# Better Care Fund planning template – Part 1

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

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

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

## 1) PLAN DETAILS

### a) Summary of Plan

| | |
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| Local Authority | **Slough Borough Council** |
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| Clinical Commissioning Groups | **Slough Clinical Commissioning Group** |
| Boundary Differences | **Slough practices are co-terminous with the Borough however we recognise the CCG will be responsible for patients registered to practices outside the borough boundary** |
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| Date agreed at Health and Well-Being Board: | **29th January 2014** |
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| Date submitted: | **14th February 2014** |
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| Minimum required value of ITF pooled budget: 2014/15 | **£2.28 million** |
| 2015/16 | **£8.762 million** |
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| Total agreed value of pooled budget: 2014/15 | **TBC** |
| 2015/16 | **TBC** |

**b) Authorisation and signoff**

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

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

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

**c) Service provider engagement**

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

Slough CCG and Borough Council have engaged providers on the integrated care agenda with independent support from the Kings 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 and aims and objectives of the Better Care Fund.

This was the culmination of a number of provider engagement strands of work.

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

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.

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

The community service s, CCG lead and Social care meeting monthly to improve the delivery of the integrated care teams and wider issues that affect all three partners.

These discussions have shaped this plan.

Healthcare providers including the local Ambulance Service (SCAS), HWP, 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, flow through the hospital and discharge especially for the elderly. 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.

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

Slough CCG and HWP have engaged in a joint audit of patients on admission to hospital which has highlighted which patients could have been treated in the community. The results of the audit have shaped the Better Care Fund plans.

Monthly commissioning and contracting meetings as well as joint sessions with NHS providers have taken place.

Social Care providers have been engaged through the Provider Forum and Partnership Boards

**d) Patient, service user and public engagement**

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

Slough CCG and Borough Council have 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 this agenda.

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

Extensive consultation with the local population took place in 2012 on the Slough Joint Wellbeing Strategy 2013-2016. The strategy and the Joint Strategic Needs Assessment

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 acute 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 our local acute trust which provided some valuable feedback on how systems could be improved for patients at discharge from hospital and has shaped the plans on a dedicated team being funded to facilitate discharge. This team is multidisciplinary and integrated into the community health and social care teams.

Slough CCG/ Slough Borough Council are engaging in a number of events through 'Call to Action' including public meetings and surveys . Engagement is planned of specific patent groups as well as wider engagement by 'going to public places to gather views.

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.

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

| Document or information title | Synopsis and links |
|---|---|
| Joint Well Being Strategy | This document sets out the vision and priorities for the Slough Wellbeing Board.<br><br>http://www.slough.gov.uk/council/strategies-plans-and-policies/slough-joint-wellbeing-strategy.aspx |
| Joint Strategic Needs Assessment | This document details the health and wellbeing needs of the Slough Population as well as basic population demographics and wider determinants.<br><br>http://www.slough.gov.uk/council/strategies-plans-and-policies/corporate-plans-and-strategies.aspx |

| | |
|---|---|
| Call to Action plan | This document details plan of engagement events planned in Sough to inform our strategy |
| Carers Strategy | This refreshed Joint Carers Commissioning Strategy sets out the shared vision and commitment by Slough Borough Council and the newly formed NHS Slough Clinical Commissioning Group (CCG) to support the health and wellbeing of Carers (including young carers) living within the Borough of Slough over the next three years. |
| Slough Commissioning Strategy for Older People | 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.<br><br>http://www.slough.gov.uk/council/strategies-plans-and-policies/adult-social-care-strategies.aspx |
| Safeguarding Adults Strategy | This strategy sets out the legal framework for safeguarding adults and how the Slough Safeguarding Adults Partnership Board will keep adults safe through the shared vision, priorities and actions set out in this 3 year strategy. |
| *7 day working development | This document outlines our bid to develop seven day working |
| *Dementia Plan | |
| *Integrated Care Team Project Plan | Joint Project plan |
| *Winter Plan and Urgent and Emergency Care Recovery Plan | These documents describe our approach to joint working through the winter period. |
| *Model of care – Long term conditions | This document outlines a service model for long term conditions |
| *Urgent Care Strategy | This document outlines a service model for urgent care. |
| * CCG 2 year operational plan and 5 year strategy | These documents outline the CCGs 2 year operational and five year healthcare strategy and will be available end of March 2014 |

