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Date of issue: Tuesday, 3 May 2016

MEETING:	**SLOUGH WELLBEING BOARD** Councillor Rob Anderson, Leader Naveed Ahmed, Business Representative Ruth Bagley, Chief Executive Iain Harrison, Royal Berkshire Fire and Rescue Service Councillor Sabia Hussain, Health & Wellbeing Commissioner Ramesh Kukar, Slough CVS Lise Llewellyn, Strategic Director of Public Health Dr Jim O'Donnell, Slough Clinical Commissioning Group Les O'Gorman, Business Representative Krutika Pau, Interim Director of Children's Services Colin Pill, Healthwatch Representative Rachel Pearce, NHS Commissioning Board Representative Alan Sinclair, Interim Director Adult Social Services Superintendent Gavin Wong, Thames Valley Police
DATE AND TIME:	WEDNESDAY, 11TH MAY, 2016 AT 5.00 PM
VENUE:	VENUS SUITE 2, ST MARTINS PLACE, 51 BATH ROAD, SLOUGH, BERKSHIRE, SL1 3UF
DEMOCRATIC SERVICES OFFICER: (for all enquiries)	NICHOLAS PONTONE 01753 875120

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.

RUTH BAGLEY
Chief Executive

sustainable forest

AGENDA ITEM	REPORT TITLE	PAGE	WARD

AGENDA

PART I

Apologies for absence.

CONSTITUTIONAL MATTERS

1. Declaration of Interest

   All Members who believe they have a Disclosable Pecuniary or other Pecuniary or non pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Section 3 paragraphs 3.25 – 3.27 of the Councillors' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 3.28 of the Code.

   The Chair will ask Members to confirm that they do not have a declarable interest.

   All Members making a declaration will be required to complete a Declaration of Interests at Meetings form detailing the nature of their interest.

2.	Minutes of the last meeting held on 23rd March 2016	1 - 6	

ITEMS FOR ACTION / DISCUSSION

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4.	SWB Future ways of working and priorities	23 - 38	

ITEMS FOR INFORMATION

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8.	Date of Next Meeting *20th July 2016*		

AGENDA ITEM	REPORT TITLE	PAGE	WARD

Press and Public

You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before the Committee considers any items in the Part II agenda. Please contact the Democratic Services Officer shown above for further details.

The Council allows the filming, recording and photographing at its meetings that are open to the public. Anyone proposing to film, record or take photographs of a meeting is requested to advise the Democratic Services Officer before the start of the meeting. Filming or recording must be overt and persons filming should not move around the meeting room whilst filming nor should they obstruct proceedings or the public from viewing the meeting. The use of flash photography, additional lighting or any non hand held devices, including tripods, will not be allowed unless this has been discussed with the Democratic Services Officer.

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Slough Wellbeing Board – Meeting held on Wednesday, 23rd March, 2016.

Present:- Councillors Anderson (Chair) and Hussain. Naveed Ahmed, Ruth Bagley, Ramesh Kukar, Dr Jim O'Donnell (from 5.22pm), Alan Sinclair and CI Wong (deputising for Supt Bowden until 6.10pm)

Apologies for Absence:- Supt Bowden, Iain Harrison, Lise Llewellyn, Les O'Gorman, Krutika Pau and Colin Pill

PART 1

58. Declaration of Interest

No declarations were made.

59. Membership Update

The Board noted that Iain Harrison would be the new representative of Royal Berkshire Fire & Rescue Service following the recent retirement of Dave Phillips.

It was also confirmed that Alan Sinclair, Interim Director of Adult Social Services and Krutika Pau, Interim Director of Children's Services formally join the Board following the departure of Jane Wood from the Council. It was a statutory requirement for the local authority directors of adult and children's services be members of the health and wellbeing board.

Resolved –

(a) That Iain Harrison be welcomed to the Board as the representative of Royal Berkshire Fire & Rescue Service.

(b) That it be noted that Alan Sinclair, Interim Director of Adult Social Services, and Krutika Pau, Interim Director of Children's Services, be confirmed as statutory members of the Board.

60. Minutes of the last meeting held on 21st January 2016

Resolved – That the minutes of the meeting held on 21st January 2016 be approved as a correct record.

61. Better Care Fund (BCF) Quarterly Report and Integration Strategy

A report was considered that summarised the position of the 2015/16 Better Care Fund (BCF) programme to the end of the third quarter; the planning for 2016/17 BCF Plan; and work to develop an integration strategy by March 2017.

Slough's was considered to be performing well in the implementation of the BCF programme for 2015/16. In the period to the end of December, non-elective admissions activity was 340 above the 2015 target but was 1.4% below the 2014 baseline. Performance was strong in other metrics such as admissions to residential care and discharge from hospital into reablement services. BCF was forecast to come in on budget for the financial year, taking account of some reinvestment to support new pilot activity released from either delayed or unapproved schemes.

A draft of the BCF Plan 2016/17 was tabled and considered. The plan needed to be submitted by 25th April and it was requested that the BCF Joint Commissioning Board be given delegated authority to sign off the final plan. A detailed review of schemes had been undertaken by the BCF delivery group as part of the planning process for 2016/17 and the Board noted the schemes making a significant impact that would be continued, pilot activity and the schemes that had not performed as expected and would be closed or redesigned. The 2016/17 programme would broadly continue the current programme of activity and also focus on out of hours transformation and establishing an integrated point of referral for professionals into short term services through the existing Health Hub.

(Dr O'Donnell joined the meeting)

A range of issues were discussed on both current performance and next year's BCF plan including the payment for performance mechanism and impact of BCF within the wider health and social care system. The Board welcomed the work undertaken to review schemes to ensure that resources were focused on strongly performing schemes and pilot activity. Integration, transformation and embedding new ways of working through the programme were key to sustaining improvement when BCF funding itself came to an end in 2010. Slough was considered to be in a good position in terms of its joint working, but needed to influence other authorities and partners locally within the health system.

It was also agreed that future reports to focus on high level summary position of progress, and crucially the impact made by BCF, with more detailed reporting to Health PDG and BCF Commissioning Board.

Resolved –

(a) That the progress report of the Better Care Programme for 2015/16 be noted;

(b) That the proposed outline plan for the BCF for 2016/17 be circulated via email and approved in principle;

(c) That the BCF Joint Commissioning Board be given delegated authority to sign off the final plan to be submitted by 25 April 2016.

62. NHS Slough CCG: 5 Year Plan Refresh and Update on 2 Year Plan

The Board received a report on Slough Clinical Commissioning Group's updated 5-year plan and 2-year operational plan and a presentation was delivered by Paul Sly, Interim Chief Officer at the Clinical Commissioning Group on the emerging System Sustainability and Transformation Plan (STP).

The STP was an overarching plan which aimed to set out how services would be transformed and how system sustainability would be reached. An intensive period of engagement between local communities, partners and local authorities would be undertaken to develop the new plan by June 2016 across the Frimley Health footprint. An agreed STP was required in order to access the £2bn national Sustainability and Transformation Fund from 2017. Sir Andrew Morris would take the lead role in the development of the plan.

The Board emphasised the importance of ensuring the plan reflected both the distinct needs of local communities across the Frimley Health footprint and drew upon the examples of best practice locally. The importance of the STP was recognised and it was discussed how partners could be best engaged in the forthcoming workshops and consultation process prior to sign off in the summer, including by the Slough Wellbeing Board. Members would receive an update report in May and were encouraged to contribute to the development of the plan in the coming weeks as the timescales were tight.

The 2-year operational plan was then discussed and Dr O'Donnell summarised the key points. Positive progress was being made in reducing avoidable hospital admissions and there was national interest being taken into the good work being done in Slough. Significant work had been done to redesign primary care to provide longer appointments for those patients who could benefit most. These issues had been discussed recently with the Health Scrutiny Panel in relation to the proposed changes to the Slough Walk-In Centre and the importance of clear communication with residents was considered to be of crucial importance to successful implementation.

Resolved –

(a) That progress to date on the CCG 2 year operational plan be noted.

(b) That the refreshed CCG 5 year plan be noted.

(c) That progress be noted on the development of the System Sustainability and Transformation Plan (STP) being developed across the 'Frimley footprint'.

(d) That partners be engaged in the development of STP and that a further report be considered by the Board at its meeting in May 2016.

(Chief Inspector Wong left the meeting)

63. Review of Online Sexual Health Service Provision

A report was discussed on the provision of online sexual health services such as ordering home screening kits for sexual transmitted infections and notification of results via modern communications. Such services were being delivered successfully online in other parts of the country, such as SH:24 available in Southwark and Lambeth, and the Board considered how best this could be delivered in Slough.

Sexual health services were currently commissioned at a Berkshire wide level, recognising there were different needs in each area. Sexual health outcomes were improving but Slough remained below key national indicators. NHS led services in Slough were primarily delivered face to face from the Garden Clinic. The shared public health team had explored the current good practice for increased digital delivery of services. A local website had been developed and new content was being added. It was recognised that there were potential benefits to shift some lower level services away from specialist provision, for example the distribution of home screening kits would be more efficient and some people may prefer to access services in this way. However, it was emphasised that digital services needed to be properly integrated into the existing local services to ensure people accessed the appropriate professional support from nurses and doctors.

The Board discussed a range of issues including the experience and evidence of SH:24 in delivering some services online. Public health consultants in Berkshire would be receiving a presentation from SH:24 in the near future which would assist in considering how best online access could be taken forward locally. Members generally felt that it was important to increase online access both because customers would want and expect to be able to receive basic services in this way, and because it could free up resources for more specialist support. It was recognised that online access needed to be introduced carefully to ensure it was properly joined up with existing local services and this would be taken forward as part of the specification for the recommissioning of sexual health services in Berkshire over the next two years.

There was also a discussion about how the existing services from the Garden Clinic could be better integrated with other local services, particularly primary care, and further consideration of this would be needed. Improving data sharing was highlighted as an example of where improved joint working and communication could improve outcomes for patients.

At the conclusion of the discussion, the Board agreed to support increase online delivery of services in principle and encourage Public Health to seek to implement as soon as possible, recognising the importance of integration with existing services. It was agreed to receive a further report once Public Health had reviewed the issues and options.

Resolved –

(a) That the report be noted.

(b) That the Board's support in principle for increased provision of online sexual health services in Slough be noted.

(c) That the Board receive an update report on progress following further work by the Public Health team to review the options and issues, primarily integration between online and other services.

64. Draft Annual Report of the Director of Public Health 2015/16

The Board received the 2015/16 Annual Report of the Director of Public Health and were asked to approve publication of draft as set out in Appendix A to the report. The report was a statutory requirement and was intended to stimulate discussion about some of the key challenges and inequalities, particularly focused on children and young people.

Board Members were invited to send any comments on the draft directly to the Director of Public Health by 1st April. The Board noted the report and agreed that the document be published.

Resolved – That the Draft Public Health Annual Report, as at Appendix A to the report, be noted and published, subject to any comments from Members.

65. SWB Annual Report 2015/16

The final draft of the Slough Wellbeing Board Annual Report 2015/16 was considered. Since the discussion at the previous meeting Members had been invited to make further comments and these had been incorporated. The document had also been considered by the Health Scrutiny Panel.

The Board made a number of further comments which are summarised as follows:

- Appendix 4 – section on health to include reference to the links between the Leisure Strategy and wider health and wellbeing agenda.
- Housing – Members raised the issue of strategic housing development in the borough and particularly the mix of developments. Whilst there was a large number of high occupancy development coming through, board members highlighted the importance of ensuring the needs of families and older people could also be met. It was agreed to bring a report to a future meeting or development session on housing strategy and Local Plan.

The Board approved the Annual Report 2015/16 and agreed to recommend endorsement to full Council.

Resolved –

(a) That the Slough Wellbeing Board Annual Report 2015/16 be endorsed, subject to the incorporation of comments agreed at the meeting.

(b) That the Annual Report be recommended to Council for endorsement at its meeting on 19th April 2016.

66. Children and Young People's Partnership Board - Update

The Board received an information report providing an update on the work of the Children & Young People's Partnership Board. The report set out how the progress in delivering the priorities identified in the Children & Young People's Plan and stated that the Partnership arrangements would be reviewed in light of the findings from the recent Ofsted inspection and SWB review.

Resolved – That the report be noted.

67. Action Progress Report and Future Work Programme

Resolved – That the Report and Future Work Programme be noted.

68. Attendance Report

Resolved – That the attendance record 2015/16 be noted.

69. Date of Next Meeting

The date of the next meeting was confirmed as 11th May 2016.

Chair

(Note: The Meeting opened at 5.10 pm and closed at 6.57 pm)

SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board DATE*:* 11 May 2016

CONTACT OFFICER: John Lisle, Accountable Officer, Berkshire East Clinical Commissioning Group (CCG)

(For all Enquiries) (01753) 636816

WARD(S): All

PART I
FOR CONSIDERATION

SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

1. Purpose of Report

1.1 To provide the Wellbeing Board with an update on the development of the Sustainability and Transformation Plan (STP).

2. Recommendation(s)/Proposed Action

2.1 The Committee is requested to note the report.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3.1 The Slough Joint Wellbeing Strategy and Joint Strategic Needs Assessment have been reviewed to as part of the analysis of system wide gaps.

3a. Slough Joint Wellbeing Strategy Priorities

The priorities in the STP reflect the need to improve overall health and wellbeing of the population. The STP will focus on those priorities that need to be delivered across the system and local areas will continue to address their own local priorities.

3b. Five Year Plan Outcomes

The STP's priorities are:

1) Making a further step change to improve wellbeing, increase prevention and early detection
2) Significant action to improve long term condition pathways including greater self management and proactive management across all providers.
3) Frailty pathways: providing proactive management of frail complex patients, having multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.
4) Redesigning urgent and emergency care, including integrated working and primary care models providing out of hospital responses to reduce hospital stays.
5) Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

Priorities 1 – 3 above particularly support the Council's Five Year Plan outcomes.

4. Other Implications

(a) Financial - These will be addressed in later phases of the STP with a high level financial analysis to be included in the June submission.

(b) Risk Management - There are no risk management implications directly resulting from the recommendation of this report.

(c) Human Rights Act and Other Legal Implications - None identified at this point.

(d) Equalities Impact Assessment -This will be undertaken at a further stage of development of the STP.

5. Supporting Information

5.1 The Sustainability and Transformation Plan (STP) has to be submitted to NHS England by 30 June 2016. It will set out the key priorities the System needs to address over the next five years. An agreed plan will be the sole vehicle for attracting transformation funding into the System.

5.2 The System has been identified as spanning the populations of Slough, Windsor, Ascot and Maidenhead, Bracknell and Ascot, Surrey Heath and North East Hampshire and Farnham CCGs. It has been named the 'Frimley System'.

