FINAL – Friday 19 Sept 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

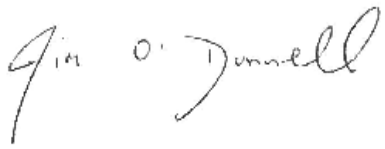
1) PLAN DETAILS

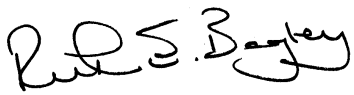
a) Summary of Plan

Local Authority	**Slough Borough Council**
Clinical Commissioning Groups	**Slough CCG**
Boundary Differences	Slough GP practices are coterminous with the Local Authority Borough but we recognise the CCG will be responsible for patients registered to practices outside the borough, especially in Windsor and Buckinghamshire. Links through Urgent Care Boards across systems will enable effective alignment to take place across these boundaries linked to the Better Care Fund.
Date agreed at Health and Well-Being Board:	**To be agreed at 24 September**
Date submitted:	**19 September 2014**

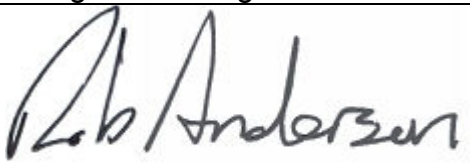
Minimum required value of BCF pooled budget: 2014/15	**£2.280 million**
2015/16	**£8.762 million**
Total agreed value of pooled budget: 2014/15	**£5.612 million**
2015/16	**£8.762 million**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Slough CCG
By	 Dr Jim O'Donnell
Position	Chair, Slough Clinical Commissioning Group
Date	17 September 2014

Signed on behalf of the Council	Slough Borough Council
By	 Ruth Bagley
Position	Chief Executive
Date	

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Slough Wellbeing Board
By Chair of Health and Wellbeing Board	 Councillor Rob Anderson
Date	17 September 2014

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Related documentation

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

Document or information title	Synopsis and links
Slough 5 year Strategic Plan	The five year strategic plan for the Slough Clinical Commissioning Group
Slough 2 Year Operational Plan 2014-16	The two year operational plan setting out how Slough CCG will commission for its local population working together with stakeholders.
Everyone Counts – Thinking Locally, Working Together. Strategic Plan 2014-15 to 2018-19	Strategic Plan for the three CCGs, three local authorities, three hospital trusts and Berkshire Healthcare Foundation Trust.
Call to Action Plan	This sets out plans of our engagement events in Slough that inform our strategy and this Better Care Fund plan
Joint Wellbeing Strategy	This document sets out the vision and priorities for the Slough Wellbeing Board
Joint Strategic Needs Assessment	This document details the health and wellbeing needs of the Slough population as well as basic population demographics and wider determinants
Slough Commissioning Strategy for Older People	This strategy identifies the commissioning priorities for Adult Social Care. Based on strategic commissioning principles and best practice it proposes specific actions to transform social care and the range of services commissioned.
Carers Strategy	The refreshed Joint Carers Commissioning Strategy sets out the shared vision and commitment by Slough Borough Council to support the health and wellbeing of Carers (including young carers) living in Slough over the next three years.
Safeguarding Adults Strategy	The strategy set out the legal framework for safeguarding adults and how the Safeguarding Adults Partnership Board will keep adults safe through the shared vision, priorities and actions set out in this three year strategy.
7 day working development	Outlines Slough's bid for the development of seven day working
Prime Ministers Challenge Fund	Proposal for transforming the delivery of General Practice in Slough.
Dementia Plan	This strategy outlines the priority actions for meeting the health and social care needs for people living with dementia in

	Slough
Integrated Care Team Project Plan	Joint Project plan
Winter Preparations and Urgent and Emergency Care Recovery Plan	These documents describe our approach to joint working through urgent and emergency care and Slough's winter periods.
Model of care – Long term conditions	This document outlines a service model for long term conditions
Urgent Care Strategy	This document outlines a service model for urgent care.
Positive Possible Future Plan	Report on community engagement event on keeping well and living life to the full in Slough 2019 and beyond.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

This section includes:

- ✓ **How we developed our vision**
- ✓ **About Slough and our JSNA**
- ✓ **Our 5 year Vision**

How we developed our vision

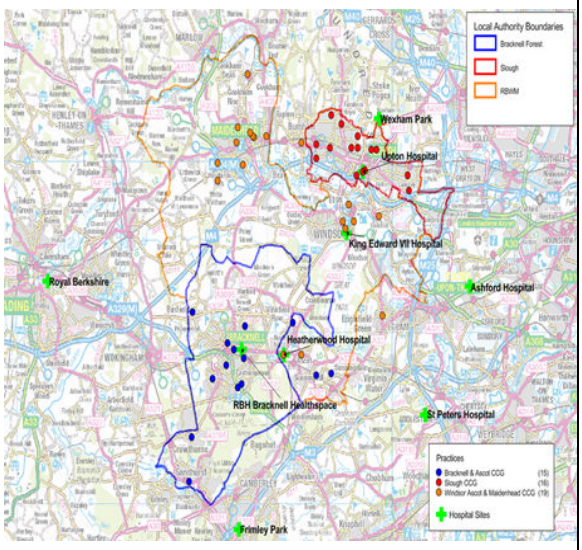
Our local vision for health and social care services in the Slough Borough is built on our strong engagement to date and feedback on what local people want to see and on what is important to them**.**

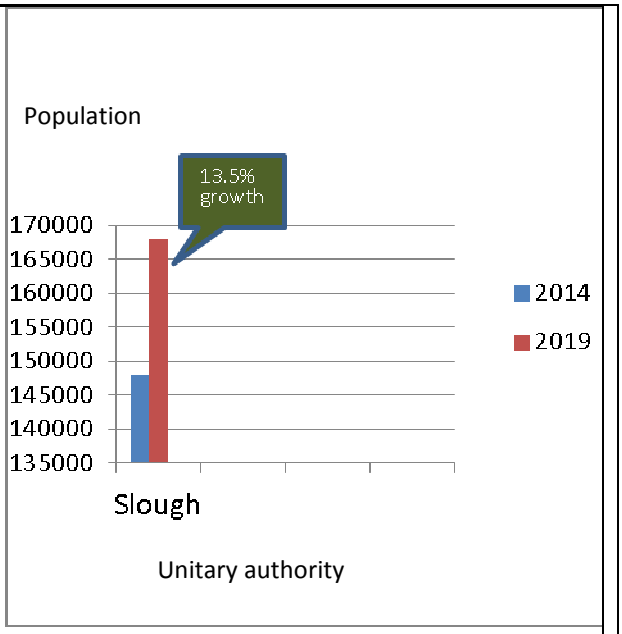
Slough's Health and Wellbeing Board launched the public consultation for its integration strategy at a system wide conference in Slough in January this year. The strategy took account of the local health and wellbeing needs identified through the JSNA and was the culmination of a number of strands of engagement work including extensive consultation with the local population on the Slough Joint Wellbeing Strategy 2013-2016.

The consultation invited views from members of the public, professionals, service providers, and members of the community and voluntary sector. (See Section 8. Engagement for further detail)

About Slough

Slough covers an area of 32.5 square miles most of which is urban; it has a registered population of 143,343. It is the most ethnically diverse local authority area, outside London and is home to a diverse community from over 80 different countries who live and work together harmoniously. Slough is a multicultural town with 50% of its adult residents and 31% of its older people from a black minority or ethnic background. Slough is socio-economically deprived in comparison with its neighbouring boroughs, Bracknell Forest and the Royal Borough of Windsor and Maidenhead. It is ranked 93/326 local authorities in terms of the Index of Multiple Deprivation with 13% of Slough's neighbourhoods being in the 20% most deprived areas of the country.





Our JSNA 2012/13 revealed that Slough has the fifth highest birth rate in England with 56.4% of all births in Slough to women whose country of origin is not the UK. The projected growth of people aged under 16 in Slough, over the next five years, is 8.06% with a total predicted growth of 6.45%.

In addition and most significantly in terms of future demand on health and care services, the people aged over 85 in Slough are projected to increase by 27.03% over the next five years. This includes a significant ethnic population with diverse needs.

The general health of many local people is poor and many people in Slough experience more years of ill health and disability than average. The population of Slough experiences higher levels of circulatory disease, respiratory disease, tuberculosis, cancer and child health issues relative to other unitary authorities and overall Berkshire and England averages. The average life expectancy at birth for people in Slough is 82.7 yrs which is lower than the national average of 84.6 yrs.

The JSNA identified a number of population groups which are typically more vulnerable across the health and care economy. These are identified in the Slough Borough Council JSNAs and include children (on protection plans/in poverty/looked after children), NEETs (young people not in education, training or employment), older people living at home, those with learning disabilities or special education needs, those with physical disability and sensory impairment, gypsies and travellers, migrant workers and their children, veterans, homeless and offenders.

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

indicate a range from zero to 20 times a year per person.

The JSNA identifies specific and distinctive needs for children in Slough:

- 20% of all non elective admissions related to children. Slough CCG spends a total of £5.3m within HWP NHS Trust on paediatric services in which £3.12m is in non-elective activity, and paediatric admissions are above the England average with admissions for children with lower respiratory tract infections the highest in the country.
- 48.8% of children speak English as a second language and there has been a 39% increase in rates of looked after children in Slough since 2007.

As a consequence Slough Borough Council and the CCG will be placing a particular focus on Childrens services via the new BCF schemes.

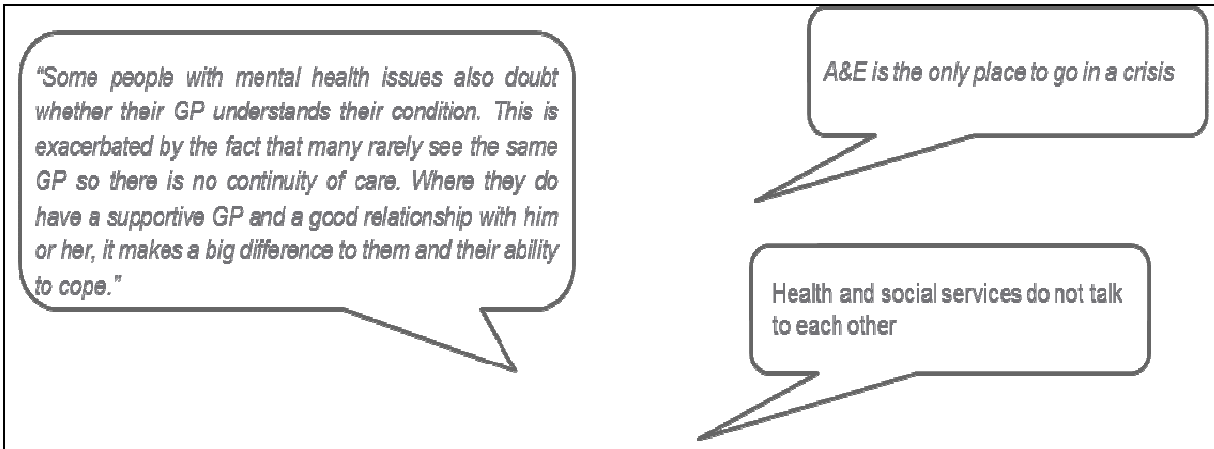
Our analysis is clear that in Slough the current pattern of health and care provision is not fit for purpose.

Slough has one main acute provider, Heatherwood and Wexham Park (HWP) Foundation Trust, which is struggling financially to cope with its demand and with quality concerns. Monitor data suggests that the Trust has the highest proportion of its income derived from non-elective activity of all the acute Trusts in England. Furthermore, data suggests Emergency Department attendances at HWP are rising. HWP has failed to meet the required essential CQC standards and has been subject to enforcement actions. It has consistently failed to meet ED waiting targets and has a vacancy rate of 10% which has resulted in significant spend on bank and agency staff. Currently, Frimley Park Hospital NHS Foundation Trust is preparing a full business case for the acquisition of HWP as part of a local strategy to address HWPs quality issues and longer term sustainability.

In terms of primary care provision a recent study by the Royal College of General Practitioners found that Slough currently has among the lowest number of GPs in England, with 22 GPs per 100,000. This has resulted in increased presentation to the A&E department at HWP (see section 4. Case for Change annex).

Taken together these factors are leading to an inappropriate utilisation of hospital based care in Slough and in particular a high rate of A&E attendances and NELs.

Our challenges and our vision for the future of health and social care in Slough, have been shared with and informed by patients, service users and members of the public, who have shared their experiences of local health and social care with us as well as their aspirations for the future. They have spoken of fragmented care and of the difficulty in accessing care.



In summary therefore it is inevitable that the local health and care economy in Slough will face substantial demand and financial pressures in the coming years. Our analysis is clear that it is not currently meeting the needs of residents as recipients of care and as taxpayers. The decreases in the annual financial envelopes and the increased demand for services are predicted to continue to rise, with both an increasing birth-rate and a growing older population. The current pattern of health and care provision is not fit for the challenge of meeting these demands, and will need to change in order to meet these challenges and the needs of our residents.

Our five year vision

Slough thrives as an exciting and diverse town with people from all around the world who choose to live and work here, and whilst we are proud of the success the town achieves we are also aware of the social and economic challenges that this diversity brings.

Our local vision for health and social care services is built on strong engagement to date and feedback on what local people want to see and is important to them. Key to this is the provision of appropriately culturally sensitive services. Our Health and Wellbeing Strategy therefore sets a clear direction; it states that by 2018, Slough's residents will be healthier, with reduced inequalities, improved wellbeing and greater opportunities to live positive, active and independent lives. Together with our residents and stakeholders we have developed the following overarching vision statement for health and care in Slough;

"My Health, My Care:
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. And our vision will see us increasingly delivering services through integrated care teams including locality based teams clustered around GP practices, as well as across a wider range of health and social intermediate care and reablement services. In the medium term we will build community resilience to enable our residents and diverse communities to start well, live well, and age well in their homes, schools and communities.

Pilot teams are already established for many of our BCF schemes and case studies are already demonstrating good outcomes for Slough people. Our JSNA is clear that our vision needs to focus on the frail elderly population, those with long term conditions and on children.

And whilst our components and within them our BCF investments are articulated below as distinct schemes, their development will take place in tandem and they all share a common set of strategic objectives (see Service Appendices).

We have formulated our overall vision and associated BCF investments, within the following four overarching programmes:

- **Proactive Care**
  Adults
  Our vision for proactive care in Slough envisages a shift to a systematic identification of vulnerable patients and those at risk. We will use risk stratification tools to proactively identify patients who require more intensive support so that we can support people to receive the right care at the right time in the right place. This will include supporting self care particularly for those with long term conditions, with the provision of information and advice and signposting so that it is not just a route in to services. The proactive approach builds on our use of risk stratification and our intention to increase the number of NHS Health Checks for people aged over 40. We will expand our pathway improvements across a range of long term conditions building on local successes with Diabetes and learning from our proactive approach to reducing falls in Slough. We will roll out improvements in cancer screening, efforts on smoking cessation, uptake and management of familial hypercholesterolemia among women. The key to proactive care will be a seamless access and response from joined up health and care teams to meet the needs identified.

  Children
  This programme will focus on the identification of children in our community who are most vulnerable and those with long term conditions, using risk stratification tools. It will take a proactive approach to supporting them with more accessible assessments and appointment times, an accountable professional, active follow up and condition management support, such that children are receiving appropriate care and support earlier on, preventing unnecessary attendances at A&E and admissions to acute care. The support would extend to siblings in families who also share similar long term conditions. Proactive care will focus on asthma management given that Slough has one of the highest rates in the country for children's asthmatic admissions.

- **Accessible Care - A single point of access**.
  We will establish a single contact point (with a single phone number) for professionals to have a quick response and gain access to a range of short term health and social care services that will support those in crisis and direct them into the right services in a co-ordinated and timely way. These schemes will work to streamline and improve access to a range of community based services via a common entry point across health and care. In this way we will seek to avoid unnecessary attendances and admissions to A&E, and facilitate timely discharges. A common point of access will allow us to develop an increase in flexibility across the use of services including the new 7 day a week service offer covering health and social care.

- **Integration: Every patient to receive a coordinated service.**
  Our vision for integration in Slough is to ensure that all patients in Slough receive joined up health and social care. The Integrated Care Programme embraces and enhances a range of existing and new services which share a strategic objective of strengthening the availability of community based services in Slough, whilst reducing the fragmented nature of the care provision. The focus will be to support patients with maintaining and promoting independence, avoiding admissions and supporting patients back into the community following acute care.

- **Community Capacity – building resilient people, communities' people and places**

We understand that focusing on statutory service provision on its own in Slough will not be enough to deal with future pressures. Our vision for integration relies on Slough residents and communities being increasingly able to take control of their own lives and working with health and care professionals to jointly plan their health and care needs. Our community capacity schemes will support this ambition. Through the Care Act and BCF programmes Slough will continue to take a strategic approach that sees better engagement with the community and voluntary sector in what it offers in terms of prevention, information and advice and community based support.

Infrastructure and Enablers

To achieve our vision for integration we understand that effective leadership is key to the implementation of what are complex change programmes. The projects in our Enablers theme focus on processes to ensure that integrated systems will enable the delivery of project outcomes. There will be a focus here on leadership and Information Technology developments to facilitate information sharing, workforce development and support for delivery of projects.

b) What difference will this make to patient and service user outcomes?

The case for major, transformational change is compelling. Slough's current initiatives do not provide a sufficient response to the challenges of demographic change and financial efficiencies. Over the next five years, the configuration and pattern of services will be changed significantly and by April 2018, people in Slough will be able to say:

What difference will that make to patients	**BCF Project**
'We have access to a range of support that helps us to choose to live the life we want'	*BCF01, 07,09*
'We are supported to achieve our goals and take control of our care and support needs'	BCF 01,04,17
If we have questions about our care we know who to contact'	BCF 11
'We have information and support to remain as independent as possible'	BCF 01,11
'We take responsibility for our health and our care'	BCF 07
'We have support for any carer(s) involved in our care'	BCF 17
'We are involved in discussions and decisions about our care and treatment'	BCF 04
'We have someone we trust so that we can get help at an early stage to avoid crisis'	BCF 04

Through the integration of health and social care, our Better Care Fund schemes and programme aim to deliver the following outcomes for Slough residents:

- Reduce avoidable emergency admissions to hospital by 3.5% year on year

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

The Slough *BCF and Project Outcomes Map* in **Appendix X** illustrates the link between each of our BCF initiatives and the intended outcomes**.**

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Over the next five years, the pattern and configuration of services will be changed in Slough in order to build health and social care capacity to better respond to the local health and social care needs and to provide consistent, high quality personalised support to people to live positive, active independent lives. The current provision of both primary and acute care will change as will the nature of social care provision. The BCF will be critical to this as this change will rely on the roll out and utilisation of a range of new community based services and a new model of integrated working. The BCF schemes are focused on the person and aim to address the multiple needs of individuals through better joined up work sharing of information and integration. The BCF is therefore a key component to delivering not just the health commissioners' integration plans, but also the Slough Borough Commissioning Strategy for Older People 2013-18 and the overall Wellbeing Strategy. The changes we envisage across our overarching schemes are as follows:

Proactive Care
Changes in the pattern of care under this scheme will result in better and earlier identification of susceptibility to disease or exacerbation, alongside joined up management of conditions though targeted risk stratification that takes account of

health and social care needs.

It will also see a change to and expansion of the range of services and resources available to residents providing information, advice and support to enable residents to manage their conditions and to remain safe and independent for as long as possible. This will relate both to children and adults. Greater access to and satisfaction with primary care is a key aim and we expect the pattern of provision in primary care will change significantly through the 7 Day working project. We expect to see a subsequent impact on the pattern of usage on A&E and emergency admissions.

Proactive Children will focus on early years and preventative children's services in order to make a significant reduction in reliance on hospital paediatric care. It will see the integration of the commissioning and provision of early years services across health and care with the transfer of 0-5 commissioning responsibilities to Slough Borough Council in October 2015.

