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Slough Borough Council

Taking pride in our communities and town

Date of issue: Friday 21st March, 2014

MEETING:	**SLOUGH WELLBEING BOARD** Councillor Rob Anderson, Leader Ruth Bagley, Chief Executive Superintendent Simon Bowden, Thames Valley Police Ramesh Kukar, Slough CVS Lise Llewellyn, Strategic Director of Public Health Dr Jim O'Donnell, Slough Clinical Commissioning Group Colin Pill, Healthwatch Representative Dave Phillips, Royal Berkshire Fire and Rescue Service Matthew Tait, NHS Commissioning Board Councillor James Walsh, Health & Wellbeing Commissioner Jane Wood, Strategic Director of Wellbeing
DATE AND TIME:	WEDNESDAY, 26TH MARCH, 2014 AT 5.00 PM
VENUE:	MEETING ROOM 3, CHALVEY COMMUNITY CENTRE, THE GREEN, CHALVEY, SLOUGH, SL1 2SP
DEMOCRATIC SERVICES OFFICER:	GREG O'BRIEN
(for all enquiries)	01753 875013

SUPPLEMENTARY PAPERS

The following Papers have been added to the agenda for the above meeting:-

* Items 4 & 5 were not available for publication with the rest of the agenda.

PART 1

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Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Slough Borough Council**
Clinical Commissioning Groups	**Slough Clinical Commissioning Group**
Boundary Differences	**Slough practices are co-terminous with the Borough however we recognise the CCG will be responsible for patients registered to practices outside the borough boundary especially in Windsor and Buckinghamshire. Links through Urgent Care Boards across systems will enable effective alignment to take place across these boundaries linked to the Better Care Fund.**
Date agreed at Health and Well-Being Board:	**26th March 2014**
Date submitted:	**4th April**
Minimum required value of ITF pooled budget: 2014/15	**£2.280 million**
2015/16	**£8.762 million**
Total agreed value of pooled budget: 2014/15	**£5.612 million**
2015/16	**£9.762 million**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	**Dr Jim O'Donnell**
Position	**Chair, Slough Clinical Commissioning Group**
Date	**29th January 2014**

Signed on behalf of the Council	
By	**Ruth Bagley**
Position	**Chief Executive**
Date	**29th January 2014**

Signed on behalf of the Health and Wellbeing Board	
By Chair of Slough Wellbeing Board	**Councillor Rob Anderson**
Date	**29th January 2014**

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Slough CCG and Borough Council have engaged providers on the integrated care agenda with independent support from the King's Fund. Qualitative interviews with NHS providers on progress with integrated care have taken place. The King's Fund hosted a system wide Conference on January 24th with health and social care providers which approved the vision, aims and objectives of the Better Care Fund.

NHS Providers

A Health and Social Care Professional Leaders Group has been established across three CCGs to engage NHS providers and commissioners. The group will steer the development of the five year strategic plan and have agreed Better Care Fund as the key focus of its joint work across the system; sharing financial strategies, working on enablers and learning from best practice.

Healthcare providers including the local Ambulance Service (SCAS), Heatherwood and Wexham Park NHS Foundation Trust (HWP), Berkshire Healthcare NHS Foundation trust (BHFT) and Buckinghamshire Healthcare Trust (BHT) attend monthly Urgent Care Programme Group meetings with the Council and CCG. The meetings have focussed on redesigning urgent and emergency care system focussing on access, patient flow through the hospital and discharge especially for frail elderly patients. The group have signed up to a 7 day service innovation proposal and an Urgent and Emergency Care Recovery Plan as part of their work. Learning

and development of the system through this group has been incorporated into discussions on the Better Care Fund.

A Clinical workshop between HWP and CCGs took place on 27th February to share the aspirations of the Better Care Fund; a follow-up clinical workshop on urgent and elderly care will be held on 3rd April with clinicians across community, primary and secondary care to co-design new pathways of care..

CCGs are engaged in the development of a Clinical Strategy linked to the acquisition of Heatherwood and Wexham Park by Frimley Park; this will ensure alignment of provider and commissioning strategies linked to the Better Care Fund over the next five years. The business case is due by the end of April within the timescales for the CCGs five year strategy.

Providers were engaged in a co-design of urgent and long term conditions services in Slough in 2012. This resulted in the introduction of integrated care teams in three practice 'networks' in 2013 supported by community and social care providers.

The health economy engaged in a three month public consultation 'Shaping the Future' on significant changes to rehabilitation services in 2013. Key local health providers; Berkshire Healthcare NHS Foundation Trust (BHFT) and Heatherwood and Wexham Park NHS Foundation Trust (HWP) were signatories to the proposals which supported significant investment in health and social care services in the community predicated on a reduction in acute bed capacity.

Social Care Providers

Health and Social Care providers have been widely consulted through the development of the Slough Joint Wellbeing Strategy during 2012. The Carers Strategy and Older Peoples Strategy which underpin this plan have also been consulted upon.

Social Care Providers have been engaged through the Provider Forum and Partnership Boards as well as the system wide workshop on 24th January.

Primary Care

Slough practices have been engaged through protected learning time sharing case studies and learning linked to integrated care teams in October and November 2013. Feedback from these events has influenced the service design and the aspirations of the Better Care Fund.

Slough CCG and HWP have engaged in a joint audit of patients on admission to hospital which has highlighted which patients could have been treated in the community.

Slough CCG has submitted an application for PM Challenge Fund to support improved access, 7 day working and the enhancement of integrated care teams. The outcome of the bid is expected by the end of March.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Slough CCG and Borough Council engaged patients and service users on the integrated care agenda through a system wide Conference on 24th January to shape the aims and objectives of the Better Care Fund. Those attending the workshop will form the basis of a sponsor group to help shape the future of integrated care.

This was the culmination of a number of strands of engagement work:

- Extensive consultation with the local population took place in 2012 on the Slough Joint Wellbeing Strategy 2013-2016. The strategy and the Joint Strategic Needs Assessment are the focus areas to develop this plan.

