Bracknell Forest Council

NOTICE OF MEETING

Adult Social Care, Health and Housing Overview and Scrutiny Panel
Tuesday 24 July 2018, 7.30 pm
Council Chamber - Time Square, Market Street, Bracknell, RG12 1JD

To: The Adult Social Care, Health and Housing Overview and Scrutiny Panel

Councillor Harrison (Chairman), Councillor Mrs McCracken (Vice-Chairman), Councillors Allen, Mrs Angell, Dr Hill, Mrs Mattick, Ms Merry, Peacey, Mrs Temperton, Thompson, Tullett and Virgo

cc: Substitute Members of the Committee

Councillors G Birch and Finnie

Observer:

Mark Sanders, Healthwatch Bracknell Forest

Non-Voting Co-opted Member:

Dr David Norman, Co-opted Representative

ALISON SANDERS
Director of Resources

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Adult Social Care, Health and Housing Overview and Scrutiny Panel
Tuesday 24 July 2018, 7.30 pm
Council Chamber - Time Square, Market Street, Bracknell, RG12 1JD

AGENDA

Page No

1. **Apologies for Absence/Substitute members**

   To receive apologies for absence and to note the attendance of any substitute Members.

2. **Minutes and Matters Arising**

   To approve as a correct record the minutes of the meeting of the Adult Social Care, Health and Housing Overview and Scrutiny Panel meeting held on 5 June 2018. 5 - 24

   Review of the Actions Log arising from the Minutes including a sickness and absence update for Adult Social Care provided by Mira Haynes, Chief Officer: Adult Social Care and an update on any issues arising since the last meeting.

3. **Declarations of Interest and Party Whip**

   Members are asked to declare any disclosable pecuniary or affected interests and the nature of that interest, including the existence and nature of the party whip, in respect of any matter to be considered at this meeting.

   Any Member with a Disclosable Pecuniary Interest in a matter should withdraw from the meeting when the matter is under consideration and should notify the Democratic Services Officer in attendance that they are withdrawing as they have such an interest. If the Disclosable Pecuniary Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.

   Any Member with an Affected Interest in a matter must disclose the interest to the meeting. There is no requirement to withdraw from the meeting when the interest is only an affected interest, but the Monitoring Officer should be notified of the interest, if not previously notified of it, within 28 days of the meeting.

4. **Urgent Items of Business**

   Any other items which, pursuant to Section 100B(4)(b) of the Local Government Act 1972, the Chairman decides are urgent.

5. **Public Participation**

   To receive submissions from members of the public which have been

submitted in advance in accordance with the Council's Public Participation Scheme for Overview and Scrutiny.

6. **Sustainability of GP Practices in Bracknell Forest**

Fiona Slevin-Brown, Director of Strategy & Operations for East Berkshire CCG and Dr. William Tong, Clinical Chair East Berkshire CCG will speak about GP practices in Bracknell Forest and what is being done to ensure they are sustainable. 25 - 34

7. **Public Conversations - Urgent Care**

Fiona Slevin-Brown and Dr William Tong from the East Berkshire CCG to update the Panel on the conversations the CCG is having with local people about urgent care services. 35 - 44

8. **Introduction to the Sustainability Transformation Partnership move to the Integrated Care System and the Governance Arrangements**

Jane Hogg, Integration and Transformation Director: Frimley Health Foundation NHS Trust, to present the Panel with an introduction to The Sustainability Transformation Partnership move to the Integrated Care System and the governance arrangements. 45 - 54

Please note: There is a hyperlink to a video on slide 3 of the presentation which is not available by clicking on it when viewing the agenda in Mod.gov. The video will be available to view at the meeting. To view the video in advance of the meeting, copy and paste the web address below into your browser.
https://www.youtube.com/watch?v=UcM92BHs9yA

9. **Community Network Approach**

Matthew Clift, Development Manager: Community Mental Health Teams for Adults & Older Adults, to present the Community Network Approach to the Panel. 55 - 104

10. **Healthwatch Bracknell Forest Annual Report 2017-2018**

Mark Sanders, Project Manager: Healthwatch Bracknell, to present the Panel with the Healthwatch Bracknell Forest Annual Report 2017-2018. 105 - 118

11. **Update on the Council's Response to the Homeless Reduction Act**

To note the Chief Officer: Early Help and Communities' report, which advises the Panel of the new obligations from the Homeless Reduction Act 2017 and the response to the new obligations which the Council has implemented. 119 - 122

12. **Executive Forward Plan**

To consider scheduled Executive Key and Non-Key Decisions relating to Adult Social Care, Health and Housing. 123 - 124

13. **Date of Next Meeting**

The next meeting of the Adult Social Care, Health and Housing Panel has been scheduled for 11 September 2019.