The key success factors here are;

- *Improve patient and user experience of health and social care services*
- *Increase the proportion of patients who feel supported to manage their long term condition*
- *Increase number of people with a health and social care personal budget*
- *Reductions in adult A&E attendance and non elective admissions to acute care*
- *Reductions in Childrens A&E attendances and admissions to acute care*

Improving Access – A Single Point of Access

These schemes will work to streamline and improve access to a range of community based services via a common entry point across health and care. In this way we will see care becoming more responsive and prevent people from escalating to higher levels of dependency or crisis point. We expect this to contribute to a changing use of acute care including facilitating timely discharges, through developing an increase in flexibility across the use of services, using the new 7 day a week service offer covering health and social care. The common point of entry or Hub will ensure that people can access the appropriate services quickly in the right place, rather than defaulting to the local hospital.

The key success factors are:

- Reduction in avoidable admissions
- Reduction in delayed transfers of care
- Improve mortality and morbidity statistics for CVD, respiratory, stroke and heart failure
- *Reduction in admissions to long-term care*
- *Reduction in the use of residential settings for intermediate care and rehabilitation*
- *Care at the right time and place*
- *Reduction in the number of people attending A&E/Walk in Centre services*
- *An improvement in the safeguarding and support to vulnerable adults and children in our communities*

Integrated Care

Making integrated care happen will not be easy and will need considerable focus of our efforts in Slough. Well-developed integrated services particularly for older people are critical to delivering the changes in the pattern of use we are seeking in Sough. Better coordination of services through our BCF investments will see an extension of case management for the complex and high risk through our locality teams, which

alongside a strengthening of intermediate care services (reablement, recovery rapid response) will lead to changed pattern of service use and greater user and patient satisfaction with services.

We know it is not just about integrating services however. These BCF schemes will support the development of new ways of working across community based health and care teams and with providers and commissioners. The enablers will be key to the success of our schemes; shared leadership, integrated commissioning, joined up front line teams, innovative skill mix across health and care; aligned financial incentives; the ability to share information. Progress with these enablers will support the new way of working such that integrated care becomes the norm, supported by integrated health and care systems and processes.

The success factors here are:

- *Increase in integrated community support services between health and social care*
- *Reduction in avoidable admissions for adults and children*
- *Reduction in delayed transfers of care*
- *Increase in service user satisfaction levels*
- *Reduction in admissions to long-term care*
- *Reduction in the use of residential settings for intermediate care and rehabilitation*
- *More effective use of resources through integration of staff roles*
- *Increase in developing alternative residential rehabilitation models in the independent sector*
- *Reduce permanent admission to nursing and residential care for over 65s*
- *Maintain the good performance of older people at home 91 days after discharge from hospital care into reablement*
- *Ensure all patients have a choice of place of death*

Strengthening Community Capacity

The changes we envisage as a result of our investments in community capacity will result in a new way of engaging with our communities in Slough, within the context of increasingly changing population needs, changing expectations and a reduced capacity within the statutory care sector to respond to needs. Our plan therefore aims to build community capacity across and within Slough's diverse and multicultural communities with the voluntary and community sector and the private sector and with Slough's many faith groups. We are clear that we can create more community based environments which are innovative and person centred and which support people within a place and a community to increase individual resilience. We will use partnership engagement through our Local Healthwatch, Health and Wellbeing Boards and Clinical Commissioning Groups, whose key role is bringing together local commissioners to agree integrated ways of improving local health and well-being. It is our intention to jointly commission new outcomes based services with the voluntary sector in order to contribute to these aims.

Aligned to this will be our plans to tackle the social determinants of health led by the Slough Public Health department with a focus on reducing some of the long term drivers of ill health which in Slough include Childhood Obesity and high rates of smoking.

The success factors are:

- *Reduce the proportion of patients falling into crisis and needing preventative statutory services*
- *An increase in reported well being amongst the residents in Slough*
- *A reduction in the reported incidence of mental health problems*
- *Increase in the range and quantum of voluntary and charitable activity in Slough*
- *Reported improvements in partnership working in Slough amongst the voluntary,charitable and business partners.*

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

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In this case for change we will present:

- The health and social care challenges facing Slough, including the specific challenge presented by Slough's rapidly ageing population
- Slough's approach to tackling its challenges - by advancing integration and an evidence base for this
- The rationale for selecting our BCF schemes and the benefits we are seeking through advancing integration

---

- **The health and social care challenges facing Slough**

Slough has used a number of sources and tools to identify its major challenges. This has included a recent fact pack from Mc Kinseys, a detailed analysis of non elective admissions by health care resource group, use of the Adjusted Clinical Groups risk stratification tool (which also underpins) the work of general practice and the Integrated Primary Care Teams in identifying patients most at risk, results of an audit on non-elective short stay admissions at Wexham Park in 2013 and an audit of people accessing re-ablement services. The Joint Strategic Needs Assessment also provides population based information.

Drawing on this information we have assessed the major challenges facing Slough's health and care system to be as follows;

- 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, tuberculosis and cancer. Rates of Diabetes, Dementia, Strokes, and mental health problems are also on the rise in Slough.
- 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 fifth highest 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 HWP
- Rising citizen expectations around the quality and location of care
- Financial constraints as healthcare sees only small budget increases, while social care sees significant decreases
- Saving requirements for adult social care of approximately 5% per annum over the next three years, requiring a fundamental review of the social care offering
- Challenging fixed points in the system, such as the troubled main acute provider HWP currently undergoing a complex acquisition process

In addition to these challenges our conversations with our population consistently tell us that we still face the challenge of providing better and more seamless care that is tailored to the individual, that is proactive, accessible and more joined up. At the moment we are not achieving this.

Before moving on to describing our response to these challenges the following sections add further granularity to two key challenges facing Slough which are the nature and scale of the financial challenge and the current overreliance on hospital based care based on a recent Mc Kinsey analysis.

The funding challenge

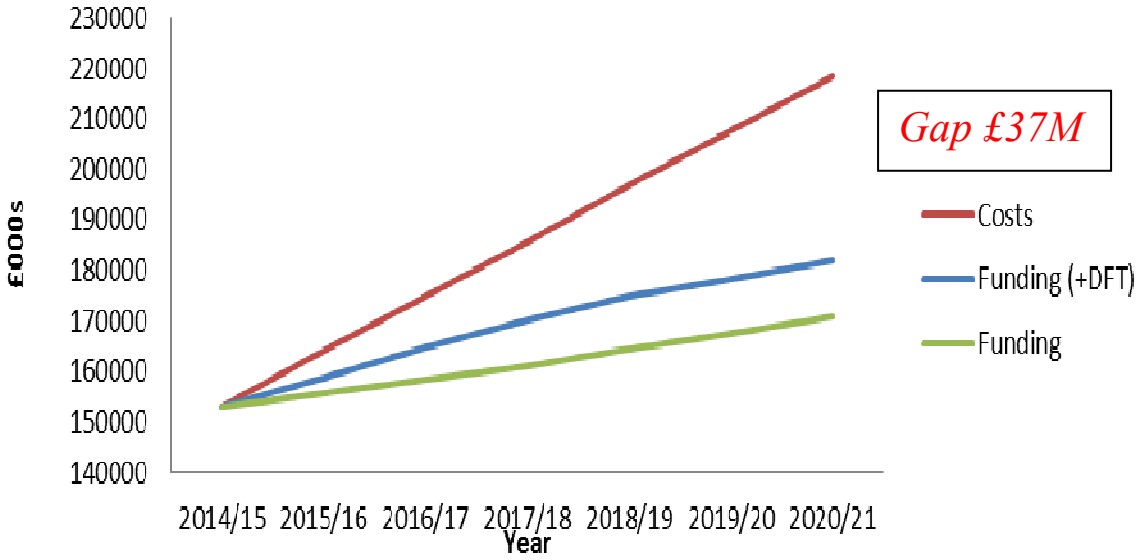
The charts below set out the scale of the health funding challenge for Slough which together with the scale of demand on social care presents an unsustainable picture unless radical changes in care patterns are achieved. Empirical analysis using proven modelling techniques has shown that, taking into account funding levels, population growth, and inflation, the financial gap for Slough's healthcare system could increase to at least £37m in five years if services were to stay as they are. Social Care in Slough faces a gap of similar magnitude. This gap could be even higher depending on the impact of demographics changes on health and social care costs. The chart below illustrates that if healthcare costs rise in line with projections the gap in five years could be of the order of £37m which together with the social care funding gap is not sustainable for Slough's relatively small health and care economy.

- The red line depicts the projected increase in demand
- The green line shows current funding assumptions

- The blue line indicates projected income following NHS England's revised funding formula

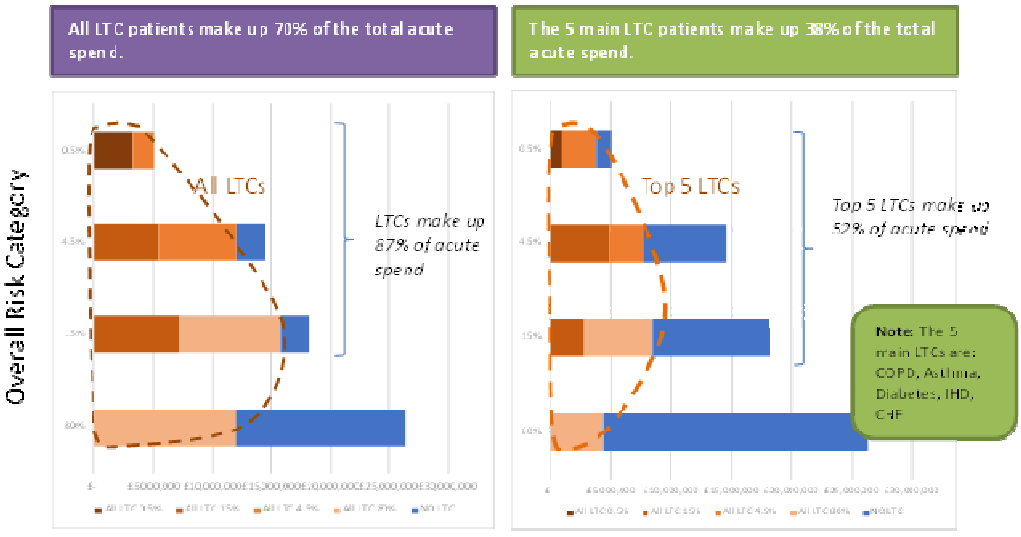
Figure 1: Financial projections for Slough CCG Source: CCG financial projections

-



The East Berkshire Federation has commissioned analytical research on the populations of the health system, to better understand which groups consume the most health resource. The research clearly demonstrated that across Slough, a small group of patients drive a significant amount of acute spending where the top 5% of very high and high-risk patients drive 31% of the total acute spend, with the top 20% driving 59% of the total acute spend.

Figure 2: Proportion of acute spend taken up by the main long-term conditions in Slough

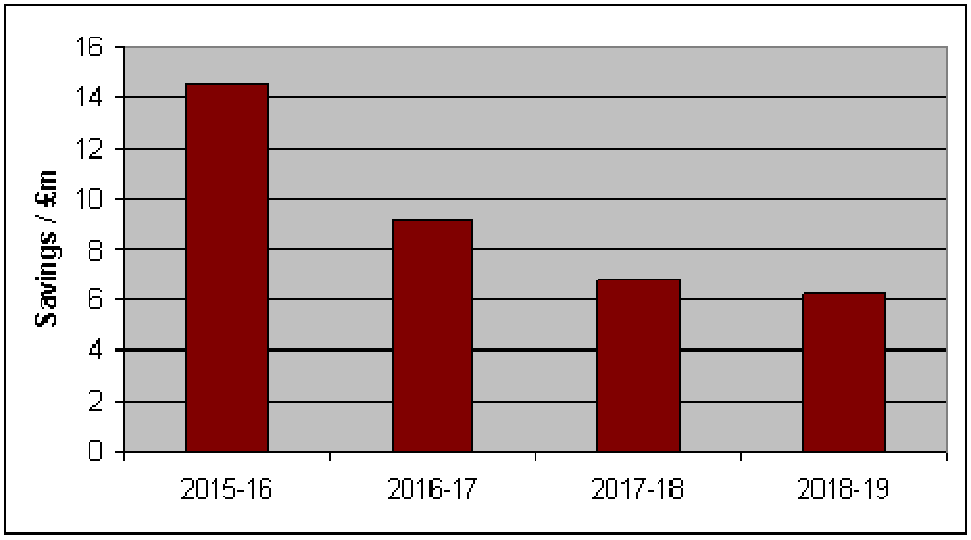


Social Care Funding Challenges

Local Government continues to see a sustained reduction in finances coming from Central Government. The 2015-16 financial year alone will see a reduction to the Council's general grant (Revenue Support Grant or RSG) of almost 30%, with the RSG forecast to shrink by 63% or over £20m over the period of the Medium Term Financial Strategy (MTFS).

The Council also has a significant number of costs pressures, and the Council is making very constrained forecasts about the impact of these; for example in the current MTFS there is no net increase in costs assumed from the impementation of the Care Act 2014.

The result of the funding reductions and cost pressures facing the Council is that SBC estimates making savings of £37m over the next four financial years of the MTFS. The profile of these is highlighted below. Due to the estimated profile of Government funding reductions, 2015-16 is anticipated to see the largest savings requirement.



Together with the funding gap for adult social care in Slough there is also a decreasing budget per head of population and a lower allocation relative to English councils. Slough is also:

- Border line lowest quintile English unitary authorities for social care related quality of life (2013/13)
- Border line lowest quintile in English unitary authorities for satisfaction of people who use services with their care and support

Seen alongside the previous analysis of Slough's poor access to and experience of primary health care, it is clear that the quality of basic health and care provision in Slough is lacking and is neither entirely fit for purpose now or for the future.

In addition the performance on the indicators such as hospital admission rates including for children with lower respiratory tract infections are the highest in the

country. A failure to meet ED targets at Wexham Park suggest that the system is struggling to manage demand at present, and is therefore not equipped to respond to the change in population. In addition, the health and social services are not configured to make best use of the resources available or the funding models. Consequently, It is critical that the right health and social care model is developed to meet the changing population and future funding models.

A closer look at hospital utilisations and Non Elective Admissions (NEL)

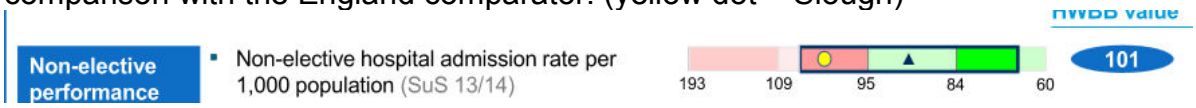
To understand our challenges in more granularity we have recently commissioned an analysis from Mc Kinsey with a focus on Slough's utilisation of hospital based care. The key findings are as follows**:**

Overall, Slough performs well on most quality indicators, but there is substantial room for improvement on NEL activity.

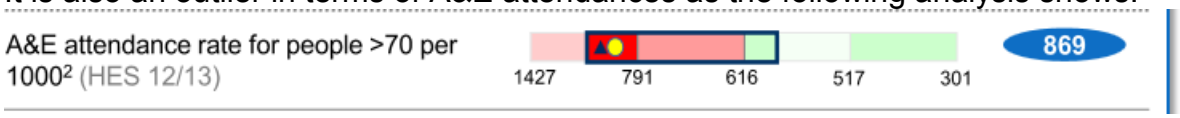
Findings of recent McKinsey Analysis of Slough's acute utilisation

- Slough significantly underperforms its peers on non-elective admission rate, and sits is in the third quartile nationally. Also, the NEL rate is growing at a rate of 6.1%, one of the highest in England, and its performance in NEL admissions for ambulatory care sensitive conditions is below that of the majority of its peers and the national average.
- In terms of quality of healthcare, Slough performs better than peers in rehab effectiveness and prevention of Fractured Neck of Femur, and is in the top quartile nationally for both of these indicators. It also matches its peer group performance in delayed transfers of care and is in the second quartile nationally.
- Slough underperforms its peer group and is in the bottom quartile nationally on the primary care experience.
- Slough outperforms most of its peer group in A&E and Outpatient Attendance rates and sits in the top quartile nationally in Outpatient attendance rate
- The indicative patient segmentation shows that Slough spends most money on the healthy adult (16 – 69) patient group.
- However, the groups where both the volumes and the average spend per capita are high are adults with 1 Long Term Condition, adults with 2 or more LTC and people >70 with 2 or more LTC. These groups are where integrated care is most likely to be beneficial and contribute the most in reducing non-elective admissions.
- Slough's main acute provider, Heatherwood & Wexham Park, has incurred deficits of £11m and £4m in 11/12 and 12/13 respectively, while providers nationally have had surpluses of ~1.5% on average.
- Slough's community care spend has been flat, while community care spend grew by an average of 12% among peers.
- The spend on primary care spend shrank in line with peers (-3% vs. -2%). However, the acute care spend grew faster than peers in 12/13 (5%vs.4%).
- An 11% increase in A&E spend, similar to that observed across the peer group, and 1% growth is observed in Payment by Results spend
- Slough's spend per capita is in line with peers in most components of healthcare. It is in the bottom quartile nationally on NEL and A&E spend (i.e. the spend per capita is much higher than the national average).

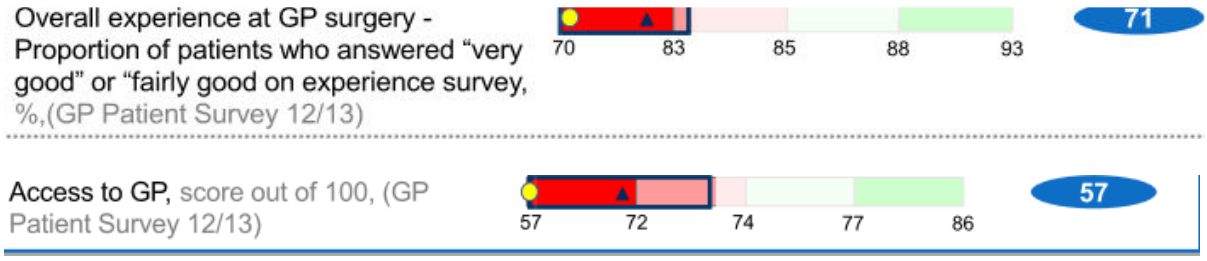
Further analysis shows Slough to be an outlier in terms of its peer group and in comparison with the England comparator. (yellow dot = Slough)



It is also an outlier in terms of A&E attendances as the following analysis shows:



This correlates strongly to the evidence of Slough patients' extremely poor experience of and access to primary care - which evidence suggests is leading to the high and inappropriate utilisation of Heatherwood and Wexham Park Acute services. A recent audit found that 86% of attendances to ED in Heatherwood and Wexham Park Hospital would have been best assisted elsewhere in the health and care system (See note on *Audit of attendances and Admissions at HWP*)



Finally we have identified specific evidence that Slough's rates of admissions in the following segments present significant opportunity for improvement:

- In 2012/13 Slough had 2190 emergency admissions for falls injuries per 100,000 people aged 65 and over. This is higher than the national figure of 2011 per 100,000 population.
- Paediatric admissions are above the England average with admissions for children with lower respiratory tract infections the highest in the country.
- Slough has a high rate of admissions for acute conditions that do not usually require emergency admissions and a high rate of unplanned admissions for asthma, diabetes and epilepsy in under 19 year olds.

So the main messages from this latest analysis confirm our assessment of the key challenges facing Slough as set out above. It confirms that our BCF plans will need to deliver a radically different pattern of provision in order to reduce reliance on inappropriate hospital based care and over time reduce reliance on health and care services generally. It identifies specific population segments and approaches based on evidence which are likely to prove successful and which are therefore reflected in our BCF initial tranche of projects.

