BCF narrative plan 2022-23

Draft 15th Sept 2022

Slough Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

- NHS Frimley
- Frimley NHS Foundation Trust
- Slough Borough Council
- Berkshire Healthcare Foundation Trust
- Slough Council for Voluntary Service
- Slough Coproduction Network

How have you gone about involving these stakeholders?

Local stakeholders are involved in planning and oversight of the BCF programme via the Health and Social Care Partnership and Place Based Committee. An outline of this 2022-23 plan was discussed at the meeting on Tues 23rd August. Our smaller BCF Delivery Group of health and adult social care partners has also discussed and reviewed the content of the plan.

Regular reports on the Slough BCF programme are produced and presented to the Partnership for key decisions, monitoring progress on schemes as well as finances and performance. The BCF plan along with the Annual Report(s) are also presented and discussed at the Slough Wellbeing Board.

Partners across the system are involved in setting metric ambitions i.e. local authority for ASCOF indicators and with Clinical Commissioning Team (analytics), Community Foundation Trust and Frimley Foundation NHS Trust for metrics relating to hospital discharge/admission avoidance as well as the Capacity and Demand Plan.

For the development of this year's BCF plan there has been early member engagement and discussion with lead members of the Slough Wellbeing Board (Wellbeing Board Chair, Cllr Natasa Pantelic, and Cllr Christine Hume) around the framework, local emerging priorities and ambitions of the Board.

The BCF programme in Slough is centre to the delivery of Integrated Care for Slough Place in partnership with the wider system. Our shared and agreed priorities were agreed and published last year (2021-22) in the Health and Social Care Plan and these still guide for prioritising the workplan, commissioning activity and investment decisions. Current and potential BCF funded schemes are therefore evaluated against the delivery of the plan. Any new business case for investment needd to identify not only how it meets the BCF criteria and contribution to performance against the metrics, but also how it contributes towards the local priorities in the H&SC Plan.

The H&SC Plan was developed together with all partners in the Partnership Board and Place based committee, including Primary Care Networks, Community and Acute Trusts and community and voluntary sector.

The Slough Wellbeing Board in this planning year is looking to how the Better Care Fund can be route through which investment can be made which will serve to further reduce health inequalities, particularly addressing wider determinants of health along with prevention, early intervention and the impact of poverty. In line with this there is a commitment to direct more investment to improving the healthy lives of Children and Young People in the Borough who represent 29% of the population of Slough. The Board is coming together as a workshop later in September (date to be confirmed) to discuss and agree the more detailed areas and approaches from which to develop business cases.

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Priorities for our BCF programme in Slough are still guided from the principles and priorities set out in our Health and Social Care Plan 2021-22. These being

- Better Access to Care
- More integrated and pre-emptive service offers
- Use of locality-based models
- Improved outcomes for mental health
- Improved outcomes for frailty
- Responding to changing demands and needs post covid-19

Last year saw some significant additional investment from BCF into social care services and supporting to improving discharge and flow from the acute hospital and the community and voluntary sector.

Key changes for BCF expenditure plan for this financial year of 2022/23 are as follows:

- Contract uplifts where applicable for staff pay increases/increments
- Additional investment into the OT/SALT service (to support young people with disabilities in Slough)
- Funding previously included for our digital telehealth programme supporting people with diabetes has been taken into our ICB digital programme allowing for the continuation of that work across the wider ICB and reinvestment of BCF
- Additional investment into Information and Advice services (now full year funding) through a contract held with Citizens Advice Bureau

New areas of spend (one-off) agreed:

- SEND Participation Officer – this is a 2 year post to support participation and engagement of young people with SEND and their parents/ families. Response to SEND inspection and one of areas of improvement identified.

- Homeless intensive support – Browns service are working directly with homeless people with chaotic lifestyles providing support work to access accommodation, health services, drug and alcohol treatment

- Interim care beds – additional capacity post-covid for discharge into step-down beds to support continued discharge and flow from hospital back to the community

In this year the Wellbeing Board is looking to BCF to support with wider health inequalities and areas of poverty, prevention and early intervention. A workshop event being held in September for Wellbeing Board members to come together and discuss how we invest to help address some of the wider determinants of health, particularly given the rising cost of living and inflation and the impact that this will have on our communities in this winter and beyond.

