**Borough Council**

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| **Report To:** | Slough Wellbeing Board |
| **Date:** | Wednesday 18 January 2023 |
| **Subject:** | Priority Two, Integration. Slough Wellbeing Strategy |
| **Chief Officer:** | Marc Gadsby – Executive Director People – Adults |
| **Contact Officer:** | Caroline Farrar – Director of Primary Care Development and Slough Place, Integrated Care Board |
| **Ward(s):** | All |
| **Exempt:** | No |
| **Appendices:** | No |

## 1. Summary and Recommendations

1.1 This report sets out to update the Wellbeing Board on the progress of work on integration and the delivery of the health and social care plan. The plan was developed between Slough Borough Council and Frimley CCG together with wider partners within the Health and Social Care Partnership.

**Recommendations:**

The Wellbeing Board is recommended to note the contents of the report and progress made by the partners in integrating health and social care in Slough.

## 2. Report

Integration is priority two within the Slough Wellbeing Strategy 2020-2025. The strategic ambitions are to:

- Increase healthy life expectancy in Slough.
- Increase the proportion of people living independently at home and decrease the proportion living in care homes.
- Increase the number of people who are managing their own care and support needs
- Reduce the number of attendances and admissions to hospital, and the length of these stays. Reduce delayed transfers of care.

To achieve these ambitions, the Health and Social Care Partnership board will:

- Develop a place-based health and care strategy, to align the current health and social care services.

- Build on the work of the Slough Better Care Fund, to increase the contributions from health and social care to the pooled budget.
- Encourage health and social care partners to work together to support and maintain providers and promote the use of collaborative commissioning of services in Slough
- Continue to work with our care users to ensure that co-production and co-design are at the heart of all that we do.
- Work to reduce the impact of COVID-19 on the physical and mental health of people in Slough

The Health and Social Care Partnership together with the Place Based Committee developed a place-based Health and Social Care Plan 2021/22 setting out our shared priorities and next steps in our journey towards integration.

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. This includes working through the Health and Social Care Partnership to ensure effective implementation of integrated health and social care.

Improved access to care

The integrated care hub – during 2022 a plan was developed for an Outline Business Case focused on inclusion of primary care and children's services within the ICH on a vacant site at Upton Hospital. At the same time discussions about the development of a Community Diagnostic Centre have been progressing in relation to the site. Due to misaligned capital funding requirements and separate programmes of work, it has been necessary to pause this work and to reconsider the best use of the available land at Upton Hospital. This affords an opportunity for closer joint working between the ICB and the council to determine the best approach to a One Public Estate strategy for health and social care services within the town, which will be progressed during 2023 utilising the extensive stakeholder engagement and business plan development already undertaken.

Significant progress has been made on the Digital First Primary Care strategy in 2022:

- All four Primary Care Networks (CSN/SPINE) have developed telephony hubs utilising additional staff and digital telephony solutions to improve telephone access to the 16 GP practices in Slough.
- 13 of the 16 GP practices have implemented the new Frimley ICB website, with clearer information for patients and improved options to self-serve for a range of administrative requests from practices.

Health inequalities

Fuel poverty and cost of living

Using the Connected Care data we have been able to identify households that require support around fuel poverty. 466 households have been identified within Slough. Health teams are working alongside community teams in SBC and are

setting up a telephone support line. This will provide residents with one clear access point for help and advice. The service is expected to go live in January and initially support the identified households in the first phase. As the service expands it will be available to a wider cohort of Slough residents.

Support to asylum seekers in hotel accommodation

Slough has a number of accommodation sites for asylum seekers which are funded by the Home Office and supported by contracted accommodation providers. This number has been growing in recent months and it has been a challenge to ensure that there are appropriate and sufficient services supporting this vulnerable population whilst in temporary accommodation in Slough.

