**Appendix A**

The BCF plan was required to be completed and submitted on an excel spreadsheet. It consists of both narrative and financial sections. The strategic narrative consists of three sections:

## 1 Person Centred outcomes

*Your approach to integrated care around the person, this may include, but not limited to:*

- *Prevention and Self Care*
- *Promoting Choice and Independence*

The vision and principles underpinning our commitment to integration remain largely unchanged since our BCF plan submission for 2017-19 and our BCF plan for Slough described our ambition for a shift from reactive to proactive health and social care to enable more people to have healthier, safer and more independent lives in their own home and community for longer, receiving the right care in the right place at the right time.

We have described our vision for being integrated as meaning delivery of a broad range of health and social care services seamlessly, regardless of organisational boundaries. Working across a complex health and social care economy, we continue to develop a proactive approach to the provision of health and social care and support in the community delivered in partnership through GP practices, the acute hospital, integrated health and social care multi-disciplinary teams, community based health and social care services working alongside local care and housing providers, as well as the community and voluntary sector whilst all being underpinned through consultation and collaboration with our residents.

The pace of progress towards our personalised and integrated care goals for 2020, supported by the merger of East Berkshire CCGs, the work within the wider Frimley ICS partnership, and the more recent set up of Primary Care Networks, is now showing real and significant improvements in the experience of Sloughs residents particularly for our targeted cohorts within the population identified through our JSNA as those living with frailty and complex conditions (including CVD, COPD, diabetes, mental health, dementia) and the support for their carers.

Slough local authority boundary and that of what was previously the Slough CCG (now as a locality of the East Berks CCG) is broadly co-terminous. It has a relatively small geographical boundary but includes the acute hospital at Wexham Park in the north; a community hospital (Upton) which also has a walk-in centre in the south; 3 adult social care locality teams and now 3 recently established Primary Care Networks for our 16 practices. Our Community Health and Mental Health service provider works across the East of Berkshire. Slough has a small number of Care Homes (6) although some of these are large in size and a strong care home and domiciliary care market.

Services are brought together through a systematic programme delivering an integrated approach adopting good practice, easier to follow pathways and a focus on success being measured in outcomes for all residents, regardless of their neighbourhood location. Resources are being reshaped with services delivered seamlessly from the service users' perspective with different skills and professional resources being provided promptly from a range of different providers but without delays, duplication of notes and plans, form filling and registration onto different systems. Notable examples of this are:

**Integrated Care Decision Making** (ICDMS) is a key workstream within the Frimley ICS plan and supported by BCF investment into a community based multi-disciplinary workforce, including additional OT, physiotherapy and Community Psychiatric Nursing

capacity to move away from reactive, crisis management provision and towards proactive, intensive personalised support for those residents at risk, identified through Anticipatory Care Planning toolkit (risk stratification) and health and social care community referrals.

**Local Area Access Points** are being created in each locality through which referrals will be made and jointly triaged through to the community teams for a rapid and integrated response and carry out joint assessment where it makes sense to do so. Phase 1 launch is December 2019 and will include practitioners from Adult Social Care, Reablement, Community Matrons and Older People's Mental Health. A working group is established reviewing activity data can captured on respective Health and Social Care systems and ways to measure the reduction in handoffs and improved outcomes of the integrated approach on the ongoing care and support needs of the individuals.

The investment in ICDMs complements the development of the new "streamed" A&E medical assessment facility at Wexham, where ambulatory care and frailty services support a whole system approach to a systematic reduction in crisis use of health and care services and avoid potential long term care. Slough's GPs, community health and social care leads refer individual patients at risk for full frailty assessment with a view to them returning to their own place of residence more quickly with integrated care and support plans/packages in place - avoiding unnecessary hospital admission or longer acute care stays. The importance of providing personalised short term support whilst a health crisis or issue is resolved has also been key in supporting carers.

**EOLC support** - acute, community health and social care specialists and voluntary sector provision united into an integrated, responsive service that meets tailored, individual EOL needs - offering comprehensive and seamless support to all those who wish to die at home. Hotline services provided through the hospice based team avert crises and address individual concerns by families and community clinicians/social care teams to deliver positive benefit in quality of end of life care for our residents, including those in care homes, and helping to reduce avoidable admissions.

**Paediatric hotline** - offers GPs immediate consultation with a paediatric consultant in the acute trust whilst parent/child is in their practice to reduce avoidable admissions. This support is regularly accessed and proving effective at avoiding unnecessary referral or attendances at A&U or PAU but also has created better understanding and communication between GPs and consultants and the weekly rota arrangements have enabled a consistency supporting dialogue and monitoring of a situation over a few days. Education materials for common childhood illnesses have also been distributed to GP practices, children's centres, health visitors, and nurseries across Slough. These were developed systematically with support from the acute trust and all key partners.