It has been agreed to hold current unallocated funding in this years BCF (£374k) in order for the Board to have this discussion and agree areas of investment that meet their priorities within the Wellbeing Strategy and help address the needs of the community in light of impact of inflation

and fuel poverty which likely to have deep and profound impact on households and communities across Slough. It is also likely that some contingency funding be held within this unallocated funding, as was the case in previous BCF expenditure planning rounds, to support with any additional demands that may occur within the local system over the winter period.

Of the current £374k CCG minimum contribution that remains uncommitted expenditure in this year, £141k will be invested to NHS commissioned out of hospital services to meet required minimum spend. Owing to the timescales between publication of BCF planning framework and deadline for plan submissions decisions on where this will be invested are still to be made and subject to completion of business cases. The Wellbeing Board has however given a direction of areas that it wishes to invest new BCF expenditure. These being areas of prevention, early intervention and wider determinants of health that will help toward reducing health inequalities in Slough.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The governance of our BCF programme in Slough continues to be overseen by the Health and Social Care Partnership and CCG Place Based Committee. These were merged to a single partnership board in last year. This partnership is a formal sub-committee of the Slough Wellbeing Board and has membership of all our partners in the delivery of health and social care in Slough including local authority, CCG, acute trust, community trust, voluntary sector, Primary Care Networks, lay members and resident representatives from our co-production network.
The role of the partnership is to:

a) Agree strategic direction for the integration of health and social care within Slough.
b) Ensure commissioned services across the partnership are aligned to deliver efficient and effective services, designed to improve outcomes.
c) Consider any issue of health and social care strategic policy, public health strategy or general community concern within Slough
d) Deliver Priority Two – 'Integration' of the Slough Wellbeing Strategy 2020-2025 on behalf of the Slough Wellbeing Board.

The joining of the H&SC Partnership and Place Based Committee formed together in order to:

- strengthen the place approach for all Slough health and care partners
- to enable us to jointly oversee the delivery of our shared integration priorities through our Health and Care Plan
- to create a stronger connection with the Health and Wellbeing Board deepening the connections between CCG, PCN and member colleagues in the local authority
- make best use of stakeholder's time
- to help strengthen the relationships between primary care and the local authority
- to avoid duplication of time and effort

Regular reports (minimum quarterly) are presented to the H&SC Partnership on BCF and related integration development and activity. In support of the Programme Management function there is also a smaller Better Care Fund Delivery group which is the core group which drives forward the delivery of the Better Care programme on behalf of the partners to the pooled budget agreement. It coordinates and operationally manages the BCF on behalf of the Health and Social Care Partnership as well as ensuring that it operates within the policy and guidance framework set nationally.
The role of the delivery group is:

- To manage the delivery of the Better Care fund programme for Slough in line with the agreed plan, budget and timescales
- To receive and monitor performance reports on key performance indicators (KPI) and take appropriate actions
- To oversee and monitor financial expenditure and forecasts within the Pooled Budget
- To review progress in delivery and performance of projects and schemes within the programme
- To review and update the risk register for the programme and those from specific projects and to escalate risks to the Health and Social Care Partnership as appropriate
- To consider new ideas and proposals for Better Care Fund activities and guide and steer development of business cases for commitment of ongoing BCF investment before being presented to H&SC Board

In addition to the Health and Social Care Plan the Council in this year published a new Corporate Plan 2022-25 which includes the priority of achieving an environment that helps residents live more independent, healthier, and safer lives. It outlines key improvement areas of focus which are:

- *Reframing of public health strategy to achieve better outcomes for weight management, smoking prevalence, and substance misuse*

- *Work through the Health and Social Care Partnership to ensure effective implementation of integrated health and social care for outcomes*

- *Increase in the effectiveness of reablement services that enable people to live independently for longer*

In addition, the Slough Corporate Plan includes an ambition to be a borough where children and young people thrive. This includes that children and young people with SEND should have the same opportunities as non-disabled children and young people. To create a town for children and families to thrive, we must ensure that this is inclusive for children and young people with special educational needs and disabilities (SEND). Slough SEND approach must improve and will seek to ensure that children and young people with SEND can grow up happy and healthy, with a voice that is heard and the same opportunities to play, socialise and reach their full potential as other children and young people. The H&SC Partnership has representation from the Executive Director of Children's Service to ensure the scope of integration activity includes and aligns that of children and young people's services.