- Consultation on the Older Peoples Strategy and Carers Strategy has also taken place

- The health economy engaged in a three month public consultation 'Shaping the Future' on significant changes to rehabilitation services in 2013. Local people had the opportunity to shape the future of rehabilitation services via public events across Slough, focus groups and patients surveys on options of change. The consultation has resulted in significant investment in social and community services predicated on a reduction in hospital bed capacity in 2014.

A survey of patient opinions of the urgent and emergency system in Slough was carried out in 2013. The survey included:-

- A large-scale telephone survey (over 3,000 patients) across three CCGs including Slough, with a representative sample of those responsible for advising and decision-making on health and care matters
- Focus groups targeted on specific population groups of parents and people with long-term conditions
- In-depth interviews with individuals caring for people with dementia
- Individual depth interviews with people who had recently attended Wexham Park Accident & Emergency department, and had been triaged into the Urgent Care Centre
- Individual depth Interviews with staff in different roles at a number of GP practices.

Healthwatch (as LINks) conducted a discharge audit within HWP which provided valuable feedback on how systems could be improved for patients at discharge from hospital. This has shaped a multidisciplinary discharge team integrating community health and social care teams at HWP.

Slough CCG and Slough Borough Council are engaging in a number of events through 'Call to Action' including public meetings and surveys. Engagement is planned of specific patient groups as well as wider engagement in local supermarkets to gather patient views. A 'Keeping Well' Programme was launched on 12th February with over 50 members of public helping co-design the future of services in the Borough based on their experiences of care.

The Council and CCG will build on this work through continued co-design and co-production with Slough users and carers on the further development of the integrated

care system in the Borough in 2014/15.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Well Being Strategy	This document sets out the vision and priorities for the Slough Wellbeing Board. http://www.slough.gov.uk/council/strategies-plans-and-policies/slough-joint-wellbeing-strategy.aspx
Joint Strategic Needs Assessment	This document details the health and wellbeing needs of the Slough Population as well as basic population demographics and wider determinants. http://www.slough.gov.uk/council/strategies-plans-and-policies/slough-joint-wellbeing-strategy.aspx
Call to Action plan	This document details plan of engagement events planned in Sough to inform our strategy
Carers Strategy 2014-17	The refreshed Joint Carers Commissioning Strategy sets out the shared vision and commitment by Slough Borough Council and Slough CCG to support the health and wellbeing of Carers (including young carers) living within the Borough of Slough over the next three years.
Slough Commissioning Strategy for Older People 2013-18	This Strategy identifies the commissioning priorities for adult social care. Based on strategic commissioning principles and best practice it proposes specific actions to transform social care and the range of services commissioned. http://www.slough.gov.uk/council/strategies-plans-and-policies/adult-social-care-strategies.aspx
Safeguarding Adults Strategy	This strategy sets out the legal framework for safeguarding adults and how the Slough Safeguarding Adults Partnership Board will keep adults safe through the shared vision, priorities and actions set out in this 3 year strategy.
*7 day working development	This document outlines our bid to develop

	seven day working
*Dementia Plan	This strategy outlines the priority actions for meeting the health and social care needs for people living with dementia in Slough
*Integrated Care Team Project Plan	Joint Project plan
*Winter Plan and Urgent and Emergency Care Recovery Plan	These documents describe our approach to joint working through the winter period.
*Model of care – Long term conditions	This document outlines a service model for long term conditions
*Urgent Care Strategy	This document outlines a service model for urgent care.
* CCG 2 year operational plan and 5 year strategy	These documents outline the CCGs 2 year operational and five year healthcare strategy and will be available end of March 2014

*** Documents will be made available on request**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

"My Health, My Care:
Slough health and social care service will join together to provide consistent, high quality personalised support for me and the people who support me when I'm ill, keeping me well and acting early to enable me to stay happy and healthy at home."

By April 2018 patients in these groups will be able to say:-

- **I have access to a range of support that helps me choose to live the life I want.**
- **I am supported to achieve my goals and take control of my care and support needs.**
- **If I have questions about my care I know who to contact.**
- **I have information and support to remain as independent as possible.**
- **I take responsibility for my health and my care.**
- **I have support for any carer(s) involved in my care.**
- **I am involved in discussions and decisions about my care and treatment.**
- **I have someone I trust so that I can get help at an early stage to avoid crisis**

We will deliver services through integrated care teams in 'clusters' based around GP practices with access to specialist and generic services to support patients needs. Pilot teams are already established and case studies demonstrate good outcomes for Slough people.

The Better Care Fund will focus on the following interventions:-

Intervention	Delivered through
Self Care and Prevention	Self-care, health and social care advice and information, advocacy, behaviour management and expectation. Telecare and telehealth solutions to promote independence Falls Prevention. Increasing access to smoking cessation for expectant mothers, Asthma management plans for children, Public health support for healthy schools in areas of deprivation linked to the 'place shaping' agenda and accessing paediatric urgent care
Care Co-Ordination	Integrated Care Teams Joint Care Planning Case Management Specialist Input as required

	Joint Assessment Accountable professional Single access point and shared clinical record Improving management of end of life care Sensory services
Maintaining and Promoting Independence	Support to avoid admission Discharge support for patients into community and back home from acute care Daily admissions and discharge information Rapid response with short term intermediate care and reablement Care Home provision

This will require:-

- Build up of a register of clients/ patients who would benefit from this care plan approach
- An Information sharing platform
- Specific interventions to support reducing paediatric emergency admissions
- Evidence based pathways of care e.g. diabetes, stroke, COPD, CHD, Falls, dementia
- Joint assessment and care planning processes e.g. accountable professional
- Organisation of practices into 'clusters'
- Development of new roles and ways of working

We will enable this to happen by ensuring:-

- Patient engagement in co-designing the new system of care
- Joint Leadership, governance and accountability in all areas of the system
- Information sharing and decision support tools
- Aligned incentives and contractual models

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The vision of the Slough Wellbeing Board and Joint health and wellbeing strategy is to make Slough a place where:

"People are proud to live, where diversity is celebrated and where residents can enjoy fulfilling, prosperous and healthy lives."

The Slough Joint Wellbeing Strategy (SJWS) was developed by the Slough Wellbeing Board. The SJWS is informed by the Slough Joint Strategic Needs Assessment (JSNA) which provides an evidence base to determine the needs of the population of Slough. In addition, the strategy builds upon a body of work that has been undertaken in Slough over the last five years, particularly the Sustainable Community Strategy but also other plans and strategies such as the Children and Young People's Plan, the Safer Slough Partnership Strategic Assessment and the Community Cohesion and Climate Change strategies.