ADULT SOCIAL CARE, HEALTH AND HOUSING OVERVIEW AND SCRUTINY PANEL
5 JUNE 2018
7.30 - 9.15 PM

Bracknell Forest Council

Present:
Councillors Allen, Mrs Angell, Harrison, Dr Hill, Mrs Mattick, Mrs McCracken, Ms Merry, Peacey, Mrs Temperton, Tullett and Dr David Norman

Co-opted Members:
Dr David Norman

Observer
Chris Taylor, Healthwatch Bracknell

Executive Members:
Councillors D Birch

Apologies for absence were received from:
Councillors Thompson, Virgo and Finnie
Mark Sanders Healthwatch, Bracknell

In Attendance:
Mira Haynes, Chief Officer: Adult Social Care
Simon Hendey, Chief Officer: Housing
Lisa McNally, Director: Public Health
Kirsty Hunt, Governance and Scrutiny Manager
Kirstine Berry, Governance and Scrutiny Co-ordinator

1. **Election of Chairman**

   RESOLVED that Councillor Harrison be elected Chairman of the Panel for the Municipal year 2018/19.

2. **Appointment of Vice Chairman**

   RESOLVED that Councillor Mrs McCracken be appointed Vice-Chairman of the Panel for the Municipal year 2018/19.

3. **Minutes and Matters Arising**

   RESOLVED that the minutes of the Adult Social Care and Housing Overview and Scrutiny Panel meeting held on 27 March 2018 and the Health Overview and Scrutiny Panel held on 11 January 2018 be approved as a correct record, and signed by the Chairman.

4. **Declarations of Interest and Party Whip**

   There were no declarations of interest relating to any items on the agenda, nor any indication that Members would be participating under the party whip.

5. **Urgent Items of Business**

There were no urgent items of business.

6. **Public Participation**

No submissions had been made by members of the public under the Council's Public Participation Scheme for Overview and Scrutiny.

7. **Conversations Approach**

Mira Haynes, Chief Officer Adult Social Care, presented the meeting with an update on the Conversations Approach including a video featuring Melanie O'Rourke, Head of Adult Community Team which detailed the first, second and third conversation approach.

As a result of Members' comments and questions, the following points were made:

The Panel were advised that needs were identified at the assessment stage and the whole process including the third stage could be completed at the initial assessment within one or two hours, certainly the same day.

It was clarified that an external auditor would monitor the approach to measure its success. The numbers of people whose conversations had ended at each stage would be monitored in order to identify where the resources would be best placed.

The role of the conversations approach was to keep residents independent for as long as possible, to reduce attendance at Accident & Emergency. Outcomes would be measured, for example where people were 91 days after intermediate care intervention and the results of the audit would be available to the business information team during the next quarter.

The Panel were told that residents would be signposted to the most appropriate and best help that could be provided in the community. If they did not accept the offer of support and they were deemed to have capacity to make a decision, their choice would be respected.

The Panel were advised that training had been extensive and that all Adult Social Care and Housing practitioner staff had received training.

Concerns were raised that some disabled individuals had lost support thorough the process and it was explained that support would not be lost or reduced but would be delivered in a different way. It was acknowledged that this could lead to a perception of reduction. Councillors were asked to provide details to the Chief Officer of any specific cases outside the meeting for further investigation.

A quality panel of officers met to review support provision assessments to ensure that proposed support or changes were appropriate.

The Panel were advised that neighbouring authorities used a similar approach and that the conversations approach in Bracknell Forest was based on a nationally recognised programme.

It was explained that officers worked closely together to take a personalised approach and where the conversations approach extended to housing needs worked closely together to provide support.

Community Connectors support residents to navigate the social care system.

As previously raised, the Panel reiterated that Members should be offered the opportunity to be trained in these techniques to assist them when working with their residents. It was accepted that Members are not practitioners but that it was important for them to understand the approach rather than attempt to refer residents themselves. It was noted that motivational questioning techniques could be used by Members in their casework.

The Chairman requested that a briefing session be organised to refresh Members' knowledge on how to interact with the public on Adult Social Care changes and how to signpost them correctly.

8. **Quarterly Service Report (QSR)**

The Panel noted the Quarterly Service Report (QSR) which covered the fourth quarter of the 2017-18 financial year (January – March).

The Chairman thanked Councillor Tullett for his comprehensive list of questions which had been submitted and answered before the meeting and requested that they were appended to the minutes (available at Annex A).

Mira Haynes, Chief Officer Adult Social Care highlighted that the first phase of the transformation has been successfully delivered despite some challenges such as an unexpected Care Quality Commission (CQC) Local Area Review in September 2017. She reported that there had been good performance across the indicators but some areas were still red. The headline from the current quarter was that consultation had been undertaken with staff to integrate the expanded Integrated Care System and Long term care teams. East Berkshire Clinical Commissioning Group (CCG) proposal to manage the continuing Healthcare function was still work in progress. The Council was advertising for Personal Assistant posts which could be paid for by residents through direct payments.