BCF has this year agreed investment to support the SEND participation work in support of the action plan developed following recent inspection and identified areas for development and improvement. There is ongoing discussion around investment in Children and Young People from within BCF to support longer term health outcomes and health and wellbeing. This needs to contribute to BCF metric outcomes but acknowledged that Slough has a comparatively young population, as identified within the JSNA. Slough has almost a third of its population aged under 18 (29%) compared with 21% nationally. Currently only small percentage of BCF investment is directly invested to CYP with most investment being into adults and older adults, specifically those with frailty and complex health needs.

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

The vision and principles for commitment to integration remains unchanged in our BCF Plan 2022-23 and is to continue to use our partnership, and the BCF investment, to achieve 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.

Our vision for being integrated is for the local delivery of a broad range of health and social care services to operate 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. This is delivered in partnership between

- Primary Care Networks and GP practices
- The acute trust
- integrated health and social care multi-disciplinary teams
- community-based health services
- adult social care services
- local care and housing providers
- community and voluntary sector
- Coproduction Network with Slough residents

Our joint priorities are laid out in our Health and Care Plan for Slough which was developed together in partnership and identifies where we are collectively aiming to promote good health and care outcomes and reduce inequality for the residents of Slough.

The plan is to develop, promote and maintain independence, because this is good for health, good for people, and good for the taxpayer and sustainability of services. This approach is achieved through:

- **Prevention and promoting self-care** through information and advice
- **Connecting individuals to their communities** to reduce the need to present in institutional settings
- When support is needed, **delivering care in a seamless and integrated way**

BCF funds a number of schemes which support the delivery of shared priorities and supporting integration of health and social care across. Key to our model of integrated care is the Integrated Care Decision Making (ICDM) which supports several additional posts creating capacity to do joint assessment, decision making and care planning. The ICDM consists of Social Workers, Mental Health practitioners (CPN), Occupational Therapists and physiotherapists. They meet together in monthly 'cluster' multidisciplinary team meetings with Community Matrons and GPs to discuss and case manage complex cases which require and benefit from multi-professional approach.

In addition to ICDM BCF has invested in the Slough Locality Access Point which a multi-professional single point of access operating Mon-Fri 9am -5pm for professional referral of cases for integrated health and social care response. This includes Social Worker, Mental Health and OT practitioner capacity to the LAP.

BCF also invests in several schemes that support in delivery of the High Impact Changes for Managing Discharge and Flow. These are outlined in the next section.

The Wellbeing Board has set its priorities within the Slough Wellbeing Strategy and integration is one of its 4 priorities. However, early engagement and discussion on BCF planning in this year has been how BCF can support and mitigate impact of the rising costs of living and the impact it will have on the health and wellbeing of Slough residents and its more vulnerable communities. The effect of fuel poverty and rising living costs will have impact on demand for local health and care services, and support of community and voluntary sector, comparable to that of the covid pandemic. Discussion is to take place at the Wellbeing Board around this and current uncommitted expenditure in BCF to be held further to agreed actions, areas for investment and development of accompanying business cases.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Enabling people to stay well, safe and independent at home for longer and providing the right care in the right place at the right time are objectives that go hand in hand with the approach to integrated care within Slough. There are a range of services with the BCF programme that contribute directly to these national policy objectives.