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

# 2) VISION AND SCHEMES

**a) Vision for health and care services**

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

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

Slough will develop an integrated health and social care system '**My Health, My Care'** that provides consistent, high quality, personalised support for residents who have a risk of hospital or care home admission. This will be achieved by providing early intervention and preventive support for patients, carers and families.

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

- I have access to a range of support that helps me live the life I want and remain a contributing member of my community
- I am supported to achieve my goals and take control of my care and support needs
- I have one point of contact, they understood me and my conditions and I could go to them with questions
- I have information and support to remain as independent as possible
- I have support for any carer(s) involved in my care
- I am involved in discussion and decisions about my care and treatment
- I have systems in place so that I can get help at an early stage to avoid crisis

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

| Intervention | Delivered through |
|---|---|
| Self Care and Prevention | Self-care, health and social care advice and information, advocacy, behaviour management and expectation.<br>Examples : Smoking cessation, structured patient education for long term conditions, behavioural change management programmes, vision assessment for falls prevention |
| Care Co-Ordination | Integrated Care Teams<br>Joint Care Planning<br>Case Management including identification of individuals at high risk of admission<br>Specialist Input as appropriate<br>Joint Health and Social Care Assessment and Navigation |

| | |
|---|---|
| | Accountable professional<br>Single access point and shared clinical record |
| Ensuring patient is in the most appropriate setting | Support to avoid admission<br>Discharge support for patients into community and back home from acute care<br>Daily admissions and discharge information<br>Rapid response with short term intermediate care and reablement<br>Improving management of end- of –life care |

This will require:-

- Build up of a register of clients/ patients who would benefit from this care plan approach
- An Information sharing platform
- Evidence based pathways of care eg. COPD,CHD,Falls, dementia
- Joint assessment and care planning processes
- Organisation of practices into 'clusters'
- Development of new roles and ways of working

We will enable this to happen by ensuring:-

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

**b) Aims and objectives**

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

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

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

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

The Slough Joint Wellbeing Strategy (SJWS) was developed by the Slough Wellbeing Board. The SJWS is informed by the Slough Joint Strategic Needs Assessment (JSNA) which provides an evidence base to determine the needs of the population of Slough. In addition, the strategy builds upon a body of work that has been undertaken in Slough

over the last five years, particularly the Sustainable Community Strategy but also other plans and strategies such as the Children and Young People's Plan, the Safer Slough Partnership Strategic Assessment and the Community Cohesion and Climate Change strategies.

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

**SJWS priorities:**

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

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

SJWS delivery:
In order to deliver the strategy and improve the wellbeing of Slough, the SWB will seek opportunities with fewer resources to:
• pool budgets together from different partner organisations
• work in partnership to address key priorities and target services
• promote public involvement in ensuring we deliver high quality and effective services

The Slough JSNA highlights the following relevant local needs:

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

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

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

- Dementia. 329 people (0.2% of the population) are recorded on Slough GP registers as having dementia, according to the Quality and Outcomes Framework for 2011/12. This is significantly below the expected number for Slough and is expected to rise following dementia awareness training funded through the national dementia challenge campaign.

