Older People Strategy 2023 – 2026

Slough Borough Council v3

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1 Executive Summary

Staying healthy, remaining independent and living at home for as long as possible are important elements in achieving a good quality of life in older age. For some this is likely to be more challenging than for others, and multiple factors, including health inequalities,[1] can affect the extent to which this is possible.

Our Corporate Plan sets out a vision for Slough where ***residents can live healthier, safer and independent lives*** with a key focus upon tackling health inequalities in the borough. This Strategy for Older People describes several key priorities to support this vision[2] and to address the needs of those who might require additional support. These priorities were borne out of national and local drivers set out in the JSNA and Observatory Data and most importantly through consultation with Older People including the Co-Production Network and residents, family and staff at Oak House Care Home in Wexham, Slough. These priorities include:

Priority 1: To reduce social isolation and loneliness for Older People
"Research has linked social isolation and loneliness to higher risks for a variety of physical and mental conditions: high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death**"** according to the National Institute on Aging. This is an issue raised by Older People in Slough through awayday engagement feedback they have told us this is a priority. A robust Dementia Action Plan is required as part of a preventative approach to minimising or delaying Dementia and tackling social isolation to sit alongside the developing Public Health Dementia Needs Assessment.

Priority 2: For Older People to have a continued sense of purpose to live their best life. "Living a life of intention or having a purpose in life, especially as you age, is integral to healthy living and longevity. Many studies have shown that aging with purpose can provide protection against Alzheimer's disease, disabilities, cardiovascular problems, and impairment, and lead to longer, happier lives" according to Maplewood Senior Living. Older People in Slough through engagement feedback have told us this is pivotal to their lives. We also see many Older People actively involved as volunteers e.g., for the Co-Production Network continuing to work with purpose and champion securing great services in Slough.

Priority 3: To live more years in good health.
Work with our partners such as Health, the Voluntary & Community Sector and communities themselves to support people with their health and wellbeing. Having a

[1] Health inequalities are described the NHS as unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider determinants of health. NHS England » What are healthcare inequalities?

[2] Taken from Slough Adult Social Care Strategy 2023.

range of appropriate provisions in place including a well-functioning adult social care market is critical here. Often people with a range of Long Term Conditions (LTCs) could evidently have poor health in old age so trying to prevent LTCs in line with the next priority are essential. There is a strong correlation between people with multiple long term conditions (MLTCs) and social care needs – this should be treated as a specific cluster of combined health and care outcomes. Clustering by multiple long-term conditions and social care needs: a cross-sectional study among 10 026 older adults in England | Journal of Epidemiology & Community Health (bmj.com) Mapping the customer journey for Older People and developing a clearer operational pathway to support the Older People priorities in this strategy linked to all priorities are the cornerstones of this strategy.

Priority 4: To work in greater partnership with the NHS and Public Health to prevent Long Term Conditions including the wider determinants of health.
Work with our partners such as Health, the Voluntary & Community Sector, and communities themselves to support people with their health and wellbeing to prevent Long Term Conditions e.g., Stroke, Cardiac Disease, Dementia, etc. Having a personalised, strengths-based approach within adult social care, encouraging independence and utilising assets within people's own communities. These will be supported by a strong focus on integrating health and social care services to deliver best value and ensure that residents can access high quality provision when this is required. As part of this work PH have been developing a dementia prevention needs assessment (in early Sep. 22)

Priority 5: To tailor Older People Information & Advice on the challenges that affect them e.g., cost of living, fuel costs, food poverty, etc
Not shying away from difficult conversations about critical issues that affect Older People and providing signposting to practical support. For example, use of independent Benefits Checkers for information on income-related benefits, contribution-based benefits, Universal Credit, tax credits, Council Tax Reduction and Carer's Allowance. Listening to Older People's consultation there is a strong desire to not live in such a digital world. SBC needs to look at how accessible standard processes are e.g., Blue Badges which appear to be wholly digital.

Priority 6: To support intergenerational families best care for their loved ones and with respect to cultural differences.
Supporting People to have greater involvement in shaping the care and support they receive. Opportunities to have "asset-based" conversations where individuals look to their family/loved ones/neighbours and wider community for support. Recognising the implications of intergenerational families who have in some cases been made up of 11 or so family members so housing requirements have seen two adjacent properties commissioned to meet their needs. There is an opportunity to use the Quality Conversations approach for gatherings insights into intergenerational families.

Priority 7: To have a choice about where I die through a co-produced end of life pathway.

Opportunities to develop with the support of carers and service users a clear end of life pathway that supports people in Slough to die in the place of their choosing. This often relies on robust co-ordination and transfers of care out of hospital environments. Slough recognises it needs to better develop its end of life pathway drawing together the various components for success. It will best achieve this in a co-produced way through the **new Quality Conversations Model** developed for Oak House **linked to all priorities.** As part of a life-course approach we should link up the entire lifespan pathway including: live well / age well and die well as the risks tend to be cumulative and increase with age.

Priority 8: To have a range of housing options to suit me in later life.
Opportunities for Older People to secure advice and access to a range of accommodation tailored to the needs of Older People**.** This is best achieved through a Housing Strategy developed with partners with particular attention to intergenerational families and developing dementia friendly places.

These 8 priorities were crystallised from a long list of Older People priorities gathered during consultation. The long list is stated below and will be part of our thinking moving forwards:

- To reduce social isolation and loneliness for Older People.
- For Older People to have a continued sense of purpose to live their best life.
- As a vision to ensure co-production underpins all our commissioning intentions for older people.
- To live more years in good health. The focus should be on 'healthy life expectancy' or adding life to years not only years to life.
- To work in greater partnership with the NHS and Public Health to prevent Long Term Conditions including the wider determinants of health.
- To tailor Older People Information & Advice on the challenges that affect them e.g. cost of living, fuel costs, food poverty, etc
- To support intergenerational families best care for their loved ones and with respect to cultural differences.
- To encourage Older People to self-care using options available in the community.
- To communicate with the people of Slough through various media, appreciating "digital" is only one avenue.
- To have a choice about where I die through a co-produced end of life pathway.
- To have a range of housing options to suit me in later life.
- Assessing the population needs in terms of the number and requirements to develop new care homes locally (residential and nursing homes) as well as 'extra care housing'.
- To develop a preventative approach to independence through technological interventions.
- Supporting older people to remain active, healthy and well.
- To help older people make the right lifestyle choices.
- To ensure falls prevention activities are available for older people to minimise the chance of falls.

The 8 priorities chosen all relate to these ambitions and are effectively a crystallised version.

1.1 How will we achieve our 8 priorities?

In delivering these Older People priorities Slough have developed robust ways of working that embrace collaboration and support positive engagement and codesign of services for all client groups including Older People. Specifically, the work around the Co-Production Network (CPN):

The co-production network was first established in 2019 and comprises members of the local community who want to make a difference in Slough, along with senior staff from Frimley ICB and the Council.

The co-production network is active in a wide range of projects. These have included:

- Recruitment of senior level staff.
- Virtual enter and view visits during the pandemic.
- Re-design of information so that it is more user-friendly.
- Workforce development – the production of videos and information under the Proud to Care initiative. It is acknowledged that the care workforce since the Pandemic has depleted.
- Tender evaluation
- Voluntary and Community Sector Grant Funding - Bid Assessments.
- In addition, members of the network participate in several key forums including the Health and Social Care Partnership Board.

Beyond this in September 2023 Slough developed a customer facing initiative called "Quality Conversations" to assess from a resident/family/staff perspective through open conversations just how positive/negative the services are that they receive. The first trial of this model took place in September 2023 at a local care home and the model forms a toolkit in or it can be used moving forwards for a range of services. The trial involved Health Watch and the Co-Production Network and was warmly received by the care home/staff/residents/family.

The power of I Statements

Through the consultation for this Strategy a range of statements were made about what was important to Older People. There is a correlation here and strong thread with the priorities set out in this strategy:

1. I would like to tell my story once.
2. I would like to take a short break from caring.
3. I want to have friends whatever my age.
4. I want to be able to have a sense of purpose.
5. I want to continue to do exercise and stay active.
6. I want to comment and improve on local services through co-production.
7. I want a Direct Payment to give me independence and choice.
8. I want to live a long, healthy life.
9. I would like technologies to help me live at home.

10. I would like a home for life.
11. I would prefer to die at home.

These I statements represent what is important to Older People in Slough and will be embedded in all of our approaches to Older People.