As part of the response to the NHS long term plan the **Ageing Well** Programme is being led across the Frimley ICB and delivered at place. Includes:

- Urgent Care Response – providing 2 hr crisis response to people in need of urgent supporting running 8am-8pm Monday -Friday

- Establishing Virtual Wards providing medical care and treatment to people in their own home in need of enhanced clinical support
- Enhanced Healthcare to care Homes to enable homes to provide high quality care in care home settings and avoiding admission to hospital
- Anticipatory Care Planning to do proactive case finding of people with frailty risk factors, co-morbidities to provide early intervention and support to maximise independence and remain at home for longer.

Falls forum and prevention work – Slough BCF funds a Falls Free 4 Life service delivered by Solutions for Health. Takes self referrals and professional referral, completes comprehensive falls risk assessment and strength and balance classes to improve postural stability. The service also includes home safety assessments to reduce risk of falls.
There is an ICB forum of wide group of stakeholders sharing best practice and reviewing pathways ensuring falls prevention part of integrated support offer to people living with frailty in local place areas. Within the forum there is to be a focus on 'upstream' primary prevention as part of the 'Live Longer Better' programme approach promoting healthier lifestyles and activity that will maintain wellness and independence in the longer term.

Integrated Care Decision Making (ICDM) has been a key part of our integrated care approach. This is an ICS designed model which is delivered at place being jointly commissioned and funded through BCF. This is both a response (reactive) and proactive, community based integrated response that helps people to remain at home with integrated, personalised response to their health and social care needs. BCF investment has funding additional capacity into supporting this activity including that of social worker, MH practitioner, physiotherapy and OT together with input from PCNs (GP, paramedic, social prescribers) to have integrated and multi-disciplinary discussion and care planning to support people with complex health and social care needs. The MDT cluster meetings are coordinated and run at neighbourhood/locality level. There are therefore for Slough four 'cluster' meetings held per month aligned to Primary Care Network localities.

The Slough **Locality Access Point** operates Mon- Friday 9-5pm giving direct daily access for multi-disciplinary triage and assessment of referrals to support professionals working with complex cases. In this year this has also been extended to Care Home providers to help support them in care of their residents in the care home and avoid unnecessary admissions to hospital and this is being supported by the community consultant geriatrician. The LAP provides a point for referral for people with potentially rapidly escalating care and support needs to provide joint assessment and integrated response to help people remain at home and avoid unnecessary hospital admissions by a route to a multi-professional, integrated, same day response. BCF provides funding for the additional capacity needed for health and social professionals to operate the LAP throughout the week.

Personalisation and person-centred care
Frimley ICS has established a Personalised Care programme to support delivery of the NHS Long Term Plan commitments on personalised care. This includes the comprehensive model comprising of six evidence-based standard components intended to improve health and wellbeing outcomes and quality of care, whilst also enhancing value for money.
Implementation is taking place through local delivery partnerships between statutory health and social care partners, the voluntary and community sector and people with lived experience.
Deliverables of the programme include:

- Support and help train staff to have **personalised care conversations**

- Embedding **social prescribing link workers** to connect people to wider community support which can help improve their health and well-being and to engage and deal with some of their underlying causes of ill health.
- Further the roll out of **Personal Health Budgets** to give people greater choice and control over how care is planned and delivered.
- By rolling out training to help staff identify and support relevant patients, to introduce **proactive and personalised care planning** for everyone identified as being in their last year of life

Slough Borough Council been transforming its Adult Social Care Services supported by People Too in order to deliver **strength and asset-based approaches**. This is establishing new and innovate approaches to delivery of adult social care, coproduced with residents and staff. Asset based approaches seek to empower people to have greater choice and control over their care and support arrangements as well as giving high quality personalised support that gives greater flexibility and value for money. Initial conversation with new people seeking support is strength based and these first exchanges are key for some people who may be able to be more independent at home. The focus of this approach was initially via the customer contact centre but now also moving to the Adult Social Care duty system and in the development of the online portal.

Reviewing processes of care arrangements have been enhanced through the introduction of a Virtual Reviewing Team funded by BCF for two years providing a more strength-based discourse into the panel process along with clearer focus on outcomes achieved and ways to maximise independence.

To help monitor the impact of using these approaches, an Adult Social Care dashboard has been developed focusing on key performance areas.

