BCF narrative plan 2023-24

Final – 28 June 2023

Slough Wellbeing Board

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

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

Slough is a unitary authority and so engagement and involvement of housing is through the Borough Council.

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 2023-24 draft plan has been first shared and circulated with the Partnership Board and discussed at the meeting on 23 May and a final version presented on 27th June for review and sign off. The focused and more detailed development of the plan is largely through our BCF Delivery Group of health and adult social care partners who review and discuss the contents of the plan and manage the operational delivery.

Regular monitoring reports on the Slough BCF programme are produced and presented to the Partnership for key decisions, updates and monitoring of progress on schemes as well as finance and performance reporting. The BCF plan along with the Annual Report at the end of the year are also presented and discussed at the Slough Wellbeing Board.

It should be noted that following the recent local elections there have been changes with Chair and Vice-Chair arrangements of the Slough Wellbeing Board. These positions will be voted on and appointed at the first meeting of the new Board on 11 July.

Partners across the system are involved in reviewing activity data and setting metric ambitions i.e. Local Authority for ASCOF indicators, the Frimley Insights Team, Berkshire Health Foundation Trust and Frimley Foundation NHS Trust for metrics relating to hospital discharge/admission avoidance as well as the Capacity and Demand Plan.

The BCF programme in Slough continues to be central to the delivery of Integrated Care for Slough Place in partnership with the wider system. Our shared priorities were agreed and published in

2021-22 in our Health and Social Care Plan and these still guide decisions for the workplan, commissioning activity and future investment. Current and potential BCF funded schemes are therefore evaluated against the delivery of the plans priorities. Any new business case for investment needs to identify not only how it meets the BCF criteria and contribution to performance against the BCF metrics, but also how it contributes towards the local priorities set out 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 partners across Slough have in this past month started a series of strategic partnership workshop sessions to progress discussions to refresh and update our priorities and through these plan our next phase of integration in Slough. These sessions have brought together senior Directors from across Frimley ICB, Slough Borough Council, the Children and Young People Partnership and Berkshire Healthcare Foundation Trust to share perspectives of each organisation, learn about our current context and challenges and identify opportunities for greater integration and produce an action plan to deliver against these shared priorities.

Integration continues to be one of the four priorities for the Slough Wellbeing Board and the BCF is recognised as the route to deliver greater integrated health and social care support to our residents in Slough. It is also key to how we can help reduce our health inequalities in the borough both through how we use and deploy existing resources and investments but also though the BCF investment Community Fund and Community Development work to further reduce health inequalities, particularly addressing wider determinants of health along with prevention, early intervention, and the impact of poverty.

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 the ICB's Slough Place Based Committee. These were merged to a single Partnership Board two years ago. The H&SC 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, ICB, 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 H&SC Partnership and Place Based Committee were 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 Slough Wellbeing Board deepening the connections between Integrated Care Board, Primary Care Networks 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 integrated care development and activity. In support of the Programme Management function there is also a monthly Better Care Fund Delivery group which drives forward the delivery of the Better Care programme on behalf of the partners to the pooled budget agreement. The delivery group coordinates and operationally manages the BCF on behalf of the Health and Social Care Partnership as well as ensuring that it continues to operate and deliver 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 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 outlined key areas of focus for improvement 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 special educational needs and disabilities (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 all children and young people. Slough SEND approach is working 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.

To support this ambition, and in response to the 2022 Ofsted Inspection, BCF has made a two-year investment to support the SEND participation work to support delivery of the action plan identifying areas for development and improvement. There is continued discussion around investment in Children and Young People from within BCF to support longer term health outcomes and health and wellbeing and will be part of the 'Developing Partnerships' work outlined above. Slough has a comparatively young population, as identified within the JSNA with almost a third of its population aged under 18 (29%) compared with 21% nationally.

At the time of submission of this plan there is also business case for combined BCF investment across East Berkshire to fund a Project Manager for a residential development providing placements for children with complex health and care needs. Governance of this specific project will be through the Frimley ICS CYP Board.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

There are few changes to our previous BCF plan for 2022/23 with the majority of our schemes being rolled forward to 2023/24

We have used funds to support our Anticipatory Care Planning approach that were previous assigned to enhancing GP support to care homes. That Care Home work is now funded through a Direct Enhanced Service (DES) contract with local practices. The funds have been reinvested for the recruitment to four case coordinator roles, one supporting each PCN. These roles are proactively case finding people using the Connected Care records to identify those who may potentially be at risk of frailty and illness and then carry out some initial screening followed, where appropriate, by a multi-agency discussion and response through the community cluster MDT meetings. This forms part of our proactive work to avoid admissions to hospital though case finding and early intervention.

There has been some additional investment assigned in this year to provide End of Life Care to remain at home supported by the Thames Hospice Care at Home service. This support was previously provided through the short term reablement and rehabilitation service. Thames Hospice are a specialist provider of end-of-life care and support to people and their families. The Thames Care at Home service has been a recent progression and extension of their support into the community to enable people to remain at home to die where possible with the support and expertise of the hospice team.