The purpose of the Slough Joint Wellbeing Strategy (SJWS) is to improve the health and wellbeing of our communities and it is vital to ensure that collective responsibility to improve this lies with the local authority, Public Health and the CCG.

SJWS priorities:

- Health
- Economy and Skills
- Housing
- Regeneration and Environment
- Safer Slough

In relation to the SJWS Health priority the SWB commit that by 2028, Slough will be healthier, with reduced inequalities, improved wellbeing and opportunities for our residents to live positive, active and independent lives.

SJWS delivery:

In order to deliver the strategy and improve the wellbeing of Slough, the SWB will seek opportunities with fewer resources to:

- pool budgets together from different partner organisations
- work in partnership to address key priorities and target services
- promote public involvement in ensuring we deliver high quality and effective services

The Slough JSNA highlights the following relevant local needs:

- Injuries due to falls are measured as part of the Public Health Outcomes Framework. In 2011/12, Slough had 2,053 emergency admissions for falls injuries per 100,000 people aged 65 and over. This is significantly higher than the national figure of 1,665 per 100,000 population.

- Excess winter deaths in Slough increased by around 14% during the winter months of 2008-2011 compared to the other seasons of the year. Excess winter deaths in Slough follow a similar pattern over time to those nationally (Public Health England).

- Seasonal flu. According to data from the NHS Thames Valley Local Area Team, 75.4% of adults aged 65 years and over in Slough received a flu vaccination between September 2012 to January 2013.

- Dementia. 329 people (0.2% of the population) are recorded on Slough GP

registers as having dementia, according to the Quality and Outcomes Framework for 2011/12. This is significantly below the expected number for Slough and is expected to rise following dementia awareness training funded through the national dementia challenge campaign.

- In addition, 4,400 people aged 65 and over living in Slough are estimated to be unable to manage at least one self-care activity in 2012. These tasks include bathing, showering or washing all over, dressing and undressing, washing their face and hands, feeding, cutting their toenails, and taking medicines. This figure is expected to rise to 5,000 by 2020 (Projecting Older People Population Information)

- Social Situation: Slough Borough Council's Adult Social Care Survey asked Service Users about their social situation in 2011/12. The Health and Social Care Information Centre's results show that Older People accessing services in Slough reported that they felt they have less social contact than the national or South East regional response. The majority did, however, feel that they have at least adequate social contact.

- Many of the above factors affect people under 65 and continue to impact into old age. They present significant challenges that require considerable service planning and partnership working.

- The JSNA highlights also that 66% of people with chronic heart failure have 4 or more long term conditions**,** and as a result, 20% of the resources of the local clinical commissioning group are used to support those with four or more long term conditions. In addition, some patients consistently use Accident and Emergency (A&E) rather than elective care. Slough therefore has a high level of non-elective admissions which puts considerable pressure on accident and emergency. A&E attendances indicate a range from zero to 20 times a year per person.

- Slough has a relatively young population with a higher than average % of the population as under 19s.

- The JSNA identifies some key needs with regards to children in Slough:-

    - Birth rates in Slough are the fifth highest in England and 56.4% of all births in Slough are now to women whose country of origin is not the UK.
    - 20% of all Non elective admissions related to children
    - Two of the four avoidable admissions categories linked to the national criteria for the Better Care fund relate to children
    - 48.8% of children speak English as a second language
    - Slough has higher than average children's outpatient appointments per 1,000 patients
    - There has been a 39% increase in rates of looked after children in Slough since 2007
    - 19.8% of children live in a household with no wage earner.
    - The carers strategy particularly highlights children and young people as a group that is particularly needing support.- Slough has a 12% children aged 0-24 as a total of all carers providing unpaid care

- Slough CCG spends a total of £5.3m within Wexham on paediatric services in which £3.12m is in non elective activity.

The aims and objectives of this BCF plan support the vision of the SWB, delivery of the priorities in the SJWS and have been put in place to mitigate local needs and improve wellbeing outcomes for Slough residents.

The delivery of improved services will be measured through a combination of existing national and local metrics outlined below. These will be monitored through the governance structure that reports to the Slough Wellbeing Board.

- Improve patient and user experience of health and social care services
- Encourage independence and self- reliance by building community capacity
- Reduce the proportion of patients falling into crisis and needing admission to hospital or care home
- Increase the proportion of patients who feel supported to manage their long term condition
- Improve mortality and morbidity statistics for CVD, respiratory, stroke and heart failure
- Reduce permanent admission to nursing and residential care for over 65s
- Maintain the good performance of older people at home 91 days after discharge from hospital care into reablement
- Reduce delayed transfers of care
- Reduce avoidable hospital admissions for children and adults
- Increase number of people with a health and social care personal budget
- Increase number of people (aged 65+) offered reablement following discharge from hospital
- Ensure all patients have a choice of place of death
- Deliver key aims of the Slough Wellbeing Strategy
- Provide more support within the community for self-care and prevention initiatives for children and young people
- Increase access to self-care for people with mental and physical health problems
- Safeguard and support vulnerable adults and children in our communities

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The BCF will be managed under three distinct programmes:-

Self Care and Prevention

This programme will focus on the information, advice and support available to residents to manage

their condition to remain as safe and independent for as long as possible. This will relate both to children and adults.

Projects under this programme are:-

- Asthma Management linked to air quality awareness
- Paediatric Urgent care
- Support for schools in deprived areas linked to the 'place shaping' agenda
- Improving access to parent support groups through PUFFELL
- Improving access to Psychological Therapies
- Information and Advice services (e.g. improving links between primary care and CAB)
- Smoking Cessation
- Falls Prevention
- Structured patient education for long term conditions e.g. through the diabetes app being developed through Social Marketing Campaigns such as Puffell and through tailored local programmes
- Support for carers including to access healthchecks
- Telehealth and telecare

Care Co-ordination
This programme will focus on integrating care for residents who require more specialist clinical and social care support to maintain independence either in a community care setting or in their own home.