5.3 The governance has been agreed and is described below:

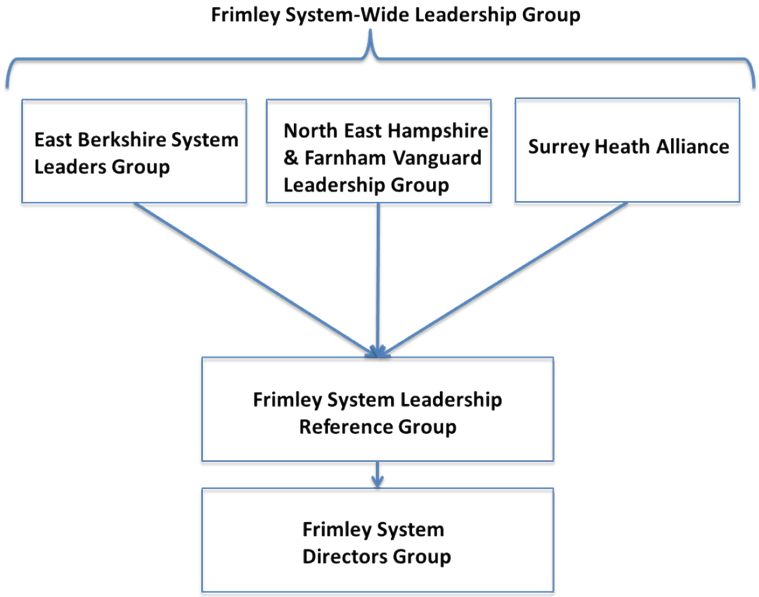
- The **Frimley System-Wide Leadership Group** brings together all of the members from these three groups (50 people) – with workshops planned for April and June. The three established groups will each sign off the STP before submission on 30th June.

- The **Frimley System Leadership Reference Group** - A new group, chaired and organised by Sir Andrew Morris to work on behalf of the three established system leadership groups to steer and ensure development of the STP, with good engagement and planning for delivery. It brings together the Clinical Commission Group (CCG) Chief Officers and leadership representatives for the public, local authorities and clinicians.

- The **Frimley System Directors Group** – This Group reports to Sir Andrew Morris and takes the lead on the day to day development of the Plan. A dedicated STP Programme Director has been appointed.

- There has been engagement with all partners in the system and there is Local Authority representation on the Leadership Reference Group and Directors Group to ensure that there is adequate reflection of the wider health and care system.

- The following diagram shows the relationship between these various groups across the System.



5.4 A key principle of the STP is that it will only cover those areas that need to be addressed at a System level. Local areas will continue to address priorities for their local communities.

5.5 The agreed priorities for the STP are:

- Making a further step change to improve wellbeing, increase prevention and early detection
- Significant action to improve long term condition pathways including greater self management and proactive management across all providers.
- Frailty pathways: providing proactive management of frail complex patients, having multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.
- Redesigning urgent and emergency care, including integrated working and primary care models providing out of hospital responses to reduce hospital stays.
- Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

5.6 These priorities emerged from a gap analysis that included Health and Wellbeing Strategies and Joint Strategic Needs Assessments and were signed off by a workshop of the System Leadership on 22 April.

5.7 Our analysis and discussions to date have identified four key transformations that our System will need to deliver over the coming five years:

1) Developing **communities and social networks** so that people have the skills and confidence to take responsibility for their own health and care in their communities.
2) Developing the **workforce** across our system so that it is able to deliver our new models of care and recognising that this transformation will be achieved through development rather than recruitment and be within today's costs.
3) Becoming a system with a collective focus on **the whole population** we serve and support throughout their lives – not a system based on sectors, organisations, services or parts of the population.
4) Using **technology** to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency.

5.8 We have identified a number of system enablers which will require attention from the system as a whole:

1) Changing the way we work together collaboratively as a system to deliver change, increasing pace and scale. Moving from the **effort stage** (gaining participation at the required scale and frequency) to the **effect stage** (targeting, delivering and demonstrating real impact at a sufficient scale).
2) Developing the **workforce** across our system so that it is able to deliver our integrated new models of care, recognising that this transformation will be achieved through new roles and working differently across and within professional groups, be within today's costs and include initiatives that improve the wellbeing and sustainability.
3) Using **technology** as an enabler for both our staff and our residents and users of services, to empower them, to change practice, drive efficiency and to improve care across end to end pathways
4) Considering how best to use our **estate and resources** across the system flexibly to support delivery of our new models of care
5) Consider **productivity and efficiency** opportunities throughout the system to achieve the same standards of effective working within all organisations and across different sectors within the system

5.9 Stakeholder engagement will continue as the Plan develops and actions to address the priorities are identified. As the STP moves into the next phase wider citizen and elected member engagement will be an area of focus.

6. Comments of Other Committees

The Board's Health and Adult and Social Care Priority Delivery Group considered the Frimley Health and Care System Sustainability and Transformation Plan 15 April 2016 Submission (See Appendix A) at its meeting 26 April and no substantive comments were received.

7. Conclusion

The Wellbeing Board is asked to note the governance, engagement of stakeholders, priorities and transformations.

8. Appendices

'A' - The Frimley Health and Care System Sustainability and Transformation Plan 15 April 2016 Submission

9. Background Papers

None

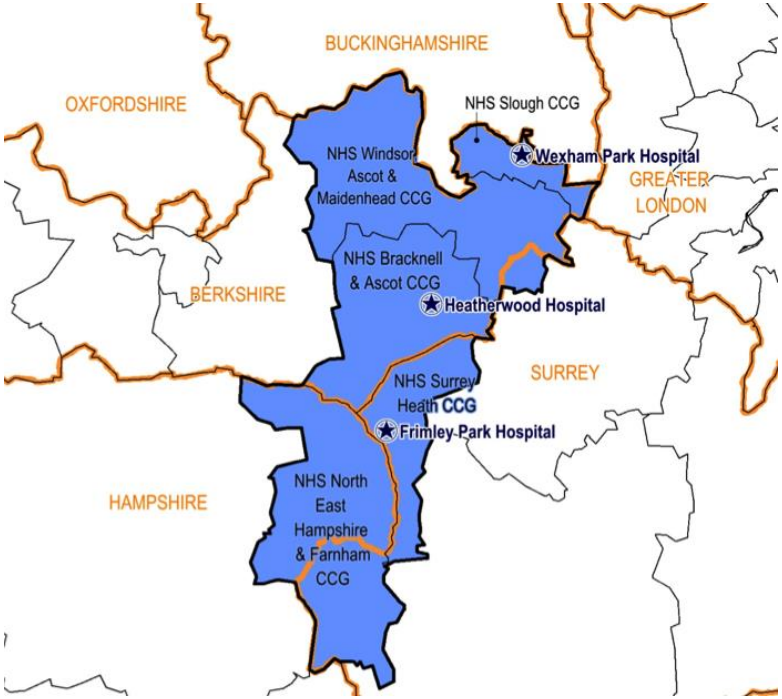
Frimley Health and Care System Sustainability and Transformation Plan

15 April 2016 Submission

Introduction to the Frimley Health and Care System

The Frimley System

The Frimley health and care planning footprint is the population of 750,000 people registered with GPs in 5 CCGs: Slough; Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham, as shown below:



Partners in the Frimley System:

The Frimley system is complex, operating across three Counties. The Sustainability and Transformation Plan (STP) builds on a strong track record of success and delivery in complex systems.

Our experience of working in complex systems will enable us to successfully deliver our transformation plans at a range of levels:

- At a local level
- At a County level
- Across the Frimley system
- With neighbouring STPs

The plan in June will describe clear arrangements for delivering the plan together in a coherent way across all of these levels.

The full list of the partners that make up the Frimley system is included at appendix 1.

Nominated lead of the footprint:
Sir Andrew Morris, CEO, Frimley Health NHSFT

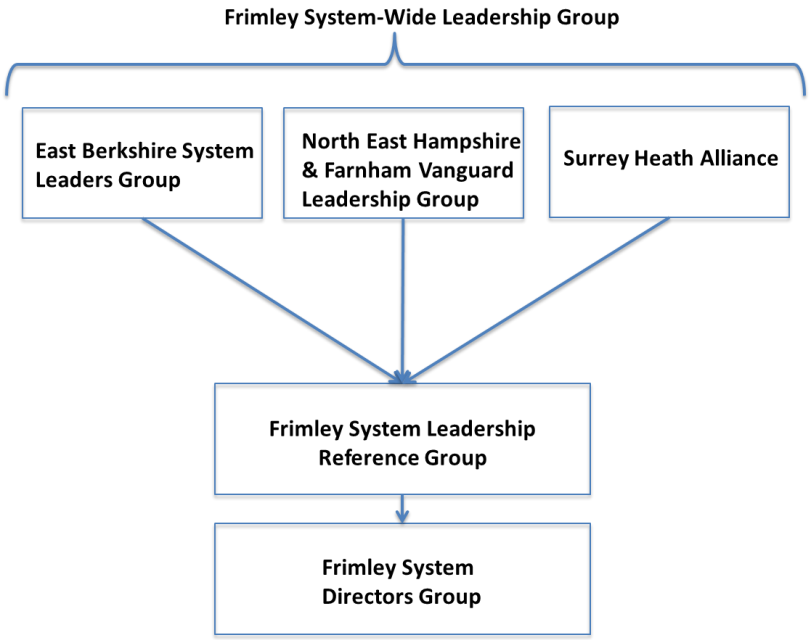
Contact for the Frimley STP:
Tina White, STP Programme Director

Section 1: Leadership, governance & engagement

Well established local system leadership groups

The Frimley system brings together a group of high performing and ambitious providers, commissioners and systems. The bedrock of effective leadership and engagement across our footprint are the 3 established system leadership groups:

- East Berkshire System Leadership Group
- North East Hampshire and Farnham Vanguard Leadership Group
- Surrey Heath Alliance



These groups have been facilitated and developed to provide effective system leadership to develop our STP.

The **Frimley System-Wide Leadership Group** brings together all of the members from these three groups (50 people) – with workshops planned for April and June. The three established groups will each sign off the STP before submission on 30th June.

The Frimley System Leadership Reference Group
A new group, chaired and organised by Sir Andrew Morris to work on behalf of the three established system leadership groups to steer and ensure development of the STP, with good engagement and planning for delivery.
Brings together the CCG Chief Officers and leadership representatives for the public, local authorities and clinicians.

The Frimley System Directors Group
Reports to Sir Andrew Morris to lead the day to day development of the Plan. A dedicated STP Programme Director has been appointed.

OD Support
The work to develop the STP is supported by the King's Fund Building Collaborative Leadership programme

Section 1: Leadership, governance & engagement

The principles underpinning leadership across the Frimley system

System Leadership Principles have been developed:

- Our collective ambition is that the people living in the Frimley system have the best possible health and wellbeing.
- We recognise that the Frimley health and care system needs to change and respond to a set of health, care and financial challenges. Our response to these challenges is to transform our system.
- 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.
- We will co-produce with and engage citizens, patients and staff to ensure that our plans and priorities are developed through the eyes of those who use, pay for and provide care.
- 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. Mutual respect and responsibility underpins how we work together.
- We will provide collaborative leadership and take collective responsibility for our system, based upon openness, trust and transparency.
- We have a track record of making good progress when we work openly, with trust, with common purpose and take new approaches to old problems. Our collective ambition is to use this track record to truly transform our system and to get great results.

Co-production and engagement

The development of our STP will be supported by the existing tried and tested co-production and engagement channels used to support transformation with the public, voluntary sector, faith groups, users of our services and citizens. These include:

North East Hampshire and Farnham:

- Vanguard communication and engagement
- 80 Community Ambassadors
- Staff ambassadors
- Collaborative trios

East Berkshire:

- New Vision of Care Design Group
- Partnership Boards with voluntary sector, local authorities and NHS providers
- On-line public surveys
- Established local community partnership forums and public meetings

Surrey Heath:

- Quarterly stakeholder and public engagement workshops
- “Making it Real” engagement events by local authority and health.
- An increased emphasis on digital communication and social media

The expertise in our local authorities will be used to support greater co-production as our STP develops and is delivered.

Section 3: Our emerging priorities

Transformational change

We are very ambitious for where the Frimley System will be in 5 years time and our STP will describe how we get there. We have started our planning for the next 5 years with a detailed analysis of the starting point for our system. We've reviewed our position against the three FYFV gaps and developed a whole system activity & financial model.

Our starting point is generally good, with many examples of high performance and evidence of local transformation.

However, the system is now experiencing increasing pressure and our modelling of the demography and financial challenges in our system clearly shows that we need to respond with much greater transformation.

Our analysis and discussions to date have identified **four key transformations** that our system needs to deliver over the coming five years:

A. Developing **communities and social networks** so that people have the skills and confidence to take responsibility for their own health and care in their communities.

B. Developing the **workforce** across our system so that it is able to deliver our new models of care and recognising that this transformation will be achieved through development rather than recruitment and be within today's costs.

C. Becoming a system with a collective focus on **the whole population** we serve and support throughout their lives – not a system based on sectors, organisations, services or parts of the population.

D. Using **technology** to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency.

Our emerging priorities

As set out on slides 6-8, our initial work identifies the following emerging priorities to be addressed through our STP:

1. Making a further step change to improve wellbeing, increase prevention and early detection

2. Significant action to improve long term condition pathways including greater self management and proactive management across all providers.

3. Frailty pathways: providing proactive management of frail complex patients, having multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.

4. Redesigning urgent and emergency care, including integrated working and primary care models providing out of hospital responses to reduce hospital stays.