Last year saw a recommissioning of our voluntary and community sector infrastructure support together with the Information and Advice service. Both of these contracts are funded through BCF and have now been awarded and are due to start under the new contract arrangements from 1st July 2023. Within this contract includes the introduction of three new 'Community Connector' roles hosted by Slough Council for Voluntary Service (SCVS) but working alongside adult social care at the front door to Adult Social Care services (2x FTE) and alongside the Hospital SW and discharge teams (1xFTE). The funding to the SCVS also includes a Community Fund of £100k to invest in local community groups. Applications for the fund are coordinated through SCVS but the criteria and priorities are jointly set between the partners and the evaluation and award of bids is also by local partners and stakeholders, including the Co-production Network.

Our Community Development work supported by PCN funding in 22/23 has now been picked up through BCF. The funds provide two Community Development Officer roles who connect with local groups and community. Priorities this year are set around reducing and mitigated the impact of food and fuel poverty, reducing social isolation and loneliness, helping to address and improve mental health and wellbeing.

Through the 'Developing Partnerships' workshop discussions currently underway we are looking at future opportunities to adopt new innovative integrated models of delivery at place that could provide greater outreach and connections into communities and how BCF investment can be used to support and deliver this. Funding to support this further partnership working has been provisionally allocated although the detail has yet to be agreed and business case, equality impact assessment would follow.

Our current joint priorities continue to be those 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

National Condition 1: 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 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care.

Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

The vision and principles for commitment to integration remains unchanged in our BCF Plan for 2023-25. We will 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 physical and mental 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 BCF invests in supporting the community and voluntary sector through its infrastructure and information and advice services for residents of the borough. This year both these services have been recommissioned. This has been a collaborative piece of commissioning work led by the local authority but with ICB partners. The new contract and specification provides further integration of the voluntary and community sector to reduce health inequalities and build community resilience. The contract includes the introduction of three new 'community connector' roles which will be supporting the Adult Social Care 'front door' – two in the community and one based in the hospital. The connectors will be supporting people to access and connect with local resources, groups and services using the new Community Directory developed in partnership with ICB, SCVS and SBC.

BCF investment funds a number of schemes which deliver our shared priority for integration of health and social care across. Key to our model of integrated care is the Integrated Care Decision Making (ICDM) and the funding of 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. These are multi-disciplinary, multi-agency teams which meet together in monthly 'cluster' team meetings along with Community Matrons and GPs to discuss and case manage complex cases which require and benefit from multi-professional approach.

In addition to ICDM model the BCF also funds the Slough Locality Access Point which is 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 relevant section below.

The Wellbeing Board has set its priorities within the Slough Wellbeing Strategy and integration remains one of its four priorities.

National Condition 2:

Use this section to describe how your area will meet BCF **objective 1: Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches

- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake

how work to support unpaid carers and deliver housing adaptations will support this objective.

Enabling people to stay well, safe and independent at home for longer is central to our vision for integrated care within Slough. There are a range of services within the BCF

As part of the response to the NHS long term plan the ICB Ageing Well Programme has been coordinated across the Frimley ICB and delivered at place. It includes:

- **Urgent Care Response** – establishing 2 hr crisis response service to people in need of urgent supporting running 8am-8pm Monday -Friday
- **Virtual Wards** providing medical care and treatment to people enabling them to remain in their own home whilst receiving enhanced clinical support
- **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.

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 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. Access to the LAP is also 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 hospital conveyance by a direct 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 been running 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 has been 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 'what matters to me' conversations

- The **Social Prescriber** link workers in each Primary Care Network 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

Falls forum and prevention work – Slough BCF funds a Falls Free 4 Life service delivered by Solutions for Health. This service 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 also an ICB forum with a 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 in line with the 'Live Longer Better' national programme approach promoting healthier lifestyles and activity that will maintain wellness and independence in the longer term.

Slough Borough Council continued its transformation of Adult Social Care Services supported by People Too in order to deliver **strength and asset-based approaches**. This programme is establishing new and innovate approaches to delivery of adult social care, coproduced with residents and staff. Asset based approaches 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. Included within this programme is a focused redesign of the 'front door' access route to adult social care and uses strength based approaches for both duty function and the community connectors.

Reviewing processes of existing care arrangements have been enhanced with additional resource through a virtual Reviewing Team funded by BCF. This is two year funding now in its second year. This has provided a more strength-based discourse into the panel process along with clearer focus on outcomes achieved and ways to maximise independence and minimise the amount of intrusion and intervention on daily living that comes with a package of care.

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) was carried out in last year leading to a new structure and framework. The review helped to re-focus the work of Reablement and Independence Service on reablement and maintaining/maximising independence. The output was to 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. Recruitment to fill the number of Reablement Assistant roles in the new service has been a challenge through this year and is currently supported through the external market. Further review of the model in this year as to how can ensure sufficient capacity and therapeutic input.

Discharge to Assess/ Home First – there is continued investment in community capacity through BCF and the ASC discharge fund in order broker and provide short-term, interim care packages that 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 increase of short-term interim D2A packages of care has in turn impacted on capacity of the Personal Budgets and Brokerage Team (PBBT) and so an additional role within that team is to be funded this year through the Discharge Fund to ensure sufficient capacity to liaise and coordinate with the provider market to set up or reinstate packages of care to support people home.

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. Additional SW capacity has been supported through the 22/23 discharge fund. We are looking to build and extend this capacity for 2023/25 through the BCF to fund on a sustainable basis. The presence of social workers on site in the hospital and the daily multi-disciplinary meetings with discharge coordinators significantly improves 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. BCF supports the commissioning and provision of equipment for both health and social care. 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 together with Community Health provider (BHFT) and ICB representatives. This forum has been valuable in sharing information and developments to support providers across the sector, it was particularly valued through the covid pandemic and for partnership engagement in establishing the Enhanced Healthcare to Care Homes framework. There are regular meetings as well as a newsletter published and circulated.