Projects under this programme are:--
- Case management including individuals at high risk of admission
- Joint health and social care assessments
- Single access points and share care records
- Medicines Management
- Integrated Care Teams
- Improving end of life care
- Sensory services
- Stroke Co-ordination

Maintaining and recovering independence
This programme will focus on supporting patients to maintain their independence and to recover quickly after a period of ill health.
Projects under this programme include
- Multi-disciplinary discharge team at Wexham Hospital
- 24/7 intermediate care and reablement services
- Nursing and residential home placements
- Continuing Healthcare
- Early Supported Discharge schemes (e.g. PACE)
- Rapid Assessment processes
- Nursing Home Placements and Domiciliary Care

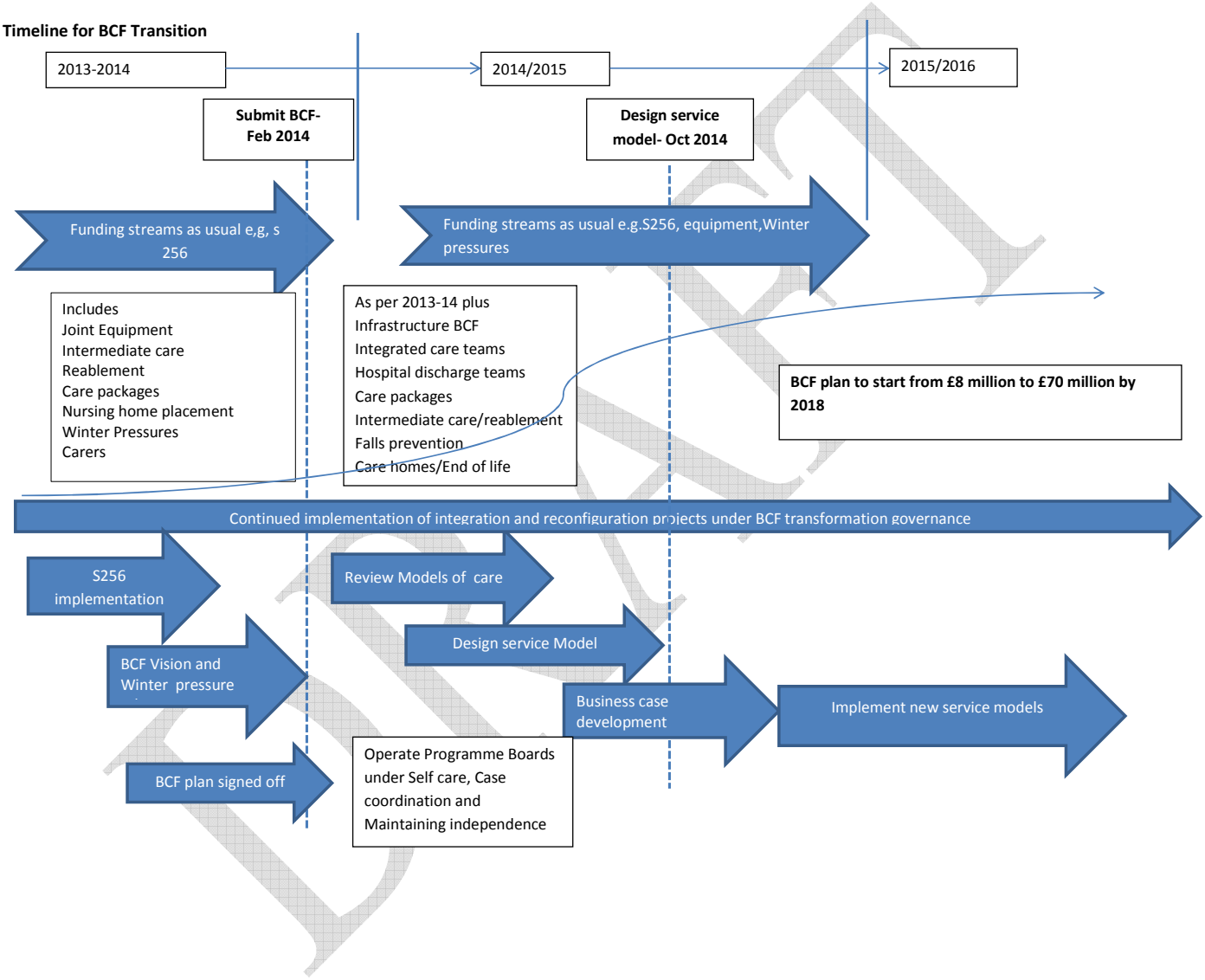
All programmes will require extensive support to ensure sustainability of system changes:-

- Governance
- Communications
- Finance
- Information and IT

- Education and Training
- Contracts and Commissioning
- Performance Management

A separate Information and IT group is to be established to develop a shared Information Platform under the vision; 'One Patient, One Record, One Care Plan'.

The BCF Commissioning Group will be working up the detailed programme and project plans underpinning the above as we work towards April 2015. In 2014/5 the focus for new investment will be in three areas: infrastructure to support enablers, sustainability of our developing integrated care services and investment in specific services to make an impact in year one.



d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The position we have signalled to acute providers is that we will be looking to reduce investment in emergency care by 3% per annum over the 5 years of the strategic plan. This will build to the 15% reduction as outlined in the planning guidance, but at a pace which means that providers can respond to the change and remain sustainable.

The CCG is developing modelling tools based on a detailed analysis of the risk profile of the population to establish the interventions most likely to affect a reduction in hospital admissions.

Our plans will result in fewer patients needing to go to hospital and those who do will be discharged earlier, potentially requiring tariff prices to be unbundled to fund different models of provision along the pathway.