**Children's asthma** - Our BCF funded Children's asthma service operates both in the hospital and providing outreach in the community. We have two specialist asthma services who work with children and young people who have attended PAU, A&E or been admitted, to help better understand and manage their asthma. They also take referrals from primary care that come in via the paediatric hotline. The service also annually visits secondary schools with its Asthma Bus visiting all 16 schools and about 600 pupils. This service has proved very effective at engaging with children and young people in years 7-8 and promoting proper use of inhalers and good asthma management through personalised plans. The nurses also work together with the school nursing team on this. The service won a Nursing Times award in 2017 and subsequently staff presented at the ARNS (Association of Respiratory Nurse Specialists) national conference in May 2018.

**Wellbeing prescribing** - BCF has supported the initial pilot and full implementation of the Slough Wellbeing prescribing service which is hosted in the Council for Voluntary services. The model is based on professional referral from a GP, Adult Social Care practitioner, a member of Wexham Park Hospital staff or the Neighbourhood team, through to one of the Wellbeing Prescribers. The prescriber will then complete a wellbeing assessment of the physical, emotional or practical needs, may then make onward referral and support into a one or more CVS support groups (many of these are funded by SCVS), and have regular contact with the person 2x per week up to 6 months.

The model is a person centred journey and guided by what the person wants to achieve, not necessarily what the professional thinks they need. Each person is asked what they would like to achieve through engaging with the service (their wellbeing outcome) and are asked at the end of the intervention if they feel this outcome has been met (and outcome tool used to evaluate). There are currently 75-80 referrals pm and 228 open cases.

**Carers support** remains a priority as is the collaborative and integrated approach working together with carers and stakeholders both locally and across the ICS. The personalised approaches to individual needs and MECC (Making Every Contact Count) has promoted understanding and response to carer requirements as well as the cared for persons individual needs. A more dynamic approach to looking at the carer role, is being adopted across all carer related services with greater responsiveness to potential changes to a person's short and longer term support needs. Examples of this can be seen in:

- ICDM teams have developed carer identification and support plans to ensure that the success of high risk patient community based services
- The integration of carers support with wellbeing prescribing ensures carers have seamless and direct access to both carer support services and wider wellbeing opportunities in the community voluntary sector
- Support for family members during EOLC has helped to alleviate potential anxiety and bereavement challenges associated with what could otherwise lead to an avoidable acute hospital experience and opened up families to counselling and support services as a natural next step from the EOLC community based programme

## 2 Health and Wellbeing Board Level

*Your approach to integrated services at Health and Wellbeing Board level (and neighbourhood where applicable), this may include but not limited to:*

- *Joint commissioning arrangements*
- *Alignment with Primary Care Services, including Primary Care Networks*
- *Alignment of services and the approach to partnership with the voluntary and community sector*

Locally, there are initiatives and programmes of activities in place, and in development, which will impact positively on life expectancy and premature mortality of Slough residents. Progress of these plans, together with new opportunities and requirements against different timetables for delivery create a dynamic and complex context for decision-making.

Slough Wellbeing Board has local leaders from across the local health and care system who work together to improve the health and wellbeing of local residents. The recently refreshed Joint Strategic Needs Assessment (JSNA) sets out the current and future

health and care needs of the population which, in turn, informs the development of our Wellbeing Strategy.

SWB includes a wider range of agencies and sectors in order to not only jointly commission and integrate health and social care service but also act as the strategic partnership for the borough. It has a broader focus that includes wider aspects of wellbeing, including a focus on the wider determinants of health such as education and training, housing, the economy and employment as well as more integrated and efficient health and social care services.

Partners on the Board have positively embraced the opportunity to develop Slough "place" within the Frimley Health and Care System and there is recruitment currently underway to appoint to a project lead to support the SWB develop its Health and Care Place Based Strategy by April 2020.

The Slough Wellbeing Board is supported by the Health and Social Care Partnership which has broad membership that include commissioners and providers in its terms of reference and also representation from the newly established Primary Care Networks. It is well positioned to effectively oversee the delivery of improved population health outcomes being at place and neighbourhood level within the context of the ICS ambitions, and therefore effect real change for local communities.

The current Slough Wellbeing strategy 2016-2020 is due to be refreshed and a workshop session on 3rd October to start this process. It will be focusing on the role of an Integrated Care System and its relationship to the Slough Wellbeing, discussing the health needs Sloughs population, exploring the wider determinants of health and agreeing the specific health priorities for focus for the next 3 years.

In line with the strategy and commissioning priorities implementation of any new business cases being considered for BCF investment have governance through H&CS Partnership and BCF Delivery group. BCF updates are reported to the H&SC Partnership quarterly on finance, performance and key areas of activity and innovation projects (e.g ICDM). The H&SC Partnership, and within it the governance of our BCF programme, provides the integration framework between borough, CCG and ICS linking together our wider organisational, strategic priorities and resources with the needs of our local communities and residents. Equality impacts of local BCF schemes, e.g Cardiowellness, are important, particularly across our diverse population and reflects in our focus on reporting outcomes where possible, rather than activity and performance measures.