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

Section 2: Overview of our gap analysis

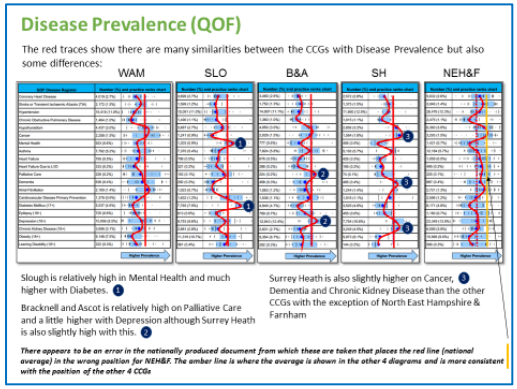
Detailed analysis of our current system gap and future challenges

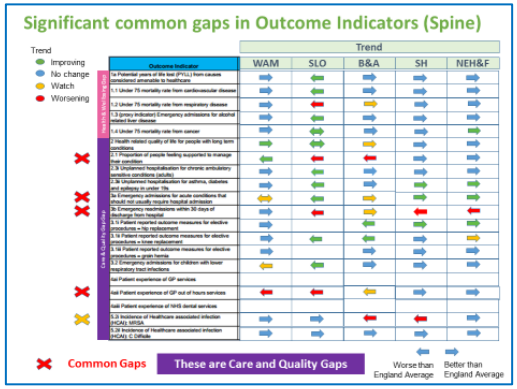
To inform the development of the STP, analysis has been undertaken of a range of data sources to provide information about the health & wellbeing, the care and quality and the financial challenge. The analysis points to a number of priorities for the system to address through the STP. The initial analysis is based on a review of:

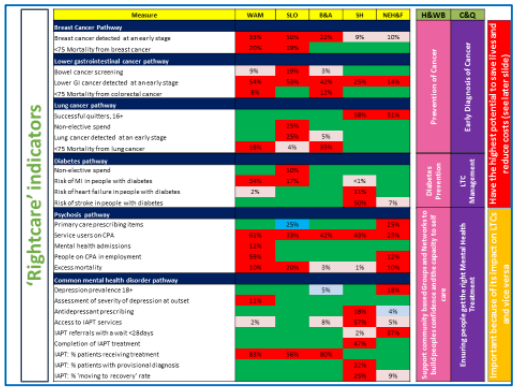
- Joint strategic needs assessments including Demographic data and population growth projections
- Public Health Outcomes Frameworks
- Health and Wellbeing Strategies
- The NHS Outcome Framework, which provides data about the performance of the NHS against the key outcomes that form the basis of the mandate given to the NHS by the government
- 'Right Care' data which provides benchmarking information about expenditure and outcomes across a wide range of clinical areas
- Existing CCG strategies and plans and joint strategies with local government
- Historical data as well as projections of current trends
- Detailed modelling of the financial gap

Example screenshots from the analysis are shown below.

The analysis demonstrates that the Frimley system has a good starting point, with some issues that have been highlighted and inform the STP. However, modelling the impact of greater need due to demographic change shows the our current improvement trajectories are not sufficient to stop gaps widening or to prevent the progress being made reversed. We need to take further action.







Section 2a: Improving health and wellbeing

Where we are now

The Frimley System population is growing, and ageing. Growth of people aged over 65 of around 2% per year and over 85s of between 4% and 6% per year. Slough has a younger population profile and the 5th highest birth rate in England.

There are pockets of deprivation across the system, but overall levels are low apart from in Slough

Disease prevalence is generally low, though at a more local level there is ward variation and gaps between expected and recorded prevalence

There are positive trends in securing additional years of life and from preventing people from dying prematurely, including death by suicide. However within localities life expectancy varies across wards closely linked to deprivation and residents with severe mental health show significantly reduced life expectancy.

Good progress is being made with reducing smoking, with some of the lowest smoking prevalence across England, however obesity and exercise trends are not changing and considerable variation is seen within communities .

There are a number of specific diseases where care improvements can be made that would improve outcomes and reduce mortality and costs. The greatest opportunity is in heart disease and stroke. Other significant opportunities exist in breast, lung and GI cancers, respiratory disease and falls and fractures.

The challenge for health and wellbeing in the Frimley System

When we model the ageing demography and current age standardised rates of illness it identifies a significant increase in prevalence and mortality for circulatory disease, cancer and respiratory disease over the next 5 years, and an increase in prevalence of cancer, dementia, diabetes and depression.

The fundamental lifestyle behaviours (NAO framework) that underpin the major causes of early ill health and premature mortality require a more concerted approach which supports people in a range of settings e.g hospital, employment. This will be coupled with an approach that targets those at most risk more effectively.

Together the approach will build on local prevention plans which are joint between local government and CCGs and use the STP system to deliver programmes at greater scale in key priority areas.

Our emerging priorities

1. Making a further step change to improve wellbeing, increase prevention and early detection.

Section 2b: Improving care and quality

Where we are now

The number of avoidable emergency admissions, readmissions and unnecessarily prolonged hospital stays are all rising. The system is struggling to maintain its historically strong operational performance against key access targets.

The number of people reporting a poor experience with general practice care out of hours is increasing.

The proportion of people who feel supported to manage their health conditions is reducing in some areas.

The trend for health related quality of life for people with long term conditions is not improving.

There are a number of specific disease areas where improvements can be made to outcomes, mortality and cost. The largest gap is in heart disease and stroke. Other significant gaps are in cancer, respiratory disease and falls. The consideration of the mental health and wellbeing of people with these conditions also needs to be embedded in interventions and practice.

The challenge for care and quality in the Frimley System

When we model the demographic impact over the next 5 years it identifies a significant increase in emergency admissions (circa 25%), significant reductions in the proportion of people feeling supported to manage their health condition and the quality of life for people with long term conditions.

Our emerging priorities

2. Significant action to improve long term condition pathways including greater self management and proactive management across all providers.
3. Frailty pathways: providing proactive management of frail complex patients, having multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.
4. Redesigning urgent and emergency care, including integrated working & primary care models providing out of hospital responses to reduce hospital stays.
5. Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

Section 2c: Improving productivity and efficiency

Where we are now

A whole system activity and financial model is being developed for all publically funded health and social care across our system. The model is flexible and can include the 12 practices in Chiltern CCG that face Frimley Health to give a complete picture. The model will show the size of the financial challenge for our system and the potential impact of introducing new models of care and potential efficiencies. It will provide a taxpayer, commissioner and provider view.

A 'do nothing' base case has been calculated showing the impact of demographic change, new housing and other growth factors; and the impact of inflation and marginal changes to the cost of provision. This shows a '**do nothing**' base case of:

Frimley STP 'do nothing' gap	20/21
Taxpayer view[1]	£248m
Commissioner view	£138m
Provider view	£110m

This assumes the gap starts with underlying Provider deficits of about £29m, The Commissioner gap is split between sectors as follows:

	20/21
CCGs	£103m
NHS England	£20m
Local Authorities	£15m

1. Including the 12 Chiltern practices increases the gap to £285m

The 'do nothing' scenario represents the local equivalent of the national £22bn challenge. In addition to being unaffordable, the implied demand would require an increase in acute bed capacity of about 25%.

Recognising that we should expect some efficiencies to be made as part of '**business as usual**' a second scenario has be modelled reducing demand by 2% and delivering 1% provider savings each year:

Frimley STP 'business as usual' gap	20/21
Taxpayer view	£110m
Commissioner view	(£5m)
Provider view	£115m

Key financial messages

- Our current ways of working and providing care are not sufficient to bridge the financial gap. Our 'business as usual' scenario still has a £110m gap.
- Commissioners planning in isolation will not bring the system into balance, and could worsen provider positions (eg stranded costs)
- We are not planning for any increase in physical acute capacity…but existing capacity needs to be used much more productively
- There is broad alignment between providers and commissioners on the size of the challenge

Section 3: System enablers

Our work to date to develop our STP has identified the following system enablers that will be required to underpin and support its successful delivery:

- Changing the way we work together collaboratively as a system to deliver change, increasing pace and scale. Moving from the ***effort stage*** (gaining participation at the required scale and frequency) to the ***effect stage*** (targeting, delivering and demonstrating real impact at a sufficient scale).

- Developing the **workforce** across our system so that it is able to deliver our integrated new models of care, recognising that this transformation will be achieved through new roles and working differently across and within professional groups, be within today's costs and include initiatives that improve the wellbeing and sustainability.

- Using **technology** as an enabler for both our staff and our residents and users of services, to empower them, to change practice, drive efficiency and to improve care across end to end pathways

- Considering how best to use our **estate and resources** across the system flexibly to support delivery of our new models of care

- Consider **productivity and efficiency** opportunities throughout the system to achieve the same standards of effective working within all organisations and across different sectors within the system

Section 4: The support we would like

Areas where **regional or national support** could help our plan:

- Expertise and practical support with workforce redesign and planning
- Access to latest national thinking on new tariff and contract structures that support system transformation
- Advice and support with implementing effective population based media campaigns that support promoting self-care.
- Support to fully resolve information governance issues so that information can be shared between providers across our system.

National barriers:

- As we move to delivery of our STP, it will be important that the national bodies are able to support system delivery and recognise that this will be different to holding individual organisations and sectors to account.

Key risks that may affect our ability to develop and/ or implement a good STP:

- Our system is committed to the collective challenge of delivering the STP, but to succeed we will require sufficient funding and resource to achieve transformation, such as Public Health resource to support self-care.

Appendix 1 – System partners

NHS Commissioners

- Bracknell and Ascot CCG
- North East Hampshire and Farnham CCG
- Slough CCG
- Surrey Heath CCG
- Windsor Ascot and Maidenhead CCG

Acute care provider

- Frimley Health NHSFT

Mental health and community providers

- Berkshire Healthcare NHSFT
- Southern Health NHSFT
- Surrey and Borders NHSFT
- Virgin Care

GP Federations

- Bracknell Federation
- Federation of WAM practices
- Salus GP Federation (North East Hampshire and Farnham)
- Slough GP Federation
- The Surrey Heath community providers

GP out of hours providers

- East Berkshire Primary Care
- North Hampshire Urgent Care

Ambulance Trusts

- South Central Ambulance Service NHS FT
- South East Coast Ambulance NHS FT

County Councils (including Public Health)

- Hampshire
- Surrey

Unitary Authorities

- Bracknell Forest Council
- Royal Borough of Windsor and Maidenhead
- Slough Borough Council

District and Borough Councils

- Guildford Borough Council
- Hart District Council
- Rushmoor Borough Council
- Surrey Heath Borough Council
- Waverley Borough Council

SLOUGH BOROUGH COUNCIL

REPORT TO:	Slough Wellbeing Board	**DATE:**	11 May 2016
CONTACT OFFICER: **(For all Enquiries)**	Dean Tyler (Head of Policy, Partnerships & Programmes) (01753) 875847		
WARD(S):	All		

FOR DISCUSSION

REVIEW OF PARTNERSHIP ARRANGEMENTS AND REFRESH OF SLOUGH WELLBEING STRATGY

1. Purpose of Report

To agree next steps following the recent consultation on a review of the Slough Wellbeing Board; our wider partnership arrangements and a refresh of the Slough Wellbeing Strategy.

2. Recommendation(s)/Proposed Action

The Board is asked to:

a) Note the findings at Appendix A from the recent consultation and appoint to a Task and Finish group to look at our ways of working so that membership, Terms of Reference and timescales can be agreed;

b) Endorse the proposal at Appendix B for how the Wellbeing Board will work and how our wider partnership network should operate in future;

c) Agree the proposed outline at Appendix C for a new Wellbeing Strategy and in particular the top three priorities for the year ahead;

d) Note the timetable at section 7 below for next steps and date for a launch of the new Wellbeing Strategy at a partnership conference on 22 September 2016.

3. The Slough Wellbeing Strategy (SJWS), the Joint Strategic Needs Assessment (JSNA) and the Council's Five Year Plan

3.a Slough Joint Wellbeing Strategy Priorities

Slough's current Wellbeing Strategy 2013 – 2016 expires shortly. This report explains the work being undertaken by the Board with partners to develop a new Strategy and to ensure that we have an effective partnership network to deliver this.

3.b Joint Strategic Needs Assessment (JSNA)

The new Wellbeing Strategy will be informed by our Joint Strategic Needs Assessment, the Slough Story and through consultation with representatives from the Wellbeing Board, its subgroups, key stakeholders and other partners.

3.c **Council's Five Year Plan Outcomes**

Slough's current Wellbeing Strategy's contributes to the eight Five Year Plan outcomes in particular outcomes 1 to 6.

4. **Other Implications**

(a) Financial - There are no financial implications associated with the proposed actions.

(b) Risk Management - There are no identified risks associated with the proposed actions.

(c) Human Rights Act and Other Legal Implications - There are no direct legal implications. The specific activity in the Strategy and other plans may have legal implications which will be brought to the attention of the Council's Cabinet separately. There are no Human Rights Act Implications.

(d) Equalities Impact Assessment - There is no requirement to complete an Equalities Impact Assessment in relation to this report although we will need to undertake one for the new Wellbeing Strategy.

5. **Supporting Information**

The Wellbeing Board held a development workshop with partners in January 2016 to:

- Review the role of the Wellbeing Board and improve our partnership arrangements;
- Identify priorities for a refresh of the Wellbeing Strategy; and
- Consider future ways of working.

The feedback from the workshop was captured in a short Outcomes report which was discussed with Wellbeing Board members after its meeting in March. The Board agreed a series of questions for consultation with those that attended the workshop in January as well as partners from the various sub groups and other stakeholders.

Appendix A to this report summarises the responses received. Based on the responses, **Appendix B** sets out a proposal for how our new partnership arrangements will operate and **Appendix C** proposes a framework for the new Wellbeing Strategy and the top three priorities for the first year.

6. Comments of other Committees

The Outcomes report from January's development workshop was also shared with the Health Scrutiny Panel, representatives from each of the Wellbeing Board's existing subgroups and other partners. All of the subsequent comments received are reflected in the analysis at Appendix A.

7. Conclusion

The work since January has focussed on ensuring that we have the right partnership arrangements in place to achieve the right outcomes for Slough. To enable this we have -

- Reviewed the role of the Wellbeing Board and sought to enable it to be more strategic so that it can have genuine influence and set direction.
- Looked at the wider partnership network and made recommendations to ensure that we are maximising the resources and capacity of our whole system for the benefit of Slough.
- Identified key priorities for a new Wellbeing Strategy where the Board can add value and make a difference.

At the discussion in March the Board concluded that as a result of the work since January we are heading in the right direction but that this is a process of 'evolution rather than revolution.'

We therefore look forward to continuing the conversation with partners to embed new ways of working and collaborating more effectively to achieve the best outcomes for Slough.

The timetable below sets out next steps –

Date	**Activity**
Wednesday 11 May Slough Wellbeing Board	Review responses to initial consultation and agree next steps
Late May - June	Consultation with wider partnership and other stakeholders such as the Health Scrutiny Panel on new arrangements and an outline Strategy Online consultation via Council website inviting views on the proposed priorities for the Strategy
Wednesday 20 July Slough Wellbeing Board	Sign off new partnership arrangements, terms of reference and Wellbeing Strategy
Thursday 22 September Slough Wellbeing Board Annual Conference	Launch the new Strategy and ways of working with the wider partnership

8. Appendices

A: Summary of consultation findings
B: Proposed arrangements for improved partnership working
C: Proposed outline of a new Wellbeing Strategy and priorities

9. Background papers

None

APPENDIX A: Summary of initial consultation findings

Consultation question: 1

We presented a number of options (including a diagram) for an improved partnership network.

1 (a) We asked… Would our proposed approach enable us to have a strategic place shaping role?

You said…Yes.

1 (b) When thinking about the various sub groups that currently exist and could exist, we asked…Why do we need a group; will a permanent group add value; and would a Task & Finish group be a better option?