- In addition, 4,400 people aged 65 and over living in Slough are estimated to be

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

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

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

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

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

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

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

- Deliver key aims of the Slough wellbeing strategy
- Increase access to self care for people with mental and physical health problems
- Safeguard and support vulnerable adults and children in our communities

**c) Description of planned changes**

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

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

The BCF will be managed under three distinct programmes:-

**Self Care and Prevention**

This programme will focus on the information, advice and support available to residents to manage their condition to remain as safe and independent for as long as possible.
Potential projects under this programme are:-

- Improving access to Psychological Therapies
- Information and Advice services (eg. primary care, NHS 111)
- Smoking Cessation
- Falls Prevention
- Structured patient medication for long term conditions
- Social Marketing Campaigns

**Care Co-ordination**

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

- 24/7 intermediate care and reablement
- Case management including individuals at high risk of admission
- Joint health and social care assessments
- Single access points and share care records
- Medicines Management
- Integrated Care Teams

**Recovering independence after a period of ill health**

- Multi-disciplinary discharge team at Wexham Hospital
- Nursing and residential home placements
- Continuing Healthcare
- End of Life Care

- Early Supported Discharge schemes
- Rapid Assessment processes

Project teams will have support from infrastructure and system enablers:-

- Governance
- Communications
- Finance
- Information and IT
- Education and Training
- Contracts and Commissioning

Separate Information and IT group to be established to develop a shared Information Platform

The BCF taskforce will be working up the detailed programme and project plans underpinning the above as we work towards April 2014..

**d) Implications for the acute sector**

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

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

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

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

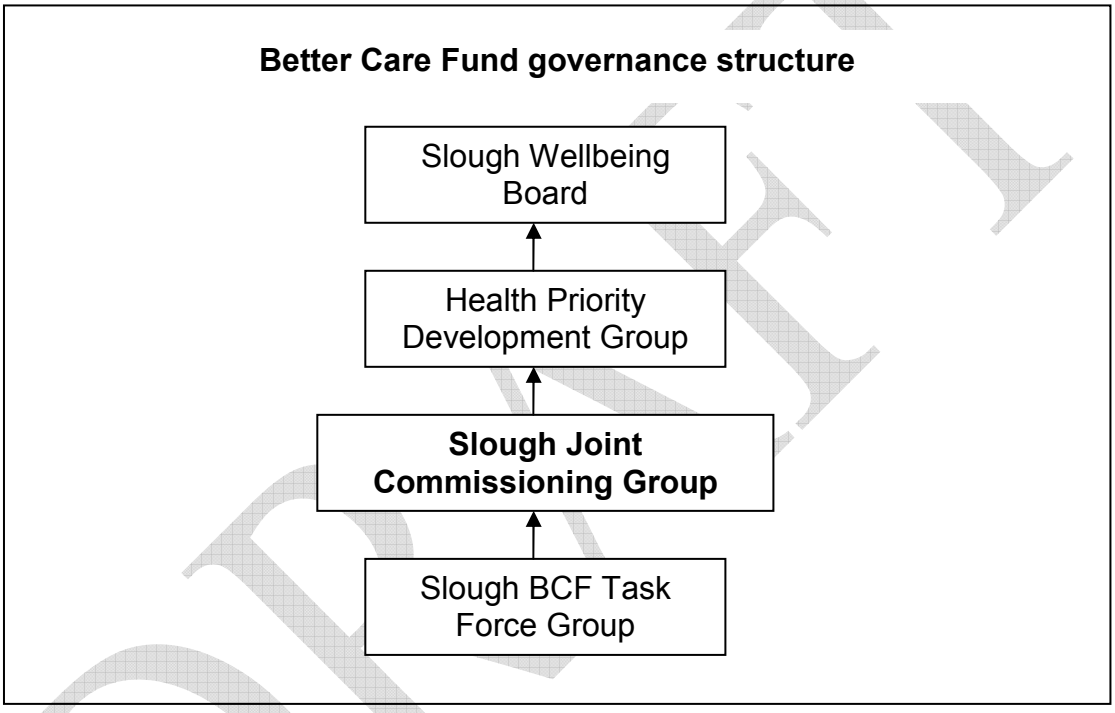
The following approach will be taken to reduce risk for the acute sector

- The pace of change envisaged is realistic and will enable Trusts to reduce their cost base in a planned way.
- Alternative support systems for patients will be invested in up front so that Trusts have the confidence to take out excess capacity and cost.
- Acute providers are fully involved in the redesign of services and, either through collaborative or competitive processes will have the opportunity to provide services or expert support outside traditional acute boundaries.