- **Slough's approach to tackling its challenges - by advancing integration and providing the evidence base for this**;

Scientific evidence and multiple case studies have shown that integrated care can have significant positive impact on patient lives, outcomes and finances. Using the above predictive analysis and through extensive consultation with our community, patient groups and stakeholders Slough has put in place a range of BCF schemes to address our challenges under our four headline themes as follows:

PROACTIVE CARE – (BCF *Projects 1-7)*
Average Impact reduction in hospitalisation: Self Care 25-30%, -37% Care Coordination -23% Individual Care Plans (Source: Richardson Dorling Reviews of systematic review of integrated care Mc Kinsey)

- Actively supporting people to self-care through the provision of information, advice, and signposting to appropriate self-help support
- Using validated predictive modelling tools and regular locality multi-disciplinary team meetings, systematically identify those with frailty, escalating needs, and risk of deterioration
- All those identified at risk or in need of a proactive care approach will be assigned an appropriate case manager, key worker, or advocate who will:
- Develop advice and information prescription
- Develop a holistic goal-orientated care plan in partnership with the individual
- Co-ordinate and oversee care delivery
- Monitor and review

The investment in *Proactive Care Children* (BCF 05 £250k) will see the roll out of a comprehensive health and care children's prevention plan aimed at shifting the pattern of care away from hospital attendance and admission.

SINGLE POINT OF ACCESS TO CARE (BCF Projects 8-9*)*

- Simplifying and improving access to all local care services through the development of an integrated multi-agency common point of access – The Hub (An options appraisal is being carried out to decide upon the best approach to a common entry point across health and care in Slough)

INTEGRATED CARE DELIVERY (BCF Projects 9-16) *Average Impact reduction in hospitalisation: 15-30% Integrated Teams, (Source Richardson Dorling Reviews of systematic review of integrated care Mc Kinsey)*

- Establish locality facing multi-disciplinary and multi-agency integrated care teams (working across traditional boundaries) aligned with groups of GP practices.
- Serving a patient population seven days-a-week in line with our successful Prime Ministers challenge proposal.
- Provide a systematic proactive planned approach to facilitating safe and timely transfer from hospital for those with ongoing needs requiring further

assessment.

- Establish a stronger and more comprehensive range of rehabilitation and reablement support services that are easily, and – where necessary – rapidly, accessed via the Hub and which deliver planned reductions in length of stay
- Support individuals to recover after illness or injury
- Provide a rapid response to deterioration or crisis and "Choose to Admit"
- Support timely transfer from hospital and consider developing the "Transfer to Assess" approach which is proving successful elsewhere.
- Expansion of the Slough Reablement programme
- Maintenance of existing Intermediate Care facilities
- Maintenance of Disabled Facilities capital Grant for better homes

STRENGTHENING COMMUNITY CAPACITY (BCF Projects 17-18)

- Actively building community capacity and resilience through our work with the voluntary and community sector.
- Expanding support for Carers through the Carer Investment Funds.
- Exploring asset based approaches to fostering community resilience building on links with Slough's active voluntary sector, local community groups and faith groups
- With the leadership of Public Health department implementing the Slough Wellbeing Delivery Plan aimed at tackling the social determinants of health. As part of making significant inroads in to the public health challenges in Slough particularly the high rates of childhood obesity, people who smoke, inactivity and consumption of excessive salt and sugar.

Note 1: Primary Care in Slough

Multiple studies identify Primary Care as the bedrock of effective health and care systems. To address Slough's historically poor provision and underpinning our BCF approach, Slough has been successful in its bid to the Prime Ministers Challenge Fund, which will transform the way in which GP services are provided in the Borough. The proposal draws on the feedback of local patients and their experience of accessing local healthcare services locally. It sees a significant investment of nearly £3m in the way local GP services are provided and accessed through investment in its people, technology and knowledge transfer.

Note 2: Urgent Care in Slough

Our analysis is clear that addressing the deficits in urgent care services in the Borough is also critical to the success of our BCF approach.

The Slough Urgent Care Programme Group is focused on redesigning the urgent and emergency care system focussing on access, patient flow through the hospital and discharge especially for frail elderly patients. The group have signed up to a 7 day service innovation proposal and an Urgent and Emergency Care Recovery Plan as part of their work. Learning and development of the system through this group has been incorporated into discussions on the Better Care Fund

- **The rationale for selecting our BCF schemes and the benefits we are seeking through advancing integration**

The vision of the Slough 5 year strategy and our approach to integration and BCF schemes has been led by the Slough Wellbeing Board over the last two years. It builds upon a body of work that has been undertaken in Slough over the last five years, particularly the Sustainable Community Strategy but also other plans and strategies such as the Children and Young People's Plan and the Safer Slough Partnership plan. More recently we have engaged in extensive consultation with user groups, patients and stakeholders in order to shape our analysis and approach to integration and the BCF schemes. Slough CCG and Borough Council engaged patients and service users on the integrated care agenda through a system wide Conference on 24th January to shape the aims and objectives of the Better Care Fund. Those attending the workshop now form the basis of a sponsor group which is helping shape the future of integrated care.

The January Conference was the culmination of a number of strands of engagement work:

- Extensive consultation with the local population on the Slough Joint Wellbeing Strategy 2013-2016.
- Consultation on the Older Peoples Strategy and Carers Strategy
- Three month public consultation 'Shaping the Future' on significant changes to rehabilitation services in 2013 including multiple public events across Slough, focus groups and patients surveys on options of change. This consultation led to significant investment in social and community services prior to the BCF.

The Health and Social Care Professional Leaders Group has been established across three CCGs to engage NHS providers and commissioners and have agreed the Better Care Fund as the key focus of its joint work across the system. They have also led on sharing financial strategies, developing enablers and learning from best practice. In addition the multiagency Urgent Care Programme Board has been instrumental in developing the analysis and underlying issues around local acute care usage. This group have secured multi partner sign up to a 7 day service innovation proposal and an Urgent and Emergency Care Recovery Plan as part of their work.

The evidence underpinning our BCF schemes is set out in the appendices along with an assessment of the benefits which can be derived for each of the targeted populations. Where possible we have tried to assign benefits to individual projects and segmented population group however many scientific studies, multiple case studies and articles point to multi factorial contributors to health and care outcomes and hospital and care utilisation rates. We have described the evidence for achievement of %reductions above and have made cautious assumptions on NEL and social care reductions where the evidence is strong e.g. The Telehealth and Telecare Whole System Demonstrator Trial which is the largest randomised control trial of telehealth and Telecare in the world, involving 6191 patients and 238 GP practices. Other studies which support the impact of access to quality primary care

are also strong albeit less directly quantitative in terms of a specific reduction in hospital and social care usage.

In headline terms the potential benefits from our integrated care schemes are as follows:(source: McKinsey Fact Pack Sept 10 2014)

- A reduction in Non Elective Admissions by 10-21%(*Mc Kinsey*). For the BCF we have assumed 3.5% pa for five years which in year one(15/16) equates to -539 admissions, with a financial value of c£803k and which over five years could deliver a benefit of c£4-5m
- The investment in BCF and non BCF schemes will contribute significantly to this reduction. The net savings will require more detailed modelling and analysis in order to attribute costs and benefits in a more granular way.
- A reduction in A&E attendances by 9-11%
- A reduction in OP attendances by 3%

Further work is being undertaken to model the impact of reductions in social care demand arising from all of Slough's early intervention and preventative schemes including those in the BCF.

Annex to Case for Change :
Note on recent Audit of population who attend Emergency Departments

Initial analysis using 2013/14 data suggests that a minority of current ED attendances are genuine emergencies.

Table 3: Split of patient attendance of ED services in the area by level of urgency

Source: South Central CSU – local system information (2013/14)

Local provider	Immediate and Very Urgent	Urgent and Standard	Non-urgent
Heatherwood & Wexham Park	14%	77%	9%
Frimley Park	22%	59%	19%
Royal Berkshire	11%	72%	18%

This demonstrates that throughout the three main providers of Emergency Department (ED) services :

- Only 11%-22% of patients using ED services required immediate or very urgent care in 2013/14, thereby making appropriate use of the available ED services;

- 59%-77% of patients using ED services had no immediate danger or distress or were in an apparently stable condition, being best served by an Urgent Care Centre (UCCs);

- 9%-18% of patients using ED services were patients whose conditions were not true accidents or emergencies, being best served by self-care or primary care settings.

Specifically,

- 86% of attendances to ED in Heatherwood and Wexham Park Hospital would have been best assisted elsewhere in the health and care system;
- 78% of attendances to ED in Frimley Park Hospital would have been best assisted elsewhere in the health and care system;
- 90% of attendances to ED in Royal Berkshire would have been best assisted elsewhere in the health and care.

.

4) PLAN OF ACTION

a) The key milestones associated with the delivery of the Better Care Fund plan and key interdependencies

This plan of action will evolve as we develop our business cases and programme boards between September and December 2014. Programme Leads will work with local service users and providers including the voluntary sector to create a pipeline of innovative solutions to address the challenges set out throughout this document. A number of our BCF schemes rely on key projects, for example there is significant cross-over and linkage between Single Point of Contact and building Community Capacity.

The BCF Schemes are subject to agreed business case processes enabling joint commissioning partners to market shape and test the market with a degree of rigour that the scheme will deliver clearly described benefits to the population we serve. The business case template considers the timeline for each scheme and the expected profile of financial flows. The template for our business cases has recently been adjusted to reflect the national conditions of the BCF so that we can be confident that each scheme addresses these.

At a workshop of BCF leaders across health and care on September 17th it was agreed to refresh overarching programme arrangements in line with our four strategic themes building in the feedback from partners and external support consultants as to how best to configure and resource the implementation arrangements to meet our key milestones.

2014/15

Q3

- Scope detail of scheme programmes and contributing project deliverables and benefits.
- Receive feedback on plan and include further details or conditions if required.
- Develop more detailed programme map of timescales and inter-dependencies
- Establish governance and reporting structure
- Draft specifications where required and business cases approved.
- Draft section 75 agreement for discussion and agreement.
- Work to support enablers and cross area working
- Continue to build evidence case for financial benefits
- Further risk profiling and establishing method for proactive case management

Q4

- Agree implementation programme between partners and providers.
- Leaders
- Pooled budget and governance arrangements agreed
- Review and commissioning of community based resource
- Data collection, balanced scorecard for performance reporting to PMO
- Finalise evaluation arrangements

2015/16

Q1

- Start of pooled budget and operation of the governance support.
- Implementation of shared records accessible across services
- Establish single point of access and integrated service

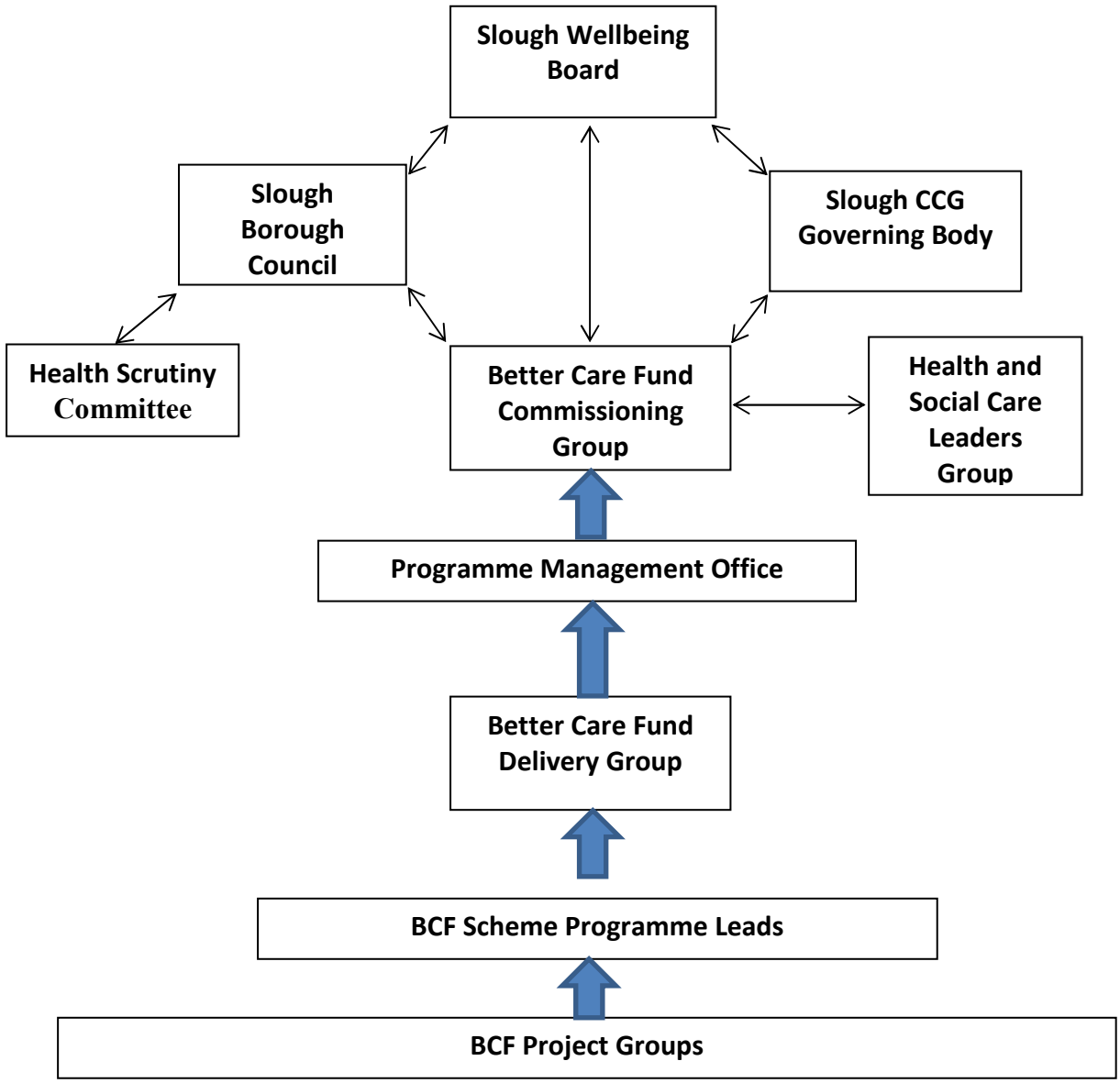
Q2

- Establish evaluation arrangements

Q3/Q4

- Review progress and performance against plan
- Evaluate impact
- Develop implementation plans for to deliver next phase of changes
- Agree implementation process with partners and stakeholders

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track



Each workstream will be led by a senior manager and each project will have a designated project manager. There will be two-weekly reporting to the BCF Delivery Group and monthly reporting to the BCF Commissioning Group against progress in implementation.

The Programme Office will be directed by the BCF Commissioning Group and will support all projects directed as part of the BCF Programme.

BCF workstreams are also integral to Slough's Wellbeing Board's objectives and will therefore reported quarterly.

The detail of the section75 agreement is yet to be developed but will include operational governance and monitoring of progress including escalation procedures.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Overarching scheme	Sub projects	BCF Reference
PROACTIVE CARE		
7 projects	Telehealth /Telecare	*BCF 01*
	7 day working	*BCF 02*
	Falls + foot care	*BCF 03*
	Accountable Professional	*BCF 04*
	Stroke Service	*BCF0 5*
	Childrens' prevention	*BCF 06*
	Puffell / self care	*BCF 07*
IMPROVING ACCESS – SINGLE POINT OF ENTRY		
1 projects	Single Point of Access	*BCF08*
INTEGRATED CARE		
9 projects	Reablement	*BCF09*
	Intermediate Care (LA & CCG)	*BCF10*
	Enhanced Intermediate Care / EOL (LA)	*BCF 11*
	Joint Equipment Service	*BCF 10*
	Nursing & Care Homes , domiciliary care	*BCF 12*
	Case Management	*BCF 13*
	IT systems & single Assessment	*BCF 14*
	Medicines Management	*BCF 15*
	Oaks EMI	*BCF 16*
COMMUNITY CAPACITY		
2 projects	Carers	*BCF 17*
	Community supporting integrated care	*BCF 18*
ENABLERS		
	Connected IT -shared IM&T infrastructure	BCF –A
	PMO Project Mgnt Joint Governance	*BCF –B*
	Social Care Capital Grant	*BCF –C*

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	How likely is the risk	Potential impact	Overall risk factor	Mitigating Actions

	to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	*Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	*(likelihood *potential impact)*	
Improvements in the quality of care do not translate in to the required reductions in acute and social care activity impacting on the funding available to invest in further preventative capacity	4	3	high	Robust oversight and continuous evaluation of the impact of new ways of working will take place via Slough's governance structure, particularly the joint commissioning group where regular monitoring of KPIs will track progress. The BCF process has secured the commitment of the NHS and local authority in Slough as well as providers, professionals, and the voluntary and public sector. This collaborative approach to achieving our vision will enable comprehensive impact assessments to take place which can then support the necessary corrective action to be taken. There will in addition be explicit risk sharing agreements between organisations. In terms of ensuring effective interventions the King's Fund has evaluated the effectiveness of our current integrated care teams and we are implementing recommendations linked to national and international best practice for their further development. The CCG is developing modelling tools based on a detailed analysis of the risk profile of the population to establish the interventions most likely to affect a reduction in hospital admissions. Finally Slough has not committed its full BCF reserve to new services pending the results of the evaluation of existing services and will retain the ability to respond to the ongoing impact assessments of the changes.
Changes to acute patterns of activity	4	4	High	Continual engagement with the local acute and other providers had been a feature

exacerbate the instability of the main Provider and plans to address this through an acquisition process prove difficult to realise, leading to prolonged uncertainty within the local provider market with an impact on the quality and financial health of the local economy				of Slough's programme and project management approach. This will continue as the local acquisition process takes shape with increasingly joint contract and performance management meetings and processes with the new organisation. CCGs are currently engaged in the development of a Clinical Strategy linked to the acquisition of Heatherwood and Wexham Park by Frimley Park. This is supported by an active health and social care professional group ensuring consistency across HWPs 3 main CCGs. Use of long term financial planning with providers to mitigate risks associated with transformation.
The financial outlook for the health and care economy continues to be uncertain and challenging with a knock on effect on the ability to invest on a sustained basis to alter patterns of care	4	5	High	Regular monitoring and understanding of government policy and implications for local services. The focus of Slough Borough Council on local enterprise, growth, job creation and skills development, will support a more resilient and healthy population. The '*Heart of Slough'* is a major investment taking place in Slough with the public and private sectors to make Slough a great place to live, work and play. This ambition and focus on Slough's assets will have a positive impact on the health of our residents, notwithstanding the uncertainties of the national settlements. The BCF Contingency along with investments in Social Care Protection and Care Act preparations will assist with this risk.
The introduction of the Care Act and wider social care reform will result in unanticipated consequences including additional unforeseen costs.	4	5	high	Work continues with modelling the impact of the Care Act within Slough supported by a dedicated programme board (LGA modelling tool) Explicit agreements on protection of social care services and implications of new statutory legislation. The full roll out and achievement of the BCF vision for Slough will support management of long term

				social care demand.
The changes to Slough's population and unexpected patterns of demand e.g. transient and or migrant populations) exceed JSNA projections resulting in greater demand for health and care services which in turn outstrip the ability of the local economy to manage them	3	3	Medium	Slough's JSNA is a continually refreshed and active assessment process responsive to tracking and understanding changes in the local population. The local authority had built up a capability in designing and delivering asset based approaches to meet the needs of its changing population and within that ethnicity and different types of demand. Public health support to SWB and associated workstreams lead on this work.
The culture change and change management associated with moving to new ways of working take longer to achieve due to operational pressures on staff, delaying the take up of new services and impacting on required activity reductions.	3	3	Medium	The vision for Slough has been widely communicated and supported with substantial co-design of the new ways of working and services with GPs and other professionals. The changes will be supported by active leadership and an explicit OD programme. Front line staff will be offered the time and support to understand the new integrated ways of working and pathways, and resources have already been identified to allow this to happen. For example Slough practices have already been engaged through protected learning time sharing case studies and learning linked to integrated care teams. Feedback from these events has influenced the service design and the aspirations of the Better Care Fund. Progress on key enablers such as collocation and information sharing will be prioritised to facilitate the change.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

In Slough the management of risk is built on a track record of pooling health and care

budgets via sector 75 arrangements within the context of strong local relationships and trust. All plans for BCF expenditure scheme proposals and developments and pooled budget amounts and proposed hosting arrangements have been developed jointly with all partners with the HWB Board and with other stakeholders.