You said…We need a group to:
- Bring together key partners across the Slough
- Direct and focus activity on the priorities
- Drive delivery across Slough

Gaps include:
- An overarching Group to lead on the Place and Regeneration agenda
- A dedicated Group to lead on the housing

Task & Finish groups could be established to deal with particular issues as and when they arise or which don't have a dedicated partnership group

Other comments:
- The Children and Young People's Partnership Board (CYPPB) is being reviewed and may need to change
- The Health subgroup of the CYPPB could report into the Adult Social Care PDG.
- The Health and Adult Social Care Group should oversee the implementation of any measures developed to tackle fuel poverty (given its direct impact on health). It should also oversee the monitoring of the Low Emission Strategy (to help combat poor air quality/reduce negative impact on some resident's health outcomes).
- The Board's relationship to the Slough Adults Safeguarding Board (SASB) works well and does not require any additional scrutiny/review
- The Preventing Violent Extremism Group should provide regular twice yearly reports on its activities.
- The Board could include a representative from the Youth Parliament to ensure the voice of Slough's young people is heard.

AN AMENDED PARTNERSHIP DIAGRAM IS ATTACHED AT APPENDIX B.

Consultation question: 2

The workshop in January identified a long list of potential priorities where the Board could make a difference.

2(a) We asked...Are these important?

You said…Yes – although you:

- Questioned why there were two housing related categories and suggested they could be combined?
- Challenged why "…smoking, reduce risk taking" were included if these relate to young people as Slough has the lowest stats in the region
- Noted that "Use behaviour change to encourage positive behaviour" is already being tackled.
- Questioned the relationship between the priorities of the Wellbeing Strategy, role of the Wellbeing Board and the Council's Five Year Plan.

2(b) We asked…Are they being done by someone already?

You said…This wasn't clear. It was suggested that an audit of what the Partnership Groups were doing would provide clarity about who is doing what.

2(c) We asked…Where are the gaps and is it realistic for the Board to do something?

You said …

- Crime - while this is essentially for the Safer Slough Partnership (SSP) to lead, the Board still needs to have strategic oversight of what the SSP and its partners are doing, to help focus/drive these groups in the right direction.
- Regeneration of town centre
- Developing Slough as a Smart City
- Heathrow expansion
- Troubled Families Programme
- Child Poverty
- Fuel Poverty
- Air quality
- Developing and promoting low carbon technologies
- Climate change resilience – preparing the communities of Slough for extreme weather events e.g. extreme cold, flood and heat waves
- Reactive and proactive emergency planning

Consultation question: 3

We set out a proposed framework for the next Wellbeing Strategy based on information from the January workshop.

3(a) We asked…What needs to be highlighted in the Wellbeing Strategy?

You said…

- The specific areas that the Board will focus on each year - what can realistically be achieved.
- Those areas where partnership or closer collaboration would enable added value to be brought for the benefit of Slough residents

3(b) We asked…Where can the Board add value – top 3 things each year and targets?

You said…

1) Increasing healthy life expectancy - directly links to deprivation, differences in gender and between wards, comparison with neighbours, life chances, poor air quality, poor health outcomes
2) Improving mental health and wellbeing - because it runs through each of the lifecycle categories identified in the consultation i.e. start well, live well and age well.
3) Housing - links to health, social mobility, community cohesion and resilience, fuel poverty, community safety, climate change
4) Encouraging Slough Urban Renewal - links between quality and condition of built environment, housing and health

3(c) We asked…Should the approach of the Board be broad based - trying to do everything – or a narrow focus on a limited number of priorities?

You said… It needs to take an interest in a large number of areas – but concentrate on the delivery of a limited number of priorities/outcomes.

3(d) We asked…Should the Board be focussing on specific wellbeing outcomes or on creating ways of working which could benefit several outcomes?

You said… A mixture of both. It should focus on outcomes, because that is how it can identify where improvements need to be made (albeit some outcomes are hard to quantify), but ways of working too which may be acting as a barrier to delivery, depending on which priorities/outcomes are identified.

Comments were also received on the detailed content of the proposed framework for the Wellbeing Strategy and these are reflected in the amended proposal at Appendix C.

Ways of working

Although we didn't formally ask any questions around this, the consultation included a summary of proposals to improve our ways of working that were identified at the January workshop. We received a number of comments on these which are set out below.

We therefore propose to initiate a Task and Finish group to explore these in more detail.

Membership

- Membership of the Board and the Partnerships Groups should be reviewed annually or bi annually.
- The elected members involved in community cohesion and resilient communities should be represented on the Board either as permanent members or as and when a cohesion/prevent issue arises/is taken to the Board.
- The Board should have a permanent representative from each of the Partnership Groups
- The acute sector should be represented on the Board.
- The Board could include a representative from the Youth Parliament to ensure the voice of Slough's young people is heard.

Relationship to other groups/bodies

- The Board needs to have some real 'teeth' to challenge the council (and others) about why they fail to respond or take action on a particular issue identified by the Board for action.
- Strengthen the relationship between the Health Scrutiny Panel and the Board, so that the Board can fully utilise the Panels wider intelligence gathering function and help inform, challenge and focus.

Task and finish groups

- These should be overseen by the Board:
- They should only be set up to deal with specific subject areas/issues/gaps not being dealt with by the partnership groups/elsewhere.
- The Board should set the priorities for each of these groups and monitor their performance – so that they are effective. These should be widely consulted on before they are set. They should focus on specific deliverables.

Forward planning and reports

- Control over the agenda/agenda planning should rest with Board members.
- More clarity (for the Board, the Partnership Groups and the others) is required about the referral process for routing issues between the various groups.
- Agenda planning needs to be a standing item on all future agendas.
- The Board should initiate the dialogue on a particular issue – then pass it on to others to investigate/explore options and report back/make recommendations
- The report template should be refreshed because the report packs are too long and not strategic enough. It also needs to form part of a common (light touch) reporting framework with similar agenda format and operating structure that all of Partnership Groups should adopt.

Performance

- The Board should provide the focus and drive what the Partnership Groups are doing and hold tem to account to really challenge them to perform/deliver.
- The Partnership Groups should report progress back to the Board more regularly and ideally before each meeting electronically.
- The Board needs a balanced scorecard or dashboard that shows performance against each outcome/target at a glance and which can be reviewed at each meeting.
- The evaluation/feedback form needs to be updated to challenge members to think about their performance and participation at meetings.

Communications and engagement plan

- The website needs to be refreshed to coincide with the launch of the Strategy.
- A digital approach for communicating with the public needs to be developed – which includes a platform for the Board to be able to share/present information about what it is doing with the wider partnership (such as their strategies and plans, agendas, action plans etc.) and the public.
- More effective engagement with our communities needs to be undertaken.
- The next Strategy needs to include a list of abbreviations and a glossary.

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Appendix B: Proposal for an improved partnership network

This review has provided an opportunity for the Slough Wellbeing Board to reset its ways of working and ensure greater focus on priorities where it can make a difference.

The Board has set an ambition to have more of a strategic vision and direction setting role. To achieve this it requires an effective partnership network to undertake operational delivery and 'heavy lifting'. The Board will seek to better coordinate activity and ensure greater clarity of accountability and ownership of agendas across and between the wider partnership and the Wellbeing Board.

We will set Terms of Reference that enable closer partnership working but are proportionate in terms of governance and reporting requirements. If we over-process the partnership in Slough we will stifle innovation and creativity. A number of groups already have clear governance and accountability arrangements and it would not be appropriate to suggest that they are all responsible to the Wellbeing Board. However the new arrangements are intended to better map the extent of activity so that it can be coordinated more effectively.

The Board will retain its status as a serviced Committee of the Council and be able to fulfil statutory requirements of a Health & Wellbeing Board.

The following groups will operate

- Health and Adult Social Care Partnership Delivery Group
- Children and Young People's Partnership [currently being reviewed]
- Local Safeguarding Children's Board [statutory]
- Local Adults Safeguarding Board [statutory]
- Safer Slough Partnership [statutory]
- Preventing Violent Extremism group
- Strategic Skills & Employment Group

The Place & Regeneration agenda will be covered by a combination of –

- Slough Urban Renewal, Transport Forums, Housing

The work previously undertaken by the Climate Change Partnership Delivery Group will be embedded elsewhere for example the emerging Housing Strategy, Council's Local Plan and Transport Plans.

Sub groups

We will also be mapping the various sub groups and key strategies / plans they deliver. We will establish Task and Finish groups to deal with particular issues as and when they arise or which don't have a dedicated partnership group

Slough Partnership diagram

The Slough Wellbeing Board will set strategic direction and act to 'hold the ring' for the partnership network, coordinating activity to achieve common outcomes.

*** Place & Regeneration: Slough Urban Renewal, Transport Forums, Housing**

Appendix C Outline of new Wellbeing Strategy

The proposed outline structure below reflects comments received during the consultation.

1. **Foreword – Chair of the Wellbeing Board**

2. **Vision**

To make Slough a place where people are proud to live, where diversity is celebrated and where residents can ~~enjoy~~ lead safe, fulfilling, prosperous and healthy lives.

3. **Top three priorities for the first year of the Strategy**

1) Increasing healthy life expectancy - directly links to deprivation, differences in gender and between wards, comparison with neighbours, life chances, poor air quality, poor health outcomes

2) Improving mental health and wellbeing - because it runs through each of the lifecycle categories identified in the consultation i.e. start well, live well and age well.

3) Housing - links to health, social mobility, community cohesion and resilience, fuel poverty, community safety, climate change

4. **Aims**

- Improve resident's health and wellbeing
- Reduce gaps in life expectancy across Slough
- Focus on the wider determinants of health such as education and training, housing, the economy and employment
- Commission better, more integrated and efficient health and social care services

5. **Key principles**

- Focus on prevention, early intervention and health promotion
- Provide opportunities for individual and community empowerment and volunteering
- Promote a culture of self care and personal responsibility
- Achieve more for less, making the very best use of resources
- Engage in an on-going dialogue with our residents, communities and patients

6. **Map of key partnership groups and strategies**

To avoid duplication we will map who is doing what and where so that there are clear lines of accountability.

7. **Evidence and performance**

We will use the Slough Story and JSNA to set out what the evidence is telling us. In terms of managing performance we will need to be careful not to make an industry of

this and not duplicate work being done eslewehere to measure progress. Some suggestions for how we might do this are set out in the table below.

8. Making a difference at key stages of people's lives

We will develop the matrix below to ensure we are confident that the Board is able to add value and that our partners are able to demonstrate how we are collectively improving people's lives.

Lifecycle	Outcomes
1 Start well - Every child the best start in life	• More families live in decent homes • Increase take up of Hib vaccine/ Men C booster • Residents make healthier early lifestyle choices • A halt in the increase in and reduce the % of children who are obese at yr6 • Increased consumption of fruit and veg • More vulnerable children and young people are safeguarded • Improved mental health services for children and young people • More young people leave education with the qualifications and skills needed to fulfil their aspirations *(specifically KS2 maths boys (white)*
2 Live well – People live, learn and work well	• Slough is a Smart city • A place of innovation, enterprise and economic growth • A regenerated and sustainable town centre • More active adults/More people use out door space for exercise and health reasons • More local people have access to good quality secure jobs • Improved detection of and provision of mental health services for adults • Stronger, safer, more resilient and cohesive communities • More adults screened for breast, bowel and cervical cancer • More adults with long-term conditions and communicable diseases are supported to manage their conditions *(such as CVD, diabetes/TB/HIV)* • Local People (and businesses) address issues for themselves
3 Age well – People live independently and safely	• Increased life expectancy and better quality of life • More integrated and patient focused hospital to community care services • More people remain independent for longer • Improved detection of and provision of improved mental health services for older people (including spread of memory clinics)

9. Statutory responsibilities[1] of the Slough Wellbeing Board

- To prepare and publish a Joint Strategic Needs Assessment (JSNA) for Slough.
- To prepare and publish a Joint Health and Wellbeing Strategy (JHWS) for Slough.
- To gives its opinion to the Slough Clinical Commissioning Group (the CCG) as to whether their Commissioning Plans adequately reflects the current JSNA and JHWS.
- To comment on the sections of the CCG's Annual Report which describe the extent of the CCG's contribution to the delivery of the JHWS.
- To gives it opinion, as requested by the NHS Commissioning Board, on the CCG's level of engagement with the Board, and on the JSNA and the JHWS.
- To encourage persons who arrange for the provision of health and/or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the area.
- To work with partners to identify opportunities for future joint commissioning.
- To lead on the signing off of the Better Care Fund Plan (BCF).
- To publish and maintain a Pharmaceutical Needs Assessment (PNA).
- To give its opinion to the Council on whether it is discharging its duty to have regard to any JSNA and JHWS prepared in the exercise of its functions.
- To exercise any Council function which the Council delegates to it.
- To ensures that strategic issues arising from Slough's Adult Safeguarding Board (SASB) and Local Safeguarding Children's Board (SLSCB) inform the work of the Board.
- To receive the annual reports of the SASB and SLSCB and ensures that partners respond to issues pertinent to the Board.

In addition, the Board has also agreed the following locally-agreed objectives:

- To act as the umbrella high level strategic partnership for the borough, this means identifying the priorities and agreeing the actions that will improve the health and wellbeing outcomes of residents and tackle the wider determinants of health.
- To deliver the Board's duty to promote joint commissioning and integrated provision, by bringing together a wider range of resources across NHS, social care, public health and other related services.
- To give the public a voice in shaping health and wellbeing services in Slough, and provide a key forum for public accountability of the NHS, public health, social care and other commissioned services that are related to health and wellbeing in Slough.

[1] Health and Social Care Act 2012

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board

DATE: 11 May 2016

CONTACT OFFICER: Alan Sinclair, Interim Director of Adult Social Services
Mike Wooldridge, Better Care Fund Programme Manager

(For all Enquiries) (01753) 875752

WARD(S): All

PART I
FOR INFORMATION

BETTER CARE FUND PLAN 2016-17

1. Purpose of Report

The purpose of this report is to inform the Slough Wellbeing Board (SWB) of the final Better Care Fund (BCF) Plan for 2016-17 which was approved by the Joint Commissioning Board and submitted on 3rd May 2016.

2. Recommendation(s)/Proposed Action

The SWB is asked to note the content of the Better Care Fund Plan for 2016/17

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The Better Care Fund programme is developed and managed between the local authority and CCG together with other delivery partners aims to improve, both directly and indirectly, the wellbeing outcomes of the people of Slough against all the priorities of the strategy but especially the Health priority.

3b. Five Year Plan Outcomes

The Better Care programme will contribute towards the outcome of more people taking responsibility and managing their own health, care and support needs.

4. Other Implications

(a) Financial

These are as outlined in the March report.

The minimum BCF pooled budget for Slough in 2016/17 will be £9,034m of health and social care funding. This is an increase of £272k on last year's pooled budget of £8,762m. £5,742m of this expenditure is social care related services. The final expenditure plan for 2016/17 is included in appendix one.

(b) Risk Management

This is as outlined in the March report.