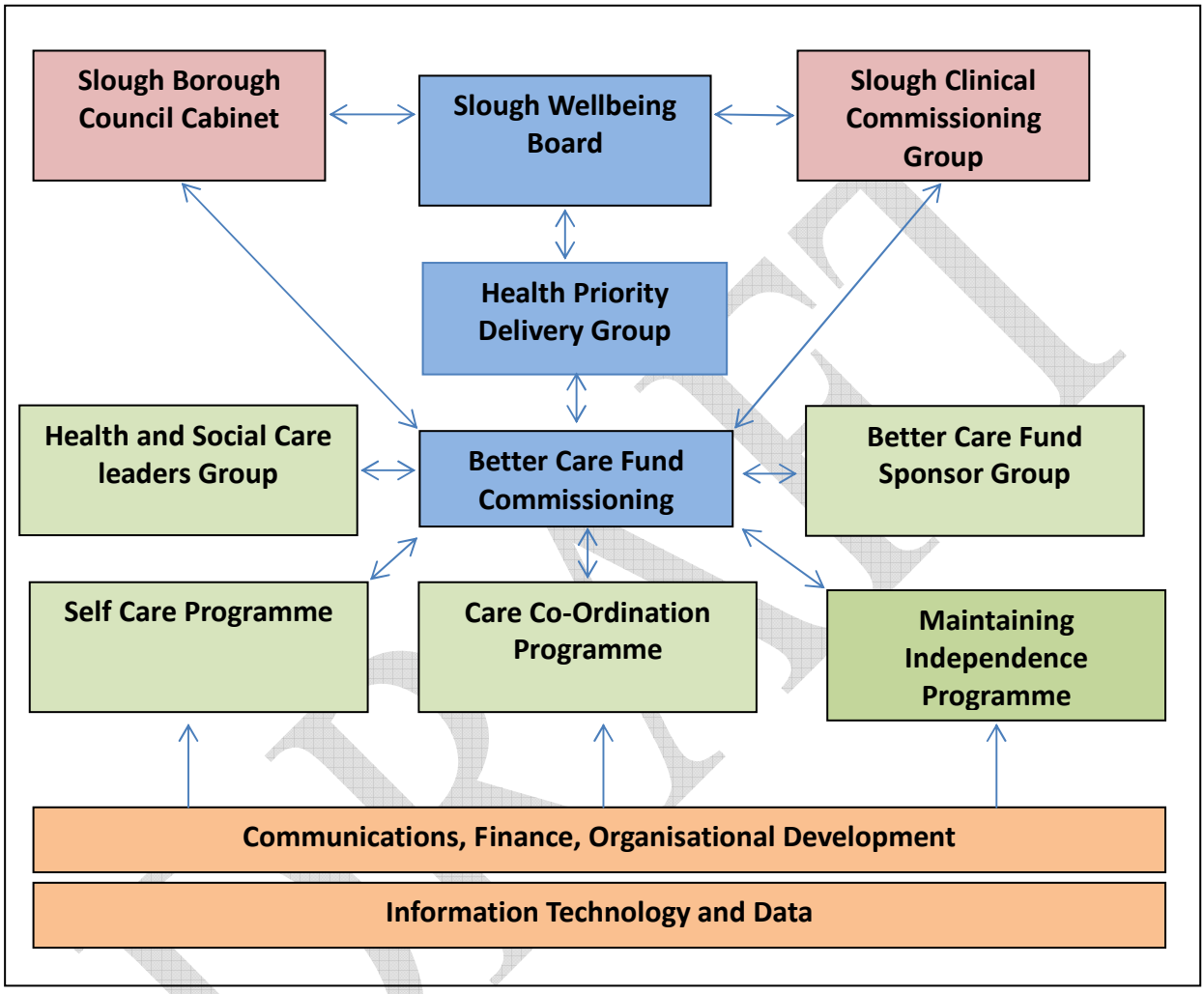
It is expected that pathway redesign will result in an outreach model for many pathways, including falls prevention, frail elderly, heart failure, and respiratory disease which will bring secondary care teams out into the community to support people and avoid admissions

The following approach will be taken to reduce risk for the acute sector:

- The pace of change envisaged is realistic and will enable Trusts to reduce their cost base in a planned way.
- Alternative support systems for patients will be invested in up front so that Trusts have the confidence to take out excess capacity and cost.
- Acute providers are fully involved in the redesign of services and, either through collaborative or competitive processes, will have the opportunity to provide services or expert support outside traditional acute boundaries.
- The SWB recognises that the BCF will, in the short term, be continuing to support activity in secondary care, until service transformation changes patient and money flows.
- The SWB also recognises the need to share in the cost risk if plans do not result in the expected change in patient flows.
- Commissioning intentions have been fed into the current business case development linked to Frimley Park acquisition of Heatherwood and Wexham Park. This will align the CCG five year strategy. The case is due for completion by the end of April.

e) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The following governance structure will manage the development of the Better Care Fund.



The Slough Wellbeing Board is well established and meets every two months.
The Health Priority Delivery Group is one of 6 strategic sub groups of the Slough Wellbeing board that oversee the implementation the Wellbeing Strategy.

The Better Care Fund Coimmissioning Group is the group that is supporting the delivery of the Better Care Fund and consists of key commissioners, finance, performance and policy officers from Slough Borough Council and Slough CCG. The group will review service models, agree the scale and pace of the BCF and agree joint commissioning arrangements from April 2014 onwards.

Three Programme Groups with commissioners, providers, clinicians, front line staff and patients will review, co-design and develop service models under the BCF in 2014/15.

A **Better Care Fund Sponsor Group** of over 50 professionals, patients, front line staff and voluntary organisations will be a touchstone for the Commissioning group as service models

are reviewed and developed.

A **Health and Social Care Professional Leaders Group** has been established across three CCGs to engage providers and commissioners in long term strategic planning across a wider geographical area. The Better Care Fund has been agreed as a key focus of the work of the group.

It is recognised that a review of governance arrangements will be required before final submission. This will include changes to the CCG Constitution, an update to the Slough Wellbeing Board and Health Priority Development Group terms of reference and robust Section 75 agreements to underpin our joint aspirations for integrated care.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Slough Borough Council has responsibility for adult social care services in the area covered by this Better Care Fund.
The partnership between Slough Borough Council and Slough CCG in delivering the Better Care Fund will protect social care services by ensuring that people with eligible social care needs under the Fair Access to Care Services criteria – which is set by Slough Council at Critical and Substantial - will continue to have their needs met. The partnership will also be supporting early intervention and prevention approaches to support people to continue living at home, reduce the number of people in crisis, promote peoples independence and involvement in their local communities and improve the inequalities in health that the Slough population experiences. This will lead to a reduced number of people and who may be at risk of being admitted to a care home or hospital and reduce the reliance of people on social care services even with an increase in demand. The partnership also supports the promotion of personalisation and people being in more control of their care needs.