In governance terms the HWBB maintains overall responsibility and oversight for the achievement of Slough's Vision for integrated care and the BCF. The HWB has delegated operational delivery to the Joint Commissioning Group.

The CCG and Council has set aside a contingency of £1.158m. We anticipate that this will cover the risk of underperformance on reductions in hospital activity (NEL) performance(including changes to demand patterns at HWP further work needed) and the protection of Social Care.

To strengthen our ability to manage acute provider contracting we are considering alternative forms of capitation with our main providers in order to align incentives towards ensuring patients are treated in the most appropriate way and place. We believe that over time this will ensure a robust risk sharing approach with our main providers
The following approach will be taken to reduce risk for the acute sector:

- The pace of change envisaged is realistic and will enable Trusts to reduce their cost base in a planned way.
- Alternative support systems for patients will be invested in up front so that Trusts have the confidence to take out excess capacity and cost.
- Acute providers are fully involved in the redesign of services and, either through collaborative or competitive processes, will have the opportunity to provide services or expert support outside traditional acute boundaries.
- The SWB recognises that the BCF will, in the short term, be continuing to support activity in secondary care, until service transformation changes patient and money flows.
- Commissioning intentions have been fed into the current business case development linked the Frimley Park acquisition of Heatherwood and Wexham Park. This will align the CCG five year strategy. The case is due for completion by the end of April.

By the end of November the Council and CCG will have held workshops to agree the principles of risk sharing and approaches to governance. They will incorporate *the **BCF Risk Good Practice Guidance*** issued in September 2014 into their agreements for managing pooled budgets.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Slough CCG and Slough Borough Council are coterminous and in population terms relatively small in scale and so we are increasingly confident of our approach to aligning BCF plans with existing plans and strategies. The BCF plans are a cross-cutting subset of the entirety of the Slough 5 year strategy and associated plans and build on much of the work already underway to deliver health and social care services locally. The interdependencies of the BCF and non BCF schemes are clearly understood in Slough and the subject of single oversight through the HWB Board and Joint Commissioning Group. We have more to do here and we recognise that as with any large-scale transformation, the total sum of all schemes, both within and outside the BCF, will act together to deliver the mutual outcomes. As such we envisage embracing all BCF and non BCF schemes within a tighter governance framework which is reflected in increasingly joined up commissioning strategies and pooling of budgets where sensible.

In terms of governance the shared CCG management team across Slough, WaM and Bracknell CCGs ensures an aligned and single approach across a range of issues. This particularly applies to the interface, contracting and performance management with the main providers including HWP. The CCGs structure allows a degree of flexibility to work across the 3 when sensible (acute contracting, primary care strategies) as well as focus on Borough based implementation. It is looking forward to forthcoming guidance on *committees in common* which offer an opportunity of increasingly effective alignment across the BCF.

The pace of change in Slough is becoming increasingly aligned across multiple strategies. The BCF and our shared pressures and demands across health and care are our catalyst in Slough to enhance the focus and speed of service integration. The challenge we face is to maintain service delivery and development of nationally-defined initiatives, such as the implementation of personal budgets, while exploring new local approaches to put the person at the centre of their care and maximise efficiencies.

The BCF plan aligns closely to the Borough's Commissioning Plan for Older People 2013-2018 and the range of plans aimed at meeting the needs of this growing population in Slough. This commissioning strategy for older people focuses on the care needs of people requiring support from Slough Borough Council and the resources available to meet those needs. On doing so, it recognises the initiatives including BCF that can delay or even prevent older people needing support. It is also aimed at aligning the ability of statutory service to ensure that public value can be assured, and outcomes improved, particularly for people with eligible needs for support. This commissioning strategy for older people will explore and detail the community and preventative opportunities for all older people in Slough and will be set within the commissioning for personalisation / transformation programme for social care services alongside broader plans for integrating health and care as described in this Plan.

The BCF plan aligns closely with the CCG's plans to improve access and quality in primary care, including the transformation agenda in primary care. This includes Slough building on the successful implementation of improved access pilot of which Slough is

one of 20 pilots nationally in the year 2014-15. As described earlier (section 3) our BCF plans also align with the important efforts in place to address the urgent and emergency care pattern of services led by the multiagency Urgent Care Programme Board.

These plans also align closely with the current plans on our acute landscape specifically the acquisition of Heatherwood and Wexham Park hospital by Frimley Foundation Trust. The CCG is actively engaged in this process and at the time of writing this Plan we understand that the acquisition is close to completion. We are alert to the potential diversion in senior leadership time that this presents to the Trust, however we are persuaded through our involvement of the overriding need to secure future stability and quality of care at the Trust. We and the Trust recognise that even greater alignment is needed here if our BCF ambitions are to be realised. The Trust has committed to engaging in a shared Transformation Board with all of Slough commissioners once the acquisition is complete (See Section 8c. Implications for acute providers)

Personal health budgets are offered to continuing health care patients in Slough and national evidence suggests that patients in receipt of a personal health budget are less likely to access unplanned care services and have more control over their own care. As such, this initiative supports the achievement of the BCF outcome and providers in order to realise the aims of the BCF Plan and we will engage with the latest announcements from NHS England in relation to a significant expansion of the personal budget offer within health.

In delivering these schemes, the use of technology will be a critical success factor. The cross-cutting theme of Information Management and Technology (IM&T) is pivotal to getting information sharing within providers and across organisations. Slough Borough Council has a track record in the use of Telehealth and Telecare and so we are alert to the potential of new Technology approaches which are available to assist patients, such as the use of Skype as an alternative to appointments for those who find it difficult to get out of their homes, or the use of assisted technology such as ‘Flo’, which allows patients to self-manage and access health professionals when needed.

These options will all inform self-care strategy and delivery.

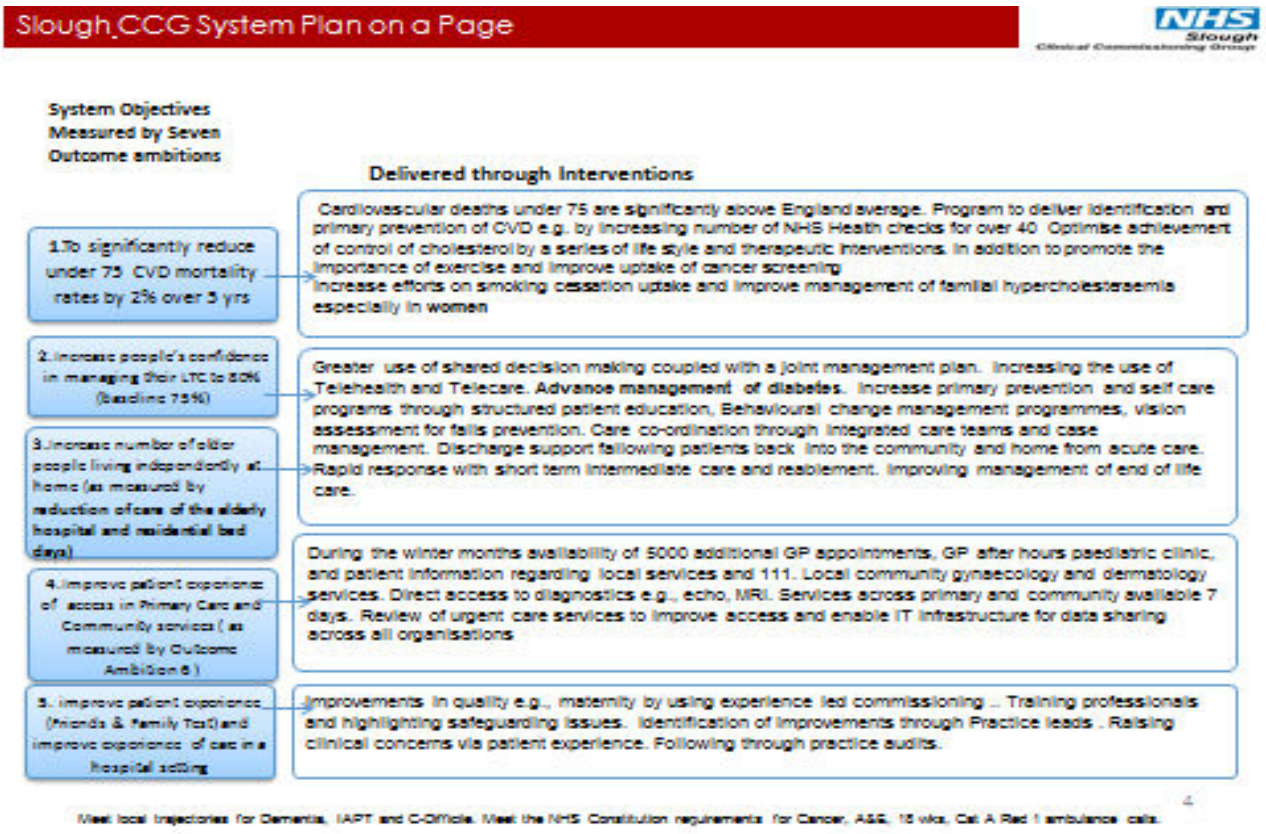
The co-ordination of the schemes and communication to ensure all initiatives are aligned will be managed by the joint delivery group overseeing the BCF.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

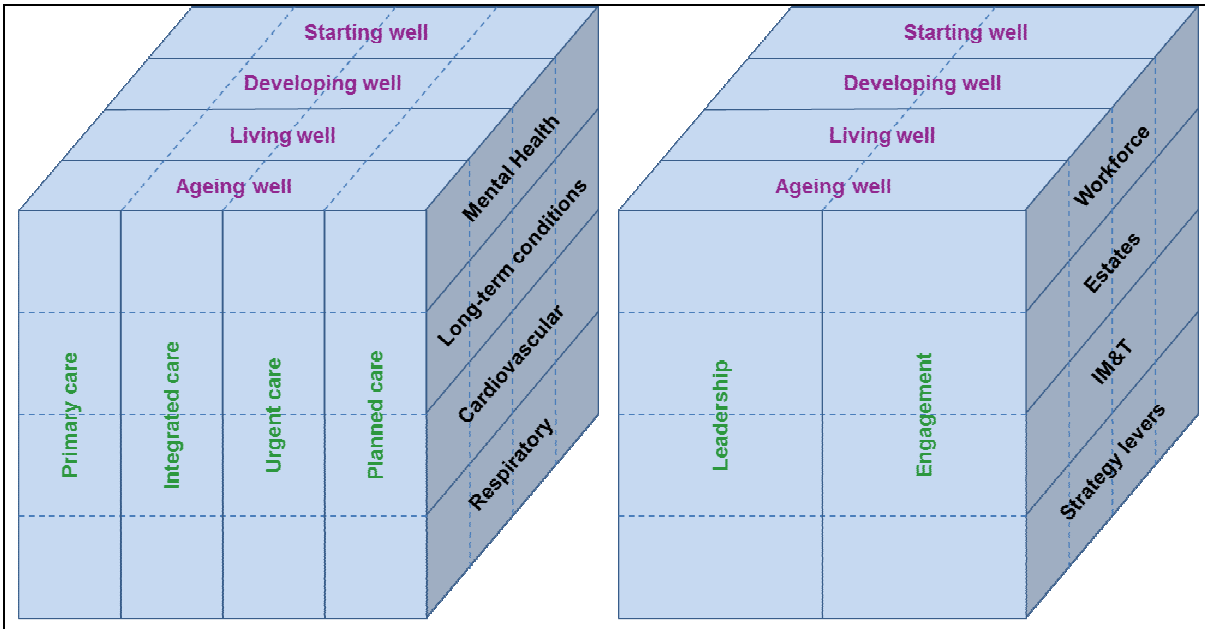
Slough is increasing alignment of both the operational and strategic plans for integrated delivery across health and care but recognises there is more to do to align both the pace and depth of integration across multiple local strategies. The areas we developed within our 2 year operational plan broadly map into the 7 outcome ambitions as set out in the planning guidance NHS England ‘Everyone Counts’ 14-15. They also correlate to the Slough Commissioning Strategy for Older People 2013-18.

Each of the 7 outcome ambitions contained within the 2 year operational plans have been mapped with an agreed trajectory of improvement over 5 years. These incorporate

many of the outcomes we are seeking through integrated care schemes and through our ambition for greater joint working across the health and care system. The following charts illustrate the 7 overarching outcomes and within that the interventions which the BCF Schemes, the Slough Commissioning Strategy initiatives and others which will contribute to achieving these outcomes. In particular the BCF initiatives are allied to a range of service initiatives funded via the *Slough Commissioning Strategy for Older People* 2013-2018 which include plans to strengthen Information and Advocacy support, strengthened home care provision, enhanced housing and sheltered housing schemes, and a range of initiatives to meet the rising incidence of people living with Dementia.



The following schematics illustrate how the enabling strategies for health and care improvement are nested within the broader and holistic life course approach which we know from evidence (Marmot) contributes even more than health and care services to the achievement of good health.



The Life Course Approach in Slough and key priorities
Starting Well, Developing Well, Living Well, Ageing Well

Starting Well

- Increase immunisation and screening rate particularly for MMR
- Promote asthma plans through an asthma and viral wheeze app
- Ensure safe transition of the health visiting services to local authorities

Developing Well

- Reviewing school nursing service, with a particular focus on the importance of children and young people's mental wellbeing
- Tackling childhood obesity
- Review CAMHS and review pathways to prevent unnecessary entry to CAMHS tier 3 services

Living Well

- New information resources to support self-care and expand access to primary prevention services; smoking cessation, weight management and alcohol harm reduction
- Expand NHS Health Check programmes focusing efforts towards specific at risk groups
- Help GPs deliver best practice support for people with diabetes
- Increase immunisation and screening rates, including NHS cancer screening

Ageing Well

- Expand Falls Prevention work
- Develop programmes for positive physical and mental wellbeing, looking at social isolation
- Work together to integrate health and social care to reduce the number of emergency admissions

All of the above aligns closely with this BCF plan, with a clear alignment from the vision to achieve person centred high quality services and value for money for the taxpayer. The specific initiatives aligning closely include children's programmes, prevention including the better care for long term conditions, to falls prevention and reduction of unplanned admissions thought better integrated care.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- **For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.**

Slough CCG (as its member practices) were selected as a national pilot (Prime Ministers Challenge) to improve access in primary care. This includes opening longer e.g. 8am-8pm Monday to Friday and at weekend for at least 8 hours each day. This was fantastic news for our system. Practices in Slough have formed into clusters and each cluster surgery will be open evenings and weekends. Additionally primary care are undertaking 12 projects to establish new ways or working in primary care from using text messaging, doctor first triage, and empowering patient participation groups.

This initiative is aimed to improve access in primary care (which is one of the key reasons why people end up attending A&E)**.** The CCG is committed to continuing this access in primary care beyond the Challenge Fund year and will be testing out integrated models and new ways of working with the community and social care teams during this financial year. The cornerstone of our strategy is to develop pro active care in primary care and develop a care planning approach to our vulnerable groups of the community especially children with long term conditions e.g. asthma and vulnerable adults

These plans align closely with BCF and to this end we have committed in our co commissioning plans the following areas:

- To work jointly with NHS England to develop and agree new 'year of care' tariff arrangements for particular patient groups and develop a service specification that will enable a team of clinicians (from primary, community, social and secondary care) to provide care for these identified groups of people e.g. people who may be at risk of hospitalisation or experiencing recurrent admissions. We intend to use the freedoms already included within the Standard NHS contract e.g. setting local flexibility where appropriate and in agreement with providers. We will be working with other CCGs within Thames Valley e.g. Bracknell & Ascot to develop joint strategies to achieve our ambition

- We will explore the potential re-design of QOF (assuming full achievement for key diseases e.g. diabetes, Heart Failure, Cardio Vascular Disease) so that we secure overall maximum achievement for our population and include our resources in this e.g. lifestyle advice clinics to achieve better outcomes for diabetes control. As part of this the opportunities created within the community pharmacy medicines use reviews service we will pilot interventions that align the medicines use services with the QOF services to achieve better disease control, e.g. asthma

- We would also like to explore a similar approach with regard to the potential re-design and delivery of all the public health targets for screening and immunisations e.g. flu, cervical smears, bowel and breast screening .

In addition we aim to utilise the £5 per patient primary care funding within operational plan guidance 2015-2017 to support management of care in our vulnerable adult and children population pro actively. This means practices are identifying these cohorts of patients (utilising already established risk assessment tools) , creating care plans and then allocating a name professional e.g. accountable GP or Nurse who would be taking care of their care throughout their contact in primary care(the named professional would provide pro active and would care for them through crisis management). This would mean that the GP/ Nurse would be first point of contact but would then at least make a minimum level of contact.

These plans all align with our BCF plans and are overseen by the single oversight mechanisms described earlier.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Slough has responsibility for all adult social care services in the area covered by this Better Care Fund plan. The partnership between Slough Borough Council and Slough CCG in delivering this plan will ensure that those with social care needs, as defined by the new eligibility framework in the Care Act, will continue to have their social care needs met. Protection of social care services through the Better Care Fund is to ensure that vital care and support services delivered in our community are maintained and also sustainable for the long term.

In accordance with the current Fair Access to Care Services (FACS) eligibility criteria, the agreed local definition of protecting adult social care services is:

Those care and support services for people who would otherwise have critical or substantial risk to their independence

The Care Act 2014 introduces new regulations and statutory guidance that set the new national framework for eligibility. The new criteria require local authorities to consider the physical, mental, and emotional wellbeing of individuals in need of care. The regulations place emphasis on undertaking combined assessments where service users have health

as well as social care needs. There is also a strong emphasis on taking into account people's fluctuating needs and their overall wellbeing.

In Slough our modelling suggests that the new eligibility framework will mean that higher numbers of people will require an assessment of need for social care services, and more people are likely to be eligible for social care services. In order to meet these anticipated pressures, an element of the BCF allocation is being directed at preventative services that seek to reduce and/or delay people's need for long-term care.

Our plans to respond to the new Care Act focus on meeting the financial demand and meeting the requirements of the new Care Act and ensuring that resources are protected for meeting our new liabilities under the Act. These include;

- the implementation and operation of the new eligibility framework for assessments in adult social care;
- the introduction of new statutory obligations to support carers;
- the implementation of a capped care cost system and setting up accounts for those funding their own care;
- the provision of enhanced information, advice and signposting services that support people with finding and managing their own care arrangements.

The BCF allocation for protecting social care services is being targeted at protecting statutory requirements in the following way;

- Enabling the council to meet increasing demand arising from demographic changes with an aging population
- Supporting an approach of early intervention and prevention that will reduce or delay the need for health and statutory social care services in the longer term.
- Continuing to support people at the earliest opportunity long before they have an eligible social care need where possible.
- Where people do need statutory social care support responding quickly with a professional assessment and personalised support planning to ensure that people are able to achieve good health and wellbeing outcomes and remain at home where possible.
- Helping maintain essential social care services
- Working with health and social care providers to ensure there is a robust and diverse market of care services to meet increasing demand
- Supporting and investing further in preventative services which help people to remain independent
- Helping meet cost pressures arising from the Care Act 2014
- Supporting innovative ways of delivering health and social care services to help realise efficiencies and savings
- Working together with our voluntary and community sector partners through our Community Capacity scheme recognising the huge contribution which they play in the wellbeing of our residents.