Simon Hendey, Chief Officer: Early Help & Communities advised that the Homeless Reduction Act was a major change at the end of April 2018 which introduced the duty to undertake homeless prevention for 56 days by creating a personalised homelessness prevention plan. He reported that to date:

- 76 households were in triage
- 35 households were under intervention which was the stage before prevention
- 24 households were in the prevention stage which meant that they had a personalised agreed plan
- 49 households were in the relief stages receiving support
- the Council had accepted the homeless duty on 13 households

The Welfare and Housing teams were now combined which gave more opportunity to support residents and additional government funding was supporting ongoing recruitment to increase the number of officers to keep pace with demand.

Lisa McNally, Director of Public Health updated the Panel on recent public health activities including that there were no red activities to comment on. She reported that Bracknell Forest had pioneered more community focused interventionist approach initiatives which were very popular. The approach had been to set up activities with people rather than to them such as the community map and physical activity groups. She reported that more traditional, structured treatment approach such as NHS Stop Smoking campaigns had struggled recently to achieve uptake and a less medicalised approach was more successful. She explained that the Community Map now had up

to 386 groups and thanked members of the Panel for their support populating it. Groups such as Junior Parkrun, Martial Arts sessions which were inclusive of all physical abilities, “Who let the Dad’s out” crèche, walking groups with 50+ members and Checkmates chess groups in libraries had all helped to boost inclusivity for groups who otherwise feel socially isolated.

She reported that, in a short time period of only two years, the data suggested that this activity has had a positive effect on reducing social isolation issues and high re-admission to hospital levels. The approach was attracting national attention such as The National Centre for Mental Health featuring it and councillors from Medway Council visiting the Council to see how it works. The Director advised the meeting that the community groups involved would come together to form a marketplace to showcase what works well rather than the visitors touring locations around the borough.

The Director updated the Panel on the changes in approach to health visiting and that child development data had seen high levels of child development across the four key areas at the age of two which meant that Bracknell Forest children were having the best start in life.

Arising from questions and discussion the following points were made:
There has been a 10% decrease in the number of clients (Jun 17 to Mar 18) from 1160 to 1040 and a gross care cost reduction of 5%, (£30.5 Million in Oct 17 down to £29m in March 18)shown on the care cost 12 month trend analysis. Although costs were complicated by complex care cases the reductions were linked to ways of working with people such as the conversations model which was helping identify appropriate support early on and new technology was also being used to support residents.

There was an increase in demand during the summer months. The approaching adulthood team work with children aged 14+ and there is a spike of demand when the school term ends and the team work closely with the Children Young People and Learning department.

It was explained that Adult Social Care had undertaken a procurement exercise for new domiciliary care providers. The previous level of 20 providers has been reduced to eight or nine and there were some transition and handover issues. During the process providers had stopped taking on packages of care but the new contracts were now in place and the Panel were assured that this situation had now been resolved.

The number of people needing double up calls (when more than one carer is required to attend a visit) over the last 18 months; had risen. When people are discharged from hospital they are medically fit, but this did not mean they are physically fit and they often needed more support until the care package could be reduced. More than one carer was required when someone needed support with a hoist or to be lifted.

It was observed that the success of getting people with complex needs out of hospital back into the community setting was costing the Council money but it was clarified that the intermediate care service was funded jointly with the CCG and the local authority. It was stated that the focus should be that hospital was not the right place for residents who were medically fit.

Members of the Panel requested further forecasting information on demand. Lisa McNally, Director of Public Health confirmed that this was possible using POPPI and housing data to produce a statistical model to show where costs and demand might

go to give an idea of trends. Mira Haynes, Chief Officer Adult Social Care also agreed to share data Adult Social Care are working on.

The Panel were advised that a public health reserve had been built up over the last 3 years. Public Health grant funding had already been used to invest in the Community Connectors service to reduce social isolation. In general, the intention is to shift budget to higher levels of need but that, before this could be done, it had to be demonstrated that savings were sustainable at lower levels of need first. More detail will be available. Any recurrent underspend must be seen in the context of the reducing level the Public Health Grant being received by the Council.
The Panel were advised that Public Health would bring future proposals to be considered by the Council in more detail for scrutiny.
Simon Hendey, Chief Officer Housing, clarified that the capital under spend in 2017/18 is carried forward. That capital has to be used to fund adult social care capital expenditure and as such could be used to fund accommodation for people with learning disabilities or to contribute towards the capital costs of the Heathlands project if that proceeds. The latter use would generate additional revenue savings for the Council as it would replace the need for the Council to enter into borrowing to fund the project equivalent to the capital contribution that is made available.