The **Slough Care Home** task and finish project group brought 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 ICS 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.

Our Urgent Care Response service went live April 2022 and is now well established and took over 370 referrals for Slough in 22/23. This work has been delivered as part of the Ageing Well programme across the Frimley ICB along with Anticipatory Care Planning and Enhanced Healthcare in Care Homes. The UCR has demonstrated significant success in keeping people at home through its rapid integrated response which avoids conveyances and admissions to hospital. The 'call before you convey' campaign, working in partnership with the South Central Ambulance Trust has been successful in reducing conveyances by promoting UCR to first responders and paramedics.

BCF makes significant investment in to strengthening community capacity and resilience in the voluntary and community sector including infrastructure support, a Community Fund, the information and advice service and support for community groups and for carers. The work with the SCVS in Slough is essential to our reaching our diverse communities, addressing inequalities and promoting health and wellbeing, particularly in areas of deprivation which are significantly higher in Slough than in other areas of the Frimley system. Numbers supported on discharge are approximate and based on percentage of overall Pathway 0 discharges. Currently there are no specific commissioned services directly supporting hospital discharge through the voluntary sector but plans are in place to develop this in this year. This is through the infrastructure contract which has been recently been recommissioned. This will continue to be provided by Slough CVS under a new contract and specification.

BCF now funds two community Development workers (previously funded through PCNs in 2022/23) which support development of healthy neighbourhoods at local level. A new workplan has been developed around these three main areas of activity:

- Support the cost of living and the reduction of poverty relating to families and individuals across Slough
- Support and strengthen existing and new Community Groups alongside community offer
- Support and engage communities to support their health and wellbeing

In this work they will continue to work with social prescribers and reach in to local communities to build resilience. They will also be supporting the training and development of the new Community Connector roles.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations

    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Our Demand and Capacity Plan for intermediate care services has helped to highlight areas of activity where we need to enhance and improve systems for service delivery as well as data collection and reporting to better inform our capacity planning for the future.

BCF makes significant investment into our Intermediate Care Services locally including the Reablement and Independence Service (RIS), Community Rehabilitation Services (CRS) with our Community Trust, additional community step-down beds and resources in Community Hospitals and Care Homes, and financial support for Discharge to Assess pathways in both professional capacity and interim care packages.

The Reablement and Independence Service went through a major review and restructure in 2022/23 in order to improve pathways both out of hospital and from community, build capacity, refocus on the therapeutic input and improve the coordination of these short-term services to expand and increase throughput. This was done will full engagement and consultation of staff across the services. It was anticipated that this would significantly reduce the need for any additional purchasing of short term reablement support from the independent sector. This has been a challenge and the demand for reablement has at times outstripped the capacity available in the service. This is in part due to ability to recruit to vacant Reablement Assistant roles. Currently the purchasing from the domiciliary care market is higher than planned but provides additional flexible capacity to ensure timely discharge and flow from the hospital. Further review and options for future model will be done in this year using the demand and capacity modelling work.

The community and voluntary sector contract has been recommissioned in this year and includes a Community Fund of £100k and new Community Connector roles (x 3 FTE) supporting people in the community. Data around those numbers supported with discharge home by the voluntary sector will be collected and reported with the start of the new contract and appointment to these roles.

National Condition 3

Use this section to describe how your area will meet BCF **objective 2: Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will

support this and how primary, intermediate, community and social care services are being delivered 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, in line with the Government's hospital discharge and community support guidance.
- how additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

As in the section above we use the Local Access Point and the Urgent Care Response pathways in order to quickly assess and respond and keep people at home wherever possible with a range of multi-disciplinary services and support, including the virtual ward.

A Home First Discharge to Assess approach has been operational since 2018. Initially this was through a small pilot scheme and then later developed as our default discharge model from 2019. BCF investment has supported the development and staffing of D2A with OT and SW capacity and additional resources for interim care packages. The Adult Social Care Discharge Fund has provided vital financial investment for the additional capacity in D2A packages of care that were required over the winter where we saw unprecedented and continued demand on acute hospital beds.

The increase in demand for short term D2A packages also put greater demand on the Personal Budgets and Purchasing Team (PBBT). The team are in constant contact with a range of domiciliary care providers in Slough coordinating packages of care for discharge from hospital. Because they are short term arrangements they require more contact and liaison from the team. Packages can change day to day and readjust before they then move on to next step in the pathway, most frequently into reablement and independence service.

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.

There has been a GP pilot diverting from people from A&E through the use of Connected Care providing real time information of those waiting to offer alternative option in the practice or urgent treatment centre (see page 16).

BCF has funded additional social work capacity to hospital team to support timely discharge. This was previously through short term additional winter capacity but has now been made recurrent to support greater capacity on a continued and more sustainable basis.

The use of the discharge fund within BCF is outlined in the section below and includes the additional investment being made into social care and community capacity to support discharge maintain flow from the acute hospital.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified - planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

How have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

Discharge to usual place of residence

Our intermediate care services are key to both supporting people to remain in the community as well as facilitating discharge from hospital. The split in activity between hospital and community varies through the year but capacity and demand modelling has been used in the design of the new service in order to try and ensure that there is sufficient capacity to respond and support both pathways. When additional capacity is required for short term intermediate care services this is purchased from the independent sector.