Please explain how local social care services will be protected within your plans

With an increasing demand for adult social care services both for older people and for people with long term conditions and a reduction in the Councils adult social care budget over the next three years of approximately 15% a major emphasis of the BCF plan is to support the delivery of social care services. The priority of the BCF plans in using the additional Section 256 funding, the CCG match funding of the Section 256 funding and the transfer of funding from acute NHS services to community provision over the next 3 years is to develop, remodel and improve our range of preventative services, our integrated locality teams and intermediate care services to:

- Promote the wellbeing of the population especially those people who are eligible for social care support
- Reduce the proportion of patients falling into crisis and needing admission to hospital or care home
- Increase the proportion of patients who feel supported to manage their long term condition and take control of their health and social care needs and services living at home
- Reduce permanent admissions to nursing and residential care for over 65s
- Maintain the good performance of older people at home 91 days after discharge from hospital care into the reablement service
- Increase the number of people offered and benefiting from a range of intermediate care services including reablement following discharge from hospital, to avoid admission to hospital and support people to be more independent at home
- Increase the number of people with a health and social care personal budget

This will support the Council to ensure that people with critical and substantial needs will continue to have their needs met and ensure that people will be supported to take more control over their care needs.

With an increasing demand for children's social care services and an increase in the

Councils children's social care budget over the next three years a major emphasis of the BCF plan is to support the delivery of preventative early help programmes to offset future demands on looked after children's teams in social care services

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

We were unsuccessful in our national bid to become a 7 day pilot but through use of winter pressures funding we have established working practices for seven day services across the Slough health and social care economy. Services are being evaluated for consideration for longer term funding linked to the Better Care Fund. This includes; rapid access assessment services, Consultant cover, diagnostic testing, intermediate care services (24/7, 2 hour response), minor injuries and urgent care services, early intervention and prevention and multidisciplinary discharge service at Wexham Park Hospital.

A local example of this has been the funding of cover for a seven day GP service into the rehabilitation service which has already demonstrated significant results in terms of facilitating discharge and preventing unnecessary admissions at weekends.

The delivery of a multi-disciplinary discharge team at Wexham Park hospital across seven days has been supported recurrently after an evaluation of the merits of the scheme to avoid admissions over the winter period.

Slough CCG have submitted a proposal for seven day primary care provision as part of the PM Challenge Fund which is currently under consideration and due for a response by the end of March.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

NHS Number is the primary identifier on NHS based systems; and the use of both the Summary Care Record and Demographics Batch Service has proven to be up to 95% successful in pilots in Wiltshire & Berkshire CCGs (and former PCTs)

The NHS identifier is not the primary identifier used in social care, but there is the facility in the social care client record management system to record the NHS identifier for any one who uses social care services. Whilst this is not recorded on every single case, there is a sizeable chunk of records which do include this (in excess of 2,800 individuals). It is therefore technically feasible for this to occur and the Council supports the use of the NHS Number as the primary identifier for correspondence across health and social care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Commitment is in place for NHS organisations; and the ability to enable non NHS providers through SCR and DBS to populate NHS Number. Slough Adult Social Care is committed to using the NHS number as the primary identifier for correspondence across health and social care services. A mechanism for updating all the current social records to ensure that all social care records have the NHS Number identified and the recording of the NHS Number for all new social care clients will be confirmed over the next few months.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems which make use of open standards for interoperability; technologies used in the past include Cache, HL7 and other open source integration engines as long as they align to our IG requirements.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Central Southern both hosts an office of the Data Service for Commissioners and has achieved Accredited Safe Haven (ASH) Status; with a Caldicott guardian in place and a thorough IG Framework which is currently being implemented throughout the organisations. Central Southern has IGT Level 2 and is working towards Level 3 for its Data Service for Commissioners Office by 31st March 2014.

While these accreditations are good for assurance there must be a legal basis for the sharing, processing and linkage of social and health data and where possible work should take place making use of pseudo data at acceptable 'small number' levels.

It is important that suitable clinical / social care advice is sought when drawing up sharing agreements to ensure that patients are not wrongly identified and that where patients/ clients have opted out of data sharing this is recognised.

Slough Borough Council is committed to ensuring the highest levels of Information Governance controls and security, both for information held by the Council and for that shared by the Council. Sharing of data is controlled to ensure compliance with legal and ethical standards, including taking individual's own wishes into account. Slough Borough Council would need to understand the detailed specifications of the exact matter under consideration before it can comment further, but would commit to undertaking all appropriate steps to support better communication between agencies wherever this would assist service users / patients. That would include ensuring the appropriate protocols and guidance are in place, as well as ensuring the confidentiality and security of data flows.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Since April 2013 SBC and CCG have piloted **Integrated care teams** organised around a cluster model of practices. These clusters teams are multidisciplinary and include health and social care professionals. The team identify patients at risk of hospitalisation using risk assessment tools as well as local knowledge. The teams work on joint assessment and care plan with a lead professional to ensure patients are managed within the community setting to avoid unnecessary admissions into hospital.

Clusters consist of a 50,000 of patient population and are currently managing a case load of 193.

As we move into the delivery of this plan we expect the number of adults being case managed with a joint care plan and accountable professional to increase to 1,000 by April 2015.

The development of integrated care teams will form a central strategy to develop joined up services in the community for patients at high risk of hospital admission or nursing home / residential home placement. Our aspiration is to grow and develop these teams to manage at least 5% of our patients in the high risk groups as having a dedicated care plan and lead professional.
The King's Fund are evaluating the effectiveness of our current integrated care teams and providing recommendations linked to national and international best practice for their further development in April 2014.

GPs will play a key part in supporting people with multiple long terms conditions and the frail elderly. The CCGs are developing a primary care strategy in conjunction with NHS England and will use the £5 a head for primary care signalled in the Operating Plan and the new GMS contract to support practices in providing enhanced support to this section of our population. There are already plans in place for 2014/15 to identify a GP in every practice with dedicated time to identify those patients most at risk of admission to hospital and provide more intensive support to these people in conjunction with the integrated primary care teams.