The status of these sites varies with a mix of emergency initial accommodation (short-term sites), initial contingency accommodation and onward dispersal sites. The Slough place team have been working closely with partners in SBC to ensure a joint and coordinated response of support is provided to these individuals from Slough.

- Local GP practices have registered individuals to provide primary care support. Clinical teams are delivering satellite clinics, providing enhanced health checks and onward support/referrals as appropriate.
- Infection control leads and teams are working alongside all key partners to ensure protocols and key information is shared particularly around infectious diseases including diphtheria and scabies.
- Safeguarding leads are working closely alongside primary care, asylum seeker site operational teams, secondary care and SBC.
- Wexham Park and the ambulance service are sighted on key information and relevant meetings to discuss sites, support and capacity of services.
- Community and voluntary sector have coordinated support with donation of clothing, toys and games.

Family health outreach pilot (“Growing a Healthy Slough”)

Health teams across health visiting and midwifery are working jointly to inform and educate parents and families on key health topics from pregnancy through to raising a toddler.

Phase 1 of the pilot took place through November and December 2022 offering classes in community locations, including areas of deprivation and prioritising residents who don’t typically engage with health classes.

Mental Health

Slough CVS completed a research project into barriers to accessing mental health support from under-represented groups. The outcome of this report has been developed into an action plan including engagement with key communities on MH issues, working with opinion leaders and community champions, cultural competency training for staff and ways through which to make services more accessible.

<u>Ageing Well Programme</u>

Urgent Care Response

- The two-hour Urgent Care Response (UCR) service has been established working with Berkshire Healthcare Foundation Trust and SBC. Data collected is showing that this pathway is proving successful in preventing admissions to hospital.

- UCR has been working with 111 and 999 to prevent admissions and has run a “Call before you convey” pilot with the ambulance service to consider rapid response options to provide clinical support in the community and avoid a transfer to hospital where possible.
- The UCR also acts as the main referral pathway for the Virtual Ward. Slough GPs and self-referrals are largest referral sources to this service.
- The Enhanced Health in Care Homes workstream is also using access to UCR to prevent admissions to hospital as well as working with local care homes to become part of the remote healthcare management pilot which is using digital technology to monitor residents health.

Anticipatory Care

- Each Slough PCN has its own dedicated ‘cluster’ meeting of a multi-disciplinary team working together to support people with complex needs and high levels of frailty. The Anticipatory Care Programme (ACP) approach was relaunched on a voluntary basis across the ICS in January 2022.
- BCF has agreed funding in this year for case coordinators to support management of the ACP in each of the four Primary Care Networks in Slough ahead of this becoming a requirement for PCNs to deliver within their contract from April 2023.
- Each coordinator can put forward appropriate cases for the multi-disciplinary team case discussions each month. This is supplemented by a dedicated ACP cluster meeting that will take place five times each year.
- The agreed MDT outcomes are recorded in the Shared Care Record for each person and the outcome of the “what matters to me” conversation reported to the GP practice to be recorded on their system.

<u>Supporting discharge and flow from hospital</u>

Slough has a number of discharge and flow pilots underway;

- High intensity A&E users (frequent attenders) identification and intervention to prevent or reduce frequency of attendance – first tranche of this pilot to be evaluated in quarter 1 of 2023.
- An A&E streaming pilot has 14 GP surgeries in Slough signed up to triage their patients who are awaiting treatment in the A&E department of Wexham Park Hospital and are able to offer those who are appropriate access to GP practice appointments. Contact is made by text, while the patients are waiting to be seen by A&E.
- East Berkshire Primary Care service is working with the high-risk patients using remote monitoring to prevent deterioration and admissions.
- The Slough Community Integration Manager attends the twice weekly medically fit call to support the Integrated Care Team to aid decisions made around discharge plans.
- The Local Access Point (LAP) informs the Discharge lead and Flow lead at Wexham Park when a known patient attends A&E or is admitted.
- The SBC Winter fund bid has been submitted, to provide additional support for the community to increase capacity and maintain discharge flow.