Links with housing in Slough

As part of the Adult Social Care transformation the Slough commissioning team are continuing to look at a range of accommodation and care options to ensure that there is sufficient access to suitable housing provision in the borough in the future for those that need support. There is an established workstream taking forward an evidence-based approach to our local need for a range of accommodation with different models of provision. These include:

- Enhancing the accommodation with support offer with opportunities for people with learning disabilities, ensuring local access to appropriate placements for supported living as an alternative to residential care
- Re-procurement of extra care housing accommodation for older people in the borough
- establishing a 'Shared Lives' scheme in Slough
- The recommissioning of homeless hostels in Slough through the Housing Transformation Fund recognising that having access to appropriate housing for people who are homeless is vital in supporting with their health, mental health, substance misuse and pathways to employment.
- Exploring opportunities for block contract(s) for accommodation that can support people with more complex needs e.g. requiring high level of supervision and support

A comprehensive **review of reablement** (intermediate care services) has been conducted in this year and a new structure and framework for provision is currently out for consultation. The output of this review will be to re-focus the work of the RRR team on reablement and maintaining/maximising independence. Business case developed that will significantly increase the reablement offer to both community ('step-up' support) and hospital discharge providing

more universal offer to help people regain baseline, maintain and maximise independence and supporting to live at home.

Discharge to Assess/ Home First – there is continued investment in community capacity through BCF to support early transition out of hospital for recovery and assessment in the community, preferably at home, or in an interim care bed. This maximises people's potential to return and remain at home for longer term and avoid permanent placement in care home wherever possible.

The Slough **Hospital Social Work Team** is dedicated to supporting the timely flow of people being discharged to the community. Last year BCF secured ongoing investment to maintain capacity in the team to manage discharge and flow. The presence of social workers on site in the hospital and the daily multi-disciplinary meetings with discharge coordinators significantly improved the communication and coordination of information gathering and discharge planning for people to return home once they have become medically stable.

There is a collaborative of **Community Equipment Services** across Berkshire under a single contract. The rapid access to a wide range of aids and equipment is essential in helping people are supported to remain as independent as possible and can remain in their own home, reducing or avoiding higher levels, and associated costs, of direct care provision.

Slough Borough Council has well established **Care Provider forums** with representatives from both the local care home market and with domiciliary care providers. This forum has been valuable in sharing information and developments to support providers across the sector, it was particularly valued by providers to provide support throughout the covid pandemic and now on the Enhanced Healthcare to Care Homes framework (within the Ageing Well programme). There are regular meetings held as well as a newsletter published and circulated.

The **Slough Care Home** task and finish project group bringing together partners initially for the implementation of the Care Home DES (Direct Enhanced Service) and supporting the clinical model of dedicated GPs aligned to care homes and supported by local multi-disciplinary teams. The group continues to meet as a multi-agency group bringing together the PCN clinical lead, community nursing services, adult social care and CCG quality team. The group has continued to run to develop further the support to Care Homes within the Ageing Well programme and the Enhanced Healthcare in Care Homes framework, most recently with a focus on the digital element with the Remote Monitoring /digital management in care homes.

High Impact Changes for Managing Transfers of Care

There has been a review and self-assessment against the 9 changes within the HICM and there is continued investment in to the various aspects that ensure that we are addressing each aspect of the model.
These include investment in:

- Alamac (shared IT system to monitor flow)
- Multidisciplinary Teams to support discharge (IRIS), including the dedicated hospital social work team aligned to Wexham Park Hospital and providing weekend cover
- Discharge to Assess – additional capacity for SW, OT and interim packages of care
- Community beds for step down in community hospital and care homes
- System resilience – GP in ED for trusted assessment and coordination of complex discharges
- Enhanced Clinical Support to Care homes supporting people to remain living in the care home when acutely unwell

There is also now access though the Shared Care Record (Connected Care) to enable our practitioners in the Reablement service to identify Slough residents who have been admitted to hospital which provides real-time information and supporting with pre-emptive planning for discharge from the time of an (unplanned) admission.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Slough's Better Care Fund contributes £216k into the support for unpaid Carers. This includes the funding for the Carers Support Service hosted by the Slough Council for Voluntary Service (SCVS)

The Carers funds our Carers Support Service giving advice and support to all Slough unpaid carers and young carers. The service carries out Tier 1 assessments and produces wellbeing plans co-developed with carers identifying what support they need and how can be met. It also includes contingency planning for if/when the carer cannot provide their caring role. For those carers needing additional support and a social care led carer assessment the service makes onward referrals into Adult Social Care (Tiers 2 and 3).