During the Winter period we have developed PACE- **Post Acute Care Enablement**
The objective of PACE is to maximize the use of 'Out of Acute Hospital Care' in a creative and innovative way, bridging the care gap where necessary to support early safe discharge and prevent inappropriate admissions to acute beds. This will ensure that patients are, when medically fit, discharged effectively and safely from a hospital setting.

It is a collaborative multi-agency approach with dedicated resource and input from various agencies. The pilot has been implemented and early indication is that this has supported the system over the winter to date. Once evaluated we would recommend this service be supported beyond winter period.

Intermediate care and reablement services provide a 24/7 service to support independence and facilitate discharge. The aim of the BCF is to review and co-design the service to ensure this meets best practice in order to recommission from April 2015.

Furthermore we will be developing models of support for patients with a mental and physical disorder by reviewing care at A&E; ensuring this incorporates liaison services including specialist skills e.g. psychiatry.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Lack of a pooled legal agreement signed off	Medium	Robust governance in place with signed off within governance structures
Lack of trust between stakeholders destabilises the success of the partnership	Medium	Strong communication about the culture change behind this programme Effective training programmes Commitment to projects beyond a one year timescale Liaison with Health education and AHSC to develop new roles and ways of working
Financial risk if BCF does not deliver	High	Robust programme and project management Monitoring of KPIs Engagement with NHS/ social care providers and care professionals Explicit risk sharing agreements between organisations
Uncertainty over long term financial allocations to health and social care due to current financial climate	High	Regular monitoring and understanding of government policy and implications for local services
Sustainability of the provider market given the scale of the change	High	Providers explicitly part of programme and project management approach Use of long term financial planning with providers to mitigate risks associated with transformation
Demographics and needs of the population exceed JSNA expectations	Medium	JSNA refreshed on an annual basis Public health support to SWB and associated workstreams
Culture change in both patients and professionals	Medium	Regular communication including co-design and co-production of new service lines. Stakeholder and OD

		programme as part of enablers for change
Social care reform impact	High	Explicit agreements on protection of social care services and implications of new statutory legislation

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Association

Finance - Summary

##

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Local Authority Slough		£ 2,804	£ *694*	£ *1,694*
CCG Slough		£ 2,808	£ *8,068*	£ *8,068*
BCF Total		**£ 5,612**	**£ 8,762**	**£ 9,762**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

The BCF plan is premised upon savings from fewer non-elective admissions to hospital and shorter hospital stays. Investment of £800k is planned in 2014/15 in new or additional services that are designed to achieve at least this level of saving. The continuation of this policy into 2015/16 is planned to increase savings to £1.2m in that year. It is planned to re-invested in-year in services to further improve local performance in these and other target areas of the BCF. There will be close monitoring of performance against targets in 2014/15 enabling corrective action to be taken in-year should it become evident that planned improvements are not being achieved. It is anticipated that £200k contingency funding will be available each year for the purpose of funding corrective actions to ensure performance targets are met, and if necessary to contribute towards overspends elsewhere in the system that result from under-achievement. £200k is the maximum additional investment it is envisaged that would be required to ensure delivery of planned performace targets.

Contingency plan:		2015/16	Ongoing
Outcome 1 - 3% reduction in non-elective admissions in 2014/15	Planned savings (if targets fully achieved)	800	800
	Maximum support needed for other services (if targets not achieved)	200	200
Outcome 2 - 3% reduction in non-elective admissions in 2015/16	Planned savings (if targets fully achieved)		400
	Maximum support needed for other services (if targets not achieved)		200

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
Prevention									
Telehealth/ telecare		£ 87				£ 87			
Puffell and self care		£ 15				£ 15			
Falls Service		£ 50				£ 50			
Childrens Prevention		£ 250				£ 250			
Care Coordination									
Joint equipment		£ 533				£ 533			
Enhanced intermediate care and end of life		£ 725				£ 725			
Reablement assistants		£ 90				£ 90			
Stroke coordinator		£ 50				£ 50			
Maintaining and promoting independence									
Ward 8 Closure& Early Supportive Discharge Service		£ 252				£ 252			
Post Acute reablement		£ 215				£ 215			
Reablement		£ 436				£ 436			
Nursing home placements		£ 400				£ 400			
Care Homes improving quality		£ 50				£ 50			
Domicillary care to expediate discharge		£ 30				£ 30			
Intermediate Care (CCG contribution to LA)		£ 857				£ 857			
Intermediate Care (LA)		£ 1,000				£ 1,000			
Disabilities Facilities Grant						£ 407			
Carers		£ 210				£ 210			
Infrastructure									
Programme and Mgt support		£ 160				£ 210			
IT systems and single assessment		£ 80				£ 80			
Governenace and reviews		£ 50				£ 50			
Social Care Capital Grant						£ 287			
Community Capacity Grant						£ 348			
Other									
Other / TBC		£ 72				£ 2,793			
Henley Suite						£ 247			
Foot care						£ 14			
Oaks EMI						£ 76			
Total		£ 5,612	£ -	£ -	£ -	£ 9,762	£ -	£ -	£ -

Association

England

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

1. We aim to reduce the number of people over 65 entering residential and nursing care by our improved performance of our suite of intermediate care services to be developed as part of this plan as well as the work of the integrated care teams and their focus on meeting the needs of older people with complex needs. 2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services- For this metric we plan to increase the number of people who are

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

na - For this indicator we have chosen a local indicator which ties into the CCG overall strategy to measure quality outcomes in patients with long term conditions.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N?A

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	801.5	N/A	721.4
	Numerator	105		100
	Denominator	13100		13878
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	95.20	N/A	95.00
	Numerator	40		65
	Denominator	40		66
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	8.3		8.3
	Numerator	9		9
	Denominator	103550		103550
		(Apr 2012 - Mar 2013) 12	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	172.3	165.4	163.7
	Numerator	2933	1460	1465
	Denominator	141838	147091	149145
		(Apr 2012 - Mar 2013) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *The national metric (under development) is to be used*		*(State time period and select no. of months)* 1	N/A	*(State time period and select no. of months)* 1
Local measure *Please give full description Average EQ-5D (health related quality of life) score for people reporting having one or more long-term conditions. Specification per the national GP Survey.*	*Metric Value*	75.1		76.0
	Numerator	743		752
	Denominator	990		990
		(Apr 2012 - Mar 2013) 12	*(State time period and select no. of months)* 1	*(State time period and select no. of months)* 1