There has been a change to the funding amount within the pooled budget as contingency to cover areas of risk. This is now set as £542,000 (reduced from £800k) and is calculated on the costs of a 2% increase in non-elective admissions. This now aligns with the CCG Operating Plan targets for non-elective activity in 2016-17. The funds from reducing this risk share are now identified for Integration within local wellbeing hubs in Slough.

(c) Human Rights Act and Other Legal Implications

No Human Rights implications arise.

There are legal implications arising from how funds are used, managed and audited within a Pooled Budget arrangement under section 75 of the NHS Act 2006.

The Care Act 2014 provides the legislative basis for the Better Care Fund by providing a mechanism that allows the sharing of NHS funding with local authorities.

(d) Equalities Impact Assessment

The BCF aims to improve outcomes and wellbeing for the people of Slough through effective protection of social care and integrated activity to reduce emergency and urgent health demand. Impact assessments are undertaken as part of planning of any new scheme or project to ensure that there is a clear understanding of how various groups are affected.

(e) Workforce

There are significant workforce development implications within the programme as we move forward with integration which leads to new ways of working in partnership with others. Changes will be aligned together with other change programme activities such as that described in the New Vision of Care being led across the East of Berkshire and the Social Care reforms within SBC.

5. **Supporting Information**

This is as outlined in the March report.

BCF Plan for 2016/17

The draft submission in March has been subject to an assurance process and feedback was provided through this process. Overall the plan was considered to be of good quality with evidence submitted on how the national conditions will be delivered. The plan also demonstrated a mature approach to joint working and the governance structure through the Joint Commissioning Board and BCF

Delivery Group is an exemplar of effective governance and stakeholder management.

Areas of concern or for development highlighted were:

- Evidence of a jointly agreed plan for reducing delayed transfers of care
- Reconsideration of the ambition for reduction of NEL admissions by 3% and alignment with CCG operating plan
- Demonstrating risk share held is not to detriment of investment in BCF schemes
- A key milestone plan of when improvements will be delivered, including 7 day working
- A comprehensive risk log
- An explanation of how dementia services are being delivered through BCF
- A description of our approach to Joint Assessment and a milestone plan of when this will be achieved
- Explanation of ambitions around admissions to residential care and reablement

These have now been addressed and described within the final narrative plan together with supporting evidence.

6. Comments of Other Committees

None

7. Conclusion

This report accompanies the final Slough BCF Plan submitted for 2016/17.

The plan will continue to be actively managed through the Joint Commissioning Board with regular progress updates to the Wellbeing Board.

8. Appendices Attached

'A' BCF Expenditure Plan for 2016-17
'B' BCF plan 2016-17

9. Background Papers

'1' Model of Care East Berkshire Hypothesis (New Vision of Care)
'2' New Vision of Care and BCF presentation
'3' Slough CCG Locality Profile 2015
'4' Operating Plan for BA, Slough, WAM CCGs 160416 final
'5' Slough Carers Strategy 2016-21
'6' Integration workshop Feb16 –SLG briefing
'7' Social Finance –End of Life incubator presentation
'8' Joint Commissioning Board - Terms of Reference
'9' BCF Delivery Group – Terms of Reference
'10' BCF Programme Risk Register March 2016

‘11’ Slough BCF dashboard month 10
‘12’ SWB BCF Report March 2016
‘13’ CCG Operating Plan – 7 day service implementation
‘14’ Connected Care – IG principles
‘15’ Connected Care – Communications Plan
‘16’ Connected Care – Consent Model
‘17’ Connected Care – Implementation Plan
‘18’ Dementia Care Strategy – Slough key actions 2014-16
‘19’ Dementia JSNA 2015
‘20’ Slough DTOC Plan 2016
‘21’ Slough BCF 2016-17 Planning Template- submission 3 Final

Appendix 1. Slough Better Care Fund Expenditure Plan 2016-17

Workstream	No.	Scheme	Scheme type	Area of spend	Commissioner	Provider	2016/17 Expenditure	New or existing scheme	Total 2015/16 (if existing
Proactive Care	1	Enhanced 7 day working	7 day working	Other	CCG		99000	Existing	99000
	2	Complex Case Management	Personalised support/ care at home	Primary Care	CCG	CCG	60000	Existing	60000
	3	Falls Prevention	Personalised support/ care at home	Other	Local Authority	Private Sector	50000	Existing	50000
	4	Stroke	Personalised support/ care at home	Other	Local Authority	Charity/Voluntary Sector	57000	Existing	50000
	5	Dementia Care Advisor	Personalised support/ care at home	Other	Local Authority	Charity/Voluntary Sector	30000	New	
	6	Children's Respiratory Care	Personalised support/ care at home	Community Health	CCG	NHS Acute Provider	95000	Existing	88000
	7	Proactive Care (children)	Personalised support/ care at home	Other	CCG		127000	Existing	177000
Single Point of Access	8	Single Point of Access	Integrated care teams	Community Health	CCG	NHS Community Provider	150000	Existing	50,000
Integrated Care	9	Telehealth	Assistive Technologies	Social Care	Local Authority	Private Sector	50000	Existing	25,000
	10	Telecare	Assistive Technologies	Social Care	Local Authority	Private Sector	62000	Existing	62,000
	11	Disabled Facilities Grant	Personalised support/ care at home	Social Care	Local Authority	Private Sector	775000	Existing	407,000
	12	RRR Service (reablement and intermediate care)	Reablement services	Social Care	Local Authority	Local Authority	2184000	Existing	2,184,000
	13	Joint Equipment Service	Personalised support/ care at home	Social Care	CCG	Private Sector	793000	Existing	533,000
	14	Nursing Care Placements	Improving healthcare services to care hor	Social Care	Local Authority	Private Sector	400000	Existing	400,000
	15	Care Homes - enhanced GP support	Improving healthcare services to care hor	Primary Care	CCG	CCG	110000	New	
	16	Domiciliary Care	Personalised support/ care at home	Social Care	Local Authority	Private Sector	30000	Existing	30,000
	17	Integrated Care Services / ICT	Integrated care teams	Community Health	CCG	NHS Community Provider	748000	Existing	748,000
	18	Intensive Community Rehabilitation	Reablement services	Social Care	Local Authority	Local Authority	82000	Existing	82,000
	19	Intensive Community Rehabilitation	Reablement services	Community Health	CCG	NHS Community Provider	170000	Existing	170,000
	20	Responder Service	Personalised support/ care at home	Social Care	Local Authority	Private Sector	60000	New	
	21	Out of Hospital Tranformation (integrated short term services)	Integrated care teams	Other	Joint		200000	New	
	22	Integration (local Wellbeing Hubs)	Integrated care teams		Joint		272000	New	
	23	Digital roadmap - Connected Care	Integrated care teams	Other	Joint	Private Sector	172000	Existing	208,000
	24	Integrated Cardiac prevention programme	Integrated care teams	Community Health	Local Authority	NHS Community Provider	150500	New	
Community Capacity	25	Carers	Support for carers	Social Care	Local Authority	Charity/Voluntary Sector	196000	Existing	196,000
	26	EoL Night Sitting Service	Personalised support/ care at home	Community Health	CCG	Charity/Voluntary Sector	14000	Existing	14,000
	27	Community Capacity	Personalised support/ care at home	Social Care	Local Authority	Charity/Voluntary Sector	200000	Existing	200,000
Enablers	28	Programme Management Office & Governance	Other	Other	Joint		260,000	Existing	260000
Other	29	Contingency (risk share)	Other	Other	CCG		542,000	Existing	867000
	30	Care Act funding	Personalised support/ care at home	Social Care	Local Authority	Local Authority	296,000	Existing	317000
	31	Additional Social Care protection	Personalised support/ care at home	Social Care	Local Authority	Local Authority	600,000	Existing	483000
							£9,034,500		

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NHS South of England

BCF Plan 2016/17 - Cover Sheet

Health & Wellbeing Board Name	Slough
Date of submission	Tuesday 3 May 2016
Has the plan been signed by CCG(s)?	Yes the plan has been circulated and discussed between Slough Borough Council and Slough CCG as well as partners in the Joint Commissioning Board. This plan has now been agreed for submission.
Date the plan was Signed off by HWB	Slough Wellbeing Board discussed the plan on Wed 23 March 2016 together with the Q3 update. The SWB agreed a delegated decision over the sign off of the final version on 3 May to the voting members of the JCB. The SWB will also review and discuss the plan at the meeting on 11 May 2016.
Are the minutes of the HWB at which the plan was agreed attached to this submission?	Minutes of the Slough Wellbeing Board meeting can be found here. Final plan not available at the time papers dispatched for a decision in advance of the final deadline of 3 May. Delegated authority given to Joint Commissioning Board to sign off the plan and SWB will receive on 11 May.

NHS South of England

Section 1 – Confirmation of funding contributions

Requirement	Response
Describe how your BCF Plan meets the minimum contributions for: • CCG minimum contributions • DFG • Care Act monies • Formers 'Carers Breaks' funding • Re-ablement funding	The Slough BCF programme for 2016/17 builds and develops that written, submitted and assured through the 2015/16 planning process. The financial plan includes the CCG minimum contribution of £8.259m together with the full Disabled Facilities Grant allocation of £775k (see Tab 4 of submission template) giving a total of £9,034,554 into the Pooled Budget for this year.
Is any additional funding from the LA or CCG(s) included?	No
Please confirm if this narrative plan, and the planning return template, has been signed by all parties and include the name, role, organisation and contact details of the authorising officer(s)	The narrative has been shared and discussed at the Slough Wellbeing Board meeting on 23 March 2016 and the outline agreed. It was noted that some of the detail and content will be subject to change between that point and the final submission on 3 May 2016.The Health and Wellbeing Board agreed to delegate approval of the final version to the Joint Commissioning Board which met and discussed the plan on 25 April 2016. All voting members of the JCB were present. These are: Alan Sinclair – Interim Director of Adult Social Services, Slough Borough Council Sangeeta Saran – Head of Operations, Slough CCG George Grant – Departmental Finance Officer, Slough Borough Council Nigel Foster – Chief Finance Officer, East of Berks CCGs
Your plan should provide a full overview of the funding contributions for 16/17 and set out any changes from 15/16. Please summarise here any changes from 15/16 and how these	The overview of the funding contributions and changes since 2015/16 are included in the planning template. Overall the expenditure plan has not changed significantly from that of 2015/16. Where they have been changes within year these have been agreed through the

Requirement	Response
have been agreed.	Joint Commissioning Board and a contract variation signed to the s75 Pooled Budget agreement. Towards the end of 2015 the BCF Delivery Group used the BCF self-assessment tool to help reflect on 2015/16 and help plan towards 2016/17. We also looked at return on investment in terms of impact on reducing non-elective activity where this was possible and whether the schemes aligned with New Vision of Care. Through this process the group identified: i) areas of activity that are performing well and how we want to build and develop these ii) projects that have been slower to get off the ground and what might help in terms of resource and/or linking and scheduling with other planned project activity and iii) areas which aren't performing so well and taking steps to further review, evaluate or redesign Together with the commissioning support unit we were able to do some detailed analysis of several of our BCF schemes and projects which tracked specific cohorts of people and their A&E attendances, outpatient's appointments and admissions. There was positive impact demonstrated in relation to: Children's Community Respiratory service, Telehealth, Care Homes, Complex Case Management and Intensive Community Team. Following feedback on the first submission of the narrative plan Slough is now adopting a revised position and is not planning any additional reductions through the BCF this year. Our ambitions for reducing NEA are now encompassed within our Operational Plan for 2016/17. We have outlined our planned gains through our QIPP programme with BCF providing the investment from which to achieve those gains. Our Operational Plan is proposing to achieve delivery of 2% increase in NEL in 2016/17 against IHAM. There will be a risk share agreement in place against this 2% of activity. Based on last year's forecast outturn this will be £542k. Details of how the risk share arrangement will operate in 2016/17 will be included in the s75 pooled budget agreement but will include a performance related element so that if improved performance is attained in 2016/17

Requirement	Response
	(under 2%) additional funding will be released in to pooled fund. There is new funding in 2016/17 for delivery of our Out of Hospital Transformation project (which will also form part of our plan for reducing DToCs), an integrated cardio prevention project and investment towards integration within local community wellbeing hubs. There is then also additional funding going into Telehealth, Care Homes, Equipment and to maintaining social care.
Please summarise the impact assessment of any changes you have made	There are no significant changes to the Slough BCF plan for 2016/17. Broadly our programme will continue in the work stream areas outlined in the original submission. Projects within the programme started at different stages and are being monitored and reported on monthly though the PMO software (Verto) to track progress. New areas of focus for our BCF integration programme in this year are the Single Point of Access (termed as an 'Integrated Health and Social Care Hub') and the Integrated Care Services (our 'Out of Hospital' transformation programme) both of which have been planned developments in our ambitions for integration locally but have been delayed mostly due to the size and complexity of these projects and capacity to take these forward in year one. In drawing up our draft expenditure plan for 2016/17 has been some additional investment into the protection of adult social care in order to meet requirements (maintaining provision of services and ensuring that local social and health care systems as a whole is not destabilised). All new projects and schemes within BCF go through Equality Impact Assessment process as part of the development of full business cases.