The Slough Carers Support service runs and maintains a Carers network and forum across Slough providing unpaid carers with regular newsletters and information but also coordinates events through which for carers can come together. It also supports several local Carer Groups across Slough including the recently established Men's Carers group.

Carers funding from BCF invests in support to Young Carers through Aik Saath ('together as one') which is a local voluntary sector organisation for young people.

The funds also provide access to one-off Direct Payments for Carers which can help with access to short break or financial support to help continue carers in their caring role.

A revised Carers Plan was developed and coproduced in 2021/22 together with local carers in this last year in recognition of the impact of covid on many carers providing additional support to the people they care for as a result of some services reducing or closing. Carers needed additional help to stay connected, reduce social isolation and having support and recognition of the emotional, financial and physical impact of the covid crisis.

A Carers Discharge Support service pilot proposal has been developed looking at identifying carers of patients in hospital and supporting them through the discharge process and once back home with help and support. They may be new to caring or find themselves having additional caring responsibilities once the person leaves hospital.

A Working Carers Matter project was conducted last year funded by the NHS England Carers programme and looked at carer support within our own workforce across the ICS (now ICB). Findings and recommendations of that work have been taken forward into the newly established ICB and led to raising awareness of carers and the identification and recognition of carers in the workforce, harmonising carer related policies across partner organisations and establishing carer peer support group.

Carers representatives are part of coproduction network in Slough proving carer perspective and input to service development and the ASC transformation programme.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Through DFG funding Slough has been delivering a range of adaptations to a disabled person's property to ensure they can remain independent in their own home. This approach met 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 adaptation.

However, following the national DFG Review (Feb 2018) we wanted to take some of the learning from the many examples of good practice, innovation and recommendations and in 2019/2020 commissioned Foundations UK to look at how DFG might can be further used to meet the wider health and social care needs of service users. The aim of this work was to produce a revised operating model, consider the future of how DFG should be delivered and develop pathways to further extend our offer to improve patient flows, promote independence and expand our assistive technology offer. The new policy also allows flexibility to support adaptations which breach the 30k limit increasing the reach of the grant.

There has since been updated guidance on DFG released in 2022 which has further informed our approach to DFG delivery. Through the proposed new Housing Assistance Policy our ambition is to transform these services from a fairly rigid DFG technical-based service to one which is more flexible and timely allows us to be more influential in terms of prevention, especially around hospital discharge and care home placement prevention to help disabled and vulnerable people to remain living independently at home for as long as they wish, and it is safe for them to do so.

Slough also wanted to be able to promote greater resident choice regarding the adaptations completed in their home and ensure they are happy with the service they receive. The service has been based upon technical surveyors with some support staff and provided very limited opportunities for individual support to those customers who needed help to navigate the often complex process of applying for a DFG. This led to delays and complaints from residents as well as increased work for the Occupational Therapy team who are trying to support customers without any clear remit or understanding of the DFG process.

The new DFG policy is currently going through internal governance routes and is planned to be presented at cabinet in November. Once implemented it will provide a more personalised approach to people who require adaptations that is based more individual needs and will remove barriers wherever possible. This moves away the traditional more 'technically-based' DFG service to that which is more customer focussed and personalised, whilst retaining the necessary core technical skills for more complex work such as those which require building adaptations.