It was explained that there were two parts to the Heathlands development. A 44 bed unit for Elderly, Mentally, Infirm (EMI) and a 20 unit Learning Disability (LD) accommodation. The LD accommodation could not fit on the Heathlands site in planning terms. Thus a feasibility study has been commissioned on another Council owned site to assess whether the learning disability accommodation can be accommodated.

The Panel were advised that it was a long term conditions pilot had now become business as usual and the Council was working with three GP clusters – North, South and bordering with Ascot.

In response to a question regarding low targets it was confirmed that there was now zero risk that use of the website would exceed capacity. Targets had been set based on what could be achieved but that the level of online services demand had exceeded expectations.
Work still needed to be done to extend access and points of contact and the Director advised that Local Government Association (LGA) funding had been applied for to provide kiosks in shopping centres and community centres were being considered
A children's health and wellbeing website was currently in development.

The Director of Public Health agreed that the work of Public Health including strategic targets should be included in future drafts of the Council Plan and was interested to know what Members of the Panel wanted to see delivered.

Members reiterated concerns regarding the sickness statistics and queried whether an anonymous stress audit had been carried out and whether staff were taking sickness days instead of annual leave. The Panel were advised that there were incidences of long term sickness included in the figures and that these absences were not attributable to work related stress.

The Panel were advised that managers follow the managing health policy and look for trends and patterns in absences. They offer support where necessary and refer to occupational health if necessary. The Council was offering wellbeing courses, had created breakout spaces, counselling was offered for the Emergency Duty Team, agile working was offered and that there are professional support mechanisms in place to support staff members.

The Panel noted that the sickness levels were consistently elevated within the ASC team in every QSR and it was suggested that the data be further interrogated and those who are on long term sick be isolated from the numbers to give a truer picture of 'occasional' sickness patterns. This would potentially provide further insight and help to explain the skew.
The Panel also asked to see how the sickness levels compared regionally and nationally to other ASC teams. The Panel felt that further investigations and a proper analysis of the sickness levels were required.

The Chairman thanked everyone for their questions and answers.

9. **Executive Key and Non-Key Decisions**

The Panel received and noted the scheduled Key and Non-Key Executive Decisions relating to Adult Social Care, Health and Housing.

Reference I072405 - Sensory Needs Contract Award
The Panel were advised that the Sensory Needs service had been brought in-house but that there was a need to contract out some services. This item related to the award of spot contracts for the Sensory Needs service following a competitive tender.

Reference I076397 - Safeguarding Adults Annual Report 2017/18
The Chairman observed that this was a routine report which would be considered in November.

10. **Development of Overview and Scrutiny Work Programme 2018-19**

Kirsty Hunt, Governance and Scrutiny Manager introduced the discussion on the consultative process which had been undertaken to develop the new Panel's work programme for 2018/19.

It was explained that Members and co-opted members of the previous two Panels, as well as officers and Executive members had been canvassed to suggest topics to be included. Members and co-opted members of the new Panel were asked to rank the collated topics in order of importance so that they could be prioritised.
It was acknowledged that more should have been done to expand on the detail behind the suggested topic areas to give Members greater context, but that this was an evolving process.

The process was not prescriptive and the aim of the process was to share suggestions, include annual budget scrutiny, support Transformation Gateway reviews and enable the Panel to respond to emerging national or local issues. The process also sought to link the work programme topics to the strategic themes of the Council Plan.

The report recommended that the current Working Groups (Task and Finish groups) should be reviewed and the Panel should agree their inclusion in the Work Programme if still relevant.

During the discussion the following points were made:

- There was a general consensus that the Integrated Care System would need to be a key feature in the Work Programme

- the work programme would need to be flexible to respond to the upcoming Social Care Green Paper, the integration of individual care budgets and the integration of social care and health items as they emerged
- The development of the Integrated Care System would require briefings as the situation develops to keep Panel Members updated
- a final report from the Housing Strategy and Supply Working Group could be expected in the autumn and that a visit to Guildford Borough Council was being planned for June 2018.
- It was clarified that the previously set up STP Working Group was no longer active.

It was agreed:

- That the current task and finish groups, The Primary Care Patient Experience Task and Finish Group and the Housing Strategy and Supply Task and Finish Group should be included in the next work programme
- To develop the work programme further at a facilitated workshop which should be organised before the next scheduled meeting of the Panel.
    - That the facilitated workshop would consider how to include the Integrated Care System in the work programme.
    - That the facilitated workshop should also consider what development requirements the Panel had.

The Chairman acknowledged that the consultation process to develop the work programme had been valuable but that the Integrated Care System (ICS) would be such a significant topic that its different elements should be investigated in more depth. The Chairman summarised for the Panel that the work programme would be developed at a facilitated workshop with the focus on the ICS.