- The Better Care Fund extended funding to provide additional capacity for interim care home placements supporting discharge of people who no longer need to be in hospital but are not yet ready to return home
- The Adult Social Care Discharge Fund was announced in November 2022 providing an additional £617k of funding to support Slough with hospital discharge with our local plan being submitted on 16 December. £430k was allocated directly to Slough as a Local Authority grant and £887k to the Integrated Care Board which was apportioned to local Place areas through a 'fair share' allocation methodology. This funding will be used to provide vital additional capacity to social care services to support hospital discharges over the winter period. This includes interim packages of care, interim care beds, assistive technology, housing related support and coordination and liaison to people with Learning Disabilities leaving hospital.

**Background**

Integrated care has been part of the government strategy and national policy for many years recognising that people too often receive fragmented care from services that are not effectively coordinated around their needs. Integrated Care (joining up services within the NHS and across health and social care) has the potential to improve people's outcomes and experiences of care, particularly for older people and for those with multiple long-term conditions and use a number of different services.

The NHS Five Year Forward View, the NHS Long Term Plan and more recently the Health and Social Care White Paper set out a welcome vision of joined-up services and a system built on collaboration rather than competition. This agenda has been taken forward by Integrated Care Systems (ICSs), which bring together providers and commissioners of NHS services with local authorities and other local partners to plan health and care services.

Integrated Care Systems take collective responsibility for planning services, improving health and reducing inequalities across geographical areas**.** They are underpinned by joint working at 'place' level, which is where much of the heavy lifting of integration takes place, driven by 'place-based partnerships' involving NHS organisations, local authorities, voluntary and community sector organisations and local communities. These are complemented by initiatives at neighbourhood level, where Primary Care Networks (groups of GP practices and other community-based services) are also working together to deliver improved services to their local populations. These place-based partnership arrangements encourage organisations to work together and focus on system-wide objectives and improving outcomes for the communities they serve.

3. Implications of the Recommendation

*3.1* Financial implications

Integration of health and social care services not only delivers a more personalised approach around individual needs with improved outcomes but also brings financial benefits to a health and care system from avoiding duplication between services and agencies involved in care of the person. Through our integrated care approach we are now able to use health and social care analytical data to identify risks and precursors to frailty and life-limiting health conditions to enable proactive, targeted approaches and interventions that will keep people healthier and living

independently for longer. We already have a pooled budget through our Better Care Fund which enables us to jointly plan, commission and deliver integrated care. Whilst this is currently still a small proportion of combined spend at place level our ambition is to increase this in future.

*3.2* Legal implications

There is a legal implication in how the Better Care Fund is used, managed and audited within a Pooled Budget arrangement under section 75 of the NHS Act 2006.

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

*3.3* Risk management implications

Risks associated with the delivery of the Health and Social Care Plan will be monitored by the Health and Social Care Partnership and Place Based Committee. An overall risk register is overseen by the committee. Individual projects within the work programme will also develop and manage their own risk registers.

*3.4* Environmental implications

None identified in this period.

*3.5* Equality implications

There is no requirement to complete an Equalities Impact Assessment (EIA) in relation to this report. EHIAs will be completed for specific aspects of the integration programme and projects as required. One of the main priorities in the Health and Social Care Plan is to address inequalities in our population. Work on addressing equalities in this period have been included in the report.

*3.6* Procurement implications

None in this period.

*3.7* Workforce implications

There are workforce implications for the future as we further develop our model of integration for health and social care. Currently we have multi-disciplinary teams working closely together who are employed by different partner organisations. This collaboration and cooperation will over time lead towards new ways of working in partnership with others which will be aligned together with other significant change management programmes such as that within the Frimley ICB workforce development programme and the developing primary care networks.

3.8 Property implications

None in this period.

## 4. Background Papers

Health and Social Care Plan 2021/22