This Strategy forms part of the following suite of strategies and toolkits (in various stages of approval as at November 23):

Slough Corporate Plan 2023 - 26
Slough Health & Wellbeing Strategy
Slough Strategic Commissioning Framework
Slough Market Position Statement
Slough Health and Social Care Plan 2020
Slough Adult Social Care Strategy 2023 -26
Slough Prevention Strategy 2023 - 28
Slough Carers Strategy 2023 -26
Slough Learning Disabilities Strategy 2023-28
Slough Autism Strategy 2023 – 28
Slough Equalities in Commissioning Statement 2023
Working Together Toolkit

2 Population Profile

The census of 2021 showed that Slough is the third most densely populated of the South East's 64 local authority areas, with around 35 people living on each football pitch-sized area of land.[3]

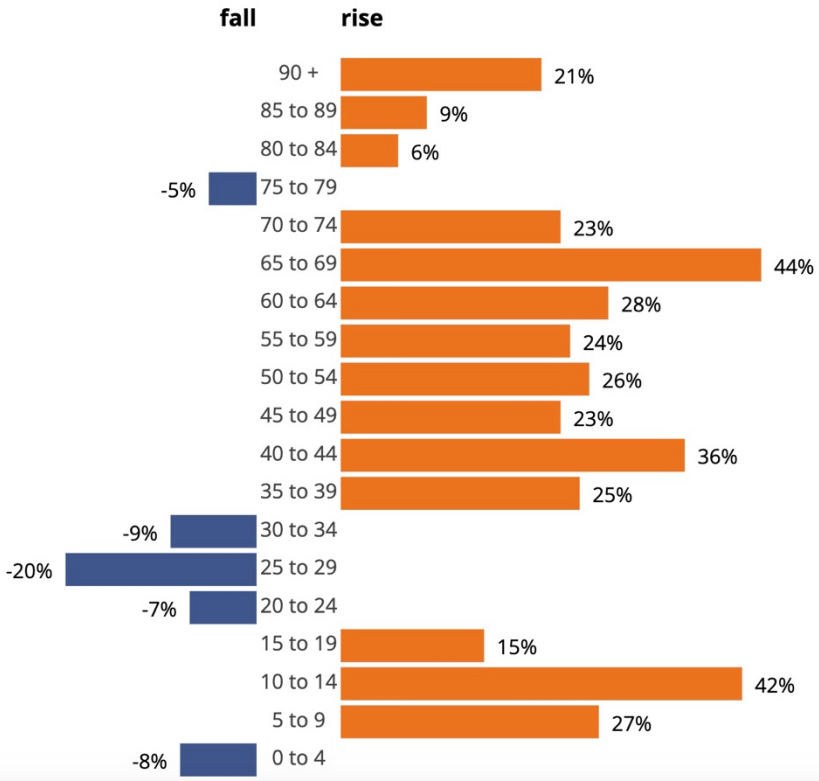
In 2021 Slough's population was 158.5K with 80K women and 78.5K men.[4] Older people aged 65 and over comprised 10% of the population, with 67% within the 15-64 category and 24% of the population aged under 15.

The population of Slough is diverse with 36% of the population being White, 47% being Asian and 8% being Black with the remainder of the population being made up of people of other ethnicities or mixed heritage.

[3] ONS Data 2021
[4] Population - UTLA | Slough | Report Builder for ArcGIS (berkshireobservatory.co.uk)

Overall, the population of Slough increased by 13.0%, between 2011 and 2021 with an increase of 19.3% in the population aged 65 and over. The increase in complexity of need is more important for Slough than the slow increase in older age population that is expected to be more significant after 2035.

Population change (%) by age group in Slough, 2011 to 2021



3 Older Adults in need of Social and Healthcare Support

Slough ranked 117th in the 2022 indices of deprivation out of 151 Local Authorities[5].

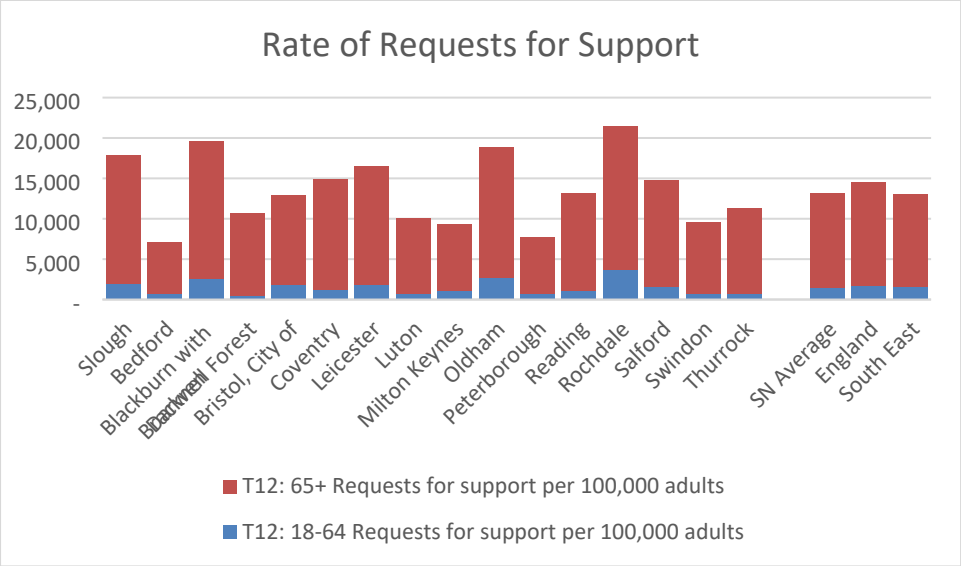
30,240 households in Slough (57.7%) are deprived in one or more dimension (compared to 51.6% in England). This is a decrease of 8% from 2011, when it was 65.1%. Slough ranks 8th in barriers to housing and services and 24th for income deprivation affecting older people.

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). Key health and wellbeing challenges for older adults in the borough include, smoking, physical inactivity, diabetes, TB, mental health issues and early deaths from cardiovascular disease.

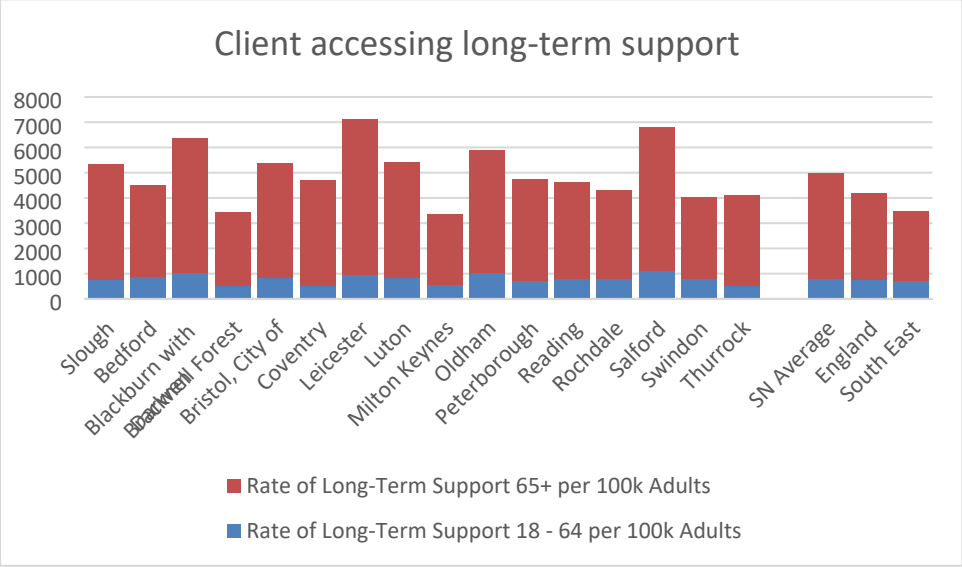
[5] 1 – most deprived, 151 – least deprived

Slough has higher demand for support services for the over 65's than the national average and a higher average spend. The increase in demand and thereby in spend is due to an increasing older population and an increase in complexity of need. The Projecting Older People Population Information System predicts that the population of those aged 65 and over will increase by 50% by 2040.

There is significantly higher demand for support for older people in Slough than the national average, the South East average and among our statistical neighbours.



Slough also has a higher number of clients accessing long-term support, against statistical neighbours, England and South-East averages.



4 Population Projections

In Slough, the older persons population (aged 65+) is forecast to increase by 16.5% from 2019 to 2025, and 33.2% from 2019 to 2030. In addition to this, the number of older adults in England with medium or high dependency (measured in terms of intervals of care needed) will increase from 1.3m in 2015 to 1.6m in 2035, 1.06m of these people will require high dependency – 24 hour care.

14% of the population are over the age of 65. This is predicted to increase by 16.5% from 2019 to 2025, and by 33% from 2019 to 2030. This is likely to increase pressure upon limited budgets for adult social care.

What does the Joints Strategic Needs Assessment (JSNA) say about Adults in Slough?

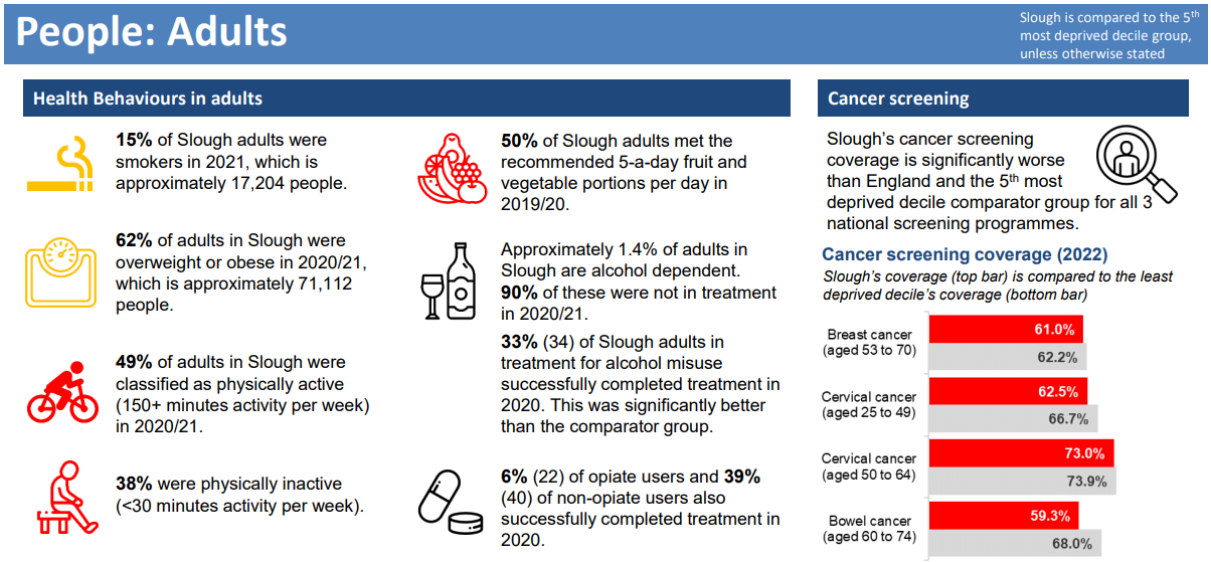
Information taken from the "Berkshire East Joint Strategic Needs Assessment: Slough Summary" February 2023