The Care Act is being led and implemented through a dedicated Programme Manager in

the local authority. There will be close alignment with the Better Care Programme through a co-ordinated programme governance function.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Social care services in Slough has considerable challenges arising from a clearly increasing demand and complexity profile for services on the rise(including dementia and long term conditions). This is set within a climate of making large scale financial savings of approximately 15% over the next three years.

The BCF allocation to protect adult social care services will focus on the principles of promoting independence and self-care so many of the services are aimed at helping people to regain and retain their independence, so that they then require reduced levels of support in the longer term following recovery from a period of illness.

A number of the BCF and non BCF service initiatives are therefore aimed at meeting the longer term needs of older people with complex needs, and for younger adults with complex health and social care needs arising from their disabilities.

The Better Care Fund plan has used additional section 256 funding together with match funding of s256 by the CCG and the transfer of funding from acute to community provision over the next three years to develop, remodel and improve our range of preventative services, our integrated locality teams and intermediate care services to:

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

These are allied to a range of service initiatives funded via the Sough Commissioning Strategy for Older People including Information and Advocacy support, strengthened home care provision, enhanced housing and sheltered housing schemes, and a range of initiatives to meet the rising incidence of people living with Dementia

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

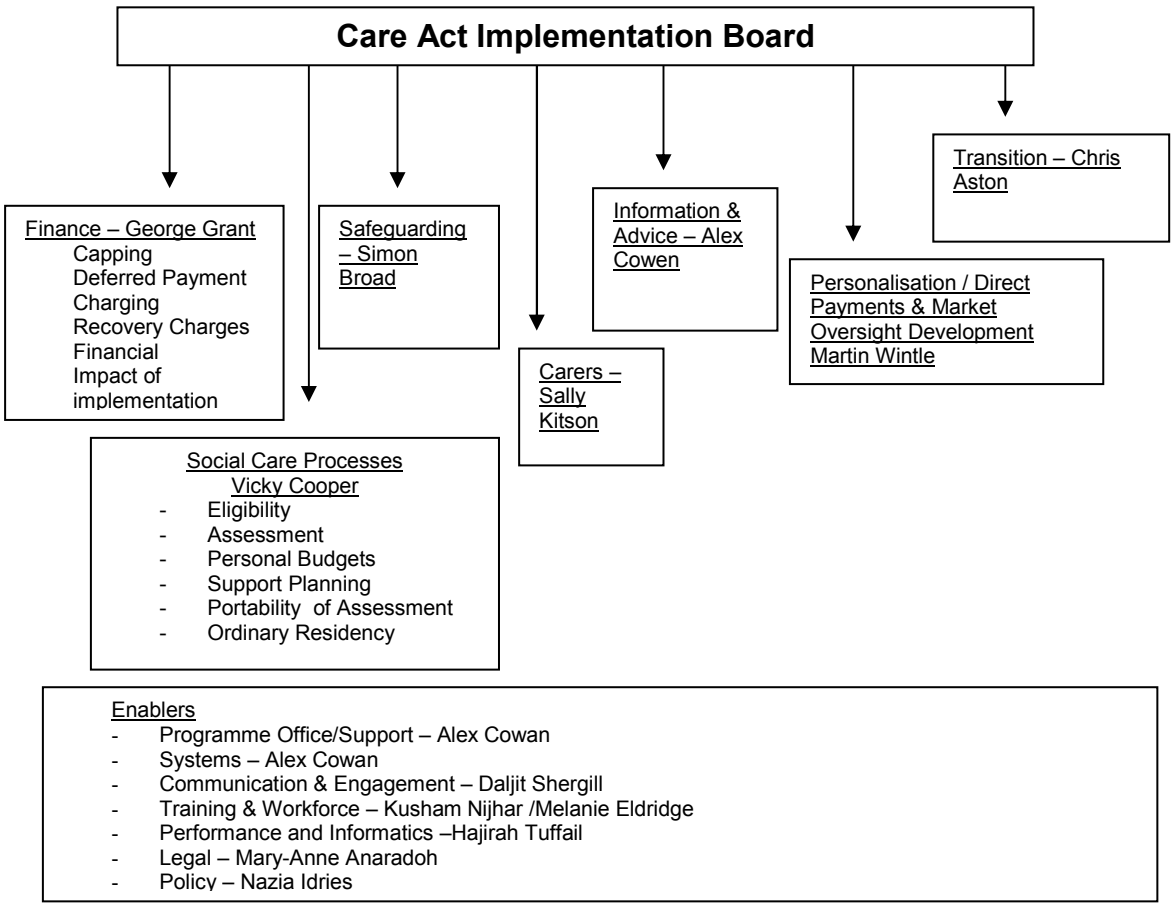
iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The overall protection investment for Adult Social Care arises from a number of different sources as follows:

- Section 256 Funding £2.3m + £0.857m = £3.157m
- Additional BCF Protection: £683k
- Care Act implementation: £317k.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Slough Council has commenced planning and preparation for implementation of the Care Act requirements. Governance arrangements are in place and progress is being reported, via the Health Scrutiny Board, the Council Corporate Management and Cabinet, to the Wellbeing Board. A Care Act Implementation Programme Board has been established, led by the Care Act Programme Manager, and several overarching workstreams and identified workstream leads to ensure timely implementation of the new and extended duties and responsibilities.



Work has commenced to enable implementation of Part One of the Care Act, the social care reforms, which come into force from April 2015. There will be close alignment with the Better Care Fund programme particularly around, particularly prevention, information and advice, self-care, and the development of community and voluntary sector.

v) Please specify the level of resource that will be dedicated to carer-specific support

A total of £210k from the Better Care Fund will be dedicated to carer specific support.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The revised plan has seen a net increased contribution to social care budgets. However since the original plan the council has held back a planned contribution to BCF for now due to financial pressures.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Slough CCG was successful in its bid to the Prime Ministers Challenge Fund which will transform the way in which GP services are provided in the Borough. The proposal draws on the feedback of local patients and their experience of accessing local healthcare services locally. It sees a significant investment of nearly £3m in the way local GP services are provided and accessed through investment in its people, technology and knowledge transfer. The investment covers a number of areas:

- More appointments
- Varying length appointments
- Increasing number of telephone consultations
- On line web appointments
- Text messaging
- Mobiles for urgent contact
- PRG development & action learning
- Practice Experience co-design work
- Working with schools 'pester power'
- Self help groups
- Friendly exercise opportunities
- Better information – neighbourhood Healthwatch

As part of delivery the fund has enabled extension of GP appointments into the evening Monday to Friday (6.30pm – 8pm) and offering booked and on-the-day appointments on Saturday and Sunday.

Slough has also used its winter pressures funding to establish working practices for seven day services across the Slough health and social care economy. Services are being evaluated for consideration for longer term funding linked to the Better Care Fund. This includes; rapid access assessment services, Consultant cover, diagnostic testing, intermediate care services (24/7, 2 hour response), minor injuries and urgent care services, early intervention and prevention and multidisciplinary discharge service at Wexham Park Hospital.

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

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

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Plans to use the NHS number as the primary identifier for correspondence across Slough providers is progressing well. Agreement has been reached across health and social care providers that the NHS Number will be the primary identifier across health and social care records. Good progress has been made during 2014/15 for expansion of the NHS Number use. The NHS Number is currently in use in all NHS organisations, and used as the primary unique and unambiguous identifier, supporting communication with other providers of healthcare services for the purpose of direct patient care. The use of both the Summary Care Record and Demographics Batch Service has proven to be up to 95% successful in pilots in Wiltshire & Berkshire CCGs (and former PCTs)

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

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Slough can confirm that we are committed to adopting systems which make use of open standards for interoperability; technologies used in the past include Cache, HL7 and other open source integration engines as long as they align to our IG requirements. A separate Slough Information and IT group is to be established to develop a shared Information Platform under the vision; 'One Patient, One Record, One Care Plan'.

We have an interoperability programme underway to create a single instance of an holistic patient record. Currently information resides in silos in the organisation that has treated the patient with very little being shared. If the initiative is successful throughout the various phases, a portal will be rolled out that is embedded within the various systems already in use in Berkshire East that will break down the information silos and facilitate data sharing at a level never achieved before. The portal can be accessed by health and social care professionals involved in the direct care of the patient only though could be accessed directly by the patient in the future.

This initiative is being split into multiple phases to ensure the expected benefits are being realised and appropriate controls are in place at all stages of the project

.

Phase 1- The Medical Interoperability Gateway (MIG) will be purchased and information sharing agreements put in place to enable GP Practices to share their data with East Berkshire Out of Hours Service and Slough Walk in Centre . Currently these healthcare settings do not have access to any medical information from primary care and use systems that are compatible with the MIG meaning a quick implementation. No cohort of patient is being targeted during this phase as this will potentially benefit any Slough resident who attends these care settings and gives consent for their record to be viewed.

Phase 2:

A cross-system programme board has been established and this group will attend workshops where the most appropriate portal solution will be selected for a 12 month pilot. This portal solution will be purchased for one year and will form the basis for a full business case for the next phase. The portal will be implemented with feeds from at least GP Practices via the MIG, an acute hospital, Berkshire Healthcare Foundation Trust and Out of Hours. There will also be the opportunity for other organisations to feed data into the portal, but is dependent on the use of the NHS number within the system, compatibility with the portal and the number of feeds that can be incorporated as part of the pilot.

This limited rollout will be the first time that multiple healthcare systems have been linked up in East Berkshire and will provide a single point of access for health and social care workers. The viewing organisations will be both health and social care and the project will be looking for a wide range of clinicians and social care workers to view the data and to compare expected benefits against those realised.

The patient cohorts that will be targeted as part of the pilot have not yet been identified.

Phase 3:

Presuming that the expected benefits were realised, the third phase would be initiated which would be to procure a full portal with feeds from all participating organisations in health and social care in Slough. Access will being given to all health and social care staff that would benefit in the direct care of patients. During this phase, the scope of the project, or future projects would also be revisited, with patient access portals and mobile working potential further benefits of using a portal solution.

There is significant evidence to support data sharing amongst organisations with NHS England supporting initiatives through the integrated digital technology fund. The Kings Fund highlight integrated care teams as a key priority and one of the enables for this is sharing data. A case study was also completed in Cumbria for data sharing through the MIG.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Slough is working together as a health and social care community to develop and implement system-wide best practice information policies and protocols to support the sharing of patient/citizen confidential information. The overarching economy group - Central Southern - both hosts an office of the Data Service for Commissioners and has achieved Accredited Safe Haven (ASH) Status; with a Caldicott guardian in place and a thorough IG Framework which is currently being implemented throughout the organisations. Central Southern has IGT Level 2 and is working towards Level 3 for its Data Service for Commissioners Office by 31st March 2014. The group work is implementing the actions from the Caldicott 2 review and subsequent response by the Department of Health. The IG Group brings together the professional standards and best practice guidance to ensure the appropriate level of information is available to support the delivery of the best possible care.

Guidance to public and care professionals will simplify consent capture across Slough's different agencies and providers while supporting sharing for the delivery of joined-up care.

A communications campaign to highlight the need to share information is to be delivered alongside the launch of these new tools.

While these accreditations are good for assurance we recognise that there must be a legal basis for the sharing, processing and linkage of social and health data and where possible work should take place making use of pseudo data at acceptable 'small number' levels. Suitable clinical / social care advice is essential when drawing up sharing agreements to ensure that patients are not wrongly identified and that where patients/ clients have opted out of data sharing this is recognised.

Slough Borough Council is committed to ensuring the highest levels of Information Governance controls and security, both for information held by the Council and for that shared by the Council. Sharing of data is controlled to ensure compliance with legal and ethical standards, including taking individual's own wishes into account. Slough Borough Council is committed to undertaking all appropriate steps to support better

communication between agencies wherever this would assist service users / patients. That will include ensuring the appropriate protocols and guidance are in place, as well as ensuring the confidentiality and security of data flows.

In terms of local IT systems there is some complexity albeit increasing synergy with the maturity of the systems across Slough. On the provider side the acute and community provider work to different major systems whilst in primary care the majority of our practices are on EMIS.

IG understanding and arrangements for consent vary across the patch and several systems have lack ability to collect information on consent to share which is part of the aim and requirement for delivery of the Care Record.

The integration technology that will support sharing and that has the ability to communicate, record, and revoke consent is possible and will offer a way to manage consent across care providers.

In the meantime all member organisations of the IG Group complete the required Information Governance Toolkit returns, and are meeting the required minimum standards.

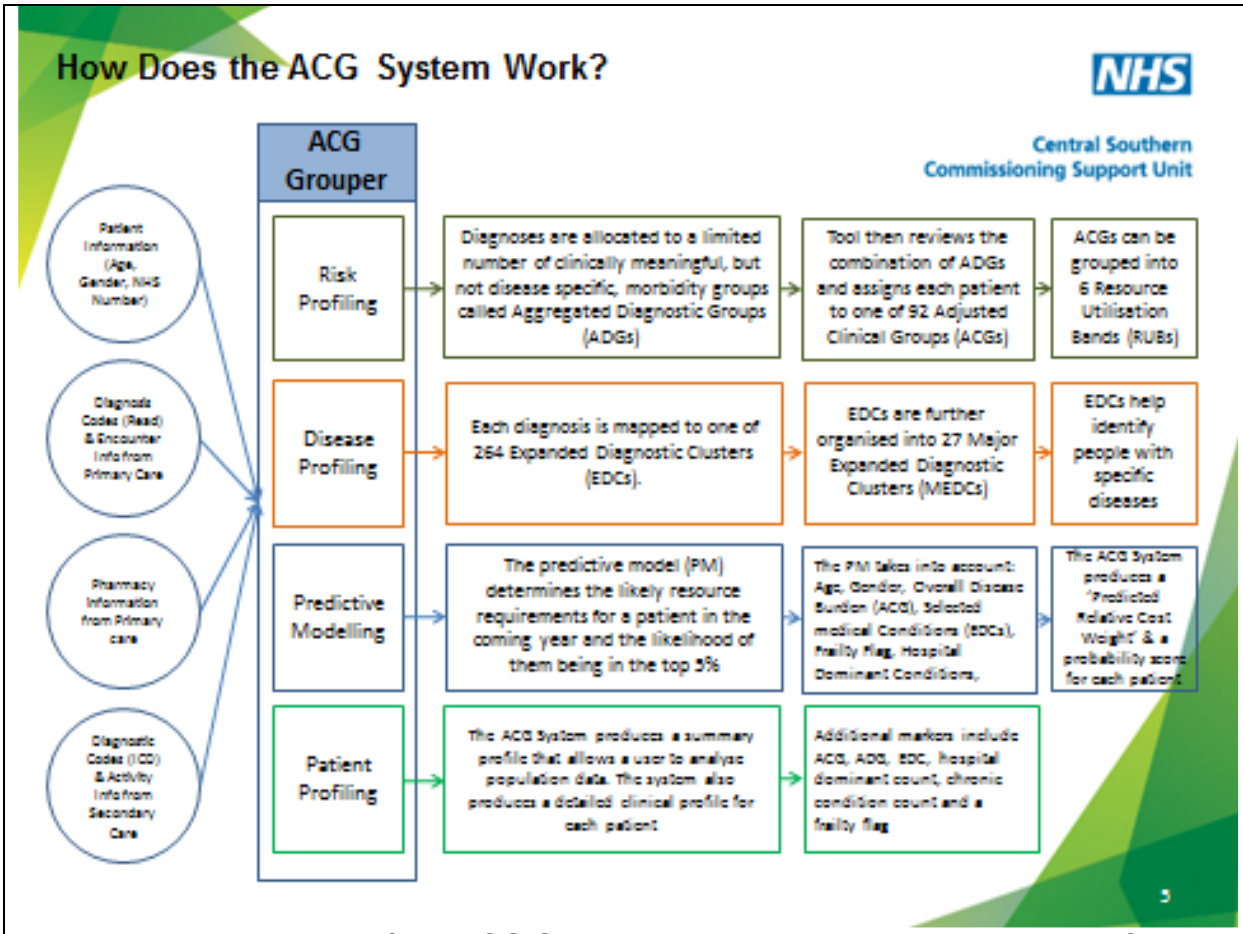
Work on the capture and use of consent against the NICE Clinical Quality Guidance is not yet underway but forms part of the baseline work. Once this is completed, it will give further intelligence on the future steps needed to support the best practice adoption of the best consent model.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Slough has a relatively small albeit diverse population (143,700) and so we are confident that by adopting systematic process across all of our general practices we can identify those at risk by segment across our whole population.

100% of our practices currently use the Adjusted Clinical Risk (ACG) predictive model, which give high accuracy levels predicting risk of hospital admission.



- The principal use of the ACG System over the last 3 years has been to find patients suitable for primary and community care based interventions such as case management
- GP practices are also using the ACG System to meet their contractual obligations relating to identification of patients most at risk of emergency admission and to discuss these at multi-disciplinary team meetings
- The CSU worked with Johns Hopkins University to develop a new predictive model that specifically identifies adults and children most at risk of emergency admission
- This model has been made available to other ACG System users in the UK
- Increasingly GPs and CCGs are using the tool to find patients suitable for a range of community based services aimed at patients outside of the top 1%

We expect this information to contribute to our case management approach which will see those most at risk being case managed with a joint care plan and accountable professional to increase to 2,000 or 0.7% of the population by April 2015. This will include all level 4(very high risk 0.5%) and some level 3 (high risk of admission) patients.

Slough is aware that by using both a good IT-based tool with all of our practice populations together with more local and softer intelligence from the professionals who know their patients and carers well and understand what the normal stable condition is for a patient, it is possible to identify patient numbers and type of support required.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

There are several joint processes already in place across Slough and the common aim of our BCF approach is to ensure that these processes become the norm across all health and care services. A number of important services provided us with learning as to how to do this most effectively in Slough.

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

The expansion of integrated care teams will form a central strategy to develop joined up services in the community for patients at high risk of hospital admission or nursing home / residential home placement. Our aspiration is to grow and develop these teams to manage at least 5% of our patients in the high risk groups as having a dedicated care plan and lead professional.

The King's Fund has evaluated the effectiveness of our current integrated care teams and provided recommendations linked to national and international best practice for their further development in the latter half of 2014.

In primary care by the end of 2014/15 a GP in every practice will be identified with dedicated time to identify those patients most at risk of admission to hospital and provide more intensive support to these people in conjunction with the integrated primary care teams.

Over the Winter period we have developed the multiagency PACE- Post Acute Care Enablement project which provides joint assessment planning and delivery of support in early discharges. The objective of PACE is to maximize the use of 'Out of Acute Hospital Care' in a creative and innovative way, bridging the care gap where necessary to support early safe discharge and prevent inappropriate admissions to acute beds. This will ensure that patients are, when medically fit, discharged effectively and safely from a hospital setting. PACE is a collaborative multi-agency approach with dedicated resource and input from various agencies.

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

The aim of the BCF is to continually review and co-design services to ensure they meet this way of working with a particular focus on recommissioning from April 2015.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

We expect our case management approach will see those most at risk being case managed with a joint care plan and accountable professional to increase to 2,000 or 1.4% of the population by April 2015. This will include all level 4(very high risk .5%) and some level 3 (high risk of admission) patients.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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

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

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

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

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

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

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

Centre

- Individual depth Interviews with staff in different roles at a number of GP practices.

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

Slough CCG and Slough Borough Council are engaging in a number of events through 'Call to Action' including public meetings and surveys. Engagement is planned of specific patient groups as well as wider engagement in local supermarkets to gather patient views. A 'Keeping Well' Programme was launched on 12th February with over 50 members of public helping co-design the future of services in the Borough based on their experiences of care. The Council and CCG will build on this work through continued co-design and co-production with Slough users and carers on the further development of the integrated care system in the Borough in 2014/15.