The Home First and the D2A discharge model ensures that the principle is to support people to return home wherever possible. BCF funds interim packages of care and support to people at home whilst the more detailed assessment for longer term needs can be carried out. In those first few days many cases (75%) will then quickly transition into a reablement and rehabilitation support package.

A **Slough Discharge and Flow Group** has been established to identify areas of priority in terms of addressing capacity and demand and coordinate and deliver actions for improvement.

Terms of reference for this group are centred around:

- achieving and maintaining local discharge rates and targets
- delivery of Action Plan ensuring discharge pathways working effective
- working in partnership to resolve any problem areas which lead to delays
- managing finance and reporting activity

Priorities identified for Slough from MADE (multi-agency Discharge Events) and analysis of demand and capacity data are:

1. The capacity and structure of the Hospital Social Worker Team
2. Additional resource to the PBBT (Personal Budgets and Brokerage Team)
3. Earlier discharge planning on the wards (where there is a high level of certainty about the discharge pathway)
4. Mental health pathways to discharge
5. Housing, accommodation, and homelessness issues
6. Capacity for pathway 3 / complex discharges, incl. dementia care placements
7. Discharge to Assess capacity (in terms of both interim beds and Home First packages of care)

Our investment from the discharge fund is allocated in line with these priorities (see expenditure plan schemes 39 - 45) and the D&F group is driving a programme of work to address the priorities identified and ensure the investment is delivering improvement in terms of impact on discharge and flow measures.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

High Impact Changes for Managing Transfers of Care

As part of BCF planning process each year there a self-assessment of our investment and activity in support of the 9 changes within the HICM and BCF provides continued and increased investment into 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) – this system supports the daily Sitrep of capacity and demand between hospital and community and is also used to create reports showing activity in acute (attendances, medically stable, escalation beds in use) but also reports on community /mental health services and GP out of hours.
- Multidisciplinary Teams to support discharge (IRIS), including the dedicated hospital social work team aligned to Wexham Park Hospital and providing weekend cover to facilitate and coordinate flow throughout the week.
- Discharge to Assess – additional capacity for SW, OT and the funding and brokerage of interim packages of care packages
- Community beds for step down/interim care beds in community hospital and care homes
- System resilience – GP in acute emergency department to provided trusted clinical assessment and coordination of complex discharges

In terms of Discharge Fund there is in this year also additional investment into

- Interim Care Packages (to support Home First/Discharge to Assess)
- Interim Care Beds (additional community beds for step-down arrangements)
- Additional brokerage support in coordinating above
- Housing related support
- LD discharge and liaison

BCF has also increased capacity in the hospital social worker team to enable early discharge planning and ensure sufficient resource to continue to meet demand at peak times within the hospital.

In this year there has been a pilot running locally through SHAPE PCN to use Connected Care to see real data of people who are present in A&E who could be seen in General Practice. This allows to review the case record, consider whether would be appropriately supported through another route and then directly contact the person in A&E by telephone or text message and offer alternative option to book the person in at Urgent Treatment Centre or an urgent/same day appointment with the practice. This has been successful in pulling, where appropriate and with consent of the person, these cases back to General Practice.

There is a pilot project of Trusted Assessor(s) with Berkshire Care Association providing TA support to discharge to care homes. This is operating in other parts of the Frimley system currently but we will be looking at the learning and evaluation of the pilot with a view to extend in to Slough in this next year.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The BCF contributes £798k towards the Protection of Adult Social Care services for the continued providing of statutory assessment, coordination and commissioning of social care service. This additional, protected funding has been vital to maintain capacity whilst local authority grants from central government have reduced in real terms.

In additional the BCF also invests £296k specifically towards the Care Act duties. This also includes funding for the Slough Advocacy services providing a range of instructed and non-instructed advocacy for people with health and social care needs, including Independent Mental Health Advocacy (IMHA) and Independent Mental Capacity Advocacy (IMCA).

BCF funding invests in areas that help prevent the need for care and support helping to maximise people's independence but also working with communities to help promote and improve individuals health and wellbeing in order to prevent or reduce incidence of frailty in later life. This includes equipment and assistive technology that aids independent living and minimises the amount of direct intervention required from a care assistant or support worker.

Much of the BCF investment is into the areas that bridge hospital and community and the interface between health and social care. These services, collectively termed as 'intermediate care', include reablement and rehabilitation, integrated care teams, community health and short term/interim care beds and packages of care. These services are all free at the point of delivery and aimed to support people to regain independence and minimise need for ongoing care arrangements in the longer term.

Other BCF investment also helps support communities and this is key to upstream prevention and building resilience. BCF funds the Slough Council for Voluntary Services (SCVS), commissioned by the local authority on behalf of the partners to provide infrastructure support to groups and communities. Slough has a strong and thriving voluntary sector with a wide range of organisations and groups across our diverse population. Proactive in-reach and support to these groups is absolutely vital in our approach to engaging and shaping the way in which we provide services and reduce health inequalities. As well as the infrastructure investment there is also the

Information and Advice Service provided by Citizens Advice, and the funding of two Community Development Officer roles.