Slough has a population of 158,495 and has increased by over 13% over the last 10 years. Slough's population is one of the youngest in England with nearly 28% of the population aged under 18, compared to 21% nationally. While the proportion of working-aged adults in Slough is higher (63%) than England's (61%), the proportion of people aged 65 and over is significantly lower at only 10% of the population. People aged 65 and over make-up 18% of the population nationally (Office for National Statistics 2023). As it stands the proportion of 65+ locally is 8% below the national average. In that context, it's very important to correctly estimate any increase projections for the next 5 -10 or 15 years

Comparators

Slough is in the 5th most deprived decile of local authorities in England. As deprivation is such an important factor for health and life outcomes, the 5th most deprived decile group figures have been used as the main comparator group in the JSNA.

As a snapshot from the JSNA we know the following about Adults in Slough:



5 System Pressures

THE COST OF DEMENTIA

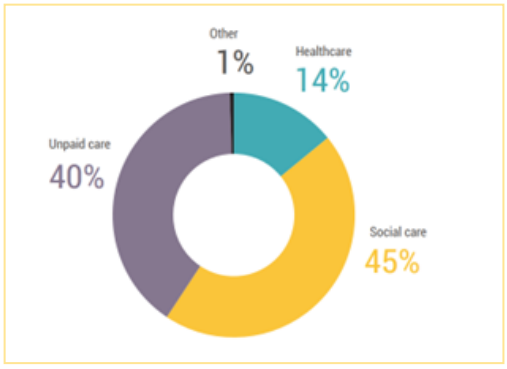
Despite Slough having a younger population profile, there are still major pressures, none more so than around 40% of people with Dementia in Slough are without a formal diagnosis. The market cost for Dementia out grows most other Long Term Conditions and set to double by 2050.

The Costs of Dementia Summary

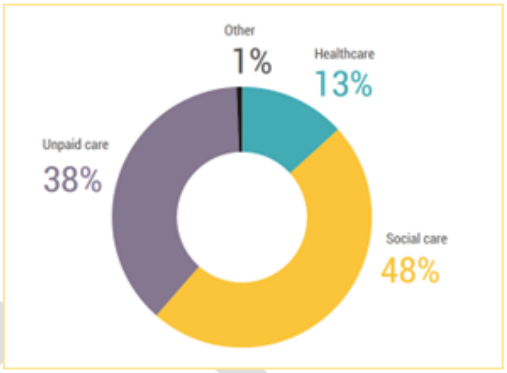
- The total cost of care for people with **dementia in the UK is £34.7billion** (an average **annual cost of £32,250 per person** with dementia) and is expected to double by 2050.
- This is set to rise sharply over the next two decades, to £94.1billion in 2040.
- These costs are made up of healthcare costs (costs to the NHS), social care costs (costs of homecare and residential care), and costs of unpaid care (provided by family members).
- The largest proportion of this cost, 45%, is social care, which totals £15.7billion.
- Social care costs are set to nearly triple over the next two decades, to £45.4billion by 2040**.**
- At the community level, the cost of caring for individuals with dementia is like cancer, and greater than heart disease and stroke.

- Two-thirds of this cost is currently being paid by people with dementia and their families.

Breakdown of total costs of dementia care in the UK, 2019



Breakdown of total costs of dementia care in the UK, 2040



Reference from: What are the costs of dementia care in the UK? | Alzheimer's Society
There will be other pressures, but this seems to be an important one to project ahead given the financials and the associated massive increase in market capacity required in Slough.

Prevalence of dementia in Slough in relation to the National and Berkshire levels

According to the Dementia PH Needs Assessment 2023 "The estimated prevalence of dementia at a national level is 0.8%. ***Local authorities in Berkshire****; Windsor and Maidenhead has the highest estimated prevalence of dementia (0.9%), Bracknell Forest 0.6% and* ***Slough have the lowest prevalence (0.4%)****. [1]"*

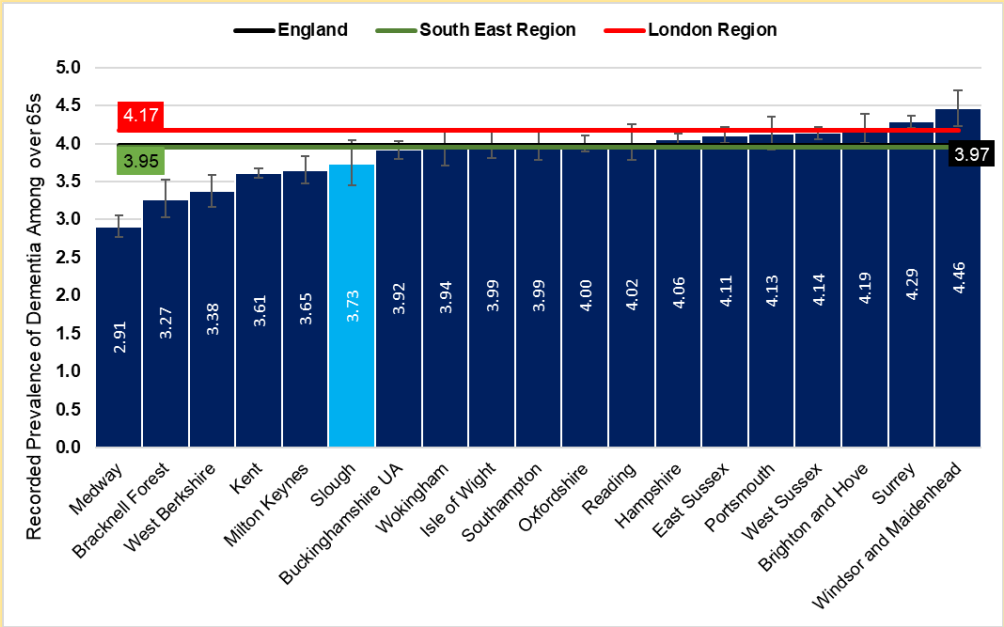
According to Slough Public Health needs assessment 2018-2019*: [2]*

- *Total population of 14,615 people aged 65+ in Slough, 5,575 residents (or 4%) were recorded as having dementia.*

Diagnosis

- *Estimated dementia diagnosis rate of the 65+ in 2019 in Slough was at 598 (64.9%) better that of the region at 65.6% and that of England 68.7%*

1. *Oxford Consultants for Social Inclusion 2023*
2. *Slough Public Health Dementia Needs Assessment 2017/18 (saved on the PH shared drive)*
3. *Slough Market Position Statement 2020-2023 www.slough.gov.uk*



6 Tackling Slough's Priorities

6.1 Priority 1: To Reduce Social Isolation and Loneliness for Older People

Slough like other towns and cities across the UK is faced with Older People living alone. This often follows the inevitable loss of a spouse/loved ones as we grow older. Living alone in older age can affect both physical and mental health and this needs to be combatted and address. As Older People as they become older can see a decrease in health and sometimes mobility which means Older People can live in social isolation and are often lonely.

The Slough the PH Dementia Prevention Needs Assessment 2023 resonates with the importance of this priority.

Social isolation and loneliness are both added risk factors to Dementia.

The Berkshire JSNA 2023 reports: **Social isolation** is the lack of relationships with others and that have little to no social support or contact. It is associated with risk, even if people don't feel lonely.

Loneliness is feeling alone or disconnected from others. It is feeling like you do not have meaningful or close relationships or a sense of belonging. It reflects the difference between a person's actual and desired level of connection. This means that even a person with a lot of friends can feel lonely.

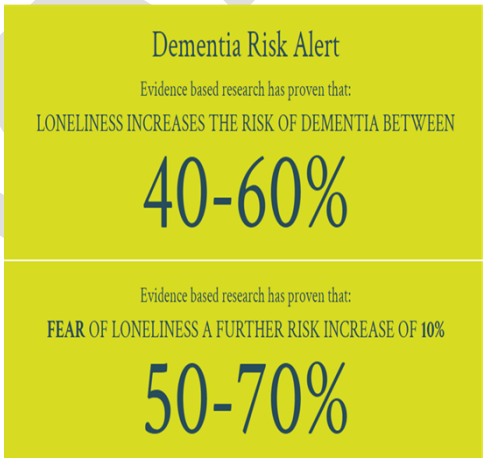
Social Isolation and loneliness are increasingly being recognised as a priority public health challenge and policy issue for older people as it can have a serious impact on their physical and mental health and quality of life. Loneliness and social isolation, however, are not just issues for older people but for all age groups. Certain risk factors increase the chances of

severe and lasting loneliness including young/older adults, low income adults, people living alone, those with long term health conditions and disability, minority ethnic groups and LGBTQ+.