- Plans are also being made to jointly host a public event to explain what the Better Care Fund will do and provide an opportunity to share experience and suggestions for improvements that could be achieved.

- **More recently in June** 2014, Slough invited its community to come together to describe a positive possible future for the whole health and care system around keeping well in Slough to June 2019 and beyond. Together, participants in the event explored:

"What can happen because we work together so that people in Slough keep well and live life to the full?"

The group worked with a facilitated visual planning process called PATH (*Planning Alternative Tomorrows with Hope)* to describe a positive possible future to support people to keep well and live life to the full. See schematic below describing visual themes from the day which will be feed in to our BCF plans going forward.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Engaging with a range of stakeholders across the health and social care economy is critical to the success of delivering integrated care in Slough. Plans have been developed in partnership across the borough, with commissioners and providers working jointly. Slough has the following main providers:

- Heatherwood and Wexham Park NHS Foundation Trust (main acute)
- East Berkshire Healthcare Foundation NHS Trust (community and mental health)
- South Central Ambulance NHS Trust
- Buckinghamshire Healthcare Trust (BHT

Engagement process are in place to ensure our NHS provider stakeholders are engaged with the BCF agenda and these include:

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

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

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

- Both Acute and community providers are members of the Joint Commissioning Group which oversees the delivery of the Better Care Fund plans. We have included both management and clinical membership to this group and this has enabled securing greater engagement with our plans

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

- As a result of Providers engagement in the co-design of urgent and long term conditions services in Slough integrated care teams have been introduced in three practice 'networks' in 2013 supported by community and social care providers. Since then we have undertaken a review of the integrated care teams model and we included the providers feedback in this review and we have thus amended the model of delivery.

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

Looking ahead we understand that deeper engagement will be needed with our main acute Provider if we are to realise our vision for integrated care. We have secured

Trust agreement for the establishment of a Transformation Board post acquisition (subject to approval) which will oversee our efforts with HWP to change the model of care in line with our vision. In the meantime the introduction of a revised training and induction programme for all consultants at the Trust with a focus on new models and approaches to care delivery (with input from Slough CCG clinical leaders) will take shape shortly and begin to contribute to the changes of culture the Trust is seeking.

See Section 8c for note on impact of acute providers.

ii) primary care providers

Primary Care

Primary care has been kept up to date with development of the overall approach within BCF and in individual project work streams

Slough CCG works with a number of GP and Nurse clinical leads who have informed the building of our integrated working particularly joint working with the community teams and hospital clinical teams to ensure consistent approaches and seamless pathways are developed
Moreover the plan and its ambition has been discussed with the Council of Members in Slough and there is broad agreement amongst our practices to work in a fully integrated way to ensure delivery of overall better care for our population.

In addition we are working closely with the clusters of practices providing access to primary care to develop further our BCF plan and enhance our implementation plans by utilising the capacity built within the current Prime Ministers Challenge fund to pilot and test out new models of delivering integrated care.

iii) social care and providers from the voluntary and community sector

Social Care Providers

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

Social Care Providers have been engaged through the Provider Forum and Partnership Boards as well as the system wide workshop on 24th January 2014.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The most significant impact of these plans on our main acute provider HWP is a reduction in hospital NEL activity of 3.5% per annum for five years from 2014/15 against the BCF baseline. In income terms this equates to a range of £803k to £1.6m.

The current highly sensitive acquisition of Heatherwood and Wexham Park hospital by Frimley FT and the timing of the acquisition business case approvals by regulators and DH has meant that the implications of the planned BCF reductions has not been factored in to the hospitals forward plan(LTFM) at the present time.

In return for acquisition related transitional relief funding the 3 CCGs have received a commitment from the Trust of their engagement in a Transformation Board in order to oversee the necessary changes needed to arrive at the new models of care for delivering these reductions. This will be put in place immediately following the acquisition (subject to it proceeding on Oct 1 2014).

We are alert to the potential diversion in senior leadership time that this acquisition process presents to the Trust, and of the risks of the Trusts forward activity and income plan not recognising BCF reductions at this point in time(and we recognise that some of these risk will obviously sit with the Trust as our integration plans take effect).However we are persuaded through our involvement in the acquisition process, of the overriding need to secure the future stability and quality of care at the Trust and have in place risk mitigation plans for managing the impact of the forward activity and income projections. We and the Trust recognise that even greater alignment is needed here if our BCF ambitions are to be realised.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

Slough has four programme schemes around which the Better Care Plan is based. These four programmes are closely linked and aim to provide a seamless and integrated service around the person. Each scheme has a number of smaller projects within in and some others which are aligned but the funding budget sits outside of the BCF.

Scheme ref no.
1
Scheme name
Proactive Care (Adults)
What is the strategic objective of this scheme?
Our vision for proactive care in Slough envisages a shift across the health and care system to a systematic identification of vulnerable patients and those at risk; where we will use risk stratification tools to proactively identify patients who require more intensive support so that we can support people to receive the right care at the right time in the right place. This will include supporting self care particularly for those with long term conditions, with the provision of information and advice and signposting so that it is not just a route in to services. The use of validated predictive modelling tools will identify those with frailty, escalating needs, and those at risk of deterioration and or acute admission in many case the elderly in Slough . All those identified at risk or in need of a proactive care approach will be assigned an appropriate case manager, key worker, or advocate who will:

- Develop advice and information prescription
- Develop a holistic goal-orientated care plan in partnership with the individual
- Co-ordinate and oversee care delivery
- Monitor and review

Proactive Care aims to drive system change by collaborative whole-system health and social care working that is wrapped around jointly identified patients to achieve improved outcomes against challenging demographic pressures.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The strategic objective for this scheme is to get services right for people living with long term conditions and frailty whilst building a more integrated approach delivering services.

We want to provide compassionate care, underpinned by a strongly-articulated evidence base around effective assessment and management of predicaments related to frailty.

Previous studies found that elderly people with the most complex health and social care needs frequently experienced disjointed and fragmented services that were difficult for them and their carers to navigate. This poorly coordinated care also increased the clinical risks in handovers and led to a high rate of admissions and readmissions to hospital that are costly with little or no improvement in outcomes.

The frail elderly with therefore be a key target population for proactive care.

From our work on our patient segmentation we know that Slough spends most money on the healthy adult (16-69) patient group. However, these groups where both volumes and average spend per capita is high are adult with one long term condition, adults with two or more long term conditions and people who are over 70 with two or more long term conditions. These groups are therefore where, for adults, a model of proactive and integrated care will be most beneficial and contribute most to non-elective admissions.

Model of Care

- Proactive Care will be using risk stratification methods to identifying key people in our community who are most vulnerable and taking a proactive approach to supporting them through care planning and providing access to a named accountable professional. It will include the targeting of effective intervention and support to those who benefit the most, and are most at risk of ill health.

- These groups of patients are identified through the use of a risk stratification tool; ACG which uses pseudonymised information to review how many admissions, bed days and accident and emergency episodes have been saved based on comparing patient activity over the previous 12 months.

- A care plan for each patient is then formulated; for those patients with less complex needs are discussed at team meetings in the GP surgeries, while those with complex needs are referred via the single point of access into the appropriate service.

- General practices will monitor hospitalisation and avoidable A&E attendances regularly and determine whether alternative care pathways might have been more appropriate. Active follow up will become the norm.

- When someone at risk requires urgent care they will have access to a named professional to guide and advise them. If in the event of another health or care professional becomes involved e.g. ambulance service, they will have access to the care plan for that person and be able to provide the most appropriate care and support and where necessary support and hand over to the right team. This co-ordination and transition will be supported through the single point of access (scheme 2).

- This joint working is supported by a shared IT system that allows information to be captured and disseminated electronically across the health and social care system.

- Team members in this system are led by a geriatrician and GP, and include hospital and community based nurses and allied health professionals, social workers and mental health professionals.

Through this system we will be improving the quality of primary care and community care services throughout Slough, where previously they often worked in isolation with marked variability in the quality, range and accessibility of services offered.

We are already looking to our strengthened primary care provision in Slough (through the use of the Prime Ministers Challenge Fund investment) to boost our proactive approach – encouraging practices to work with their patients to identify and facilitate options and services to meet their patients' needs.

Through the proactive approach we envisage the model of care leading patients to the most appropriate form of support so that they are not falling through gaps in service and defaulting to use of hospital based care. This will include for example those areas which we need to strengthen such as;

- Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role.
- Frail older people have access to services to prevent falls.
- A comprehensive service for those with dementia must be available and accessible.
- Services are available to reduce polypharmacy in frail older people.
- a structured care management plan, shared with the patient with systematic follow-up
- a multi-professional approach with mechanisms to enable closer working between primary care and specialists
- Refer onto an ambulatory emergency care pathways with access to multi-disciplinary teams should be available with a response time of less than 24hrs for older people who do not require admission but need ongoing treatment.
- Make use of clinical tools and consultation techniques that normalise the discussion

of mental and emotional aspects of physical illness.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Slough CCG with Slough Borough Council is leading the commissioning of this programme. Heatherwood and Wexham Park Hospital is the secondary Trust provider but others involved in the delivery chain will include Berkshire Healthcare Foundation Trust, the South Central Ambulance Service and the community and voluntary sector.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Proactive Care is a model of care based on national and international evidence of best practice, which aims to achieve whole system health and social care integration, in order to support and deliver better outcomes for customers/patients. Guidance was launched by NHS England in May 2014 for the Avoiding Unplanned Admissions enhanced service (ES) which is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission

The enhanced service requires GP practices to use a risk stratification tool and the Proactive Care Programme will be following this guidance for risk stratification with assurance provided by the local Area Team

Lewis G (2010) '"Impactibility models": identifying the subgroup of high-risk patients most amenable to hospital-avoidance programs', Milbank Q 88(2), 240–255

Steventon A (2013). Evaluation methods – where can predictive risk models help? http://www.nuffieldtrust.org.uk/sites/files/nuffield/adam_steventon_evaluation_methods_080713.ppt

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£375k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The outcome and impact will be measured through

- Increasing coverage of the Slough population by risk stratification approaches
- Increasingly numbers of patients directed to appropriate levels of care including joint assessments
- Reductions in accident and emergency attendances and admissions through reduction of crisis in the target populations
- Increasing levels of confidence in the targeted populations in self managing their care

needs and ability to seek support
- Increasing confidence of carers.
- Increasing numbers of people with long-term conditions and co-morbid mental health problems taking up self-management support programmes.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This scheme will be monitored and assured through the Better Care Fund Programme Board but also via the Slough Locality Group meetings with each GP practice to assess progress and impact as well as the monthly Performance Meeting.

What are the key success factors for implementation of this scheme?

- Provision of appropriate IT information accessible across providers
- Roll out of risk stratification tools and approaches across all practices and other parts of the system
- Increasing alignment of health and social care risk stratification approaches and systems
- Workforce training and education – as part of the transformation work
- Build mental health skills in primary care and other settings, using training programmes
- Strengthening disease management and rehabilitation programmes through inclusion of psychological or mental health input developed specifically for physical health care professionals.
- Collaborative working and joint audit
- A series of steering groups and workstreams meetings

The outcomes will be more difficult but not impossible to achieve and local sharing of good practice and learning will enable the proactive approach to move at pace.

Scheme ref no.
1 b
Scheme name
Proactive Care (Children)
What is the strategic objective of this scheme?

This programme will be focus on the identification and more effective care of children in our community with long term health conditions and on those where through more preventative measures and active management strategies we can reduce the current overreliance on acute A&E and inpatient care.

The model will use the approaches described in the preceding section for *Proactive – Adult,* in terms of validated risk stratification tools in addition to other identification methodologies (schools Health Visitors, LAC's,) to target those who will most benefit.

It will taking a proactive approach to those children and their families by supporting them with more accessible information and advice, assessments, appointment times, an accountable professional and active follow up and condition management support, such that children are receiving appropriate care and support earlier on.

The support will extend to siblings in families who also share similar long term conditions. Proactive care will focus on asthma management given Slough has one of the highest rates in the country for children's asthmatic admissions.

The aim of the investment in *Proactive Care Children* (BCF 05 £250k) is to shift the pattern of care away from hospital attendance and admission towards a more appropriate home and community based service.

This investment in Children's Proactive Care model includes the following projects:

PUFFELL/Self Care

- To deliver improved client experience, consistent assessments and referrals integrated tier 2 and 3 working and self help options where practicable. All based on the integrated pathways attached.

Metime Pregnancy Programme

- To align services that currently are commissioned separately to deliver an integrated 12 week programme in pregnancy to not only reduce smoking but also improve self-esteem, maternal and child health and paternal engagement
- To co-deliver; smoking cessation, nutrition, physical activity and parental mental health interventions in partnership with 'mothers and fathers to be' who do not meet the thresholds for either the Family Nurse Partnership (for mothers under the age of 19 years and who have significant vulnerabilities) nor the FAST programme (for parents of children of 3 year olds and over who are in school).
- To ensure improved data sharing (with the users consent granted antenatally)

between smoking cessation services, health visitors, general practices, early years and community health and social services (in accordance with OFSTED requirements)
- To independently monitor the outcomes in 2015-16 to inform the commissioning cycle for 2016-17
- To follow up the health and wellbeing outcomes of the children and families through the two and a half year check and the early years foundation stage on entry to school.
- Physical activity for children and families: To deliver improved client experience, integrated working and self-help options based on integrated pathways.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

PUFFELL/Self Care

- The model of care and support requires the development of a new wellbeing hub to support the attached pathways. Staff working in the hub will be contracted into that hub for the period of the trial and a full business case prepared after that.
- All young people aged 11-18years for the self-harm pathway
- The trial will take place in volunteer schools where vulnerable young people are based as well as in mainstream schools as comparators

The provision of preliminary training and support to PCAMHS staff, educational psychologists, behaviour support teams, GPs, school staff, school nurses and social care staff. Costs include the app development for each phase and additional tier 2 staff to man the hub if required (it will operate virtually in the evaluation period) and tier 3 staff to provide governance.

The programme will contribute to the reduction of Non Elective Admissions:

- Identified “young people at risk”
- Having a named accountable professional
- Care is as set out in the planned pathways
- Children’s Health Prevention
- Paediatric urgent care
- Early discharge
- Extended GP services (Weekend specialist clinics)

Metime Pregnancy Programme

- The integrated model of care and support is based on the US (Stanford University licenced) expert patient programme and adapted in the Wirral by Solutions4Health (the current smoking cessation provider and licence holder).
- Two models of service have been tested to date; a train the trainer model or an in house delivery model. A third model of integrated services is to be tested in this programme

- To coordinate and monitor the delivery of an integrated 12 week programme of activities accessible to families (as requested in the recent engagement research)
- Referrals to come from the Family Nurses or general practices and for those families who do not meet the threshold for either FNP or other local parenting programmes
- Data on outcomes to be shared (with prior consent) between early years partners who can influence other health and wellbeing outcomes

The services to be aligned to the HV service pathways during the co-commissioning phase of April 2015- Oct 2015 and then subject to outcomes being met to be co-commissioned from 2016-17.

Physical Activity
To include:

- Walk and Talk service
- SBC Leisure services for 14-25 year olds
- The provision of preliminary training and support to general practice staff
- The costs of seated exercise for each phase
- The costs of a physical activity coordinator
- Care as per agreed attached pathways

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

PUFFELL/Self Care

Public Health commission the existing PCAMHS service. SBC commission tier 2 services from Mott McDonald. Schools commission behaviour support and educational psychology services (which are self funded). The CCG commissions the tier 3 CAMHS services.

Metime Pregnancy Programme

- Public Health fund core smoking cessation services from Solutions for Health and receive reports in as near real time as possible, through an N3 compliant real time data monitoring system

- Public Health have received additional Big Lottery Funding to deliver a range of physical activity and cooking skills programmes - this temporary income will cease in October 2014 but has provided insights into optimum delivery and a network of trained volunteers and community chefs who can not only train those who wish to continue in cooking skills but also provide people with skills for employment. The latter would require a weeks additional course to be set up.

- Public Health will inherit commissioning responsibilities for health visiting in October 2015 but will co-commission from April – Oct 2015 with NHS England.

- SBC leisure teams deliver and monitor all sporting and activity programmes in the

borough.

- SBC subcontracts Mott McDonald to manage its early years services and children's centres also provides a parental mental health project for vulnerable families.

- Slough CCG commission; maternity services, adult mental health services and contribute to a local charity Home Start who support mothers suffering from depression.

All of the above are required to work more collaboratively along agreed infant and maternal mental health pathways which need to be in place for delivery of the 0-5 Health Child programme. The recent Slough insight work undertaken to recommission maternity services also highlighted better communication pathways were needed between HVs and maternity services.

Physical Activity

- Public Health Slough to commission the existing Walk and Talk service
- SBC Leisure commission services for 14-25 year olds
- The CCG variously commission physical activity for adults

.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence base for PUFFELL / Self care and physical activity will be shown in each pathway as its developed.

Metime Pregnancy Programme

The evidence base lies within the Stanford University licenced programme initially called the Expert Patient Programme which has been specifically adapted for pregnant women in the UK by the S4H community interest company. The first pilot was called the Metime Club in the Wirral in which self esteem rates rose and quit outcomes exceeded those expected among similar routine and manual groups.

The evidence base for the Expert Patient Programme can be found at http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/expert-patients-programme.aspx

The evidence base for Mindfullness (stress management techniques to reduce anxiety and depression) can be found at *http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?LinkFrom=OAI&ID=12014012068*
The evidence base for the 0-5 Healthy Child programme can be found in the national HV service specification available at *http://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/res/#serv-spec*

NICE guidance PH27 for maintaining a healthy weight, before, during and after pregnancy is found at http://www.nice.org.uk/guidance/ph27/chapter/recommendations

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£250k. This includes, but not limited to, the following projects: We will also be developing schemes and pathways for children with common conditions such as asthma and gastroenteritis.

PUFFELL/Self Care

- Courses for Mindfulness training for additional hub staff to roll out to schools
- Pro rata costs of an additional educational psychologist to work in the hub for the trial period part year effect for 6 months
- CAMHS deck for anxiety and depression (contribution to full costs)
- Pro rata costs for an additional behaviour support lead to train relevant staff in schools
- Clinical governance costs for BHFT to support the hub and evaluation
- Additional bank therapists cost according to need to be defined during the trial period
- Costs of outreach training to practices will be covered by the hub staff (through backfill from the wellbeing hub).

Metime Pregnancy Programme

The cost effectiveness model for evidencing the long term impact of the service would need to be evaluated using accepted social return on investment toolkits

The immediate additional funding needed to aid service redesign is as follows;

- Courses to train Metime facilitators with additional 12 week smoking cessation costs for up to 45 participants
- Training for First Aid, DRB checks and CP training
- Costs of cooking classes for families
- Costs of venues

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Puffell / Self Care

- Reduced rates of self harm
- Improved use of self help and wellbeing app options
- Integrated care when needed
- Consistency of understanding of each other's roles in the pathway
- Improved quality of care and step down care

- Clear patient and staff expectations of the, pathways approach for various conditions and timescales for change
- Improved patient and family satisfaction

Metime Pregnancy Programme

- Improved self esteem
- Improved quit rates prior to maternity in routine and manual groups (NB 53% achieved in Wirral)
- Integrated care and consistency of understanding of each other's roles in the delivery programme
- Improved quality of care
- Clear patient and staff expectations of the timescales for change
- Improved patient and family satisfaction
- Birth weights to be collected through maternity services

Physical Activity

- Improved use of self help and wellbeing app options
- Increased hours of activity
- Integrated care when needed
- Improved patient and family satisfaction

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Puffell / Self Care

- Baseline activity and outcomes of all Slough referrals to be understood prior to the changes and following the changes
- APP feedback on postcode of use
- Wellbeing hub monitoring data.
- CPE monitoring data.
- A and E monitoring data

Metime Pregnancy Programme

- Baseline activity of numbers of families on FNP waiting lists or who do not qualify or DNA
- Baseline low birth weights
- Baseline rates of CO monitored mothers smoking in maternity
- Postcode of users within the S4H database showing highest need areas
- Home Start - numbers of women accessing their service in the cohort
- IAPT numbers of women accessing their service in the cohort
- HV antenatal and core 0-5 monitoring data.
- Early years assessment data

Physical Activity

- Baseline activity and outcomes of all Slough referrals to be understood prior to the changes and following the changes

- APP feedback on postcode of use
- Service monitoring data.