The BCF investment into a Community Fund forms part of the infrastructure support and provides opportunity for community groups to bid for small amounts of funding for activities that contribute to improving health and wellbeing and reducing health inequalities. This helps build community resilience and provide support networks within communities and away from statutory health and care services. The additional funding for two Community Development Workers is also key in supporting this approach. These BCF funded roles are proactively reaching in to communities, particularly where may be less frequently heard or greater deprivation or inequalities, to listen and help to connect to support and opportunities for funding.

BCF is central to the closer integration of social and health care services in Slough. Investment has supported the establishment of new integrated assessment and care coordination which wouldn't have been possible without the additional professional roles funded in these multi-agency, multi-disciplinary teams. There is more detailed description of these above (see page 8). This integration and cooperation generally, and in the care and support planning around the individual, is central to the aims of the Care Act legislation.

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)

Our current Carers Support Service provides advice and support to all Slough unpaid carers and young carers. It is an infrastructure support service with over 600 registered carers and provides support to local carers groups, empowers and strengthen carers skills so that they can develop community projects to support the wellbeing of carers in their community. It also brings carers groups together via Slough Carers Support Network Forum and provides opportunity to empower carers to make the right choices and seek the financial and practical support they need to feel confident, motivated and in control.

Other activities include:

- **SCS monthly newsletters** to carers providing a range of information to carers covering Employment and Wellbeing, First Aid, Mental Health Awareness, Carers Rights sessions and much more. It also gives information on coffee mornings and other carer physical health activities for improved wellbeing.

- The **Slough Carers Digital Support Service** is an online service to ensure our carers can access carers information and advice and join other online carers groups and activities. Currently provides support to approximately 50 carers.

- **Slough Carers Forums** – these are run quarterly and is a platform for sharing best practices, learning, and networking opportunities. This helps to bring communities together from diverse cultures and backgrounds and encourages groups to share best practices and enhance their service provision.

- **Strength-based conversations –** the service can refer into income boost, benefits and housing information and advice and respite referrals. We offer a more structured optional Tier 1 strength-based carers assessment at the point of contact when carers register with Slough Carers Support Service. Hidden carers are encouraged to take part in this assessment. Our current capacity enables us to provide up to 100 tier 1 Carers assessments per year, including our referral services. Priority will be to register new hidden carers.

- **Carers Groups -** as an infrastructure support service it can offer support to establish and develop groups providing support to carers. It current supports 5 identified carers groups across the Borough.

- **Slough Partnership Board –** this brings together Slough Carers Support Service, Adult Social Care, Slough Borough Council, Health commissioners and providers with our carers groups to improve and meet the needs of Slough carers by working in collaboration.

- The **Slough CVS Wellbeing Friends** service is run by a coordinator and 40 volunteers offers support to 160 vulnerable Slough residents who are feeling isolated. This service is an opportunity to talk about problems, emotions, and issues in a secure safe and confidential environment. Speaking with a trained volunteer offers independent and non-judgemental alternative support.

- Partnership collaboration with our **social prescribing teams** to support carers to access more community and voluntary led projects, encouraging carers to engage in more social, creative, and physical activities to improve their health and wellbeing.

- The **SCS website** is accessed on average by approximately 600 users per month, accessing information, advice, and training opportunities. The SCS website has proven to be extremely useful particularly with so many carers currently facing financial crisis and poverty.

- **Carers Discount Card** - a family and friend carers discount card providing a range of exclusive offers and discounts as an incentive to register with SCS. The aim of this scheme is to promote the health and wellbeing of carers whilst alleviating some of the financial strain that is often placed upon them by their role.

The Carers Support Service has been recommissioned as part of the voluntary and community sector infrastructure contract and from 1st July 2023 this element will be going back in-house to be provided directly by Slough Borough Council. Work has been underway to ensure a smooth transition of this service and continued support for our unpaid carers and young carers in Slough.

Carers funding from BCF also invests into support to Young Carers through 'Together As One' which is a local voluntary sector organisation for young people. The group offers support and activities to young carers and is integrated within its wider youth services that support and engage with children and young people across Slough, promoting community cohesion, anti-bullying, anti-racism and reducing isolation.

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 new Carers Strategy for 2023-26 has been developed in this year around the following five priorities:

1. Enabling carers access information, advice and guidance
2. Identify and recognise carers
3. Promote carer awareness
4. Person centred support
5. Integration and partnership work

As a shared strategy it identifies the importance of working together across our organisations and partnerships and areas of opportunity this brings in improving the support for unpaid carers. These include for example:

- Training professionals in NHS including working with social prescribers, social care and other agencies to identify, value and work with carers and ensure their work is underpinned by clear knowledge on where to get information and advice.
- Focus on improved identification of young carers in schools and services which work directly with families, including our own frontline staff as well as commissioned providers.
- Supporting GP across our Primary Care Networks, particularly through social prescribers, to recognise carers as this is often the starting point in a carer's journey and know where to signpost them for support in their communities.

With the emphasis on integration and partnership approach to delivery we aim to ensure that carers receive comprehensive and coordinated support. To achieve this, we will:

- Ensure there is collaboration between health and social care services which can help to ensure that carers receive coordinated support. This could involve sharing information and working together to address the carer's physical and emotional health needs.

- Integrate our resources to support carers by providing access to information, resources, and support services in a timely manner.
- Involve the voluntary sector to play a key role in supporting carers to provide a range of services, such as respite care, counselling, and financial support.
- Engage with the community to raise awareness of the needs of carers and provide support at the local level. This will involve working with community groups, faith-based organisations, and other stakeholders to develop community-based support networks.