Equally, the **Public Health Dementia Prevention Statement 2023** states:

There is strong evidence that many adults aged 50 and older are socially isolated or lonely – putting their health at risk.

- Social isolation significantly increased a person's risk of premature death - rivalling smoking, obesity, and physical inactivity. Social isolation was associated with about a 50% increased risk of dementia.
- **One-third of people with mild-to-moderate dementia experience loneliness**. 30% are moderately lonely and 5% are severely lonely, reports one of the first major studies to look at the issue. These figures are comparable to the general population of older people.
- People with dementia who live alone, and who experience social isolation, depression and lower quality of life are more likely to feel lonely. Some researchers found no association between loneliness and dementia-specific factors.
- Loneliness was associated with higher rates of depression, anxiety, and suicide.



References:
Summary report: The State of Ageing 2022 | Centre for Ageing Better (ageing-better.org.uk)
Social isolation linked to lower brain volume and higher dementia risk - Alzheimer's Research UK
Loneliness and Social Isolation Linked to Serious Health Conditions (cdc.gov

Equally, Older People can struggle with their independence in manage daily living tasks and evidently become isolated and alone. If they cannot live alone, it may ultimately result in them living in a residential/nursing home with people they are not related to or for who they are likely to have formed friendships with beforehand. The isolation may have

diminished to some degree as there is company, but it is likely to take time to develop trust with staff and fellow residents.

Slough is mindful of it's role in supporting health and well-being in the borough. Consultation was key here – a need to empower Older People to go to A&E at the right time (they don't want to cause a fuss).

There are a range of housing options beyond care homes such as Extra Care housing where people have their own independent flats (with any care going in) and shared accommodation such as a lounge for socialising – tv, board games, quizzes, etc. This type of accommodation is normally "tenancy" based (rent or alternatively Shared Ownership related) and means people have given up their own home to live there. This kind of setting is often helpful in Older People developing new friendship networks, reducing loneliness, and maintaining a level of independence. Slough has two established Extra Care provision namely The Pines and Northampton Place and very much see the opportunities and advantages in minimising loneliness and isolation for Older People in Slough. There is a wider priority 8 in this strategy about increasing the housing options for Older People in Slough.

6.1.1 Extra Care services and advantages

- On site restaurant supplying hot meals 7 days a week.
- Regular social care activities for those who wish to join in.
- Communal cleaning and garden maintenance.
- All properties are linked to a 24 hour alarm system, to respond to emergency situations.
- A team of carers give support and assistance with personal needs as part of a formalised care package.
- Emergency care is available through the night. All care is assessed on an individual basis.
- An estate manager working on site.
- You are living at home not in a home.
- You have your own front door and decide who comes in.
- Couples and friends can stay together.
- There is a mix of able and less able older people.
- 24 hour care services are available if you need them.
- You get support to keep your independence.
- You have control over your finances.
- There is a small shop on site.
- There is a hairdressers shop with a visiting hairdresser.
- There is a mobile chiropody service every six weeks.

Working with the Voluntary & Community Sector there are an array of non-statutory opportunities to support.

Slough operates several universal services which are available to anyone in the borough to support their health and wellbeing to keep active, mentally and physically This includes

libraries, parks and a number of new leisure centres – with a wide range of facilities and activities available – including gyms, swimming pools, fitness classes and swimming lessons for children and adults. Older People want to undertake a range of activities including sitting down exercise. An opportunity to support Older People consider better lifestyle choices to manage their wellbeing.

In addition to this the Council and its partners commission or operate several services to support residents to stay fit and healthy and achieve a good quality of life. As part of this strategy there is an ambition to create a new Older People Steering Group to oversee this strategy. This means holding SBC and its partners to account in delivering on the priorities and actions set out in the Older People Action Plan.

One of the benefits of the new Older People Steering Group would to be securing a range of Older People who may able to link us with other Older Peoples groups in the community. They may also be able to set up a network of Older People to help in combatting any social isolation or loneliness in the group, most probably in an indirect way. It is likely there will be opportunities through the new Community Connectors to make the links and develop the VCS Community Sector further.

6.2 Priority 2 For Older People to have a continued sense of purpose to live their best life

It doesn't matter what age a person is, the importance of having a sense of purpose is key. It effects how we feel about life, how it shapes who we are, our self-esteem, etc.

It will shape a person's mental health and wellbeing. It's in this context Slough Borough Council recognises the importance of linking with its partners in the NHS, Public Health and the Community & Voluntary Service to make a difference. Late in life Older People may wish to seek employment – voluntary or private sector as part of a new life, in retirement to meet new friends and use their skills and experience. Beyond this there will be opportunities to attend voluntary sector clubs and societies to engage in Slough with people of all ages to share conversations, get involved in a range of pass times and to add value to any of these opportunities.

There are the Slough Integrated Community Hubs who have designated Community Connectors to help link people to areas of interest in terms of e.g. leisure centres, clubs and the like as well as information about their rights, public services, etc. These are explained in this Strategy under Priority 4. Many of these opportunities will enable Older People to interact with others, thus combatting social isolation as well as potentially opening horizons and providing renewed interests. People want to tell their story once Coordination of care, get hospital appointments on one day rather than over several days.

In addition, SBC aims to promote choice and independence for Older People through the following:

Personal Budgets and Direct Payments - the road to empowerment, choice and a sense of purpose

The Council is committed to helping people to live independently with more choice and control over the care and support they receive.

Promoting wellbeing is not always about the Council meeting needs directly. It is just as important for us to provide people with the information they need to take control of their care and support and choose the options that are right for them.

The Council provides information to everyone eligible to receive social care support, about the indicative cost of their care and they are supported to make decisions about how they spend that money; this is called 'self-directed support'.

Direct Payments is one way in which self-directed support can help individuals to have greater control of how they receive the help they need, allowing the individual to buy the service directly or to employ a personal assistant instead of the council arranging services on behalf of the individual. In doing so they are often able to employ family or friends from their own cultural and religious background with specific language skills. Older People asked for this strategy to improve the direct payment offer and to look at how to make it easier for people to access or to get an authorised person to act on their behalf.

During 2022/23 over 165 Carers one-off payments, 425 service user direct payments were administered allowing 590 people to purchase care and support to meet their needs as appropriate to their protected characteristics.

Slough currently has the second highest percentage of community direct payments across the South-East.

The Council is committed to maintaining and increasing the number of people who can access Direct Payments. Equally looking at wider opportunities such as ISF and pooling of Direct Payments between those sharing similar interests. This might be welcomed by Older People who e.g. may like to club together to go for lunch or visit an attraction together.

6.3 Priority 3: To live more years in good health.

Slough Borough Council recognises with the wonders of modern medicine and what its needs analysis tells us about people living longer is seen as a positive thing. The evidence suggest that: "Technological advances – from the applied use of genomics, to the use of video consultations with a GP – offer real opportunities to improve health care." Advances in health care technology offer huge potential to improve the NHS but are no 'silver bullet'

Advanced sensors, health data and AI algorithms will empower healthcare professionals to develop precision diagnoses, personalized treatment, tailored health management and

effective monitoring, all without a hospital visit. The hospital will come to you; care will be everywhere. **How will new technologies benefit ageing and longevity? | World Economic Forum (weforum.org)**

However, due to a range of Long Term Conditions many Older People suffer at the expense of the quality of that life which can be impaired. Older People can lack the quality in these later years so the importance here is to maximise the quality of their experiences in these later years. Slough Borough Council wants everyone to live an as active and healthy lifestyle as possible, making best use of local facilities.

The Council operates, commissions or implements plans with partners for a range of services which are designed to deliver the right level of support to residents at the right time. This can range from lower levels of intervention to enable Older People to stay independent within their own homes for longer through to residential and nursing care when these become necessary. It is clear people aspire to having a Single Assessment and to tell their story once. Older People have been clear, they want accessible ways of interacting with SBC, not just digital options. Carers Leads have talked about their workloads and how much of this must be to complete e.g. Blue Badge applications for carers who are Older People and not so familiar with Information Technology. In that sense disempowering Older People. However, increasingly there are many ways Slough empowers Older People to manage their own life including health:

6.3.1 Maintaining positive psychological health

Any resident in Slough aged 17 and over can access talking therapies in Slough operated by Berkshire Healthcare Foundation Trust. One of the biggest factors that Older People face in terms of their wellbeing is being alone and social isolated which may dramatically have an impact on their overall health. This can be for a range of difficulties including:

- work stress
- sleep
- coping with a physical health problem
- obsession and compulsions
- trauma-related stress
- relationships
- stress
- motivation or low confidence
- frustration about not living up to own expectations.
- excessive worry or panic attacks
- phobias
- depression.

The types of therapies offered include:

- Cognitive Behaviour Therapy (CBT), Computerised CBT and ‘guided self-help.’ These help people make changes in the ‘here and now’ to improve how they feel and resolve

problems. Therapists help individuals to understand the nature of their difficulties and agree set goals to work on to overcome them.
- Stress Less workshops and wellness courses
- Counselling for depression – including relationship difficulties.