Section 2 – Narrative overview

Please describe the local vision for health and social care services, including changes to patient and service user experience and outcomes.	The vision for the Slough BCF still the same as that described in the 2015/16 submission. Slough Better Care Fund plan The overarching vision is that: *"Slough health and social care services 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."* Our vision seeks to preserve the values that underpin a universal health service, free at the point of use, alongside a social care system which continues to be subject to financial assessments and contribution. However we envisage fundamental changes to how we deliver and use health and care services. Through working together, we will enable people living in Slough to live longer, be healthier, and have a better quality of life, especially in the communities with the poorest health. We will join our systems and processes together to ensure that we effectively and proactively identify and support residents at an early stage and provide support to those who need it the most. We will simplify and offer to all our residents' ready access to a comprehensive range of generic and specialist services to support their needs. Our vision will see us increasingly delivering services through integrated care teams including locality based teams clustered around GP practices and we already have shared plans for two sites where this will happen as part of new building development. We will also bring together a wider range of health and social intermediate care and reablement services. In the medium term we are also making strong progress towards strengthening community resilience so as to enable our residents and diverse communities to start well, live well, and age well in their homes, schools and communities. The delivery of the BCF programme is aimed at delivering the following outcomes: • Reduce avoidable emergency admissions to hospital *(this is monitored overall but also within specific projects by tracking at individual level via NHS no. to ascertain impact of intervention. The target is to manage and hold growth to 2% increase).*

	• Improve patient and user experience of health and social care services *(this is monitored overall via GP and service user (ASCOF) survey but also within projects e.g. telehealth)* • Encourage independence and self- reliance by building community capacity *(forms part of our proactive care and strengthening community capacity worksteams and impact measured through complex case management impact and activity and our community navigator project. Our revised local indicator will also measure and report on people's confidence in managing their own health)* • Reduce the proportion of patients falling into crisis and needing admission to hospital or a care home *(this is monitored through our complex case management project but will also form part of our Out of Hospital Tranformation programme).* • Increase the proportion of patients who feel supported to manage their long term conditions *(this is measured though the GP survey and reported through public health locality profile. We will also be measuring and reporting on patients confidence to manage their own health).* • Improve mortality and morbidity statistics for CVD, respiratory, stroke and heart failure *(this is monitored through service and project reporting activity)* • Reduce permanent admission to nursing and residential care for over 65s *(target set within BCF metrics and monitored on BCF dashboard and through ASCOF reporting to Slough DMT).* • Maintain the good performance of older people at home 91 days after discharge from hospital care into reablement *(as above)* • Reduce delayed transfers of care *(as above)* • Reduce avoidable hospital admissions for children and adults (*NEA of children monitored*

	and reported in BCF dashboard) • Increase number of people with a health and social care personal budget *(no targets set for people with health personal budgets social care PB target set and monitored through SBC ASCOF)* • Increase number of people (aged 65+) offered reablement following discharge from hospital *(no targets set but measured and monitored through the RRR service reporting).* • Ensure all patients have a choice of place of death *(performance being baselined and improvements driven through the East Berkshire End of Life strategy).* • Provide more support within the community for self-care and prevention initiatives for children and young people *(this has started with asthma management with additional investment identified to extend in year two)* • Increase access to self-care for people with mental and physical health problems *(through the 'Talk before you Walk' CCG campaign, the joint Information and Advice Strategy in development and the Community Navigators in the newly commissioned SPACE consortium)* • Safeguard and support vulnerable adults and children in our communities *(Monitored and reported through the respective Children and Adults Safeguarding Boards)* **What difference will it make to patients and service users?** If we are successful in our delivery we will hear the following positive messages from those people who use our services: "We have access to a range of support that helps us to choose to live the life we want" "We are supported to achieve our goals and take control of our care and support needs" "If we have questions about our care we know who to contact" "We have information and support to remain as independent as possible" "We take responsibility for our health and our care"

	"We have support for any carer(s) involved in our care" "We are involved in discussions and decisions about our care and treatment" "We have someone we trust so that we can get help at an early stage to avoid crisis" Our workstreams for the BCF remain the same for 2016/17. These are • Proactive Care • Single Point of Access ('integrated point of referral' for short term services) • Integrated Care Services (our 'Out of Hospital' Transformation programme) • Strengthening Community Capacity As we take forward our programme for this next year it is also increasingly important that we ensure that BCF aligns with the New Vision of Care programme which has been working to develop the design model for the care of people across our area. This programme has brought together a wide range of people from different organisations involved in care of people with complex needs along with public, patients and carers. The New Vision of Care hypothesis is attached here together with a presentation made to an Integration workshop hosted in Slough in Feb 2016. Appendix 1. Model of New Vision of Care East Berkshire Hypothesis Appendix 2. New Vision of Care and BCF presentation The programme of change within the BCF is also closely aligned together with the changes taking place within the social care reform programme in the local authority. In our approach to working both with communities (through our new voluntary sector contract) and with individuals are moving away from a model of assessment of need towards an asset based approach. This is a 'three tier' approach which can be described by: i) an 'early help' function whereby people are provided with personalised information and advice with call-backs ii) tailored short term support at times of crisis when people need additional care and help, and iii) long term care where required (but incorporating I&A and short-term too). This 3 tier approach also complements and mirrors the approach of the CCG to patients access to GP and primary care where firstly they have access to good information and advice

	('Walk before you Talk'), then for those people who need it they have access to same day appointments and at the third tier there is complex case management whereby people have proactive support with their long term conditions to help stabilise and gain confidence in managing their own care. The CCG and Council together will build on the strengths of the Community Hubs in Slough and work has already started for the adult social care teams in the neighbourhoods that we serve in order to strengthen the relationships that we have with people, communities, the voluntary sector and partners. By creating a circle of support for people in the heart of our communities the Council and partners will be able to better support the citizens of Slough so that they can to have an independent life for as long as possible. This vision for the community hubs will see local centres becoming a collaborative work place for community facing professionals and communities, so that our staff can apply the "3 tier asset based conversations" in a diverse multidisciplinary environment and maximise earlier preventative, outreach and close signposting solutions for the citizens of Slough. The programme is in three phases and is actively pursuing opportunities to build a whole community based model together with CCG where we have joint working space, practices and multi-disciplinary working with General Practitioners and Community Health colleagues. We are also looking to develop integrated care within neighbourhood sites, or 'clusters', at a very local level. We know that our community centres provide a focal point and facilities to foster greater level of local communal activity and bring residents, the local business, neighbourhoods, and smaller organisations together to improve the quality of life in their areas. Slough Borough Council has started on development of both i) an Information and Advice strategy and ii) a Prevention strategy with workshops already held together in partnership with CCG, public health, community and voluntary sector and other stakeholders. There has been a pilot patient navigator project run over the past 12 months with three local voluntary sector organisations each working with a different GP practice. The learning from these pilots is now been evaluated and taken forward with a transition to a community navigator function across the borough being co-ordinated through SPACE in voluntary sector consortium. This has now started and several of the volunteers participating in the pilot are

	continuing to develop their role and a first training session being run on 22 April and being ready to commence by 1 May 2016. Links to the existing pilot practices will continue but will develop a more targeted support though a social prescription scheme where GPs will complete and make a referral. This will then be rolled out to all 16 GP practices as volunteers are recruited and trained, as well as to other community based points of access.
Supporting documents which contribute to the local vision for health and social care services	Slough Joint Strategic Needs Assessment is used to assess the current and future healthcare and wellbeing of residents of Slough. The JSNA informs the development of the Joint Wellbeing Strategy. Slough Joint Wellbeing Strategy (2013-16) has following priorities identified: • Health • Economy and Skills • Housing • Regeneration and Environment • Safer Communities Our ambition for health is that by 2028 Slough will be healthier with reduced inequalities, improved wellbeing and opportunities for our residents to live positive, active and independent lives. **Slough Clinical Commissioning Group locality profile (2015)** Provides a detailed profile and analysis of Slough's population including demographics, lifestyle and health behaviours, children and adults health profiles, and an analysis of the GP survey results. Appendix 3. Slough CCG Locality Profile 2015 **CCG operating plan 2016/17** Appendix 4. CCG Operating Plan Slough Borough Council – 5 year plan The plan is a key driver outlining the priority outcomes for the Council by 2020 which

	includes: • More people will take responsibility and manage their own health, care and support needs. • Children and young people in Slough will be healthy, resilient and have positive life chances. **Joint Carers Strategy 2016-2021** This strategy outlines Slough vision and commissioning intentions in relation to carers, updating to meet requirements within the Care Act and aligning local priorities with the four national priorities for carers: • Identification and recognition • Realising and releasing potential • A life outside of caring • Supporting carers to stay healthy Appendix 4. Slough Carers Strategy 2016-2021 **Promoting and supporting the wellbeing of residents with the voluntary sector** This strategy outlines the partnership approach between Slough Borough Council and the CCG to working with the voluntary sector. This is an outcomes approach to commissioning which aligns activity in the sector with the shared ambitions and improve outcomes being sought for Slough residents. The re-commissioning of the voluntary sector was a large commissioning project within 2015-16 resulting in the award of a contract to the new 'SPACE' consortium (Slough Prevention Alliance Community Engagement) which started in January 2016. **New Vision of Care** During 2015/16 the East Berks CCGs together with Chiltern CCG have been working with Frimley Health FT, Berkshire Healthcare FT, Local Authorities, voluntary Sector and the public to develop a new and transformed model of care to commission health and social care services for people with complex needs. Though the project partners have developed a new and transformational vision of care to help avoid unnecessary admissions to hospitals and care homes and the loss of independence. This will be for adults but the vast majority of intensive uses will be people with more complex conditions. Key project areas for delivery

	are: • Workforce Development • Communication and engagement • Collaborative leadership • Aligning incentives • Share Your Care • System governance
Describe how the BCF contributes to the local implementation of the vision of the FYFV and the move towards fully integrated health and social care by 2020; and the aspects of the change the local area is intending to deliver using the BCF.	The East Berkshire Clinical Commissioning Groups draft Operating Plan for 2016/17 sets out the responses to the nine 'must do's' for our system as laid out in "NHS "Delivering the Forward View" (see appendix 4)Strategically the BCF programme contributes to delivery of strategic themes of: - Self management and prevention - Primary Care - Person centred co-ordinated care - Urgent Care Discussions are at an early stage around our plans for integration for 2020. A workshop was held in February bringing together representatives from across the East of Berkshire. The session was very positive and generated a lot of discussion around elements of integration but generally there was a recognition of our shared the same goals and outcomes for our communities and a commitment from those present to doing this together. A brief summary report for the Systems Leaders Group is attached in appendix 6. Appendix 6. Integration workshop Feb16 – SLG briefing
Please list the issues that the BCF will be used to address in the local area	The case for change in the 2015/16 submission continues but an updated picture which includes the following: • An aging population, with more people needing more care. Over the next 5 years the number of people aged 85 and over is expected to increase by 27.3%;

	• Higher levels of long term conditions particularly circulatory diseases, respiratory disease and tuberculosis (incidence of cancer lower than national and SE average). • Increasing rates of diabetes, dementia, strokes, and mental health problems. • An inadequate primary care base - amongst the lowest number of GPs in England • Ongoing and increasing demand on A&E attendances and on acute hospital beds to deal with urgent care admissions, exacerbated in winter • A rising birth rate - the highest crude birth rate in England, placing increasing demand upon services • An overreliance on acute admissions for children- some 20% of all non elective admissions- for Slough this equating to a £3.12m spend in acute hospital care • Rising citizen expectations around the quality and location of care • Financial constraints as health and social care see significant decreases in their budgets • Saving requirements for adult social care of approximately 5% per annum over the next three years, which has led to fundamental review of the social care offer
Explain how the BCF will address quality and reduce costs based on segmented risk stratification. (Reference local issues and how integration will be used to drive improvement). If relevant please provide supplementary data to support the case for change, including quantifying levels of unmet need, issues of service quality, and inefficiencies in service delivery.	Proactive Care is one of the four workstreams within our BCF programme through which we are taking a systematic identification approach to identifying patients who are at risk and making targeted interventions. Within our Complex Case Management project we are using a risk stratification tool (ACG) to identify those patients who require more intensive support and targeting intervention through period of regular appointments with GPs (integrating the running of the complex case finding process together with the targeted use of extended access within the Prime Ministers Challenge programme). We are now monitoring activity of this cohort of patients month to month and although at early stages there are signs of significant reduction on admissions and A&E attendances though this approach. There are currently 568 patients proactively case managed through this project who see their GP once every 3 weeks for a 20 minute appointment. Within this cohort there has to date been a 28% reduction in both non-elective admissions and A&E attendances as well as 37% reduction in outpatients first appointments. We will be commissioning a new integrated cardiac prevention programme in 2016/17 which will also be using proactive case finding methodology of people at risk and who will benefit

	from a range of early interventions to improve cardiovascular health. In response to the high number of non-elective admissions of Children for asthma and respiratory difficulties in October 2015 we started running a community respiratory service in Slough which is led by the acute hospital. There are two nurses who follow up in the community those who have attended or been admitted to hospital for additional education, training and support to the children and their families. They also work together with practices to provide support to GPs and practice nurses with guidance and support about managing respiratory conditions. In the last quarter there have been 50 home visits and 3 nurse led clinics and 14 GP clinics. We are looking to extend our complex case management approach in primary care further to identify children and young people (under 18s) who would benefit in a similar way. We will also link the process to identify those people suitable for support through the PCICT (Primary Care Intensive Community Treatment service) and our Telehealth scheme. Risk Stratification is also in use for the Directed Enhanced Service (DES) for identifying the top 2% of the population most at risk of admission / re-admission to hospital, with multiple co-morbidities. Further opportunities for risk stratification being explored are around identification of people towards the End of Life Care to identify earlier and support advanced care planning so that people can be given appropriate health and social care support, services and intervention in their own home and a choice in their place of death. In support of the above we have developed an End of Life Care Strategy led by our East Berkshire End of Life commissioners steering group and in conjunction with the EOLC providers steering group, which outlines the 'ideal' end of life care service model improving outcomes for people towards the end of life, including people's experience and quality of care through greater service coordination and increased out of hours provision and as a result a reduction in unplanned admissions. The ambitions for palliative and End of Life care follow those of the national framework for local action 2015 -2020, published September 2015. This East Berks Commissioners group is also working with Social Finance to test the practical

	feasibility of making improvements to the EOLC model: · Understand our local population need and current service provision · delivery the key principles on improvements to the end of life care service model, in particular through preventative and community based services · Test and develop the operating and financial model assumptions to build on both the investment case for the EOLC Incubator and the business case for the CCG Appendix 7. Social Finance – EoL incubator model presentation

Please provide a description of the specifics of the overarching governance and accountability structures in place locally to support integrated care, including:
 	
• A description of the specifics of the management and oversight in place to support the delivery of the BCF plan?
 	
• An articulation of the arrangements in place to support joint working?
 	
• Key milestones associated with the delivery of the plan of action in 2016-17?
 	
• A fully populated and comprehensive risk log, with evidence that it has been developed in partnership with all stakeholders and a description of how risks will be managed operationally including:
  • A quantified pooled funding amount that is 'at risk'
  • Demonstration that this has been calculated
	The BCF Programme for Slough has strong governance arrangements in place which have worked effectively in the first year of running the programme through a pooled budget s75 agreement. The governance arrangements are described in the 2015/16 plan.
	