As part of the new voluntary sector infrastructure contact there are three new community connector roles which will be created to support people, including carers, to find help and support they need in their local area. One of these connectors will be based in the acute hospital and will be supporting carers of patients in hospital, with the help of volunteers, supporting them through the discharge process and once back home with help and support.

A Working Carers Matter project was conducted in 2020/21 funded by the NHS England Carers programme and looked at carer support within our own workforce ICB. This led to raising awareness of carers and the identification and recognition in the workforce, harmonising carer related policies across partner organisations and establishing a regular carer peer support group across the ICB. ICB staff can also now register as a carer on their electronic staff record.

Carers representatives are part of our shared Coproduction Network in Slough providing carer perspective and input to service development and the ASC transformation programme. They have also been involved in the production of the new Carers Strategy and design of the new Carers Support in-house service.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Through DFG funding, Slough has been able to provide a range of adaptations to disabled individuals' properties, enabling them to maintain independence in their own homes. This approach aligns with the legislative frameworks provided by the HGCRA Act (1996) and the Care Act 2014, which require ASC to assess and arrange appropriate assistance, including statutory entitlements to community equipment and minor adaptations.

In 2019/2020, Foundations UK was commissioned to explore how Slough could use DFG more effectively to meet the broader health and social care needs of service users. The objective of this project was to develop a revised operating model, consider the future delivery of DFG, and establish pathways to extend our offerings further. The aim was to improve patient flows, promote independence, and expand our assistive technology services. One of the key outcomes of this initiative was the development of a new Housing Assistance Policy to support our revised approach, allowing flexibility to support adaptations exceeding the £30,000 limit and increasing the reach of the grant.

The new policy was implemented in November 2022 and incorporated updated guidance on DFG released in the same year, which further informed our approach to DFG delivery. The new policy granted us additional powers, such as discretionary grants and reduced administrative processes, including financial assessments. It also enabled the funding of additional staff members, thereby

increasing the service's capacity. Furthermore, the funding for the staff group was made possible through capital funding.

The DFG capital grant allocation from the Government for Slough in 2023-24 is £1,140,680, and this investment is expected to be maintained and potentially increased in the future.

The Independent Living Team has now been integrated into Adult Social Care from Housing. This integration has provided ASC with significant opportunities to implement changes more efficiently, resulting in improved delivery processes. Consequently, the new policy, team structures, and processes have been implemented, with the desired outcome of better integration between social care and adaptation services and reduced overall delivery costs.

The service has already begun reaping the benefits of these changes, as evidenced by our stairlift implementation timeline. Previously, the average waiting period following referral to the ILT team was one year, whereas our new KPIs aim for a 30-day turnaround post-referral to our stairlift provider.

To support staff in adopting the new ways of working and policy, workshops have been conducted, and new tracking documents have been introduced to ensure we achieve the expected timelines.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Yes Slough has made use of the RRO and has £150k allocated for this purpose.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes

How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5

In 2019, Frimley ICS launched its strategy, 'Creating Healthier Communities' putting Health Inequalities 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. This looks at disparities in 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 Southeast Region. If this variation is addressed, an estimated 147 heart attacks and 220 strokes could be avoided each year in the Frimley population. 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 several 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 Health and Social Care Partnership. It's also the focus of the Council's Corporate Plan identifying the health and wellbeing challenges for the borough include ensuring every child has 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. Slough's demographic is such that over half the population would be included in the Core20plus5 cohorts. The Developing Partnerships work currently underway is actively reviewing and refreshing our partnership priorities and looking at developing an action plan of key deliverables as partners on these areas of health inequality.

Full Health inequality impact assessments are completed as part of any new business case or significant recurrent investment proposal from the Better Care Fund. Overall the BCF programme is about an integrated approach that achieves improved and more person-centred health outcomes for Slough residents. The management of the BCF at place level also allows us to innovate and try new approaches and models of delivery that help reach into underrepresented communities where we know there is higher rates or prevalence of certain conditions and/or lower access to available services and some of these are outlined below.

Updates from 2022/23 plan:

Following the Covid-19 pandemic and BAME programme, which highlighted the greater impact on communities and groups within Slough's diverse population, our local **Health Inequalities Board** was established and continues to meet monthly. This group took forward work on Community Wellbeing Champions (understanding vaccine hesitancy and promoting vaccination take up), the mobile outreach to vulnerable groups over the winter period, and the population health work at PCN with our designated GP lead on health inequalities. This past year, the group has continued to target issues such as fuel and food poverty resulting from the cost-of-living crisis, the winter vaccination uptake and an outreach service for perinatal support for young mums and families.

BCF continues to contribute 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 work reports into the ICB's Living Well programme.

There was full investment into the **OT/SALT service supporting young people with disabilities** in schools across Slough, having found a significant delay in being able to access SALT services, which impacted children and family carers. The scheme 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, this is achieved by working alongside an Educational Psychologist and school SENCO leads. We anticipate stemming the demand on statutory service provision over the short to medium term.