11. **Date of Next Meeting**

The date of the next meeting will be 24 July 2018 at 19.30

Minute Annex

Questions and answers, submitted in advance of the meeting, in relation to Minute item 8 – Quarterly Service Report (QSR).

CHAIRMAN

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Annex A

Quarterly Service Report Questions

Q1. Could you clarify the "significantly increased demand", whereas the graph on P31 suggests a reduction in the number of clients from 1,160 to 1,040?

A. The demand is predominantly for complex care e.g double up care, the graph shows how the conversations approach and increased focus on earlier intervention and prevention should help reduce/delay demand for long term care

Q2. From the same graph, could you explain the significant rise in costs between June and September 2017?

A. 3 main drivers for the escalating demand spike over the period June to September 2017 were down to the following

- Pressures from Young People transitioning from CYPL to adult services.
- Summer vacation cover for young people in education placements.
- Dom care market pressures during the transition to the new framework.

Q3. What is the forecast public health reserve of £1.039m to be used for?

A. The PH service has reduced its spend by delivering more services via an asset based community development approach and by making more use of digital delivery. Aside from allowing the Council to accommodate the planned reductions in the PH Grant, the reduced spend allows more investment in preventative work at higher levels of need - where it will have a greater and more immediate impact. For example, PH funds will now be funding the Community Connectors Programme delivered by ASC, as well as providing an integrated prevention service into social care (including an expanded programme of strength and balance sessions).

Q4. What is the "large roll forward" of the capital budget likely to be used for, in relation to disabled facilities and / or is this likely to answer item 1.7.11?

A. The expectation is to use capital balances to fund the investment the infrastructure needed to support lower cost community support and respite options such as community hub schemes, extra care housing for LD and extra respite beds/capacity which is part of the overall transformation plan objective to relieve pressure in the local care market.

Q5. In relation to item 4.6.11, although this shows green, could you provide any information about the treatment at home / hospital avoidance schemes for those with LTCs, in the very top percentile (i.e. a previous CCG pilot)?

A. Discharge to assess beds in Nursing home and Residential Home alongside D2A community support in a person's own home provided by Community Intermediate Care Services
Weekend working to ensure we are able to avoid hospital admission

Assessment and Reablement Centre Brants Bridge delivered by Berkshire NHS Foundation Trust
Links with GP practice and Community health e.g. District Nursing
Respite provision
Links to CPN

Q6. Item L310 indicates a massive increase in persons accessing online PH services so, is the current target realistic, is the portal capable of handling the load and what are the services being accessed?

A. The number of people accessing the Public Health Portal has significantly exceeded expectations. We have taken care to ensure the capacity of platform is robust, and are now using a new content management system that gives the site greater stability. The risk that demand will exceed capacity of the site or even slow the website down is very low.

All services are receiving are attracting a high level of access - with the highest being the services for new parents (eg: Baby Buddy App). Other popular online services include Kooth and Safe Sex Berkshire (which can both be accessed via the portal). Each section also includes links to our PH Facebook page where residents regularly give us feedback and ideas.

Q7. Can you explain why section 6 (page 41) does not include any health actions, in relation to self-reliant communities, such as social isolation, partnership projects with residents and the mapping of community groups etc., concentrating instead on anti-social behaviour and crime / CSP issues, only?

A. Yes absolutely agree and this will be rectified in the Q1 to reflect the work being undertaken with warm welcome map, Connections Hub and social prescribing.

Q8. Can we have a brief update on the Integrated Care System (ICS), if it has not been discussed specifically at Agenda item 9 and the Intermediate Care Service (ICS) model?

A Workstreams are progressing and BFC have a rep on these.
Branding has been approved by the Health and Wellbeing Alliance Board
ICS has submitted its operating plan 2018/19
Community Intermediate Care is being expanded to included, 7 day working, and an enhanced team to include, Nursing,therapy and CPN. This will ensure increased capacity to reable and right size packages of care. Full consultation has been undertaken with staff on the new way of working.

Q9. Can we understand what sites are being discussed, in relation to the second location for an integrated health hub and have an update on the Heatherwood site?

A. At present the estates programme is considering hubs at both Brants Bridge and Heatherwood. These are subject to outline business case approval through the ICS estates group and if approved will form part of the Full Business Case development for submission early in 2019. The CCG continue to explore opportunities to develop the community and primary care offer within the Bracknell locality recognising the housing and population growth forecast for the coming years. There have been discussions with the Councils Estates and Planning team to look at options including TRL and the Blue Mountain development. The CCG have commissioned a strategic needs assessment for Primary care for those areas of

Bracknell where the largest pockets of housing development will be taking place in the next 5-20 years to ensure they are adequately planning primary and community integrated care models together to help meet those population needs.

Q10. Can you explain the continuing skew in the levels of staff sickness, particularly in the ASC section, which is averaging over three weeks, per employee, per annum and what is being done in relation to both sickness management and / or stress auditing, within that section, at least?