The DFG capital grant allocation from Government for Slough in 2022-23 is £1,140,680 and this is expected to maintain this level of investment and possibly increase further in the future. The anticipated staffing requirements to deliver the full DFG spend within budget is approximately 2 full-time technical officers and 2 caseworker type roles along with administrative and management support. The 2008 Services and Charges Order allows the charging of fees for technical and OT services for preparing and delivery of DFG and therefore the proposal is that the posts should be capital funded from the DFG allocation on a fixed fee basis.

The current Independent Living Team is located within Adult Social Care, albeit as a separate team. This provides us with significant opportunity to more closely integrate social care and adaptation services and reduce overall delivery costs. A significant amount of the works will not require technical input and will be directly appointed/ordered by the assessing OT or appropriate support staff; including all stairlifts and hoists and ramp works. As Adult Social Care already provides support to residents those support roles will to be increased and enhanced to include support for the casework side of applying for a DFG. Technical skills will still be available for DFG work but these will also be within the Adult Social Care structure providing better response and outcomes for residents whilst still having oversight of standards and quality of work. To ensure a consistent, person-centred approach to the delivery of aids and adaptations we will also be moving toward both the clinical and technical side to DFG to sit within single manager under the OT service manager's remit.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

In 2019 Frimley ICS established its strategy Creating Healthier Communities in which reducing Health Inequalities is at the heart of the approach and forms one of two overarching objectives for the programme. These are to increase overall life expectancy and reduce the differences in healthy lives lived of our residents.

This programme adopts a clear methodology using our shared population health data generated from the Connected Care platform looking at disparities of health outcomes for evidence of variation between social groups, populations with protected characteristics, geography within the system and comparisons with other healthcare systems. Within this methodology is the CORE20+5 approach looking for clinical areas requiring accelerated improvement within 20% of the most deprived cohort of our population.

Examples of health inequalities being addressed across Frimley ICB:

Living Well

- Our detection of known and unknown residents with hypertension is one of the lowest in the South East Region. If this variation is addressed, an estimated 147 heart attacks and 220 strokes could be avoided each year in the Frimley population as a whole. We have multiple projects and pilots underway in our Places with the greatest identified need to address this
- Ethnic minorities living in Britain are at higher risk of a number of smoking related diseases than white Britons. Those already more susceptible to these diseases further increase their chances of ill health if they smoke. On average, people of black African, black Caribbean and South Asian descent in the UK have strokes earlier on in their lives, with black people twice as likely to suffer a stroke overall. We are working with FHFT to implement a new smoking cessation service which will support 7,500 patients per year to give up smoking.

Starting Well

- Obesity rates in UK primary school children saw their 'highest annual rise' in 2020-21 with children living in 'the most deprived areas' more than twice as likely to be obese than those in more affluent locals. According to NHS Digital, the prevalence

of obesity is more than double for children living in 'the most deprived areas' at 20.3% versus those living in the 'least deprived' at 7.8%. To tackle this growing issue, we are investing in a childhood obesity programme which can be targeted at our communities which have children who would benefit most from this intervention.

The link between deprivation and challenging housing conditions with poor health is particularly true in Slough. Life expectancy is significantly below the national average and women on average can expect to live the last 24 years of their life in poor health (compared to 20 years on average in England), while men can expect to live the last 18 years of life in poor health (compared to 16 years in England).

Reducing health inequalities is central to the work of the Slough Wellbeing Board and also the newly published Slough Corporate Plan. Key health and wellbeing challenges for the borough include ensuring a healthy start to life, improving childhood obesity, oral health, smoking, physical inactivity, diabetes, TB, alcohol and substance misuse, mental health issues and early deaths from cardiovascular disease.

Locally a Health Inequalities group was formed following the covid pandemic and the BAME programme which highlighted the greater impact on communities and groups within Slough's diverse population. This group has recently taken forward work on Community Wellbeing Champions (understanding vaccine hesitancy and promoting vaccination take up), the mobile outreach to vulnerable group over the winter period as well as the population health work at PCN with our designated GP lead on health inequalities.