6.3.2 Assistive Technology

- Assistive technology is one of the tools available to Older People to remain more independently at home with the help of gadgets and gizmos to allow their health to be monitored and their safety assured. This is helpful for family and are designed to be as non-intrusive for the older person as possible.
- The Council currently operates the Careline service to provide monitoring, protection and support to people remotely, typically, via a device connected to a telecommunications network. A device (a pendant or pull cord) which sets off an alarm when the user needs assistance, such as a fall, enables the person to live independently with greater confidence that they can call for help when they need it and provides professional assurance, they have implemented a considered way to mitigate risk.
- Our strategy is to connect modern assistive technology into the heart of our adult social care and support services in an integrated way. The benefits of Assistive Technology are wide ranging, from giving independence to people by supporting them to complete daily tasks, to acting as a communication method for people who need emergency help.
- In the latter part of 2023, SBC are undertaking an Assistive Technology diagnostic to see how we can enhance our use of digital technology to better support individuals living at home.
- The Careline service is also transferring to an existing provider to ensure that a working service is available with a switchover from analogue to digital telephony services.

6.3.3 Domiciliary Care

- Domiciliary Care plays an essential role within the local health and social care system. Care workers provide care and support to individuals with assessed needs within their own homes, to enable them to stay independent for longer. Our strategy is to commissions services which deliver care and support activities, administration of medication, helping people with transfers (for example from bed to chair), helping with washing, dressing and toileting and other forms of personal care. Our local domiciliary care providers enable people to return home after a hospital stay, thus ensuring that hospital discharge takes place on time and that individuals do not need to stay in hospital longer than necessary. There is a need to empower Older People to go to A&E at the right time, in case of serious episodes e.g. heart attack, stroke, etc.

- Local authorities are required, under s5 of the Care Act 2014, to ensure a diverse and sustainable market to meet eligible assessed care needs including care at home for those who require it. This includes provision of directly commissioned care as well as provision for those in receipt of Direct Payments and self-funders.
- The Council currently contracts 27 providers registered with the Care Quality Commission to deliver domiciliary care services within the borough and the current commissioning strategy is to periodically undertake procurements via the Adult Social Care Dynamic Purchasing system. Despite market and demand pressures we have been able to maintain a sufficiency and diversity of supply (in keeping with Section 5 of the Care Act 2014), secured at competitive prices.

6.4 Priority 4: To work in greater partnership with the NHS and Public Health to prevent Long Term Conditions including the wider determinants of health.

One of the greatest challenges faced is supporting people across the NHS and Social Care are those that have a range of Long Term Conditions (LTCs). Often people have more than one condition which are referred to as "co-morbidities." There is often a pattern, if you have Cardiac Disease, you may also have Diabetes. In which case it requires careful medicines management to ensure people with LTCs are given consistent advice on e.g. medication to avoid unnecessary hospital admissions. In Slough there is a model of support around "anticipatory care" which follows and pre-plans with those who have a family history of LTCs. In doing so many of these are preventable through lifestyle changes. This potentially increases the quality of life for those who have a family history and at best prevents or delays them having an LTC.

6.4.1 A Spotlight on Dementia as a pillar of this Older People Strategy

In Slough one of the biggest local and national challenges is around those with Dementia (see statistics earlier in this strategy). There has been a significant prevention needs assessment for those with Dementia developed by the Public Health Team as referred to earlier in this strategy. The present and future demand of Dementia in the borough is well understood, albeit some people, up to 40%, are out there with Dementia but it's undiagnosed. This strategy shows the trends and impact from the PH Dementia Needs Assessment along with information shown here, helps give a focus on Dementia acting as one of the pillars of this Strategy. A pillar that shines a light on one of the biggest priorities for this strategy.

Nationally there is a wealth of interest around Dementia. According to Slough's PH Dementia Prevention Assessment "Building on ambitions of outlined in 2015, the Prime

Minister's Challenge on Dementia 2020 reaffirmed the nation's commitment to carers and people with dementia and established a range of new goals for dementia care from diagnosis through end of life.

In addition to creating supportive and inclusive environments, the challenge emphasizes the need to develop research, raise awareness, and coordinate care with a trained workforce.

Furthermore, the NHS Five Year Forward View, recognises dementia as a priority area with a specific aim to diagnose more people with dementia earlier to allow treatment to help slow the progression of the disease.

To achieve this, the NHS Five Year Forward view aims to provide a consistent standard of care for patients and to support clinicians or advisors, with proper care plans developed in partnership with patients and families.

Locally the Executive Summary in the PH Dementia Needs Assessment 2023 states:

PH Dementia Needs Assessment 2023 Summary

- Dementia is a clinical syndrome (group of symptoms) characterised by difficulties with one or more areas of mental function. The condition affects around 944,000 people across the UK (2021) and the numbers are set to rise to over a 1.1 million by 2030. The total cost of care for people with dementia in the UK is £34.7billion (an average annual cost of £32,250 per person with dementia) and is expected to double by 2050. The local dementia healthcare cost is projected to increase by over 70% in 2030 as compared to 2019.
- In Slough, the current levels of dementia prevalence are lower than SE and England average, due to our borough's youngest population age (33.9 years). However, the expected dementia prevalence is estimated to be higher than the recorded prevalence and is increasing among older adults aged 65 and over. It is also estimated that around 40% of people living with dementia are still undiagnosed, while emergency admissions are higher than both SE and England average – an indication of a higher need for dementia acute care services locally.
- Several modifiable risk factors for dementia have been identified and some of them are known as 'early-life risks', such as less education, affecting cognitive reserve; while midlife, and later-life risk factors tend to influence cognitive reserve and triggering of neuropathological developments. In Slough some of these risks including smoking, physical inactivity, excess drinking and poor dietary habits are more prevalent and of real concern. We have an Integrated Health & Wellbeing Service contract run by the Solution for Health that offers various evidence-based interventions to tackle these lifestyle risks factors.
- There are several dementia care services locally including the Slough Memory Clinic supporting GP practices and an important pillar of the local dementia care pathway; and the Alzheimer's society that operate across East Berkshire offering various forms of dementia support. However, local stakeholders view is that there are not enough services locally as well as capacity and funding issues.
- This needs assessment will serve as a baseline document that will support the second phase of this work with main objective to support the dementia care

model/pathway locally. Continuing to work in close collaboration with all key partners and stakeholders locally is important as part of monitoring and evaluating our work. A dementia care task & finish group is proposed to take forward this work and develop a dementia action plan for Slough.

6.4.2 What resources are in place in Slough to support the preventative agenda for Long Term Conditions?

6.4.2.1 Integrated Wellbeing Hub

To support residents to maintain their health and wellbeing, the Council commissions Solutions for Health to deliver an Integrated Wellbeing Hub. This provides a single point of contact for a range of preventative services, including:

- NHS Health Checks
- Falls prevention.
- Cardio vascular disease risk assessment
- Smoking Cessation
- Weight Management
- Alcohol Brief Intervention – the need to have a preventative approach to alcohol consumption for Older People.

The current contract sees the hub extended by 1 year to 5th September 2024 with an option for 1 final year's extension if required.

6.4.2.2 The Voluntary and Community Sector

The Council has recommissioned the voluntary and community sector to deliver activity in Slough for the next five years (2023 – 2028). Funding (through the Better Care Fund and Public Health) covers several important areas, including infrastructure, a volunteering and matching service and a directory of services – providing up to date information on all the voluntary and community groups operating in Slough. The importance of a service directory - knitting clubs, joined up personal budgets. Equally, for support for Social Prescribing – GPs having the info to prescribe voluntary sector opportunities.

6.4.2.3 Stroke Support Services

The Council commission The Stroke Recovery Service (SRS) to support older adults who have suffered a stroke to rebuild their lives after stroke. The impacts of stroke often last a lifetime and we know that people's needs change over time. It is critical that people affected by stroke receive the support they need in the long-term to rebuild their lives and lead the best

life possible. The Stroke Recovery Service ensures that people affected by stroke receive the vital input and support they need.

6.4.2.4 Better Care Fund

The Better Care Fund's (BCF) central aim is to support the delivery of integrated health and social care for the population of Slough. Our shared priorities were agreed and published in the Health and Social Care Plan (2020-21) which is our place-based strategy.

The Plan was developed with a range partners, including Primary Care Networks, Community and Acute Trusts and the community and voluntary sector. Co-ordination of Care is critical to ensure time and resources are used most effectively. Equally, we need a single record of care build on the "connected care" project medical management accessible across health and social care. It is recognised that Connected Care needs to be more comprehensive in its access e.g. to adult social care providers. More specifically in terms of the Voluntary Sector, a Service Directory of voluntary sector opportunities.

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.

Priorities for our BCF programme in Slough include:

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

The plan is to develop, promote and maintain independence for not just for older people, but the whole borough to prevent admissions to acute care, care homes and reliance on health and social care service in the future. 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.**

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

- **Urgent Care Response** providing 2 hr crisis response to people in need of urgent supporting running 8am-8pm Monday -Friday
- **Establishing Virtual Wards** providing medical care and treatment to people in their own home in need of enhanced clinical support.
- **Enhanced Healthcare** to care Homes to enable homes to provide high quality care in care home settings and avoiding admission to hospital.

- **Anticipatory Care Planning** to do proactive case finding of people with frailty risk factors, co-morbidities to provide early intervention and support to maximise independence and remain at home for longer. The key importance of the prevention of Long Term Conditions E.g. Diabetes, Heart Disease, Strokes etc through integrated working with health and other partners. Loneliness can be a bigger killer than any Long Term Condition and that needs careful consideration.
- **Falls forum and prevention work** through Slough BCF funds a Falls Free 4 Life service delivered by Solutions for Health to complete comprehensive falls risk assessment and classes to improve postural stability. In terms of wider prevention work there is a need to look at early identification of "at risk groups."

The Council will continue to work with its partners though place-based mechanisms to support further integrated services. An opportunity for greater Integration with health both at a local level e.g. with GPs and more broadly at ICB level.