A. I am unable to explain the continuing skew in the levels of sickness however, We have a managing ill health policy which staff have been trained in and follow, we have had staff on long term sickness relating to serious medical conditions, three staff have been off with stress relating to family bereavements. Staff are referred to Occupational Health for advice and recommendations, and each staff member has a return to work interview. Staff who have been off with stress have a stress assessment undertaken. Staff are also offered confidential Counselling sessions and take these offer up with Harmony. Staff have been offered flu vaccines, are provided with protective clothing and antiseptic gel/wipes we have had some people absent with prolonged respiratory infections. Staff have been invited to wellbeing sessions and are now able to sit in the newly refurbishes atrium areas which have been designated break out areas.

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Actions Log

Adult Social Care, Health & Housing Overview and Scrutiny Panel
From Meeting of 5 June 2018

Action/Information Request	Response
Action 1 **7. Conversations Approach.** Arising from Minute 7 relating to the Conversations Approach, the meeting was advised that the role of the Conversations Approach was to keep residents independent for as long as possible, to reduce attendance at Accident and Emergency. Outcomes would be measured, for example where people were 91 days after immediate care intervention and the results of the audit would be available to the business information team during the next quarter.	On 11 July 2018 Melanie O'Rourke, Head of Adult Community Team advised that the 2017-18 outturn for Adult Social Care Outcome Framework (ASCOF) 2B, the percentage of older people at home 91 days after discharge from hospital into re-ablement/rehabilitation services was 87.0% Rohan Wardena, Transformation Programme Manager advised that reporting to track the new conversations approach was only implemented from April 2018. The data that tracks key performance indicators (KPIs) is currently not available. As soon as the data becomes available it will be provided to the Panel.
ACTION 2 **7. Conversations Approach.** Arising from Minute 7 relating to the Conversations Approach, concerns were raised that some disabled individuals had lost support through the process and it was explained that support would not be lost or reduced but would be delivered in a different way. It was acknowledged that this could lead to a perception of	On 11 July 2018 Melanie O'Rourke, Head of Adult Community Team advised that the Chief Officer: Adult Social Care had not received details of any specific cases for further investigation.

Action/Information Request	Response
reduction. Councillors were asked to provide details to the Chief Officer: Adult Social Care of any specific cases outside the meeting for further investigation.	
ACTION 3 **7. Conversations Approach.** Arising from Minute 7 relating to the Conversations Approach, the Chairman requested that a briefing session be organised to refresh Members' knowledge on how to interact with the public on Adult Social Care changes and how to signpost them correctly.	Mira Haynes, Chief Officer: Adult Social Care suggested that this action is synergistic with action 4 and should be included in the Member training being organised by Kirsty Hunt, Governance and Scrutiny Manager. Since the last meeting, Kirsty Hunt, Governance and Scrutiny Manager has been in discussions with officers from Adult Social Care, Health and Housing (ASCH&H) on developing a session for Members to combine elements of the conversations approach and motivational questioning - this is not yet resolved but it is intended to be delivered in Autumn 2018. In the meantime, Rohan Wardena, Transformation Programme Manager provided briefing notes and a presentation which Kirstine Berry, Governance and Scrutiny Co-ordinator circulated to Members and Substitute members of the Panel on 13 July. Members were asked if any additional training requirements identified after reading the briefing notes and PowerPoint presentation, could be fed back to Kirsty Hunt for inclusion in the Member training in the autumn.
ACTION 4 **Carried Forward from the Minutes of 27 March 2018** **Item 92. Conversations approach.** It was also suggested that motivational questioning, the technique behind the conversations approach, could be offered to all members as part of the member development programme to support their work with residents.	On 12 July Kirsty Hunt, Governance and Scrutiny Manager advised that she has been in discussions with officers from Adult Social Care, Health and Housing (ASCH&H) on developing a session for Members to combine elements of the conversations approach and motivational questioning - this is not yet resolved but it is intended to be delivered in Autumn 2018.
ACTION 5 **8. Quarterly Service Report (QSR)**	Awaiting a response.

Action/Information Request	Response
During the Director of Public Health's update it was observed that the success of getting people with complex needs out of hospital back into the community setting was costing the Council money but it was clarified that the intermediate care service was funded jointly with the CCG and the local authority. It was stated that the focus should be that hospital was not the right place for residents who were medically fit. Members of the panel requested further forecasting information on demand. Lisa McNally Director of Public Health, confirmed that this was possible using POPPI and housing data to produce a statistical model to show where costs and demand might go to give an idea of trends.	
Action 6 **8. Quarterly Service Report (QSR)** **Following on from the action point above……** Mira Haynes, Chief Officer Adult Social Care also agreed to share data Adult Social Care are working on.	On 11 July 2018 Melanie O'Rourke, Head of Adult Community Team advised that the Joint Strategic Needs Assessment (JSNA) is the key source of data used by the Adult Social Care team to source demographic and profiling information. As part of the Adult Social Care, Health and Housing (ASCH&H) 2018-19 Transformation Programme, the team will be looking at demand planning and forecasting and are currently validating the data on a case by case basis.
Action 7 **8. Quarterly Service Report (QSR)** Work still needed to be done to extend access and points of contact and the Director advised that Local Government Association (LGA) funding had been applied for to provide kiosks in shopping centres and community centres were	Awaiting a response.