	The Slough Wellbeing Board is the statutory committee with responsibility for overseeing the BCF programme in Slough. It is the decision making body and receives quarterly updates on progress and developments.
	In support of the SWB there is then a BCF Joint Commissioning Board which provides the strategic direction for the BCF programme and also meeting quarterly Appendix 8. Joint Commissioning Board Terms of Reference
	
	A Better Care Fund Delivery group is then the 'engine room' for driving forward the programme and this group meets approximately twice a month. These meetings alternate between:
	i) Performance, Finance and risk monitoring (with attendance of finance officers)
	ii) Business case development and service review
	Appendix 9. BCF Delivery Group Terms of Reference
	
	There are then various task and finish project groups which meet to take forward discrete project work and scheme development within the BCF programme. As well as feeding into the delivery group for progress and management they report monthly into the PMO function

using clear analytics and modelling • An articulation of any other risks associated with not meeting BCF targets in 2016-17 • An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and payment arrangements	within Slough Borough Council and monthly into the CCGs project management software (for reporting on progress on QIPP and BCF projects to the Senior Leadership Team). There is a risk log kept for the BCF programme overall reviewed by the BCFDG and the Joint Commissioning Board (JCB) Appendix 10. BCF Programme Risk Register – March 2016 There are also monthly reporting and overview of the BCF dashboard to: - Slough CCG QIPP and performance committee - monthly - Slough Operational Leadership team - quarterly (or more frequently as required) - Locality meetings (with representatives from GP practices across the borough) The dashboard for Month 10 of the BCF programme is included in appendix 11. Appendix 11. BCF Performance Dashboard Milestones for delivery of the 2016/17 BCF programme Q1 • Development of full business case and PID for the Integrated Hub (Single Point of Access for professional referrals with agreement to the target operating model for Slough. Project Board established. • Data collation and analysis for the Out of Hospital Transformation programme. Outline business case developed for agreement and sign up of partners • Commence procurement of Care Home enhanced GP support service • Develop specification for integrated cardiac prevention service Q2 • Project implementation of workstream activity to establish Integrated Hub • Development of full business case for the Out of Hospital Transformation programme for agreement of partners. Governance agreed and established. • Procurement process for integrated cardiac prevention services Q3

	• Integrated Hub comes into operation • Out of Hours Transformation programme starts

Section 3 - National Conditions

Plans Jointly Agreed Does the BCF Plan cover a minimum of the pooled Fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the HWB area, and is it signed off by the HWB itself, and by the constituent Councils and CCGs? Explain how, in agreeing the plan, have you engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people. Please illustrate: • There is joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan • This includes an assessment of future capacity and workforce requirements across the system • The implications for local providers have been set out clearly for HWBs so that their agreement for the deployment of the Fund includes recognition of the service change consequences?	Yes the BCF plan is a jointly agree programme of work supported through a minimum pooled budget as specified. The plan for 2016/17 has not at this time been agreed by the Slough Wellbeing Board although they are regularly appraised of developments and a report was presented at 23 March summarising Q3 progress and outlining the expenditure plan and activity for 2016/17. Appendix 12. Slough Wellbeing Board BCF Report 23 March 2016 Health and social care providers are represented and engaged throughout the BCF programme through the Joint Commissioning Board (see terms of reference for membership) but also many are also involved directly within individual project planning / steering groups. Workforce development has been identified as a key risk to the successful implementation of BCF activity. Gaps in effective ways of working, skills and capacity - in care homes and domiciliary care markets in particular - are a common challenge across the area. Nursing and Occupational therapist capacity is stretched with competition of staff between acute providers and private organisation community services and GP practices. Within our BCF we will be joining with WAM and Bracknell colleagues in order to take a proactive and collaborative approach to addressing these shared workforce issues together with a other key workforce development opportunities. It is agreed that in Q1 2016/17 a task and finish group will jointly identify with WAM and Bracknell BCF colleagues the skills shortages relating to our immediate priorities and current BCF projects. Terms of Reference have been developed and highlight the commitment to an overall timeline for progress as follows:

As the Disabled Facilities Grant (DFG) will again be allocated through the BCF, please confirm that local housing authority representatives have been involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.	Q1 - Scoping opportunities and current areas of progress/excellence Q2 - sharing and engagement with other to develop agreed plan Q3/4 - Implementation We will develop a joint draft action plan with key milestones by end June 2016 relating to BCF challenges that we can actively progress within available resources. Sharing of the good practice between areas and organisations that is currently in place will enable some immediate, tactical progress. However, we recognise that this working group will need to extend its engagement, influence and collaboration with the wider CCG and regional and national agencies to align our local need within other collective approach eg: South East ADASS programme, recruitment and retention programme in BHFT, homecare and care home staff including that of registered managers through our Provider engagement forum, developing reablement and intermediate care capacity through our Out of Hospital Transformation programme, the voluntary sector community navigator support developing through our SPACE consortia, and Primary care staff. The New Vision of Care programme may have a valuable role to play in taking this forward, but no assumptions are made presently until our analysis is complete and resourcing a forward plan can be scoped.
Maintaining the Provision of Social Care Please specify the total amount from the Better Care Fund that has been allocated for supporting of adult social care services and confirm: • That at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified • The amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Overall there is around £5.742m of the Better Care Fund going into social care or related activity. This compares to £5.127m of planned spend within the 2015/16 BCF plan. Details are contained in tab4 of the Planning template. Social care covers areas of: - Telehealth - Telecare - Disabled Facilities Grant - RRR services (intermediate care and reablement) - Joint Equipment - Nursing Care placements - Domiciliary Care

Please describe how the local adult social care services will continue to be supported in a manner consistent with 2015-16. Has this support been agreed locally and, as a minimum, does the funding and services maintain in real terms the level of protection as provided through the mandated minimum element of local BCF agreements of 2015-16? In setting the level of protection for social care in your local area, please describe how you have ensured that any change does not destabilise the local social and health care system as a whole? Please include a comparison to the approach and figures set out in 2015-16 plans and confirm this approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14.	- Intensive Community Rehabilitation - Responder Service - Carers - Community Capacity - Additional Social Care Protection Within the expenditure plan there is £296k allocated as the local proportion for implementation of Care Act duties and £210k that is dedicated to carer-specific support. In 2016/17 some of the underspend that has arisen from BCF projects that have either ended or started later than planned has been invested back into social care. £300k was invested into provision of additional equipment across health and social care and approximately £300k additional funding directly into front line services. This is now sustained investment that is being carried forward into our plan for 2016/17 with an additional £260k of funding for equipment across health and social care services, £25k increased investment in Telehealth and additional £117k for additional social care protection.
7-Day Services Please detail your plans to deliver 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care, and how your approach to 7-day services will: • prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week • support the timely discharge of patients, from	**Social Care**: Slough residents already have 7-day access to intermediate care with a 2 hour response time for urgent need, from a multi-disciplinary team 7 days a week between 8am and 10pm. This part of the service is aimed at preventing unnecessary hospital admissions and supporting discharge. There are also social care practitioners based on site at Frimley North hospital site to facilitate discharge. Use of SRG funding has also supported the establishing of working practices for seven day services across the Slough health and social care economy. **Mental Health** Slough has a 24/7 response for Mental Health through Berkshire Healthcare NHS Foundation

acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care • is underpinned by a delivery plan for the move to seven-day services, which includes key milestones and priority actions for 2016-17	Trust (BHFT) out-of-hours crisis response team to respond to people with mental health needs. The Home Treatment team provides a 24/7 service, preventing inappropriate admission and facilitating discharge for people with non-acute needs arising from Dementia. **Acute** Through our collaborative commissioning arrangements we will be reviewing the 7-day working arrangements in our acute provider and putting in plans to ensure these are comprehensive so that no person is admitted to, or stays in hospital longer than necessary. Schemes to strengthen 7 day working around the acute trust (Frimley Health NHS Foundation Trust) have been piloted using winter pressures (SRG) monies. Following evaluation, successful pilots will be extended further. **Community** Slough offers a walk-in centre open 7 days a week, 8am till 8pm, for all minor injuries and illnesses. This is primary care led, and also provides for integrated pathways into intermediate care, and social care support as well as the existing Primary Care (GMS) and GP Out of Hours service. **Primary Care** Practices in Slough have been operating extended access to GP supported through the Prime Ministers Challenge funding to meet the challenges for patients who find it hard to access primary care during core hours Monday to Friday. This offers appointments into the evening Monday to Friday (6.30pm – 8pm) and offering booked and on-the-day appointments on Saturday and Sunday. It also proactively uses opportunity for regular or extended appointments for those people at risk who have been identified though the complex case management process. Further information on our position on seven day working is appended to the CCG 2 year Operating Plan 2016/17 Appendix 13 – CCG Operating Plan – 7 day services
Data Sharing on the NHS Number	

Please use this section to demonstrate that the right cultures, behaviours and leadership exists locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. In your response please confirm if: • you are using the NHS Number as the consistent identifier for health and care services, and if not, your plan to do so • you are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls • you have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when you plan for it to be in place • you have ensured that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights (In line with the recommendations from the National Data Guardian review) Please also describe how these changes will impact upon the integration of services.	Currently across Berkshire there are 17 different organisations that hold data in one or more systems relating to an individual's health, social care and wellbeing. There are different culture, systems & technology, processes and legislation which drives each of the organisations it is always difficult to get a single view of a person at a point in time. What the Connected Care solution is offering the is ability to have a single point of access to a person's health and social care records giving accurate and up to date information at the point in time of accessing the data. This supports the different integrated services in the following ways: • No need for multiple laptops to access health and social care data separately • Access to real time data reducing the need for phone calls to various organisations to collate pieces of information • Reduce the amount of time required to contact the relevant organisations in relation to a person. • More accurate data • The ability to streamline the integrated services better by creating true single assessments The ability to streamline the transfer of a person from one service to another by developing health and social care pathways As part of the procurement there were a number of technical requirement s which the preferred bidder has signed up to in relation to Open APIs. The benefit to the use of APIs. The APIs will define what data is shared between the various systems and is what will support the real time access to data. Open APIs will then future proof going forward data exchanges between the multiple systems any changes in technology and legislation. The Connected Care Implementation team consists of an Information Governance Group across Berkshire made up of the Caldicott Guardians, business representatives and technical people to ensure that the appropriate controls are put in place in the new solution. For Slough this includes the Slough BCF Programme Manager, the Transformation Manager (SBC) and the IT Strategy Manager (SBC). The guiding principles and development of the group were defined around the principles developed by Dame Fiona Caldicott, the Information Governance Oversight Panel and Information Governance Alliance. Copies of the ToR and the IG Principles are in appendices 14 and 15 for reference.

	Appendix 14. Connected Care IG Principles Appendix 15. Connected Care IG Steering Group ToR All organisations are obliged to ask for consent to share and disclose information to other organisations and inform the person how and what data they will be sharing with what organisation. The Connected Care projected has an overarching Communication Work stream which is chaired through the NHS and made up of representatives from each of the organisations and members of various patient groups. Depending on the organisation there will be different points of consent models and again part of the IG work stream have developed a consent model which will be adopted by all organisations. Once the Connected Care projected is implemented all organisations who are involved will be updating their websites to direct the person to the guidance around the consent to share model and the opting out process. Attached for reference is the consent model and the communication plan. Appendix 16. Connected Care Communication Plan Appendix 17. Connected Care Consent Model The ways in the which the changes will impact and support integrated services will be as follows: . Streamline and align business processes . Reduce duplication of information and data entry across multiple systems . Allow access to real time data for health and social care practitioners . Reduce the amount of time contacting multiple organisations for the appropriate information or the correct point of contact . The ability to create joint care plans across health and social care by using structured data across multiple systems . The ability to work mobile and more effectively with real time access to data . The roles and responsibilities will define that the appropriate teams will have access to the information they require to enable them to do their job rather than inundate them with lots of information they do not require.

	Currently the NHS number is not used as unique identifier across health and social care services. For Social Care in Slough the NHS numbers are collected for all new entrants to services and we are in the process of updating historical records through our review processes. We will also be implementing a tool to enable us to routinely check and match NHS numbers safely and securely pending completion of the IG toolkit to enable us to move towards getting an N3 connection which is required in order to implement. Currently the implementation is also limited by the support the HSCIC can give to authorities to provide this matching service and we not able to give a firm date by which this will be complete. The timeline for Slough BC being connected to the Connected Care interoperability interface with the NHS number is by March 2017. Appendix 17. Connected Care implementation plan
Joint Approach to Assessment Please identify which proportion of the local population will be receiving case management and named care coordinator and which proportion of the local population will be receiving self-management help - following the principles of person-centred care planning. Please demonstrate if you plan to identify dementia services as a particularly important priority for better integrated health and social care services, supported by care coordinators (for example dementia advisors). Please include a description of plans for health and social care teams to use a joint process to assess risk and plan care, and agreed milestones demonstrating how and when this condition will be fully complied with.	There is active complex case management of that cohort of people who are identified as being at risk of an admission to hospital (through risk analysis and case finding activity). These are currently offered time limited (3 month) regular GP appointments to proactive support in managing their long term complex conditions. The move towards having a named care co-ordinator is captured and described within the New Vision of Care model which each area across the East of Berkshire is signed up to. Within our planned approach to integrating short term services ('Out of Hospital transformation') we are describing within our deliverables to have adopted a joint and trusted assessor approach through this process. The BCF supported a Dementia Care Advisor in last year and had been built into the expenditure plan to continue funding through 2016/17. The advisor provides advice and support for people diagnosed with dementia, their carers, family and friends. This information includes: • local support services • getting a break • legal planning • support for carers • living well with dementia

	• national support services • money matters Slough also has a dementia action plan for delivering improvements to diagnosis and support and the experience of people with dementia in care homes. Appendix 18. Slough Dementia Strategy – key actions 2014-16 Appendix 19. Slough Dementia JSNA 2015
Agreement on the Consequential Impact of Change Please describe how the impact of local plans has been agreed with relevant health and social care providers and whether there been public and patient and service user engagement in this planning, as well as plans for political buy-in. Your response should demonstrate that these align to provider plans and the longer term vision for sustainable services. Please also articulate how mental and physical health are considered equal, and that your plans aim to ensure these are better integrated with one another, as well as with other services such as social care. You should also demonstrate clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans.	Please refer to 2015/16 BCF plan for public and patient engagement and involvement in developing our programme of change. In terms of overseeing the development of our BCF and engagement in delivery our acute trust provider has representation at our BCF Joint Commissioning Board. BCF Planning also forms part of discussions that take place at the Systems Leaders Group to ensure alignment across the system. In respect of provider plans, the Frimley Health operational plan for 2014-2016[1] states that "The impact of the Better Care fund and other National initiatives to reduce Hospital care will be felt through reduced patient volumes and associated income. Should these reductions exceed underlying growth (i.e. present a net reduction in activity for the Trust) then there will be a net reduction in income. There will however also be a reduction in associated cost, thus mitigating the financial impact of the change. The key task for the Trust will be firstly to continue to grow catchment to minimise any net reduction in income, and secondly to drive out as much associated cost as possible should there be a net reduction in activity." The Frimley Operational plan aligns with many of the key drivers for the BCF, including the development of a consultant delivered 7 day a week service, reducing delays in discharging patients through improved communication and discussion with social care teams. Previous sections explain how there is alignment between the overarching BCF plan, CCG operating plans and provider plans.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338357/FRIMLEY_Operational_Plan_14-16_1_.pdf