Following the **Mobile Family Health Clinic** ran last winter we have built on the success and learning from this approach to run a next phase with a pilot **roadshow/outreach model of support to mothers and families** (those who are pregnant and/or with children up to 2 years old), with a particular focus on engaging BAME residents. Designed by health visitors, midwives, and our local health inequalities GP, a series of outreach health and wellbeing classes have been taking place in Slough to help support children and families to have a healthier start to life. Phase 1 delivered classes at community locations across Slough; 12 outreach weekly community sessions were delivered between November and December 2022, with 33 parents and families in total attending the free health and wellbeing classes. A total of 7 topics were covered throughout the programme: Healthy eating and exercise; Caring for you and your baby; Baby and child feeding;

Child development and milestones; Common childhood illnesses; Keeping your child safe; and Your wellbeing. From March to July 2023, phase 2 involves accessing established community networks and groups set up to support pregnant women, families, and children. So far, 11 classes have taken place, with participant numbers ranging from 2-25 across various locations; particular interest from parents has centred around baby/child milestones and development, as well as common childhood illnesses. A report outlining the outcomes and data from this programme is currently in development.

Slough piloted a **Diabetes Telehealth remote monitoring programme,** working with an independent digital health management provider to support people with chronic diabetes to manage their condition. Patients take and enter daily readings for blood pressure, sugars, and weight via smart device or text, to ensure they stay within set parameters. When recordings fall outside of these, alerts are generated which are monitored and managed by a 1st line support team. The team escalates patients in need of practice intervention through dedicated channels (email/telephone) to avoid delay, whilst a regular telephone check-in from a diabetic nurse provides personalised support. This has been taken up across the wider ICB, supported by the Digital programme. Scaling up discussions are currently in progress to support other practices and pathways. Work is also underway to adapt this remote management approach for Heart Function and Hypertension, and to extend this to Chronic Obstructive Pulmonary Disease (COPD) soon. Practices can become involved by engaging with the project team, and once the practice introduces remote monitoring via text message (or other preferred method), EBPC will complete onboarding activities with the patient. We are still working with our IT development partner, Docobo, to support patients using handheld tablets to provide remote monitoring to the 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 Homes framework and development of digital approaches the Connected Care programme has partnered with Docobo healthcare technology to offer remote monitoring support to care homes. This is a Frimley ICS programme to all care homes across the system. One Slough care home has done live with others in development and awaiting training. The East Berkshire Primary Care staff support the remote monitoring with their clinical team.

Population Health Management – facilitated by our GP Health Inequalities Lead, SPINE PCN carried out a detailed review into the correlation between material, social and health deprivation in primary care. Participating patients were of a cohort living in areas of high deprivation with 2-3 chronic conditions; they carried out a questionnaire (DiPCare-Q) and some case studies. Key insights highlighted significant differences in levels of and uptake of support within the population. Over 2,647 questionnaires have been fully completed (6221 eligible but incomplete). Those who completed the questionnaire saw a 4.35% increase in health checks since May ’22, 6.64% increase in HbA1c and BP reviews, and 0.11% increase in treatments target achievement for Diabetes and Hypertension. Next steps: developing volunteers and resident Champions to build capacity and resilience in the system; working with faith leaders to reach wider communities; establishing a social central MDT (including voluntary sector, social prescribers, community development workers, citizens bureau, housing, and employment); creating a health and wellbeing residents’ panel; continuing support for cost-of-living and Poverty Forums; and rolling out a digital version of the DiPCare-Q through Accrux.

The DiPCare-Q also formed part of the **Fuel Poverty Summit** organised by Frimley Health and Care in November 2022. This event included further review into the exacerbation of physical and

mental health problems in Winter weather and in Frimley ICS's most deprived areas (deciles 1-4), fuel poverty insights, and access to support services. Case studies and workshops took place to establish targeted actions, such as: collaboration with energy companies in the interest of vulnerable residents (e.g. SSEN Priority Services register providing free support during a power cut); raising awareness of energy tips and parameters (e.g., 18-degree home minimum); targeting MH/social isolation through support for Social Prescribing; working with Community leaders to target stigma surrounding the winter support system; setting up small-scale financial incentives to support both local businesses and residents; and maximising integration to share resources and raise awareness of available support services.

We have been focused upon **improving health checks through Learning Disability recording on GP registers.** Our practices have been working to review, improve, and increase the recording of people with a learning disability or Autism on their registers. This work continues to be vital to ensuring that Learning Disability Annual Health Checks are reaching our population, helping 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 across East Berkshire, continue to 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 promote mental health and wellbeing, thus mitigating the impact of stroke on their lives.

BCF supported Browns service locally with additional one-off funding to help support homeless people with intensive community support. There are also PCN funds to provide a primary care clinical service to rough sleepers. This also now includes Mental Health support through a pilot project of a Mental Health dual diagnosis worker (continued funding through Rough Sleepers Drug and Alcohol Grant).

We are continuing to employ an integrated approach to the coordination and support of our **asylum seekers residing in local hotels** (temporary contingency accommodation) and to those dispersed into local housing accommodation in the borough. We are working together with primary care and the voluntary sector to provide advice and navigation support to local services. Our focus this past year has been on meeting hotel residents' health needs and on infection control following the opening of a second hotel open set up as Initial Accommodation (short term – 48 hour) but subsequently became a site for placing arrivals under infection control measures. Although established for short stays those placed, including families with children, were staying longer than envisaged and so as well as initial health needs there was an identified need for additional support from the Council and the community and voluntary sector. This was mobilised and coordinated through a partnership working group which continues to meet as a multi-agency group together with the Home Office to address issues or concerns including safeguarding and risk of exploitation.