Action/Information Request	Response
being considered and a children's health and wellbeing website was currently in development. The director of Public Health agreed the work of Public Health including strategic targets should be included in future drafts of the Council Plan and was interested to know what Members wanted to see delivered.	
Action 8 **8. Quarterly Service Report (QSR)** The Panel noted that the sickness levels were consistently elevated within the ASC team in every QSR and it was suggested that the data be further interrogated and those who are on long term sick be isolated from the numbers to give a truer picture of 'occasional' sickness patterns. This would potentially provide further insight and help to explain the skew. The Panel also asked to see how the sickness levels compared regionally and nationally to other ASC teams. The Panel felt that further investigations and a proper analysis of the sickness levels were required.	Mira Haynes, Chief Officer: Adult Social Care confirmed that an update on a sickness and absence levels for Adult Social Care will be provided under the agenda item, Minutes and Matters Arising for the Adult Social Care, Health and Housing Overview and Scrutiny Panel meeting on 24 July 2018.
Action 9 **10. Development of Overview and Scrutiny Work programme.** It was agreed that the current task and finish groups, The Primary Care Patient Experience Task and Finish Group and the Housing Strategy and Supply Task and Finish Group should be included in	On 12 July 2018 Kirstine Berry, Governance and Scrutiny Co-ordinator confirmed that both Task and Finish groups are included in the work programme. • Kirstine Berry, Governance and Scrutiny Co-ordinator and the Task and Finish group lead Member are working closely to review the group's output and focus objectives. • The Primary Care Patient Experience Task and Finish Group are carrying out face-to-face

Action/Information Request	Response
the next work programme.	visits to surgeries to collect best practice data. The next meeting of the group is on 19 July to feedback results and collate responses to date.
Action 10 **10. Development of Overview and Scrutiny Work programme.** To develop the work programme further at a facilitated workshop which should be organised before the next scheduled meeting of the Panel. ○ That the facilitated workshop would consider how to include the Integrated Care System in the work programme. ○ That the facilitated workshop should also consider what development requirements the Panel had.	The next scheduled meeting of the Adult Social Care, Health and Housing Overview and Scrutiny Panel is 24 July 2018. Kirstine Berry, Governance and Scrutiny Co-ordinator consulted Members, Substitute Members, Co-opted Members and Colleagues and scheduled the facilitated workshop for 23 July at 7.30pm.

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Issues Arising Since the Last Meeting on 5 June 2018

Issue Arising	Action taken
"The Big Conversation" A second Bulletin supplied by the East Berkshire CCG	The second Bulletin was circulated to Members, Substitute Members and Colleagues of the Adult Social Care Health and Housing Overview and Scrutiny Panel on 21 June 2018 by Kirstine Berry, Governance and Scrutiny Co-ordinator. The bulletin is the second in a series about conversations the East Berkshire Clinical Commissioning Group (CCG) is having with local people, providers of urgent care and stakeholders about what matters to people if they have an urgent health need or concern. There is an exciting opportunity to re-design the way urgent care services are delivered with the input of local people. There are new national urgent care standards which local services will have to meet and the CCG contracts for urgent care services all need to be re-procured in the near future. The second Bulletin sets out what the CCG hope to achieve and provides an update of how the conversations are going so far. The aim of the CCG is to work with local people to design changes that make sense for patients, communities and the tax payer. As part of the conversations the CCG is having it is seeking to understand why people choose particular urgent care services, what is important to them about who they see and the location of services. The CCG also wants to understand what they can learn from what is already provided and how things could be done differently in the future.

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Bracknell and Ascot – Health Needs Profile

- The registered population is 141,742.
- The CCG's resident population is estimated to increase by 19% by 2039, which is a significant increase. The most significant population change is in older adults aged 65 to 84 and 85 and over.
- The most deprived areas are in parts of Wild ridings and Central, Great Hollands North and Great Hollands South.
- 25% of the CCG's total registered population are under 19 and B&A locality have a higher proportion of children seeking emergency care in A&Es, particularly 0-4 years olds (PH Profile).
- The prevalence of cardiovascular diseases, cancer, respiratory diseases, diabetes, chronic kidney disease, mental health disorders and dementia is lower than the national prevalence rates and comparator CCG group.
- The prevalence of depression is higher.