Agreement to invest in NHS out of hospital commissioned services Please detail your agreed plan for using your share of the £1 billion that had previously been used to create the payment for performance element of the fund, in line with the national condition guidance, linking back to the summary and expenditure plan tabs of your BCF planning return template. Please describe if you have considered whether a local risk sharing arrangement is required, supported by analysis of the likely risk of unplanned activity in the area based on their track record of performance. Please make reference to the consideration of the long term trend in admissions, and the success of schemes implemented to date. If a risk sharing arrangement has been agreed please explain how the decision was arrived at, and illustrate the conditions are appropriate and consistent with guidance. For NHS commissioned out-of-hospital services, and services that were previously paid for from funding made available as a result of achieving your non-elective ambition, please confirm if these continue in a manner consistent with 15-16 and provide evidence to support any changes to service provision from 15-16 plan.	There is £1.649m within the 2016/17 plan for NHS commissioned out of hospital services (Tab 2 on summary template). Investment has been identified in this year for our 'Out of Hospital Transformation' programme which will see further integration of our local short term services and is a major workstream for our 2016/17 plan. Currently Slough community care services are provided by both Slough Adult Social Care and Berkshire Health Foundation Trust, providing a range of bed based, community based and home based services. These are: 1. Slough Borough Council: Recovery, Rehabilitation and Reablement Services: • Occupational Therapy and Physiotherapy • Rehabilitation (home based) • Reablement (home based) • Recovery & Reablement (bed based) • End of Life 2. Berkshire HealthCare Foundation Trust • Intensive Community Rehabilitation (2 weeks- community) • Assessment Rehabilitation Centre (community) • Recovery & Rehabilitation (bed based with nursing) The core objectives from both services are to : - Manage increased patient complexity in the community - Offer step up and down responses, to prevent hospital/residential admissions, - To facilitate timely discharge - Decrease the levels of ongoing reliance upon statuary services, through promoting independence - Improve patient choice and control, and satisfaction of what and how services are delivered to meet their outcomes - Delivering services closer to home - Support to patients to remain in their own home during a period of rehabilitation and assessment; increasing the opportunity to maximise independence and reduce the numbers of long term care

	Within our original 2015/16 BCF plan Slough committed to achieving a 3.5% reduction in NEL admissions through its BCF. There has been encouraging signs of positive impact through delivery of our first year's programme although we did fall short of our target overall. For 2016/17 we have aligned our NEL activity with that of the CCG Operational Plan (see page 3-4) and identified a risk share of £542k within the BCF against a 2% increase in NEL activity. Further detail is to be agreed on use of the risk share should BCF successfully impact and contain an increase to under 2% . This will be included in our s75 Pooled Budget agreement. Throughout the development of the 16/17 BCF planning and submission processes, there has been close dialogue and liaison with the parallel development of the CCGs' operating plans and supporting financial models. This collaborative approach has taken into account a number of new and historical considerations including: • National requirements of the 2015/16 funding streams, particularly those associated with the NEA admission targets. These established the parameters of each local contingency fund relating to the 3.5% NEA targeted improvement for the 15/16 period • New 16/17 national CCG planning assumptions reflecting the Integrated Hospital Activity Model data (IHAMS) • Impact on NEA data recoded using SUS data sources rather than MARCOM • Impact of local population data which is reflected in the HWB/BCF footprint and overlay with CCG data sources It is recognised that all these changes create a complex platform on which to establish a clear year on year position and basis for monitoring the future delivery of both operating plan objectives and BCF targets. There is an expectation that continuing pressure from 15/16 will be carried forward into 16/17, particularly on NEAs. The plans reflect joint working to mitigate and manage increased demand for services within a common financial envelope. Meeting both QIPP objectives and individual BCF plans and work streams is recognised as being key to the success of all stakeholders. Each Better Care Fund will continue to reflect a tailored contingency arrangement which has

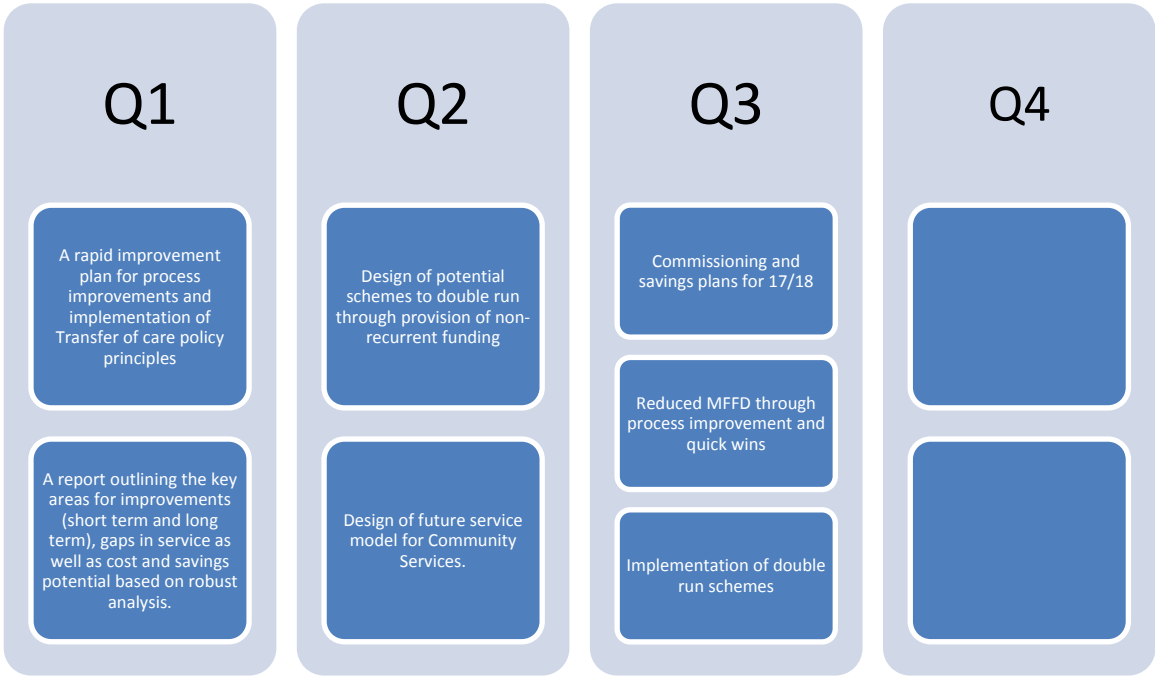
	been reviewed and aligned to the new reporting requirements and data gathering processes. Substantial Improvement to the data monitoring mechanisms is in hand to ensure that improvements to performance are captured, analysed and understood at a level of detail not previously provided. This will enable individual BCF and the partner CCGs to recognise the impact of improvement programmes, their sustainability and the platform of progress/baseline from which the improvement measures are being gauged. This will promote opportunities to enhance: • piloting of innovative projects and subsequent upscaling to maximise benefits • benchmarking performance between areas and • access to best practice • reconciliation with other measures that will reflect consequence of change • contract management discussion with key providers As 16/17 unfolds, the performance will be mapped and decisions can be made at individual BCF level to manage its local contingency arrangements within the context of the local and regional context.
Agreement on Local DToC Plan Please provide assurance, with supporting evidence that you have established a stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. Please describe how your plan sits within the context of an overall plan across the health and care system to improve patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge)? Please confirm your target is reflected in the relevant CCG(s) operational plan, and that you have considered	DTOC plan for 2016 – a whole system approach An East Berkshire wide transformation programme to improve performance on DTOC and transform our 'Out of Hospital' services and care pathways is being developed together with providers partners and other stakeholders. This will that ensure a coherent narrative be adopted between acute trust providers and all 3 CCGs. More information will be available on this as the project develops during this year. Within the our project for the development of our DToCs improvement plan there are three main objectives: 1. Comprehensive Berkshire East review of short term services which prevent admission and support appropriate early discharge form an acute setting 2. Reduction in Medically Fit patients waiting for discharge within Frimley Health (WPH).

the use of local risk sharing agreements with respect to DToC, with clear reference to existing guidance and flexibilities and with reference to the track record of current performance In agreeing the plan, please detail you methods of engagement with the relevant acute and community trusts and confirm that the plan has been agreed with your providers. Please also detail any engagement with the independent and voluntary sector Please demonstrate clear lines of responsibility, accountabilities, and measures of assurance and monitoring, taking into account national guidance and best practice (as set out in technical guidance)	3. Re defining services required to sustainably manage flow through the wider health and social care system Re-basing 'medical fit for discharge' to 'medically fit for transfer' will benefit the wider health and social care system as long as joint community services are able to provide the ongoing care and support; proactively and rapidly respond to individual patients; move from 'assess to discharge' to a model of 'discharge to assess'. The opportunity is clear. As acuity of patients increases, the flow through the system will continue to be challenged. This will lead to disrupted patient flow, with people not receiving the right care in the most appropriate environment. Failure to address potential capacity issues within the community outside of the hospital will also lead to continued blockages and affect the quality of care received across health and social care. **Baselining** The programme will be undertaking a robust analysis of the health and social care system; along with the wider provider market which includes understanding patient flow within care with nursing; residential and the homecare providers; along with housing. This analysis will describe the market; current process; the reasons for admissions, tipping points into care (included LA funded support), delays in system -wide patient flow and activity levels, gaps and opportunities. In order to achieve the objectives and outcomes based on firm evidence, rapid analysis and information gathering will need to take place. This will include but not be limited to: – MFFD analysis for East Berkshire (All hospitals) – Analysis of WPH /FPH data (also need to include all other areas including A+E) – Admissions data/ including the 'tipping' point into statutory services – Occupancy rate – Dependency levels (if we can) – Readmission Data – DTOC data – Service Reviews – Review of BCF arrangements across east Berkshire – Review of contract arrangements – both health and social care – Analysis of Discharge policy against current practice (Gap Analysis) – Pathway process mapping, which includes discharges from A+E. – Clinical audit input

- System Workshops
  - Issue Identification
  - Solution Generation

From the analysis, it is expected that short term solutions and process improvements should be achievable as immediate actions. These will start the process of reductions in MFFD. For more complex discharge issues, a more robust Root Cause Analysis work will be required.
The main aim for the end of the first quarter to re configure the hospital; creating a step down nurse led ward with the associated tariff. This ward will accept at point of discussion to transfer and then complete discharge arrangements eg TTA's ; transport; nursing home assessment etc.

Appendix 20.Slough DTOC Plan 2016



Scheme Level Spending Plan Please confirm if your scheme level spending plan, submitted as part of the BCF Planning Return template, accounts for the use of the full value of the budgets pooled through the BCF.	Yes. The scheme level spending plan has been completed in planning return template and accounts for the full value of the minimum pooled budget required.
National Conditions If you have not already done so, please include here an explanation of how the targets against the National Conditions have been set, and your plans for how these targets will be met, and whether they represent a realistic assessment of the impact of BCF initiatives on performance in 2016-17.	Targets reflect the performance of our BCF in year one and our ambition in year two to continue improving our performance against the BCF metrics whilst delivering transformational change in the way in which services are delivered in Slough. Metrics and target performance activity against these has been discussed and agreed through both the BCF Delivery Group and the Joint Commissioning Board meeting on 25 April. **NEL ambition** has been covered above (pages 3-4). Whilst we will continued to track and monitor performance against NEL admissions there is no target for reduction in BCF as it is now aligned with the CCG Operational Plan. **Residential Admissions** Sloughs forecast outturn for 2015/16 for residential admissions has been slightly lower than target (72 against a planned 77). We are committed to improvement in the rate of admissions against our plan for 2015/16. Numbers of admissions for Slough are low and small changes in activity can make marked difference to the annual rate. Historically Slough has been high on this indicator but has improved in successfully reducing admissions to care homes since 2012/13. Our ambition is to maintain this good performance against an increasing population and an increase in those who present with complex needs. We will support more people at home through DFGs, equipment and reablement support, providing short term support when

	required and not making decisions about long term when in acute hospital. **Reablement** Slough has been high performing in terms of its reablement activity for older people in recent years. It was our ambition in 2015/16 expand the reach of the service and offer reablement to a greater number of older people discharged from hospital. We acknowledged that our success rate would drop against a larger cohort of patients but the denominator increased significantly more than anticipated. Our 91 day indicator has reduced further as a result to 88%. For 2016/17 we plan to maintain our higher level of activity but with this regain a higher success rate of 90%. **Delayed Transfers of Care** Our DTOC activity in 2015/16 has seen significant variation between quarters. We aim to reduce this variation and reduced our average rate per quarter over the year from 555 to 429. This requires achieving actual target activity of 470 reduced bed days per quarter (per 100,000 of people 65+) or better. **Local Metric** We have chosen to change our local metric in this year from 'Average EQ-5D (health related quality of life) score for people reporting having one or more long-term conditions' to 'Confidence in managing own health'. Both of these are metric related to the GP patient survey but following discussion at the Delivery Group and the Joint Commissioning Board it is agreed that the confidence indicator is a better indicator of the outcome we are aiming to achieve for people in terms of having access to good access to primary care, good quality information and advice when needed and being proactively supported to manage health conditions. There are a number of BCF and other related activity that support improvements against this measure which includes: • Early Help • Complex Case Management • Telehealth and telecare • Information and advice • Community navigators

Metric : GPS33 Confidence in managing own health - confident (total)	Effective proactive management of people with long term and complex health conditions. Evidence of impact of a move to self care, complex case management, access to information and advice, innovative and flexible ways of support.
Rationale	This is an important marker of the effective shift towards people being empowered and supported to better manage their own health. It fits with the Slough BCF workstream of Proactive Care
Definition	The percentage of patients who respond to their GP survey question 33. "How confident are you that you can manage your own health?". It includes all patients who answer the question and responds as either 'very confident' or 'fairly confident'.
Source	GP Patient Survey
Reporting schedule for data source	Frequency:

		GP Survey every six months Timing: 6 month lag Baseline: January 2016 baseline rate of 90%

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SLOUGH WELLBEING BOARD - ATTENDANCE RECORD 2015/16

MEMBER	13/05	15/07	23/09	11/11	21/01	23/03
Naveed Ahmed	P	Ap	P	Ap	P	P
Cllr Rob Anderson	P	Ap	P	P	P	P
Ruth Bagley	P	P	P	P	P	P
Simon Bowden	Sub (Cl Wong)	Sub (Cl Wong)	P	Sub (Cl Wong)	P	Sub (Cl Wong)
Cllr Sabia Hussain	P	Ap	P	P	P	P
Ramesh Kukar	Ap	P	Sub (Jesal Dhokia)	P	P	P
Lise Lllewellyn	P	P	P	P	P	Ap
Jim O'Donnell	Sub (Carrol Crowe)	Sub (Dr Iyer)	Ab	Sub (Sangeeta Saran)	Sub (Sangeeta Saran)	P
Les O'Gorman	Ap	P	Ap	P	P	Ap
Dave Phillips	P	P	P	P	P	
Colin Pill	P	P	P	P	Ap	Ap
NHS England representative	Ap	Ab	Ab	Ab	Ap	Ab
Jane Wood	Sub (Alan Sinclair)	Sub (Alan Sinclair)	Ap	Sub (Alan Sinclair)	Ap	
Iain Harrison						Ap
Alan Sinclair						P
Krutika Pau						Ap

P = Present
Ap = Apologies given
Sub = Substitute sent
Ab = Absent, no apologies given

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