• The SWB recognises that the BCF will, in the short term, be continuing to support activity in secondary care, until service transformation changes patient and money flows.
• The SWB also recognises the need to share in the cost risk if plans do not result in the expected change in patient flows.

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

**The following initial governance structure is proposed to manage progress and implementation of the Better Care Fund.**




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

The Slough Joint Commissioning Group (consisting of senior commissioners, finance directors and performance managers from Slough Borough Council and Slough CCG) is a new Board that will meet monthly and will:

- Be accountable for health and social care partnerships between Slough Borough Council and Slough CCG – including the Better Care Fund
- Provide leadership for the development and delivery of the Better Care
- Manage and monitor the finances of the Better Care Fund to ensure that funding is spent as planned and in the best way to deliver the agreed outcomes
- Manage and monitor performance in relation to key outcomes and metrics
- Report bi-monthly to the Health PDG
- Escalate key issues/concerns or successes to the Slough Wellbeing Board via the PDG update process

**A formal terms of reference for this group will be developed over the next couple**

**of months**

**The Slough BCF Task Force Group** is the group that is supporting the delivery of the Better Care Fund and consists of key commissioners, finance, performance and policy officers from Slough Borough Council and Slough CCG. This group will continue to support the Slough Joint Commissioning Group to develop and implement the Better Care Fund.

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

# 3) NATIONAL CONDITIONS

**a) Protecting social care services**

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

Slough Borough Council has responsibility for adult social care services in the area covered by this Better Care Fund.
The partnership between Slough Borough Council and Slough CCG in delivering the Better Care Fund will be aiming to protect social care services by ensuring that people with eligible social care needs under the Fair Access to Care Services criteria – which is set by Slough Council at Critical and Substantial. The partnership will also be supporting early intervention and prevention services to reduce the number of people in crisis and who may be at risk of being admitted to a care home or hospital. The partnership also supports the promotion of personalisation and people being in more control of their care needs.

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

The emphasis of the BCF plans to:

- 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
- 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
- Increase the number of people with a health and social care personal budget
- Increase the number of people (aged 65+) offered reablement following discharge (from hospital)

This will support the Council to ensure that people with critical and substantial needs will be met and ensure that people will be supported to take more control over their care needs and reduce the number of people being in crisis.

**b) 7 day services to support discharge**

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

We were unsuccessful in our national bid to become a 7 day pilot but through use of winter pressures funding we have established working practices for seven day services across the Slough health and social care economy. Services are being evaluated for consideration for longer term funding linked to the Better Care Fund.

This includes; rapid access assessment services, Consultant cover, diagnostic testing, intermediate care services (24/7, 2 hour response), minor injuries and urgent care services, early intervention and prevention and multidisciplinary discharge service at Wexham Park Hospital.

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

**c) Data sharing**

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

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

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

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

Commitment is in place for NHS organisations; and the ability to enable non NHS providers through SCR and DBS to populate NHS Number is viable for a first run of systems.

Slough Adult Social Care is committed to using the NHS number as the primary identifier for correspondence across health and social care services. A mechanism for updating all the current social records to ensure that all social care records have the NHS Number identified and the recording of the NHS Number for all new social care clients will be confirmed over the next few months.

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

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

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

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

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

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

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

**d) Joint assessment and accountable lead professional**

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

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

Clusters consist of 50,000 population of patient and are currently managing an initial caseload of 900 patients.

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

During the Winter period we have developed a PACE- **Post Acute Care Enablement**

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

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

**Intermediate care and reablement services** provide a 24/7 service to support independence and facilitate discharge. This service will be further evaluated with a throughput into the service maximized and indeed expanded.

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

**4) RISKS**

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

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

| | | |
|---|---|---|
| Social care reform impact | High | Explicit agreements on protection of social care services and implications of new statutory legislation |