Mental Health research work was carried out through the Slough Council for Voluntary Services (SCVS) on understanding the barriers to accessing mental health support services, particularly across BAME groups, where connection to services is low. The results from the report identified specific suggestions for bridging this gap, such as: cultural competence/inclusion/peer mentoring training for NHS professionals; training in MH 'First Aid' for non-health professionals; making space for voluntary and community organisations (VCOs) in community hub settings to share resources; linking CMHT wellbeing professionals/link workers/social prescribers to VCO settings (e.g. mosques, churches, refugee support centres); recruiting more community outreach workers

(supported by CMHT and Mix teams); and supporting the need for trusted community interpreters. CVS has already put together a cultural competence training programme for NHS professionals.

BCF investment is made into an **'AccessAble'** which is an interactive web-based access guide to Slough town. It is an accessible online resource providing detailed access information on a wide range of venues, sites, and locations. These include libraries, restaurants, health centres, leisure facilities, shops, etc. This continues to provide essential information to people with disabilities, sensory needs, and wheelchair users, enabling them to look at access information and facilities available, so they can plan their visit before leaving home. This is not only a essential resource for our residents with mobility or access needs and support but also for visitors to the town.

Further actions from this year:

Through an integrated partnership between NHS Frimley, SCVS, and Slough Borough Council (SBC), an online **Slough Community Directory** has been established, supporting the function of social prescribing by facilitating residents to access a variety of local activities and services. The need for a 'one-stop shop' directory was a key action taken from a borough-wide Social Prescribers' workshop in March 2022, to ensure both health and social activities were accessible in one place. Key priorities for the website have been maximising its accessibility and outreach to wider demographics of Slough's diverse population. Website link: Slough Community Directory – Activities and services to keep Slough residents fit and healthy (sloughhealth.org).

The website was launched in March 2023 at Slough CVS's **Social Prescribing World Café Day**, where stakeholders discussed the development of social prescribing in Slough and the role of community engagement in improving wellbeing and tackling community health inequalities. Since the Directory launch and Comm's campaign, unique views on the site have more than quadrupled, and social media engagement has risen from 1.4% to 33.4%. Responsibility for the site will be sustained by SCVS, who have incorporated specific roles for monitoring the site and ensuring its sustainability. The Directory steering group is currently gathering resident feedback on the site, so the Directory will continue to be updated.

SCVS has been undertaking a range of other projects to target health inequalities in Slough. They currently receive £100k BCF funding for a Community Fund which encourages small groups to apply for local grant funding. The #OneSlough partnership community fund has **supported organisations which address health inequalities in Slough**, including Asian Carers Group, Amana's Journey CIC (warm meals for Winter), Parenting Special Children, and The Slough Job Creation (digital accessibility programme). SCVS also managed to secure external funding for a range of groups such as Slough Refugee Support, Autism Berkshire, and Home Start Slough, as well as sourcing £320 each to various care groups in Slough, providing warm spaces in Winter for carers and their cared-for.

SCVS also ran a **Multi-agency Discharge Event (MaDE Week)** with Frimley Health and Care in March 2023, to support improved patient flow across the system, recognise and unblock delays, and challenge, improve and simplify discharge processes. SCVS covered the Reception, Gastroenterology, Respiratory, and Acute wards of Wexham Park Hospital, disseminating relevant information to aid patients post-discharge, and raising awareness of local support services. 65% of patients engaged with MaDE and were particularly interested in the Community Directory (25%), Carers Information & Advice, (15%) Cost of Living information packs (12%), and Befriending Services (11%).

Having launched as a pilot partnership with Slough PCNs in April ’22, the roles of 2 **Community Development Officers** from SBC have been established, who were fundamental instigators for the Community Directory. Their other work has included: collaborating with Social Prescribers to connect with community services and boost SP referrals; creating solutions for Health MOT check-ups at community groups; disseminating ‘Warm kits’ at Christmas and cost-of-living resource packs; coordinating digital poverty courses; supporting community groups to secure external funding (£85,700 by the end of 2022); holding a monthly poverty forum with 70 partners; setting up a Slough Community Support Café; securing £9k for a cost-of-living support programme for schools; introducing ‘Warm Spaces Slough’; and coordinating Slough’s Great Winter Get Together (approx. 1000 people reached). The Development Officers also conducted research (‘Strong, Healthy and Attractive Neighbourhoods’ survey for each PCN area) in tandem with the DiPCare-Q, SCVS’s Mental Health review, and GP Access (Healthwatch), building their results into wider social prescribing development and targeted plans. This survey maximised its outreach to unregistered residents to encourage them to register with their GP and facilitate access to support.

Finally, the **Digital Buddies programme** has been launched to address health inequalities arising from digital poverty in Slough, through enhancing digital accessibility and residents’ IT skills. Key focus has centred around improving digital literacy and confidence, increasing NHS app utilisation, and reducing isolation and loneliness. Secondary benefits have included alleviating practice clinical and non-clinical capacity through improved digital access route uptake, and a reduction in avoidable encounters. So far, the programme has enrolled 176 participants in total, 40 of whom have made significant progress through the level system (basic, intermediate, and advanced), and with 50 new NHS app signups. The project has also helped to gain insight into the challenges faced by those who lack access to digital technology and shown that targeted help can improve their ability to use digital devices and boost confidence. The project team's focus on building relationships with residents, understanding their needs and what gets them engaged, has been crucial to the programme's success thus far.