In terms of hospital admissions preventative work in the community could revolve around better medicines management especially for those with co-morbidities. Ensuring advice responds to all their medication/conditions as this could reduce unnecessary admissions to hospital.

An opportunity to look at the key worker role – NHS/Social Care, badge is less relevant, it requires skills that span both partners. Co-location of workers across NHS and social care is key to the success of any integration plans.

Prevention starts at the front door. **The ASC Front Door Project**

The Front Door Project is a central feature of a new preventative approach towards delivering adult social care in Slough. Key elements of the project include:

- Ensuring a timely response when seeking support from Adult Social Care.

- Implementing an asset and strength-based approach to enable people to identify their strengths and allow them to stay as independent as possible.

- Diverting from adult social care by take of alternative community-based support as appropriate.

6.4.2.5 Community Equipment Services

The Berkshire Community Equipment Service (BCES) provides a variety of equipment for adults, children and young people with long term conditions and disabilities. Following an assessment from a qualified practitioner equipment is provided on loan from the local authority. The service is currently commissioned on a joint basis between 6 local authorities and Integrated Care Systems across Berkshire.

6.5 Priority 5: To tailor Older People Information & Advice on the challenges that affect them e.g. cost of living, fuel costs, food poverty, etc.

Information and Advice in Slough is predominantly sitting between the Councils Community Team as an activity and the Voluntary and Community Sector. From July 2023, the Council has be funding Community Connector roles within Adult Social Care to help residents (who do not need social care) to access the range of voluntary and community sector services available in the town. There is much merit and opportunity in co-commissioning with Public Health especially in terms of a preventative approach and the wider determinants of health.

Advice and Information

The Council also commissions Citizens Advice East Berkshire to provide free, up to date advice and information for Slough residents on several key areas. This includes:

- Housing
- Adult Social Care
- Legal Relationships
- Benefits and Tax Credits
- Signposting to VCS
- Cost of Living

Fuel Poverty

A household is fuel poor if they are living in a property with an energy efficiency rating of band D or below and are left with a residual income below the official poverty line once they have spent the required amount to heat their home. Evidence shows that living in cold homes is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups (Office for Health Improvement and Disparities 2022) In 2020, 5,180 households in Slough were fuel poor.
Given the pressure on the economy in the UK because of e.g. the war in Ukraine and the possible impact of Brexit, most people has felt the impact on their cost of living. Inflation has spiralled to e.g. near 20% inflation on food meaning the average weekly shop has been unaffordable for most. There has also been the huge hike in the price of petrol which has

affected everyone in terms of the cost of going to work, going about their business. Some people will have stopped using their car or sold it.

There was also the massive increase in the cost of utilities primarily gas and electricity which along with the other cost of living pressures will inevitably mean people lose their mortgages or become unintendedly homeless.

The Boost Team exists in Slough that assist in checking e.g. benefits entitlements to ensure people are aware of all the benefits they can claim at this time. We want to support everyone to be as self-reliant as possible.

The new Older People Steering Group to review the requirements with the wider older people population in Slough. This is to assist the Front Door having as much relevant information as possible to support Older People to self-care.

This activity may need one-off events e.g. Carers Rights Day in November is one such event that deals with the complex issues arounds rights of carers. The Council to pro-actively help carers often many who are Older People navigate their rights.

6.6 Priority 6: To support intergenerational families best care for their loved ones and with respect to cultural differences.

At a broader level the Council has a commitment to ensuring that Older People are adequately supported often in their caring roles. From July 2023 carers services have been transferred back into the Council. The service will undertake carers assessments and facilitate and coordinate access to several carers support groups in the community. A focus of the new service will be to implement the **Slough Carers Strategy 2023-26**, including developing partnerships arrangements between the Council and Carers. An established Direct Payments team facilitates one off payments to carers who are eligible. The Slough Carers Strategy dovetails with this strategy and add strength to both offers.

In terms of intergenerational families several carers might be supporting kin in the same household. There may be added complexity to these arrangements and the need for wider support. It is important not to make any assumptions about intergenerational families, rather greater collaboration with families and through a range of cultural groups developed organically in Slough.

It is important we are mindful of associated housing options which are shaped by the size of intergenerational families which are culturally predominant in Slough. It can see families of e.g. 10 or more living together with several generations. It means with limited housing stock and inflationary challenges this is a pressure point in Slough. There are opportunities for Adult Social Care and Housing to work more closely on a joint housing strategy for social housing and beyond.

It needs some tailored engagement with these intergenerational families likely through a range of existing cultural groups that are linked to wider social care activities. We will deploy our new engagement model “Quality Conversations” that sees very open dialogue

between SBC and service users/family members and, as appropriate, staff. Our first experienced was at Oak House care home in Wexham and we worked collaboratively with Health Watch and the Co-Production Network. An action to develop a Quality Conversation for intergenerational families in Slough is included in the Older People Action Plan at the end of this Strategy.

It is important to assess what do they need to live independently, are they accessing support as family carers, there may be younger carers involved too and each carer requires support. As above with the new Slough Carers Strategy 2023-26 we need to ensure we support these diverse needs to minimise the risk of carer breakdown through a range of support. It is important that all SBC carer interventions are available to any carer, but particularly intergenerational family carers given the level of independence they are sustaining. If SBC had to pay for this care, if there weren't any willing family carers, SBC could see costs spiral and as such celebrate such intergenerational family carers for the fabulous work they do in self-caring in the community.

Arising from the Quality Conversation will be a standalone Intergenerational Family Action Plan to meet the needs of this community. This fits with wider work in the borough to examine housing options for all client groups to include intergenerational families and Older People.

6.7 Priority 7: To have a choice about where I die through a co-produced end of life pathway.

Our end of life approach is to work in partnership to support end of life of care, which rests across social care and health, to deliver a range of interventions through the reablement team, as well as in hospices and hospital settings.

We have developed services to enable older adults to die at home where this is their wish through the provision of Advance Care Plans, involvement of family, will making facilities etc. We can provide domiciliary care payments and deliver end of life support services in older adults where this is requested.

We also commission hospice care through The Thames Valley Hospice, Phillis Tuckwell Hospice in Surrey and end of life virtual ward beds through the local community service.

Hospital at Home is underpinned by close partnership working across health and social care and through integrated community teams. Implementation should be led by the integrated care system (ICS) and delivered by appropriate secondary care, community health services and primary care working collaboratively.

However, the end of life opportunities are, in part, fragmented and in conjunction with NHS and other partners, there is a real opportunity to develop a co-produced end of life care pathway for key decisions about where people choose to die, often at home and away from hospital. Now it is disjointed in that various professionals e.g. Re-ablement Service deliver end of life care and there is a Continuing Health Care fast track for supporting individuals'

journeys in the NHS. There is a chance to develop a golden thread and ensure better co-ordination of End of life Care in Slough.

We are continuously seeking to find ways to strengthen our approach towards co-production and will be considering ways to do this over 23/24 and beyond. We need for co-production of Older People in Slough, beyond the established Co-Production Network so everyone who wants to can have a say. How can the CPN help us to co-produce the End of Life Pathway in Slough? How can a wider set of volunteers be commissioned to review services including Health Watch volunteers too?

Where possible working with partners to establish peoples choice of where they would like to die is important. People often prefer to die at home and away from hospital and it takes a great deal of co-ordination and working in partnership to realise such wishes.

6.8 Priority 8 To have a range of housing options to suit me in later life.

There are opportunities for Older People to secure advice and access to a range of accommodation tailored to meet the needs of Older People. Some of these opportunities have been set out when the strategy looked at the priority 1 "To reduce social isolation and loneliness for Older People" as its critical to look at with this lens to ensure that social interactions are carefully considered with any housing opportunities made available. Building social resilience is likely to add positive years to life too.

There is the opportunity to craft a strategic vision about what housing needs look like for Slough which would need to be co-produced with Older People and their support networks.

From that Slough may revitalise its approach through a Housing Needs Options Panel where housing, operations and commissioning can come together to ensure they future proof opportunities, minimise voids, maintain lists of suitable housing and ensure intelligence gained so far is acted upon where it makes sense to do so or to programme for the future. In the past housing providers have been curtailed in e.g. developing supported housing as Slough could not commit to block and voids. Evidently risks will be sitting with the housing providers. Work is underway to have developmental meetings with housing providers to talk about need and demand and explore new ways of working together.

Within the mix of the strategic housing vision, housing colleagues can help plan on the mix of tenure, the type and numbers so that we don't have under or over supply of housing resources. It needs to take on board the increasing higher acuity of Older People and those with Dementia to ensure appropriate settings that give a level of independence, social interaction and safety.

Many Older People remain independent in their own/rented homes – with a partner or alone but as the years progress and often following loss of a loved one, there is a need to consider other housing options. Care homes – residential and nursing for higher acuity but

where there is a level of independence there are several independent housing options to consider.

Housing colleagues have been consulted in relation to housing matters affecting Older People. The biggest challenge in relation to Older People accommodation is the lack of supported housing especially for those with complex needs and complex hospital discharge. There is limited interim "step down" accommodation in order they can go through a period of reablement as well as move on post rehabilitation especially those with neuro, MH Substance Misuse, etc. Equally there are numbers of Older People who don't meet the threshold but need a pathway to independent living. Equally there are some challenges around the willingness of some landlords to adapt their properties to ensure they are fit for purpose. Housing recognise the importance of securing the right kind of properties to reflect the numbers of intergenerational families in the borough.