What are the key success factors for implementation of this scheme?

Puffell / Self Care

- A multiagency wellbeing hub to be established and staffed to cope with the additional training demands before the pathways are launched
- As near possible real time demand monitoring.
- Commitment by all partners during the trial period and beyond if successful

Metime Pregnancy Programme

- A multiagency Metime partnership to be established around selected early years centres
- Staff to be trained must be able to support the additional training demands before the pathways are launched
- As near possible real time demand monitoring.
- Commitment by all partners during the trial period and beyond if successful
- Results to be reported through priority group three to the CYP board
- Integrated pathways to be included in the new 0-5 HV service specification due to be in place by April 2015 and in the revisions to the S4H service specification
- Ongoing training and licence costs to be identified

Physical Activity

- Sustained partnership through the Slough Sport and Leisure working groups
- Leisure strategy links
- Effective outcomes monitoring.
- Commitment by all partners during the trial period and beyond if successful

Scheme ref no.

2

Scheme name

Single Point of Access

What is the strategic objective of this scheme?

The strategic ambition for this scheme is to address the current fragmentation of access to care within Slough by developing an integrated multi-agency health and care single point of access capability.

The Single Point of Access (SPA) scheme will provide one centralised point of contact across the whole system for health/social care professionals, available 24/7 through which will drive a model of care that provides simplified processes, a consistent approach, equity of access to services, less bureaucracy, less duplication and enhanced audit and learning abilities.

The SPA will have the following objectives:

- Health and social care professionals working within the borough will be able to easily access, or be efficiently signposted to, the services and support, advice and information they require through just one call to one point of access
- It will be easier to navigate the system anytime throughout a 24 hour / 7 day week and, along with other BCF schemes, will help to achieve a seamless and consistent patient and service user flow throughout the whole system
- The use of consistent referral criteria will assist active management of cases and help to prevent circumstances where someone is delayed or 'on hold' whilst the right service is accessed
- Through joint working , across organisational boundaries, the SPA will be better able to meet patient and service user's needs for support through an efficient and effective triage and referral system and improved communication which will assist in achieving improved outcomes
- The creation of a more efficient system that provides the required support for patients and service users on a timely basis
- Reduced delays and greater coordination at the point of referral (SPA) as they pass through to appropriate services that allow their needs are responded to through more timely way.
- Initial assessment and onward interventions facilitating the right service and high quality care safely and effectively from the right team in the right place at the right time.

The proposed scheme will enable services to meet some of the population's needs as defined in the JSNA and a number of the requirements of The Care Act.

An options appraisal is currently being carried out to decide upon the best approach to realising these aims.

Overview of the scheme

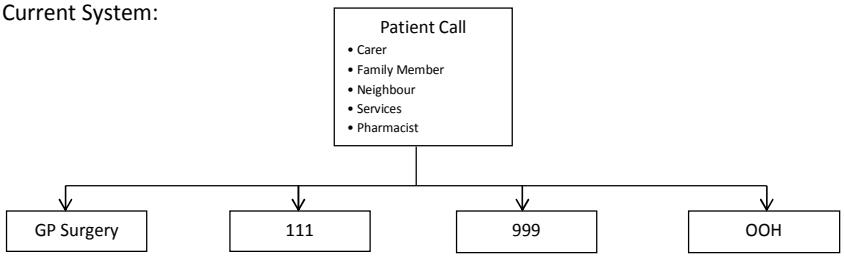
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

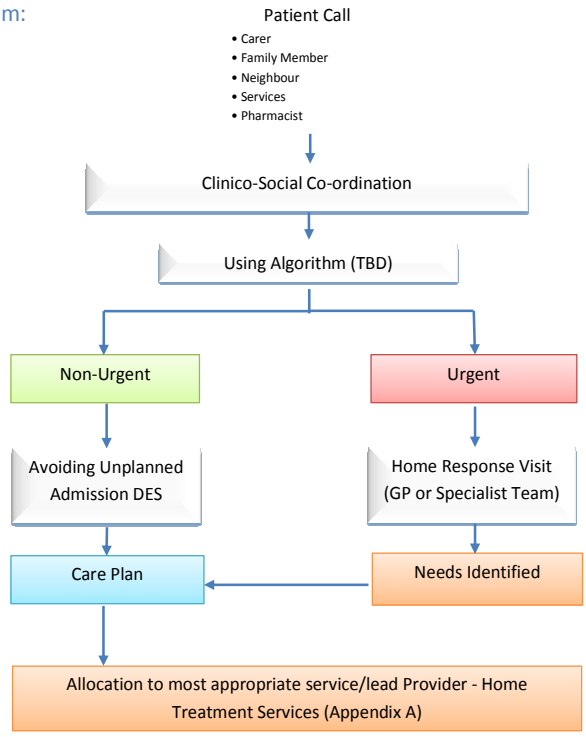
This schemes builds on the Proactive Approach described previously and together move the system from one of inefficient fragmentation to a more coherent approach as the following schematic illustrates.

Rapid support closer to home in crisis for: FRAIL ELDERLY

Current System:



New System:



There are currently several different points of access to care within the Slough locality, all with different arrangements and resources, using different referral criteria for eligibility into specific services. Few of the existing points of access are available 24/7. This creates inconsistency, fragmentation and duplication which in turn cause confusion, frustration and inefficiencies.

The current system does not always meet the needs of patients, service users and staff. It does not provide a seamless pathway for patients and service users, who are often passed between services with the result that they might not receive the support they require at the right time, and can sometimes fall between services meaning delays and deterioration in health conditions. Equally professional's time is wasted through being passed between referral points.

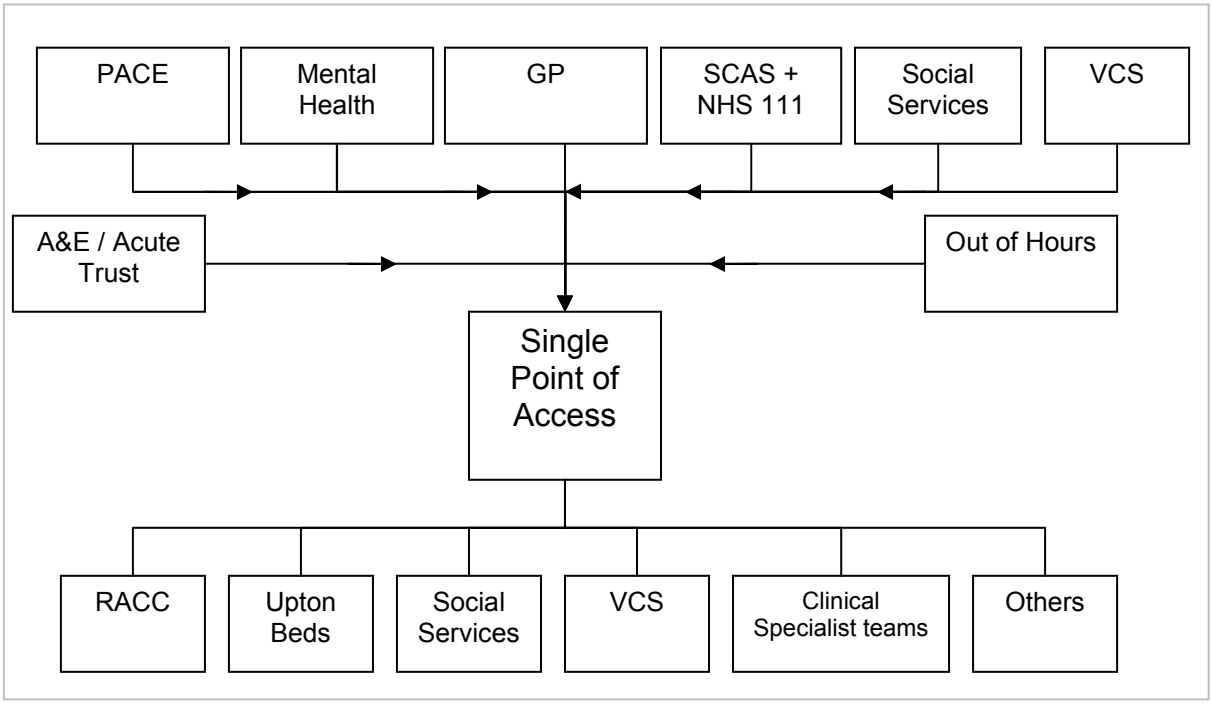
The aim is to create a model of referral and initial assessment that moves from a fragmented set of health and social care services to a co-ordinated service based around

people's needs, that is easily accessible through a single point of access.
.

Whilst the scope of the model is still subject to discussion and mapping of patient flows, it is likely that it will comprise the following key elements:

- A first point of contact for GP, ambulance and health and social care professionals for rapid triage into the appropriate service
- A 7-day service, 24 hours a day
- Assessment and onward referrals-responsibility and accountability for management of all referrals for health and social care services sits within one integrated team
- Support to existing 24 hour telecare and telehealth monitoring (ie - remotely monitoring both care environments and health status), and the provision of real-time health advice as required.

The following schematic illustrates our vision for the new SAP system



As part of the detailed scoping work, the Project Board will explore options relating to who is best placed to deliver the integrated health and social care hub and from where. Currently there is an integrated health hub run by Berkshire Healthcare FT and there is also a single point of access into integrated care and short term reablement services in Slough Borough Council ('RRR' service).

The development of an integrated single point of access will require a significant culture shift across health and care professionals in Slough as it relies on deeper collaboration, partnership working and integration across local government and the local NHS at all levels. There will be a need for staff to embrace change and to focus on doing things differently and not just delivering more of the same (Appleby *et al* 2010).

This initiative will align with the frail elderly pathway and will be closely interrelated with a

number of other proposed BCF schemes, for example:

- The interoperability of IT systems, including the electronic sharing of information using the NHS number as the unique identifier, will significantly enhance the efficiency and effectiveness of the SPA,
- A 24/7 Single Point of Access for health and social care will support the implementation of a number of other BCF projects by providing an effective and timely resource for triage, provision of advice, information, support to referrers and so potentially reducing delay in the management of referrals.

As part of the Integrated Service provision (scheme 3.) there will be benefit to patients and services users who are in in need of urgent care or support and who are in high risk groups with complex health and social care needs and with multiple long term conditions. The intention is of reducing the occurrence of additional health prob
lems in the longer term in this cohort and proactively support them to achieve greater control and ability to manage their health and social care.

The volume of patients that will benefit from this scheme is yet to be determined, as the detailed design of the integrated health and social SPA has not yet been agreed. However it is anticipated that the 2% with high risk of unplanned admissions will be included. The baseline will be determined from the current activity through the existing main points of entry into the system

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery of this scheme will be designed, managed and controlled by a dedicated SPA project group, reporting to the BCF Programme Board

The aim is to establish the SPA by April 2015

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A lack of joined-up care has been described by National Voices as a huge frustration for patients, service users and carers. (National Voices 2011). Emerging evidence suggests that developing an integrated single point of access for health and social care where services are co-located (either virtually or in reality) is more convenient for users, and has the potential to help enable more integrated and timely care (Imison *et al* 2008).

Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011).

The literature confirms that focusing on patients at highest risk leads to better outcomes (Hofmarcher, Oxley and Rusticelli, 2007) and that focusing on improving patient care helps to overcome professional boundaries for staff working in an integrated and

collaborative structure (Heenan and Birrell, 2006).

Whilst this will initially be for professional referral into local support services this may become a public facing service at a later stage providing information, advice and support.

The single point of access would be the point through which telehealth monitoring alerts would be directed. There is evidence of the benefits of telehealth monitoring which demonstrates that patients in crisis can be identified in a more timely manner and intervention planned to help them manage their condition more effectively (Chumbler et al, 2009, Whole System Demonstrator (WSD) programme, 2008; Poole 2006)

The establishment of a single point of access for health and social care in conjunction with other transformational improvement schemes is identified as being best practice, as demonstrated by initiatives across the country, eg: NHS North West London, Torbay & Southern Devon Care Trust, Dorset-area Partnership and Bridgewater Community Health NHS FT. However, many of these initiatives have yet to publish robust, evidence based evaluations of their impact. In addition, as most of the initiatives include a number of different improvement schemes, it is not yet possible to identify with certainty the unique impact of developing a single point of access health and social care hub.

References:

1. National Voices (2011) http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/principles_for_integrated_care_20111021.pdf (retrieved 7-7-14)
2. Imison C, Naylor C, Maybin J (2008). *Under One Roof: Will polyclinics deliver integrated care?* London: The King's Fund.
3. Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011 - *Integrated care for patients and populations: Improving outcomes by working together* – a report to DH and NHS Future Forum from The King's Fund and Nuffield Trust: http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf
4. Hofmarcher, Oxley and Rusticelli, 2007; Heenan and Birrell, 2006 - *Integration of health and social care - A review of literature and models - Implications for Scotland* (2010) Prepared for the RCN in Scotland by Hilary Robertson - http://www.rcn.org.uk/__data/assets/pdf_file/0008/455633/Hilarys_Paper.pdf
5. Health Education England Strategic Framework, (2014); http://hee.nhs.uk/wp-content/uploads/sites/321/2014/06/HEE_StrategicFramework15_final.pdf (retrieved 7-7-14)
6. Chumbler NR, Chuang H-C, Wu SS, Wang X, Kobb R, Haggstrom D, Jia H. *Mortality risk for diabetes patients in a care coordination, home-telehealth programme*. Journal of Telemedicine and Telecare 2009; 15: 98-101;
7. The Whole System Demonstrator (WSD) programme; launched in May 2008; involving 6191 patients and 238 GP practices across three sites, Newham, Kent and Cornwall. See: http://3millionlives.co.uk/about-telehealth-and-telecare#sthash.WCZv5OAv.dpuf (retrieved 7-7-14)
8. Poole T (2006). *Telecare and older people*. London: Kings Fund - http://www.kingsfund.org.uk/topics/telecare-and-telehealth/what-impact-does-telehealth-have-long-term-conditions-management (retrieved 7-7-14)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB

Expenditure Plan
£200k
Impact of scheme: Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Existing points of access for health and social care will be reduced to just one and brought together to work around patient needs, rather than around organisational boundaries. • Improved communication, transmission of information and data sharing within and between health and social care teams operating within the locality. • Faster response times which should reduce delays in referrals and should expedite discharge by facilitating the co-ordination of timely support and care (where telehealth monitoring is included in the scheme, will also provide quicker response to ensure effective proactive management of patients and service users) • Co-ordinated management of cases with aligned referral criteria should prevent people from being lost between services • Contributing to enhancing patient and service user satisfaction as the difficulties and frustrations they experience whist passing through a complex and un-coordinated health and social care system will be reduced if not removed. • A number of these potential outcomes could assist the acute unit in achieving greater efficiencies through improved patient flows
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
During development of this scheme, the Single Point of Access project board will undertake ongoing monitoring of progress. As part of implementation, the project board will determine the process for regular assessment, review and evaluation of the SPA. It is likely to be agreed that providers working within the Integrated Health & Social Care SPA will be required to collect data around service utilisation and service user satisfaction; in particular from the perspective of whether the new model of service provision makes a difference to those on the receiving end through reducing delays and hand-offs, along with whether patients, service users and referrers report a better, more seamless, experience of care. Project evaluation will involve both qualitative and quantitative evaluation to ensure that the SPA is operating effectively and is achieving its objectives. Key objectives will be agreed during development and will include delivering better outcomes and customer experience for patients and service users and the SPA's contribution to the achievement of targets within the Better Care Fund metrics. Evaluation will be undertaken through analysis of data and satisfaction surveys and recorded on the project dashboard. The findings from the reviews will be reported to The Wellbeing Board.
What are the key success factors for implementation of this scheme?
The scoping, planning and development of an integrated single point of access will take place during 14/15 with the aim of having an agreed model of an integrated SPA in place

and operational by [June 2015], although this might be in the form of a pilot to ensure the success of the initiative prior to full roll-out.

Whatever the final design there will be a need to:

- Achieve agreement, support and commitment for the scheme from all key stakeholders, including agreement of project plan. This will include identifying any conflicting organisational priorities / different ways of working between the various organisations, any potential impact on the services required by other providers and any perceptions of professional boundaries that may hinder the project and agree action to address these
- Facilitate the creation of a collaborative culture that emphasises team working and the delivery of highly co-ordinated, consistent and patient-centred care
- Agree where/how the SPA is to be established, be that in a virtual or actual location
- Ensure that effective IT systems are in place to support delivery of care and that appropriate and relevant information is available to the right people in a timely and easily accessible manner
- Identify and address any real and perceived barriers to data sharing across the constituent parts of the local health and social care system that might impinge on the effectiveness of the SPA
- Ensure appropriate governance processes are in place
- Ensure availability of staff in sufficient numbers with the right skills to provide adequate staffing in response to anticipated number of contacts.
- Anticipate and address any impact that increasing the number of contacts for accessing community support in people's normal place of residence might have on the services required from other providers (i.e. community healthcare services; independent domiciliary care providers, etc)
- Provide the required education and training to equip the existing and future workforce for this new model of care
- Clarify and align the interface with other BCF and integration project workstreams

Scheme ref no.
3
Scheme name
Integrated Care
What is the strategic objective of this scheme?
The Integrated Care Programme embraces and enhances a range of existing and new services which share a strategic objective of strengthening the availability of community based services in Slough, whilst reducing the fragmented nature of the care provision. Running through each of the different service components is our BCF investment in enablers, which will support joint working and shared delivery processes and systems, in order for the health and care workforce to be able to provide coordinated care to their clients. Their development will take place in tandem with the *BCF Proactive Approach* and the

Single Point of Access capability which will increasingly drive integrated systems and process in support of more joined up care. Whilst we have articulated our schemes as distinct elements they share in common a set of strategic objectives as follows:

- Meeting medium and high levels of health and social care needs for patients in their own home or in a bed based service provided in a local nursing care facility
- Managing increased patient complexity in the community
- Offering step up and down responses, to prevent hospital admissions and to facilitate timely discharge
- Decreased levels of ongoing reliance upon services, through promoting independence
- Improve patient choice and control and satisfaction of what and how services are delivered to meet their outcomes
- Increase flexibility and capacity of provision, ensuring that the community bed capacity will have the ability to manage more complex nursing needs
- Delivering transfer to assess as close as practicable to a persons own home.
- Support to patients to remain in their own home during a period of rehabilitation and assessment. This will particularly benefit peple with dementia and increase the opportunity to maximise independence and reduce the numbers of long term care

The core elements of the integration BCF schemes and their strategic aims are as follows:

Locality Integrated Care Teams (LICTs)
These multidisciplinary teams based around clusters of GP Practices provide a joined up health and care response to the identification, assessment, care planning, onward referral and treatment of care needs (where appropriate). Many of their clients will be the frail elderly albeit not exclusively. They will maintain a seamless interface with the range of community and intermediate care services on offer in Slough (see below) to ensure that those who are vulnerable and at risk are receiving the short term support needed as their condition changes over time or as crisis occur. This will work to prevent unnecessary hospital admission or to provide short term support following a hospital episode. The BCF investment will support an expansion of the case management approach for clients with complex needs ensuring they are receiving the necessary support to allow them to remain at home and independent for as long as possible.