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NHS
Bracknell and Ascot
Clinical Commissioning Group

NHS
Windsor, Ascot and Maidenhead
Clinical Commissioning Group

NHS
Slough
Clinical Commissioning Group

Preparing 5 year plans for Berkshire East Unit of Planning
March 2014

NHS Bracknell and Ascot Clinical Commissioning Group

NHS Windsor, Ascot and Maidenhead Clinical Commissioning Group

NHS Slough Clinical Commissioning Group

Thinking locally, working together

- Focus system reform around treating people as individuals; supporting their whole health and care needs

- Distinct local service models for primary and integrated care;
- GPs to develop proposals with patients in their communities and unitary authorities
- Effective use of the Better Care Fund to deliver integrated care
- Cross-boundary sharing and peer review across unit of planning
- Secondary care proposals developed across the unit of planning, working with the Area Team

- Key aspects drawn together at the unit of planning:
- Non-elective, elective and specialised services
- Key enablers; IMT, workforce, finance, governance
- Cross-cutting “Champions” responsible for quality, mental health, children’s

- *One document with separate descriptions and service transformation sections for the three CCGs*

- *DRAFT by 4th April*
- *Final Version by 20th June*

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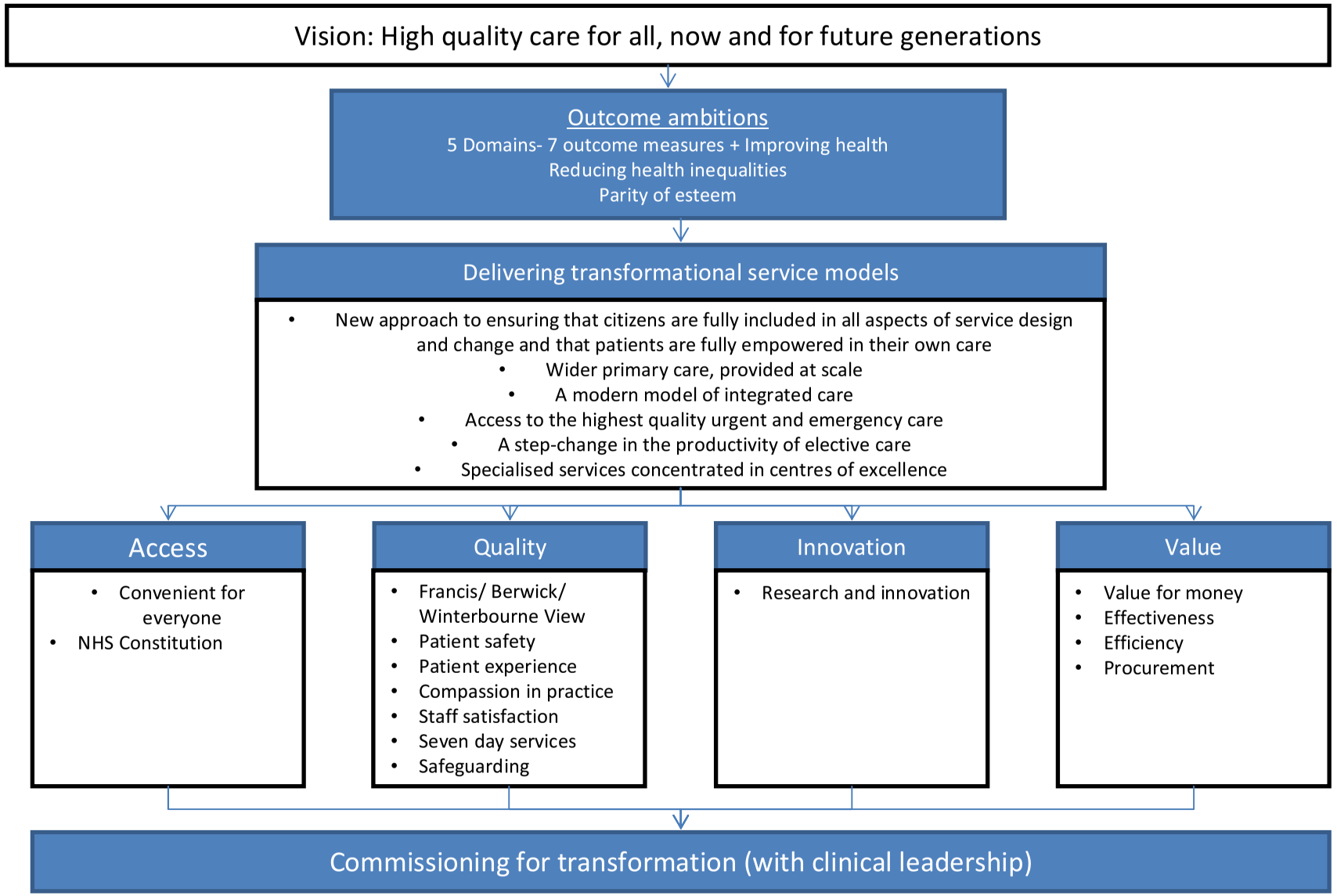

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Transforming local health and social care

These slides set out key themes of the transformation of local health economies. Local themes will be led by CCGs. Themes on the next slide will be led at the unit of planning level. In addition, individuals will be appointed as "Champions" of Quality, Mental Health and Children's services, to ensure that these areas are properly addressed.

Theme

Wider primary care, provided at scale

(CCG Lead)

Modern model of integrated care

(CCG and Unitary Authority Lead)

Cross-cutting themes

Patient and clinical co-design

Empowering patients to manage their own health care

Improving access, quality, innovation, value

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Transforming at the unit of planning

Theme	Cross-cutting themes
Citizens included in all aspects of service design and change	Patient and clinical co-design
Access to the highest quality urgent and emergency care	Empowering patients to manage their own health care
A step-change in the productivity of elective care	Improving access, quality, innovation, value
Specialised services concentrated in centres of excellence	

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