BCF contributes directly towards services that support people with weight management and offer an integrated cardio-wellness service identifying people at risk of cardio-vascular disease and hypertension

This year full investment into OT/SALT service supporting young people with disabilities in schools across Slough. There is significant delay in being able access SALT services in Slough which impacts on the children and family carers. The proposal adopts a whole school system approach to ensure earlier identification and intervention. Through adopting proactive practices, the child can be supported at a lower level by the school within a highly skilled and competent educational environment and reducing demand on statutory services. Schools will be trained to use a whole classroom approach so all children and young people have the best start in life. Where more individual focus is required, by working alongside Educational Psychologist and school SENCO leads. We anticipate stemming the demand on statutory service provision over the short to medium term.

Earlier this year we ran a Mobile Family Health Clinic pilot for two months supported with winter surge funds. This was an integrated approach and was successful in helping to reach into communities to provide health checks and information and advice to around 330 people, around 10% hadn't seen a GP for over 5 years. 30% of people were unaware of underlying medical conditions and encouraged them to have early diagnosis and treatment.

The next phase of this work is a roadshow/outreach model of support to young mothers, those who are pregnant or planning for a baby and proposal in development to run a series of outreach evenings in the community providing information and advice. Evaluation of this next phase will form part of the learning and evidence gathering for the children's hub to be established in the new year.

In this past year Slough piloted a Diabetes Telehealth monitoring programme working with an independent digital health management provider to support people with chronic diabetes to understand the manage their condition. Using a digital platform on a tablet the person would take and enter their daily readings to ensure that stayed within set thresholds and parameters. A regular telephone check in from a diabetic nurse provided personalised support. This has now been taken up across the wider ICB supported by the Digital programme. Working with new IT development partners, Docobo, to support patients using handheld tablets to provide remote monitoring to diabetes hub providing digital health management and support to help people better manage their diabetes

Digital support to Care Homes – as part of the enhanced healthcare in care home programme. A pilot project is being rolled out with Docabo healthcare technology to support care staff and clinical leads with digital health care management of residents.

Population Health Management – a case study has been completed in SPINE PCN looking in detail of a PCN population and the correlation between deprivation and health. This looked at an age cohort with 2-3 chronic conditions living in area of high deprivation. Early insight is highlighting significant differences in levels of support with the population and looking at how we can work through local community champions to raise awareness, engage and understand experiences to address barriers to access and improve health outcomes.

A recent focus on improving healthchecks through Learning Disability recording on GP registers – practices have been working to review, improve and increase the recording of people with a learning disability or Autism on their registers. 156 new patients were coded, a 16% increase. This work is vital to ensure that that Learning Disability Annual Health Checks are reaching our population helping to reduce health inequalities, and that reasonable adjustments are made to enable this cohort to access timely and relevant health support as and when required.

Our Stroke support services commissioned with the national Stroke Association provide essential support to stroke survivors and their families. A particular strength of the service has been to support people to maintain or return to employment and/or access to benefits which promotes mental health and wellbeing and mitigating some of the impact of stroke on their lives.

BCF has supported Browns service locally with some one-off funding to help support homeless people. There has also been primary care funds to enhance the currently primary care clinical support we offer rough sleepers and homeless through a pilot project of a Mental Health dual diagnosis worker.

We have an integrated approach to the coordination and support to our asylum seeker hotel (temporary contingency accommodation) and to those dispersed into local housing accommodation in the borough working together with primary care, voluntary sector providing navigation support to local services and advice.

Mental Health research work is currently being carried through the Slough Council for Voluntary services (SCVS) on understanding the barriers to accessing mental health support services particularly across particular groups within the BAME community where numbers of people connecting to services are low.

There is a proposal for Dementia Care Coordinator role being scoped and developed currently and is aimed at improving diagnosis rates and reaching communities where there are lower rates compared with expected prevalence. It will also be a role bringing together partners across the

wider community looking at ways through which to promote the development of Slough as 'dementia friendly' town.

BCF investment was made into a AccessAble guide to Slough town which is an online resource giving detailed access information on a wide range of venues, site and locations. These include libraries, restaurants, health centres, leisure facilities, shops etc. This provides essential information to people with disabilities, sensory needs, wheelchair users enabling them to look at access information and plan their visit and facilities available before leaving home.