Reablement, Intermediate Care and Enhanced Intermediate Care
This range of services have the strategic aims of offering short term and or rapid response to support clients to regain their independence either following a crisis at home or post hospital episode. They achieve this through targeted reablement plans and seek to maximise independence thereby reducing people's reliance upon long term services and admissions to residential services. The 3 elements of this service are:

- Reablement support to promoting increased independence pre and post hospital
- Rapid response in event of crisis to avoid need for admission
- End of life care
- Palliative care

Once the input has come to an end the LICTs and case managers for those with complex needs take back responsibility for the ongoing care needs.

Nursing and Care Homes and Domiciliary Service

The focus for this service for Slough is to reduce the need for nursing and residential care placements with increased use of domiciliary care and enhanced intermediate care. The service is being redesigned to create a shift from a reliance on residential care to increasing the demand for reablement at home in order to reduce need for long term care. In line with our strategic driver to keep people in their own with home we recognise the vital fast track CHC assessments and community equipment has in providing a cost effective solution. The purpose of this scheme is to provide interim home care social services and timely assessments to help facilitate prompt hospital discharge(largely of frail elderly people), to prevent delays in hospital discharges, to reduce re-admissions, and to avoid premature. They will work closely with the LITCs and Intermediate Care services to ensure that care is joined up using increasingly shared processes and systems for care delivery.

They will require a specific BCF project to enable a **Shared Assessment and IT** capability to support care delivery and information sharing.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This integration theme proposes to develop a “whole system” approach to joining up ways of working across core community services which although organised to meet different needs and managed separately, will increasingly become multidisciplinary across health and care with shared assessment processes, treatment pathways, working practices, skill mix, and information systems.

The services are at varying degrees of integration. Currently some elements of the services are more integrated (for e.g. the intermediate care services) but residents who use multiple strands of the service often experience delays in care due agencies working in silo, lack of communication and different opening times and working practices from the each provider.

Models of Care

Integrated Locality Teams

These multidisciplinary teams are aligned around clusters of general practices in Slough. They will take referrals from across health and care professionals as well as increasingly via those identified with the Proactive Care risk stratification approach, as well as from the Slough Single Access Point. Input is typically provided on a weekday basis with out of hours support provided from an increasingly joined up out of hours service as well as the Intermediate Care services - whether Rapid Response End of Life (an additional integrated pathway for Palliative Care will be developed) or the recovery team. Case management forms a key part of the service model for those with complex needs and or at high risk and this will be expanded through the BCF investment.

Reablement, Intermediate Care and Enhanced Intermediate Care

The BCF fund will see a significant investment in the range and responsiveness of

intermediate care services in Slough addressing historical deficiencies in this area.

These services currently operate 7 days a week and from 8.00am to 5:00 pm. with the out-of-hours service provided outside daytime operating hours. The arrangements with out-of-hours services ensures that there is a continuity and consistency of service for patients either discharged from acute services or require a service to prevent admission. Referrals are made through a single point of entry, 2013/14 and response is guaranteed within a maximum of two hour (but usually less), providing reassurance to referrers and other partners. Over 30% of referrals are from acute services to facilitate a discharge, looking ahead the service will integrate further with primary care to encourage referrals (this is currently below 10%). The service includes step-up and step down beds, 15 beds are for this purpose. The vast majority of patients (95%) are supported in their own home. In accordance with the Slough Commissioning strategy for older people, there is further development of the service with Health and Social Care working together to develop a joint approach towards prevention and to integrate continuing health care assessments within the service.

Nursing and Care Homes and Domiciliary Services including enhanced Joint Equipment services

As part of the commitment for more people to be cared for in their own home, there will be investment to form a new jointly funded Health and Social Care Assessment Service, and increased investment in the in the Joint Equipment Service and assistive technology, through proactive targeting of cohorts at risk. These will be identified through multiple forms including Proactive Care, Social Care, GP's, patients and their families to enable care at home. Outside of BCF, Slough is increasing its number of units in Extra Care Housing; this is a viable opportunity to provide an alternative method of service delivery for local residents in need of residential/nursing home placements. The additional BCF investment will build on work already taken place with care homes via primary care input which is reducing the number of admissions from care homes to the acute sector. This in turn will contribute to NEL admission targets.

Population Cohorts being targeted

Frail Elderly

Our BCF investments will enhance and improving the alignment of services in place for the frail elderly cohort, ensuring a consistent approach to prevention, early intervention and demand from this high risk group.

Those with long term conditions:

Our BCF investments will take the form of focused support targeting patients of long term conditions to recover quickly after a period of ill health. In line with the duties under the Care Act, this strand will look promote wellbeing through increasing Health Action Planning, Carers Assessments, working with GP's to identify high risk cohorts, and the development of apps to promote management of patients own health.

Priorities include:

Coordination and improvement of services for **Stroke** patients and carers,
Coordination and improvement of services for **Dementia** patients and carers,
Coordination and improvement for **Respiratory Care** patients and carers

Single Assessment and IM&T

Underpinning the success of the above is **joint case management** and information sharing. This scheme will provide a platform for single assessments and sharing of care key data, (from GP's, Acute Services, and health and social care providers) to improve communication and our response to a crisis enabling the right care by the right people at the right time. This will bring about a step change in the way health and social care services work with local residents, allowing patients to have a positive experience and to only have to tell their story once.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enhanced intermediate Care: Service delivery is integrated and is provided by Slough Borough Council, in order to meet the anticipated 20% increase in demand 5 additional posts (fte) have been recruited. A review of intermediate services is underway with an action plan to be developed implemented by December 2014.

Management of long term conditions: Slough Borough Council is the lead commissioner for dementia and stroke patients and carers, the service is provided by Berkshire Healthcare Foundation Trust (BHFT), and the latter with the Stroke Association. The Council along with the CCG will commission services for medicines management and the integrated respiratory service, this will form part of wider joint commissioning arrangements across the East of Berkshire, it is anticipated the Business Plan will be approved in September 2014 with a go live date of January 2015. The service is currently provided by Berkshire Healthcare Foundation Trust.

Care at Home: Opportunities to fund a joint CHC assessment service to improve patient experience and outcomes will be explored during 2014 as this coincides with a number of services currently being re-commissioned. This provides a platform to redesign services to incorporate joint arrangements to deliver health and social care services. Slough Borough Council is the lead commissioner for domiciliary care and nursing and residential placements. The Council is commissioning its domiciliary care service and increasing the number of providers on the framework from 15 to 20. This will be in place form 1st April 2015 and will be able to meet the increase in demand. The Joint Equipment Service is provided by NRS HealthCare and jointly commissioned across the seven Berkshire CCG's and six Berkshire local authorities. The scope of service has been increased to include telecare and tele-health.

This scheme will contribute to the improvement targets of the following metrics:

- Permanent Admissions of older people to residential and nursing care homes
- Proportion of older people who were still at home 91 days after discharge from hospital into reablement services
- Delayed transfers of care
- Reducing Non Elective Admissions
- Patient/service user experience
- Health relate quality of life for people reporting having one or more long term condition

Long Term Conditions - Integrated Respiratory Service
The service will be commissioned in partnership with the three East Berkshire CCG's. Current providers and enables are Heatherwood & Wexham Park Hospital Trust, Frimley Park NHS Foundation Trust, Royal Berkshire Hospital Foundation Trust and Berkshire Healthcare Foundation Trust. A full service specification has been submitted, it is anticipated the integrated service will be implemented during 2014/15

Single Assessment and IT: Separate Information and IT group has been established to develop a shared Information Platform under the vision; 'One Patient, One Record, One Care Plan'.

An element of the service is provided by Berkshire HealthCare Foundation Trust and Slough Borough Council. Following a full business case, this service will be jointly redesigned by the CCG and Slough Borough Council. The next stage will detail the service specification and evaluate the capacity for managing demand and change. It will also ascertain the level of readiness in the current system for the implementation of the new model – identifying areas of quick wins and planning a whole system implementation for 2015.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Research by the Kings Fund and Nuffield Trust show that significant benefits can arise rom, integrated care, specifically in cases of where cohorts are targeted whom care is not coordinated. Slough has a significant number of residents who are multiple users in our health and social care economy, by coordinating their care; this is lead to a better experience and increased efficiencies.

Establishing a single point of access and assessment in line with other transformation changes is identified as best practise as demonstrated by Nuffield Trust (www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011), such as Torbay, West London Alliance, Bridgewater Community Health NHS. The results include reduced use of hospital beds, low rates of emergency admissions for those over 65, and minimal delayed transfers of care. Further examples are:

- Hereford's integrated care organisation based on eight health and social care neighbourhood teams is in development to support the personal health, well being and independence of frail older people and those with chronic illnesses such as diabetes, stroke and lower back pain. Early successes include lower bed utilisation and reductions in delayed discharges from hospitals.

- North Somerset developed four fully integrated and co-located multi-disciplinary teams provide case management and self-care support to older people. The aim is to prevent complications in diseases and deterioration in social circumstances. Based around clusters of GP practices, the service brings together community health and social care workers, community nurses, adult social care services, and mental health professionals.

More people presenting with a frailty syndrome crisis can be safely assessed and managed at home. This requires dedicated, well-led, multi-disciplinary community teams. Many frail older people, once identified, will require comprehensive geriatric assessment (CGA) (British Geriatrics Society, 2010). This is defined as a 'multi-dimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long-term follow-up.

Case study: HSJ published on 13th May 2014 by Camden CCG
http://www.hsj.co.uk/home/commissioning/improve-frail-elderly-care-with-evidence-not-intuition/5070273.article#

Local independent review of all Intermediate Care Services in Slough was completed in July and will inform the development of this work and will be incorporated in to the business plan.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Service element	**Amount**
Reablement	£741k
Intermediate Care	£857k
Enhanced Intermediate Care	£725k
Joint Equipment Services	£533k
Ward 8 closure and early supportive discharge	£252k
Case Management	£748k
Nursing & Care home, Domiciliary Care	£480k
Single Assessment and IT	£208k
Oaks EMI	£76k
Total	£4620

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The key outcomes anticipated are:

- A reduction in non-elective admissions from a defined cohort of patients from a given baseline;
- An reduction in readmissions from a defined cohort of patients from a given baseline;
- Increase in successful discharge to integrated teams;
- Reduction in admissions from care homes;
- Increase in number of avoidable admissions facilitated by the service;
- Improved EOL outcomes;
- Increased effectiveness of reablement.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This is currently being developed and designed by the Integrated Care Project Board. The outcomes will be measured in absolute terms and will cover a range of parameters to report the following:

- Patient Experience
- Number of admissions avoided
- Indicators showing improvement in Quality
- Indicators show any savings released as a result of changes to the pathway

There is also an agreed set of output performance measures that have been agreed as the balanced scorecard for the service.

For the respiratory project the outcome measure are currently being developed and designed by the Integrated Respiratory Project Board. The outcomes will ensure all information available to the 3 CCGs for audit purposes, and will be required to support the CCGs in monitoring the quality of the service. This will include:

1. Activity
2. Performance targets
3. Case mix information
4. Referral information (to include appropriateness of referrals)
5. Clinical Audit results
6. User satisfaction
7. Incidents / complaint
8. Annual reports

What are the key success factors for implementation of this scheme?

- Strategic Buy-in from patients, primary and secondary care, and service providers (use of single assessment, and data sharing);
- Awareness of the service to ensure referrals and intake of service;
- Defining the scope of care and support to be delivered through the integrated care scheme;
- Agreeing and supporting standards for care planning, review, terminology, information and communication;
- Work force sustainability –expertise, ability to redeploy and skill set to deliver the changes required;
- Governance process for sharing data;
- Suitable IT infrastructure to facilitate shared services.
- Time required for deployment including training element
- Aligning incentives and contracting requirements across a whole-system frailty pathway will be time consuming
- Project management support
- Managing patient expectations
- Financial sustainability

Scheme ref no.
4
Scheme name
Strengthening Community Capacity
What is the strategic objective of this scheme?
• To actively build community capacity and resilience through our work with the voluntary and community sector. • Expand the support for carers through the Carer Investment Funds. • Exploring asset based approaches to fostering community resilience building on links with Soughs active voluntary sector, local community groups and faith groups • With the leadership of Public Health department implementing the Slough Well Being Delivery Plan aimed at tackling the social determinants of health. As part of making significant inroads in to the public health challenges in Slough particularly the high rates of childhood obesity, people who smoke, inactivity and consumption of excessive salt and sugar.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The aim of the scheme is to support and mobilise the resources that exist in the Borough so that with greater co-ordination and direction can more effectively contribute to the health and wellbeing of its residents. Slough has a thriving voluntary and community sector with over 450 national, regional and local charities and community groups serving the needs of Slough people. Growth and development of the sector has historically been ad hoc and opportunistic where groups and organisations have responded locally to local needs from a variety of funding sources. Several of the charities have been separately commissioned by the local authority or Slough CCG or both. Many are funded through charitable trusts and many more rely on small donations and the support of volunteers to deliver services. Within Slough there are a number of voluntary organisations who are providing health and social care support to Slough residents, but this is not currently set within a co-ordinated care planning framework with the GP or social care service. Integrating care together with the community and voluntary sector through a model of joint commissioning or co-production will maximise the contribution of the voluntary sector to the health and wellbeing of people in Slough. The process for this is at an early stage and will form part of the initial work in this scheme. The vision for this scheme is to achieve greater partnership with voluntary and community sector in our integrated model of care and achieve better outcomes for people of Slough through the advice, support and services that are, or could be, delivered by the

sector.
This is achieve through the following channels:

- Co-operation: whereby several VCS agencies work together in providing different services to same patient.
- Collaboration: coming together for joint planning and pooling of resources (especially volunteers).
- Co-ordination: bringing wider benefit through the sharing of information and making referrals to each other.

Proposal:

1. Mapping of voluntary sector health and social care services – funded and unpaid.
2. A database of voluntary sector organisations and activities (e.g. lunch club, walking groups etc)
3. One volunteering/civic responsibility website used by all VCS groups – volunteers and their skills are available to all charities.
4. Community wellbeing forum – for professional health care staff and VCS groups.
5. To establish support from the VCS to be part of an integrated service, including referral from single point of access and working around clusters of GPs, .
6. Top down approach for the development of peer support networks around GP clusters (e.g. asthma support group etc)
7. Establish an e-directory of VCS menu of services: a single source of information for the service users and professionals.
8. Commissioning of dedicated support to those leaving hospitals who have experienced a fall. Co-ordinated support from VCS and statutory sector.
9. A call for action from volunteers to tackle the top 5 agreed priorities.
10. A volunteer co-ordinator post co-located in VCS and statutory sector.
11. Volunteer Public health champions trained

Key to strengthening our community capacity is also the way in which we provide support to Carers. Slough has developed an interim joint strategy in partnership with local carers to understand what is important to them and what is important to help them in their caring role.

Carers provide a huge amount of unpaid support to people with health and social care needs. Part of this scheme is to enhance and extend the support that is available to carers to support them in their caring role. This includes young carers who may be caring for an adult with a long term condition and provision of carers education.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Lead commissioners are Slough Borough Council and Slough CCG

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

The community sector
Feedback through sector representatives is that there are many people who are or willing to volunteer but need to work together with health and social care services to look and how and where this valuable resource be best directed and utilised to maximum benefit. There is substantial evidence base on the contribution that the community and voluntary sector brings to improving health and social care outcomes within the communities they serve.
There is a large evidence base of voluntary sector schemes that contribute to positive health and social care outcomes of people. These include handyperson's services, home from hospital, befriending, peer group support, financial advocacy, information and advice.

Through integrated care there is also evidence of benefits to health and care services which include:

- Supporting people to manage their general health and wellbeing
- Pre-admission support
- Identifying early warnings
- Co-ordination between the patient and other multidisciplinary teams
- Early intervention prevention escalation to a crisis
- Reduction of unnecessary or avoidable admission
- Ongoing support to people living with dementia and their carers

Age UK Improving Later Life – what works, 2014
Age UK Right Care, First Time: services supporting safe discharge and prevention hospital admission and readmission.
Age UK Cornwall and Isles of Scilly, Pioneering integrated care pathway for older people recognised by HSJ awards

Supporting Carers
The 2011 national census data indicated that there were a total of 11,626 people who provided some level of unpaid care to a relative or friend. This is about 14% of the area's population compared to the national average of 12%. The census also showed a 13% increase in number of Carers between 2001 and 2011 which is above the average in England (11%) and other areas of Berkshire.

In 2012/13 there were:

- 448 Carers who requested an assessment with just 62% who were receiving services.
- 495 disabled children living in Slough with their families received a short break, thereby also benefiting parent Carers and their siblings. Of these 84 children accessed overnight short breaks and a further 36 families received a Personal Budget in lieu of a short break.
- The latest JSNA suggest there could be 729 young Carers in Slough; although they largely remain a hidden group and are difficult to profile.
- The 2011 Census recorded higher numbers in that 377 aged up to 15 years and

976 aged 16-24 years provide regular care.

Data from the 2011 Census also highlights that from the 11,626 identified carers:

- The majority of Carers 31% (n 3705) are aged between 35 and 45 years, the largest category, over 40% of Carers in this age group provide 20 to 49 hours unpaid care a week
- BME Carers make up 65% (n 7556) of the Carers in Slough, reflecting the local population profile.

Slough Borough Council and the CCG fund a number of different support services to support them in their caring role.

In consultation on the development of the strategy Carers told us that they would like to see the following:

- Access to Emergency Support ;
- Access to respite and short breaks;
- Information on what it means to be a carer and their own wellbeing;
- Access to Primary Care
- Training for processionals
- Information, Support and Guidance
- Increased support for young carers

Some of these areas (e.g. access to primary care and emergency support) will form part of other BCF project workstreams. There is however particular focus within our plan to offer greater support to younger carers, adults who are caring for people with dementia and stroke and carer education.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£210 Carers
£200 Community Capacity support to integrated care

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

To be developed by November 2014

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

To be developed by November 2014

What are the key success factors for implementation of this scheme?

- *Reduce the proportion of patients falling into crisis and needing preventative statutory services*
- *An increase in reported well being amongst the residents in Slough*
- *A reduction in the reported incidence of mental health problems*

- *Increase in the range and quantum of voluntary and charitable activity in Slough*

Reported improvements in partnership working in Slough amongst the voluntary,charitable and business partners

ANNEX 2 – Provider commentary

Name of Health & Wellbeing Board	Slough
Name of Provider organisation	Heatherwood & Wexham Park
Name of Provider CEO	Grant Macdonald
Signature (electronic or typed)	Grant Macdonald

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	15,611
	2014/15 Plan	14,961
	2015/16 Plan	14,320
	14/15 Change compared to 13/14 outturn	-650
	15/16 Change compared to planned 14/15 outturn	-641
	How many non-elective admissions is the BCF planned to prevent in 14-15?	n/a
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-641

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We recognise the level of aspiration of the Health & Wellbeing Board, and note the numbers relate to the total population of the local authority area rather than any one acute provider organisation.
2.	**If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Our forward plans recognise the aspiration for reducing the number of non-elective admissions through provision of care in alternative out of hospital settings

Name of Health & Wellbeing Board	Slough
Name of Provider organisation	Berkshire Healthcare Foundation Trust
Name of Provider CEO	Julian Emms
Signature (electronic or typed)	Julian Emms

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	15,611
	2014/15 Plan	14,961
	2015/16 Plan	14,320
	14/15 Change compared to 13/14 outturn	-650
	15/16 Change compared to planned 14/15 outturn	-641
	How many non-elective admissions is the BCF planned to prevent in 14-15?	n/a
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-641

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We recognise the level of aspiration of the Health & Wellbeing Board, and note the numbers relate to the total population of the local authority area rather than any one acute provider organisation.
2.	**If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?**	n/a
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	BHFT looks forward to continuing engagement with commissioners in the design of out of hospital services that underpin the planned change in acute non-elective activity outlined by the BCF