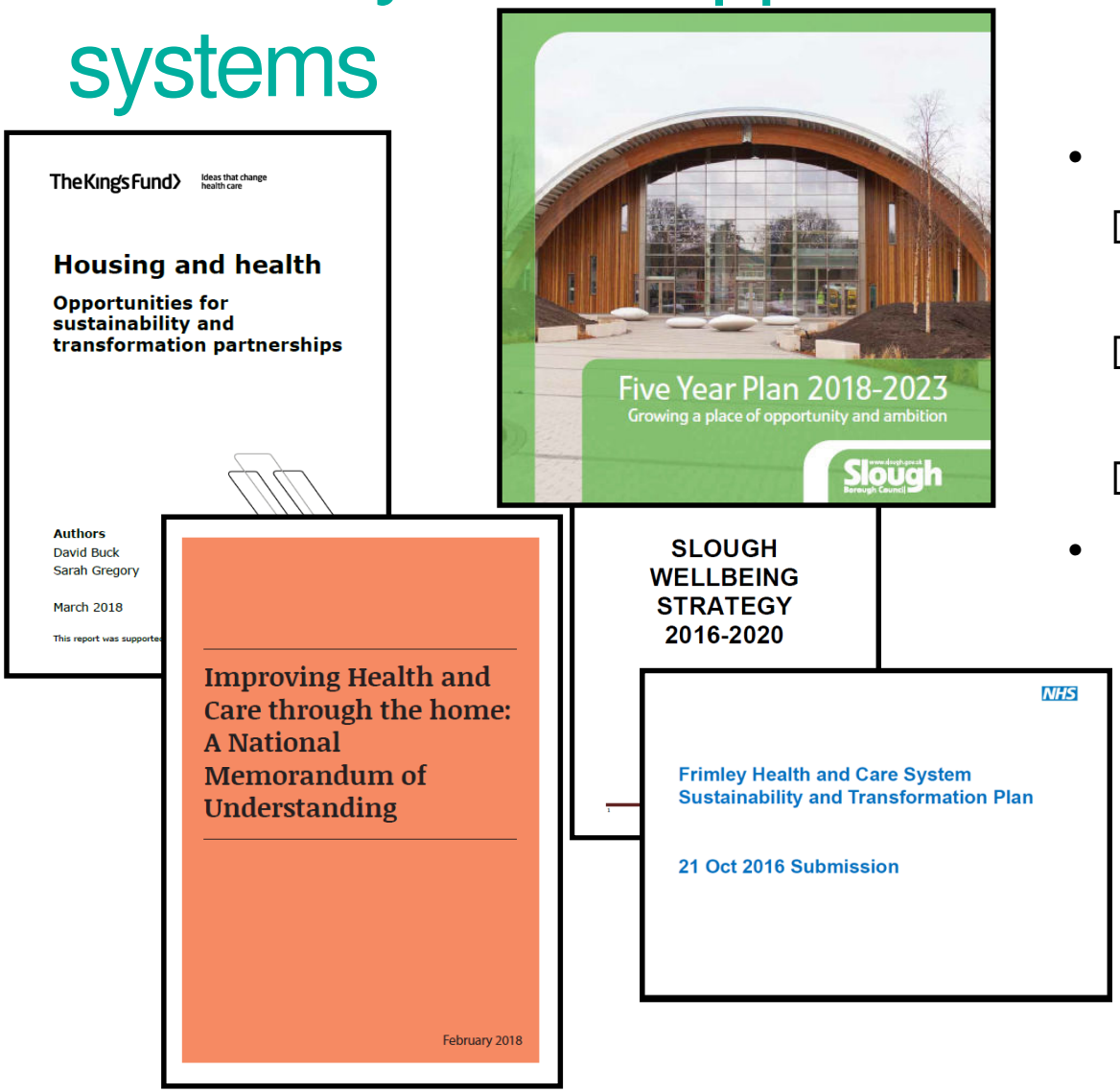
- Increase and improve early intervention and preventative activity when ACEs are evident in the home environment
- Work with housing providers and tenants to address vulnerability and risk through evidence based practice
- Mitigate and prevent the experiences of ACEs and the transference of these experiences to the next generation
- Principles of early intervention, prevention, collaboration and integration are integral
- Strongly align with the 7 well-being goals and the 5 ways of working set out in the Future Generations (Wales) Act 2015 and support the principles set out in the Social Services and Well-Being (Wales) Act 2014
- Recognise how housing providers can intervene earlier and identify opportunities for prompting positive action that is ACE informed
- Understand the prevalence of ACEs for those at risk of homelessness and how this can be prevented using an ACE approach
- Develop and test training and tools which provide staff with the skills and knowledge to enquire, intervene and respond to prevent the transmission of ACEs to the next generation

Welsh example

Project outcomes:

- Better staff engagement and relationship with tenants and their families
- ACEs are identified routinely
- Reduced evictions
- Protective factors enhanced for identified families
- Improved partnership working between health, housing and police
- Future generations have improved access to life opportunities

Whole systems approaches / integrated systems



- King's Fund: 3 priorities:
  - Supporting discharge from hospital
  - Strategic use of NHS estates
  - Mental health
- Broader need to focus across the life course

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