Where there have been "void" cost for Older People this is where there is several 1 bed properties that are less in demand for Older People. One of the key improvements Housing are keen to be part of is some clear pathways to help pull all the issues and challenges together and to have clarity on flow, ownership and accountabilities.

On a wider note there have been challenges in future proofing substance misuse accommodation and ensuring a best fit with those that live there already especially in general needs setting.

6.8.1 Residential and Nursing Care

The Council commissions both residential and nursing care for older adults across the borough with some care being 'spot purchased' in neighbouring boroughs due to the small footprint of the Slough Borough Council area. The Council is committed to providing the best quality care with a focus on patient and family involvement, providing a 'home' environment with activities and innovative delivery of a stimulating environment for all older adults including best practice care for EMI and dementia patients. This is none less so evidenced at Oak House, Wexham which was subject to a Quality Conversation review in September 2023 as described earlier in this strategy.

Our strategy is to review how we commission and deliver all older adults nursing and residential care with less reliance on 'spot purchasing.' Over 2023-24 we will be commissioning more block contracted beds, particularly for those older adults with challenging dementia behaviours and those older adults between 55 and 65 where short-term nursing care is required.

6.8.2 Extra Care

Extra Care services were picked up under priority 1 and play a vital role within the Health and Care system, not only by delivering care to people aged 55 and over who are assessed as requiring it, but also by averting the need for individuals to move into more expensive residential care. Extra care balances independent living with an enhanced sense of security where service users receive support to manage their tenancies.

There are two extra care schemes in the borough with 126 properties across the two schemes.

The Council has recently commissioned the care and support elements across the schemes, with a new provider taking on the operation in September 2023. Aside of the two extra care schemes in Slough there are several other options:

6.8.3 Private Rental /Social Housing

Under Section 106 regulations planners must build a range of social housing as part of any new development along with other social housing (with affordable social rents). There is also private landlords who charge market rate rentals which may be less affordable to those in receipt of services.

Sheltered Housing

Supported Living Flats/bungalows

Older People Shared Ownership

Retirement villages

Share Home Options

Immediate step down from hospital

If Older People are having problems with their current home, the NHS suggest they can use the "Housing Options for Older People online tool".

Beyond these more independent housing options there are broadly more traditional residential and nursing care homes providing regulated care for higher acuity service users. Slough commissions from a range of care homes in the borough, the largest provision being Oak House in the Wexham Area which has 120 beds. Self-funders may purchase their care directly from a care home if they don't meet the Local Authority/NHS thresholds. There are a range of regulated care homes in Slough in terms of e.g. small family homes and larger homes with a different offer. Slough work with the homes to quality assure their offer and to encourage providers to continuously improve. We welcome ideas for change, improvement and to hear when things are good. These will go forward for review by our Older People Steering Group.

The Co-Production Network who review Slough Provision from a carer/user perspective do so for services across the board from a qualitative perspective. This can give positive assurance to those using services that there are these unregulated spot checks and a look beyond regulated assurance. In doing so the Co-Production Network build up a bank of views and experiences in which to assist Slough BC to co-design services using all this rich intelligence. Slough BC would encourage others in receipt of service to volunteer for quality

assurance reviews of our services so it can widen the net of reviewers having a say from a range of perspectives.

One of the significant pressures in future years will be meeting the housing and support needs of those with Dementia in Slough. It can be a complex journey with Dementia varying from early onset to complex Dementia that requires bespoke nursing needs. We will want to continue to better understand the condition and welcome more recent research and possible medication that could slow down the condition. Slough will keep up to date with research in order Slough can adapt its offer around Dementia. Slough has a resource around Dementia through the Public Health Dementia Needs Assessment developed in 2023 providing an evidence base for Dementia in Slough.

6.8.4 Disabled Facilities Grant

In 2023 the Council implemented a new Housing Assistance Policy. This sets out the Council's approach towards utilising the Disabled Facilities Grant to support the delivery of adaptations in the homes of older and disabled residents in Slough. This helps people to remain living independently, confidently safely and with dignity in their own homes. Housing assistance can help to reduce the impact of a disabling environment and therefore maximise independence.

There are significant opportunities for Adults Care to strategic plan with Housing and look at areas of interest e.g. shared lives, Housing Allocation Panel, Future proof housing, managing voids, matching vacancies, etc.

6.8.5 Reablement Service

The Council currently operates a registered reablement service, remodelled in 2022. The aims of the service are to support individuals to regain skills and independence following a stay in hospital. Services are provided free of charge for a six week period and the focus is upon minimising any long term requirements for adult social care. The service also takes referrals from the community to prevent hospital admission.

7 Action Plan

This Slough Older Peoples Commissioning Strategy 2023/26 provides a vision for the next 3 years. An Older People Steering Group comprised of older people and professional stakeholders will oversee the delivery of the strategy and the action plan. The Action Plan contains action plans and deliverables and these will be reviewed by the Steering Group, once convened. Further stretch targets will be also be included to ensure continuous improvement.

	Actions	**What we will work on to achieve these actions**	**How we will know if we are being successful.[6]**
1	To continuously improve Slough meeting the needs of its diverse older people's population.	To develop **more engagement opportunities for Older People** beyond the Co-Production Network to enable a stronger voice and to hold SBC and partners to account for the delivery of this strategy. To partner with Healthwatch with the Enter & View visits. To include the **new Quality Conversations Model** developed for Oak House **linked to all priorities.**	Creation and effectiveness of a new Older People Steering Group to hold SBC and partners to account for this Older People Action Plan by January 2024. Measures: As contained in this Older People Action Plan are delivered. Outcomes Framework.
2	To see continuous improvements for Older People through **a new customer journey**. Older People being adequately supported in the borough.	Mapping the **customer journey** for Older People and developing **a clearer operational pathway** to support the Older People priorities in this strategy **linked to all priorities. Putting the Older Person at the centre of everything that we do.**	The development of a customer journey and operational pathway for Older People for Slough by 30th September 2024.A co-design exercise with Operations and Commissioning which is co-produced with Carers and Service Users.

[6] Actions and timeframes will be reviewed once the Older People Strategy Steering Group has been convened and will be subject to the availability of staffing resource.

			Measures: Feedback from the range of Older People Groups across Slough. Feedback from the CPN, new Older People Steering Group (once developed) and the new Hubs etc.
3	**To support the dementia care model/pathway** locally. Continuing to work in close collaboration with all key partners and stakeholders locally is important as part of monitoring and evaluating our work.	A **dementia care task & finish group** is proposed to take forward this work and develop a standalone **Dementia Action Plan for Slough.** Dementia is the pillar of this strategy. **Linked to priority 1 & 4.**	**A robust Dementia Action Plan** by January 2025 as part of a preventative approach to minimising or delaying Dementia and **tackling social isolation linked to priority 1**. Measures: A range of associated KPIs in line with the Public Health Prevention Needs Assessment.
4	To re-develop **an End of Life Pathway**.	To ensure all the elements of the pathway are joined up to help **people die in the place of their choice** **Linked to Priority 7**.	A robust End of Lifeway co-produced with Older People with targets for change by April 2025. Measures: KPIs to be developed. But, to include qualitative feedback from family members and professional stakeholders.
5	To develop a new **Older People Steering Group**	To monitor and **hold partners to account for this Older People Strategy and Action Plan** to ensure positive outcomes for Older People **linked to all priorities.**	To convene an Older People Steering Group by January 2024. Measure by the deliverables and outcomes achieved through this Older People Action Plan.
6	**To develop new housing options for Older People**	An Older People housing options project group is required to map out a range of housing options to help e.g. **minimise social isolation linked to priority 1 and 8.**	**New Housing Options for Older People** are prescribed in Slough's Local Housing Strategy reflecting the demographics e.g. larger intergenerational families at one end and a mix of tenure that would equally see

			accommodation for students at the other end. Measures: KPIs as included within the Local Housing Strategy. Work to commence with the Housing Department in Spring 2024.
7	**To engage with intergenerational families**	To have a specific **Quality Conversation exercise** with **intergenerational families** around their caring role. **This is linked to priority 6 and 8.**	Use of the **Quality Conversation toolkit** to undertake a Quality Conversation exercise to finding out the needs of intergenerational families by 30th September 2024. The outcome will be **a standalone Intergenerational Family Action Plan** to meet the needs of this community.
8	**To see improvements in the VCS** delivering services for older people in accordance with the service specification	Implementation of the VCS Commissioning Plans. With less day care what other day opportunities could be developed to enrich the lives of Older People. **Embedding Community Connectors** into Hospital Social Work Teams and at the ASC Front Door **Linked to priority 2 & 4.**	Contract Monitoring Satisfactory delivery against KPIs set out within the service specification recognising the developmental approach 85% of those OPs diverted at the front door are referred into a VCS offer by 31st August 2024.
9	**Integrated Wellbeing Hub.** Align smoking cessation services with those across East Berkshire	Implementation of Commissioning Plans in time and to budget. Co-production of service design. Hub extended by 1 year to 5th September 2024 with an option for 1 final year's extension if required.	New services already commissioned in time for existing contract expiry ie by September 2025. Measures: Improvements in PHOF and ASCOF Indicators. Customer satisfaction KPIs included within specification.