The ICDM programme within the ICS operational plan is delivering integrated care planning and personalised support aimed at minimising emergency interventions for at risk residents with frailty and complex conditions. It is a broad range of activities that includes:

- Improved hospital discharge pathways to reduce avoidable delays in acute environment and support a safe and timely return into a community based environment with personalised support programmes to meet individual needs
- Care home capacity and consistent quality of care in both nursing and residential homes
- Domiciliary care and reablement services to support continued independent living
- Housing adaptation, AT and equipment maximising independence
- Raising the profile of dementia and in the support for people with dementia and their carers

- Falls prevention through falls risk assessment and multifactorial interventions including education and awareness, strength and balance classes and greater collaborative working between partners to identify and refer to appropriate services
- Investment in wellbeing prescribing to maintain confidence and social engagement and connecting people with their communities and support services available
- Reduction in avoidable NEL admissions of children by education, asthma service, GP hotline and alternatives to A&E including NHS111
- Identification and support for carers, including young carers and carers employed within our ICS member organisations

All of these different programmes are characterised and underpinned by the common ethos, embedded within our overall BCF approach to integration, which flows within different work strands but also binds them together. They are:

- Person/family at the centre and being able to lead and plan their own health & wellbeing, managing their own resources
- A focus on independence
- Building on the assets of the individual and their community; supporting and mobilising individuals & groups
- A co-produced approach, doing 'with' and not 'to'
- Embedding personalisation and personal budgets (Direct Payments and PHBs)

## 3 Your approach to integration with wider services (e.g. housing)

*This should include your approach to using the DFG to support the housing needs of people with disabilities or care needs.*

Through DFG funding we provide a diverse range of adaptations to a disabled person's property to ensure they can remain independent in their own home. Our approach meets both the legislative framework provided by HGCRA Act (1996) and the Care Act 2014, including ASC to assess and to arrange for appropriate assistance, including statutory entitlements to community equipment and minor adaptations but we are also committed to learning from the many examples of good practice, innovation and recommendations referenced in the national DFG Review (Feb 2018). The use of DFG has been expanded to the following areas:

- Relocation Grant to support Slough residents eligible for a DFG where it is more suitable and practicable to move rather than remain in their current property
- Hospital Discharge Grants to support Slough residents aged 65 years and older being discharged from hospital and require small grants for heating/minor repairs that would otherwise delay a hospital discharge
- Handyperson services – to help with small building repairs, minor adaptations to prevent hospital admission
- Fast-track applications – to help with minor adaptations using trusted assessors and other professionals
- Funding in Excess of the Maximum Amount – to fund adaptations with a clear return on investment in excess of the DFG grant limit if £30,000

For 2019/2020 the Partnership have engaged Foundations UK to work closely to identify how the grant can be further used to meet the wider health and social care needs of service users. The aim is to produce a revised operating model, consider the future of how DFG should be delivered and develop pathways to further extend DFG to improve patient flows, promote independence and expand our assistive technology offer

Working in partnership

We recognise the importance of close working between housing, social care and health and this is integral to our wellbeing strategy. Our JSNA provides a detailed profile of our population needs and we recognise the importance of timely availability of aids and adaptations for residents at developing, living or ageing well stages of life in order to maintain their independence and quality of life. Our priorities include a particular focus on cardio-wellness, diabetes, COPD, falls prevention and reducing isolation. The importance of carers and including their needs and considerations in how we support them and the people they care for including use of equipment, adaptations and digital technology is reflected in our BCF plans.

Examples of partnership working with Housing include:

- Joint commissioning and tendering of 16+ Support and Accommodation with particular emphasis on the provision of support for young people with LD, Behavioural and transitional needs. Extensive consultation and engagement with operational staff, service users and local providers to develop a service aimed at reducing or delaying the need for statutory services and support individuals to maintain their tenancies and manage their own health and support needs.
- Development of an inter-agency approach to tackle the issue of hoarding in collaboration with environmental health, mental health and housing. The aim of this project is to reduce DTOC and ensure vulnerable service users can maintain tenancies and manage their own health.

Under the ICS, Slough is also leading on development of ABI (Acquired Brain Injury) pathway. In partnership with RBWM and BFBC, this project will develop plans for jointly commissioning a service for young people with acquired brain injury. The aim of this project is to address a lack of local provision where young people often placed in residential care with people who are much older, or with different types of need.

Provision of more innovative, cost effective technological solutions is a very dynamic environment and we are continuing to work with specialist partners to expand and develop its use. We have had a successful telehealth pilot programme funded by BCF which has evidenced positive outcomes for people using remote digital solutions and requiring less direct intervention. We are looking at options for:

- Provide greater equality of access and adoption to all our residents
- Sourcing equipment and aids from a wider range of equipment suppliers
- Work within the wider context of housing adaptations where appropriate
- Grow and develop in line with the evolving needs and provide outcomes that are personally relevant and valued by all users
- Develop new telehealth and telecare provision seamlessly alongside existing equipment provision