		Linked to priority 4.	
10	To **embed a personalised, strength-based approach** into our practice.	**Implementation of the ASC Transformation Programme linked to priority 4.**	50% more personalised approaches as demonstrated in the Contact and Referral Data collated as part of the ASC Balanced Scorecard by 30th August 2024 Measures: Satisfaction Survey
11	Embed the **ASC Front Door Projec**t	Project Group established under the **ASC Transformation Programme.** **Linked to priority 4.**	Increased access by the Front Door to preventative services including the VCS by 75% by August 30th, 2024. 25% reduction in the number of people receiving Adult Social Care by 30th August 2024.
12	**Community Equipment**	**Recommission** our **Community Equipment** Services in 2024. **Linked to priority 4.**	Service delivering as reported to Cabinet in November 22 and in accordance with the specification. Reduced demand for adult social services by 25% by 30th August 2024.
13	**Assistive Technology**	**Facilitate an assistive technology diagnostic** to understand how the Council can make best use of technology to support independence especially for Older People. **Linked to priority 3.**	Diagnostic concluded on time and to budget. Plans in place to develop the **Assistive Technology Offer** by end of 2024. Measures: KPIs established as part of developmental work.
14	**Reablement review**	**A review of the reablement service** to ensure that is delivering against stated aims and	Review undertaken and next steps agreed by 31st December 2024

		achieving value for money.	ASC Transformation Programme.
15	**Domiciliary Care**	Recommissioning of domiciliary care as well as replacement care. Contracts for unregulated as well as CQC regulated care. **Linked to priority 3.**	Services in place and care market for domiciliary are functioning effectively. KPIs in contracts. Measures: CQC rating reported regularly into DLT.
16	**Extra Care**	**Full implementation of new contract** for extra care services. **Focus on reducing isolation** and **bringing the community in** e.g. hairdresser, exercise classes to the setting. Encourage the voluntary sector to visit and for activities to happen on/off site.	Measures: Contract delivering against KPIs. Satisfaction survey: Resident satisfaction what ambitions are there for 75% of tenants satisfied?
17	**Residential and Nursing Care**	Expand provision where there are current gaps. This includes nursing and respite care. Care Home Market Retender increasing the number of block contracts.	Recommissioning of block contracts to expand the number of arrangements. Adequate provision in place to meet demand. Progression of the **Market Position Statement** (due to be presented to Cabinet in Autumn / Winter 2023/24)
18	**Stroke Support Services**	From 2024 onwards the Stroke Association Recovery service will be commissioned as a single ICB wide service being led by Frimley ICB. **Linked to priority 4.**	New services in place. Measures: From 2024 onwards, KPIs within service specification delivered. KPIs relate to outcomes to: • Improve the confidence of stroke survivors • Reduce social isolation, • Increase choice and independence. • Embed healthy lifestyles. • Increasing the numbers returning

			to employment after a stroke.
19	Developing current **Information and Advice**	Boost Team exists in Slough that assist in checking e.g. benefits entitlements to ensure people are aware of all the benefits they can claim at this time. We want to support everyone to be as self-reliant as possible. **Linked to priority 5**	SBC records all the signposting and advice given to evaluate the impact and make use of any rescue funds available from some voluntary sector organisations are targeted appropriately. Making sure Older People can guide this ambition through the Older People Steering Group. Listening to Older People's desire **to not live in such a digital world** e.g. renewing a Blue Badge can only be secured on-line in Slough. This frustrates Older People and means more reliance on family/friends/voluntary sector to do this on their behalf i.e. doesn't assist Older People to self-care.
20	**Developing a Housing Strategy for Older People**	To ensure that we continue to look at new and independent housing options for Older People. Looking at Slough's makeup looking to support models for inter-generational families. Additionally options for step down from hospital so Older People can regain skills and convalesce. **Linked to priorities 1, 6 & 8.**	To develop in partnership with housing **a Housing Strategy for Older People.** To ensure that over the next 10 years or more we have enough housing to meet the needs of Older People in Slough. Links to Housing Department and conversations taking place over 2024.
21	**Co-production**	Developmental planning around co-production to continuously strengthen	Members of the co-production network feel as though co-production is effective in the borough.

		the approach. **Linked to all priorities.**	Quantify the numbers of engagements, things that have changed consequently? What could we measure in a meaningful way? Qualitative assessment and feedback.
22.	**Recommissioning of DP Support Services**	This appertains to the **Pre-Payment Card** Service. Live project in 2023. **Linked to priority 2**	A **Framework in place by March 2024**. Will assist Older People manage their DP and provide greater transparency for SBC.
23.	**Promotion of ISFs** with service users/providers as part of a continued promotion of the DP scheme.	**Easy read leaflet** developed for promoting the offer. A revitalised approach to increase the numbers of those pooling together to have an ISF. **Linked to priority 2.**	Continuous Improvement with developments **across client groups.**
24	**Addressing Social Isolation.**	Capture data from Community Connectors, social workers, service users and family members to guide future commissioning activity and small grant programme in the town**.** **Linked to priority 1.**	Gather further data to inform activity to address social isolation. Feed into the small grant programme for the VCS where additional funding of services tackling social isolation would be beneficial. Measures: Outcome from small grants programme.

8 APPENDIX 1

CONSULTATION FEEDBACK

SBC Away Day for People (Adults) Strategy and Commissioning Team and Members of the Co-production Network 26th July 2023

An Away Day for the People (Adults) Strategy and Commissioning Team and Members of the Co-production Network was held on 26 July 2023. The following views were obtained, through consultation, to inform this Older Peoples' Commissioning Strategy and there is a hyper link to where the consultation has added to this Strategy (see "Go to Section):

Theme	Feedback	Minimum Inclusion in Strategy (Page Number)
Loneliness & Social Isolation	Addressing loneliness and isolation that's a big need	Go to section
	Conflict between keeping people at home and take up of domiciliary care which could increase loneliness	Action Plan
	Be good to include generational groups	Go to section
	Combatting Loneliness – bigger killer than some of the Long Term Conditions	Go to section
	Social Isolation – big effect on well-being.	Go to section
Keeping active	We need to get people active	Go to section
	Sitting down exercises	Go to section
	Reablement / physio /rehab Rehab support to improve independence, not as care replacement	Go to section
	Rehab support reduces the need for long-term support reduces hospital readmission	Go to section
	Rehab need to support people to do the tasks	Go to section

Prevention	Frailty aspect is linked to force. How do we include falls prevention support?	Go to section
	Look at early identification of "at risk groups"	Go to section
	Voluntary Sector – service directory - knitting clubs, joined up personal budgets	Go to section
	Social Prescribing – GPs having the info to prescribe voluntary sector opportunities.	Go to section
	Health inequalities	Go to section
Life Style Choices	Are there lifestyle changes low hanging fruit?	Go to section
	Talking groups, quality of care is important. Individual needs to take into consideration, food, exercise nutrition	Go to section
	Alcohol strategy for Older People	Go to section
Information & Advice	Understanding finance, and how expensive is	Go to section
	Integrated customer insights – a single repository	Noted
Resources/VFM	There is a lack of resources - no Days centres so we need to link people into groups	Go to section

	Please asset-based conversations	Go to section
	Manage the market	Go to section
	Co-Production – underpins all	Go to section
	Broader consultation	Go to section
	Care workforce since the Pandemic – depleted, need a local workforce plan.	Noted
	Co-location of workers across NHS and social care	Go to section
Integration	Coordination of care, get hospital appointments on one day rather than over several days	Go to section
	We need a single record of care build on the connected care project medical management	Go to section
	Prevention of Long Term Conditions working with health e.g. Diabetes, Heart Disease, Strokes etc integrated working with health.	Go to section
	Prevention of LTCs	Go to section
	LTCs – health profile for Slough – preventable – strokes, cardiac, diabetes, dementia.	Go to section
	Integration with health – local level e.g. with GPs and more broadly at ICB level	Go to section

	Joint risk stratification of the most complex cases fits with Slough's approach to Anticipatory Care	Go to section
	Step down from hospital	Go to section
	Co-commissioning with Public Health.	Go to section
	Medicines Management – to avoid unnecessary admissions.	Go to section
	Integration : Key workers – NHS/Social Care, badge is less relevant	Go to section
	Health & Wellbeing Board – working across partnerships - fire, police, community safety.	Go to section
Direct Payments	How to improve the direct payment offer how to make it easier for people to access or to get an authorised person to act on their behalf	Go to section
	Personal Budgets, Direct Payments and ISFs?	Go to section
Assistive Technology/Telehealth and DFG	Need a plan within the strategy	Go to section
Housing	Strategic Planning with Housing - shared lives, Housing Allocation Panel, Future proof housing, managing voids, matching.	Go to section

	Bring back, sheltered housing wardens	Noted
End of Life	Quality of life in final years of life – wonders of modern medicine mean people live longer, at what price, at what level of quality of life?	Go to section
	Die in place of choice (often not hospital) – need an end of life pathway that gives choices.	Go to section
	Will you need an end of life pathway supporting people to have choice in where they live their last days	Go to section
Self Care	Need to support, prevention and improves independence from formal services	Go to section
	Single Assessment - tell your story once.	Go to section
Miscellaneous	AI – use of AI in gathering data and showing trends.	Noted
	Reablement and Home Care (contracts 27 providers and DPS)	Noted
	First contact is important it's shapes the relationship going forwards	Noted

	Full conversations about critical issues e.g. tackling poverty, cost of living, fuel etc	Go to section
	This might be too exhausting for some older people dependent on the tests	Noted
	Beyond CPN, need to engage with wider population of Older People.	Noted
	How to empower Older People to go to A&E at the right time (they don't want to cause a fuss)	Go to section