General Practice in Bracknell and Ascot

- 15 practices with 18 premises - Two practices merged in July 2018 for sustainability and future proof
- Estates pressures and opportunities
- Digital benefit to be realised through more online access to services and assured support for self care and prevention
- Integrated working reducing duplication for services and better joined up care for patients underway
- Good levels of training placements for GPs – need to retain new GPs and expand placements to other members of the wider team in practices

Our ambition for General Practice Sustainability

- To identify plans to close the **workforce** gap including non workforce options, support existing roles and promote the development of new roles
- To support development of **primary care networks** and further development of GP federations *for a more sustainable future service*
- To promote solutions to **release time** in general practice through implementing initiatives to reduce the workload
- Improved use of IT and technology solutions to support decision making, self care, prevention and contribution to closing workforce gap
- To improve seven day access to general practice for routine and same day appointments
- To ensure engagement across the system and to use stakeholder feedback to develop plans
- Optimising estates and working with 'one public estate' principles to secure fit for purpose environment and capacity to deliver care to our growing populations
- General practices will have a voice in the decision making at ICS system level to influence the agenda and raise the profile of service delivery
- Support general practice leadership development at practice, network/federation and system level

ICS General Practice Transformation Programme 2018/19

This programme will support the delivery of the *General Practice Forward View (*GPFV) and the priorities set out in the *Accountable Care System Memorandum of Understanding*. There is a maturity index developed locally with NHSE for primary care networks; general practices at scale aligned with evidence based local CCG plans.

<u>For 2018-19 our focus will be on supporting general practice sustainability and the key deliverables will be:</u>

Workforce

- A plan to close the GP workforce gap by:
  - Increasing recruitment of GPs via the NHSE International GP Recruitment programme
  - Plan to improve retention of existing and newly qualified workforce
  - Increase the numbers and range of other health professionals working in general practice
  - Improved use of technology as part of the solutions to close the workforce gap

Workload

- Primary networks defined and a programme in place to support delivery of 100% coverage
- Organisational development programme in place for general practice including federations
- Plans in place to deliver Time for Care actions across STP area
- Action plan to assess resilience of practice across STP area

Infrastructure

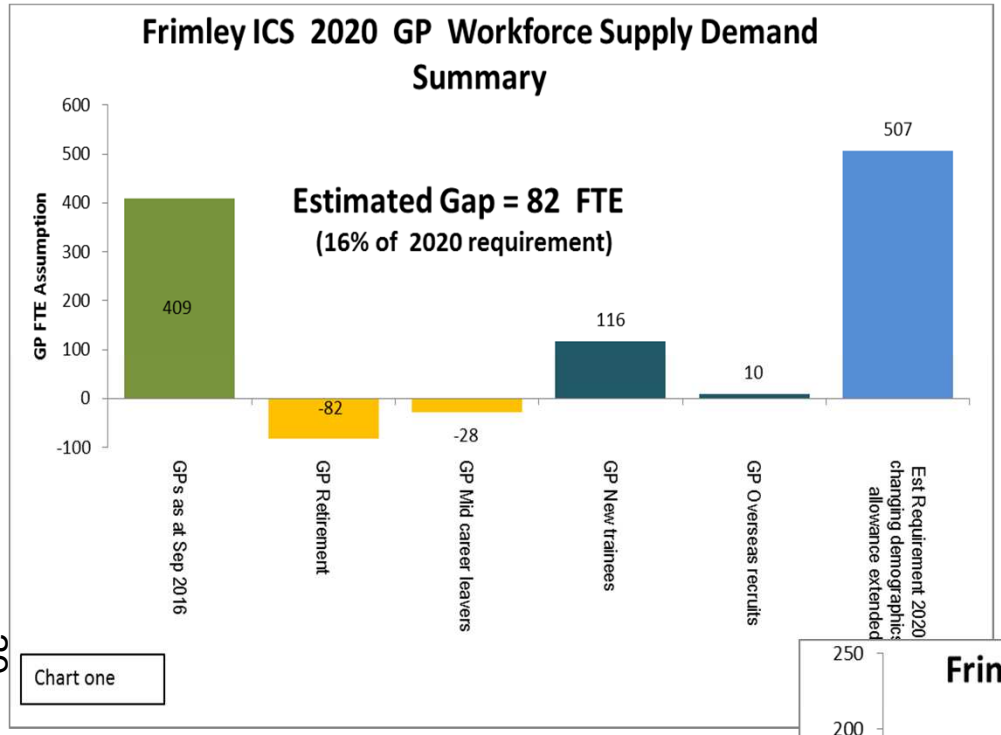
- Introduce online consultations or alternative technology to improve access and resilience to all practices
- Increase the number of online activities such as appointment booking and prescription ordering
- Process in place to develop and deliver estates business cases

Care Redesign

- Deliver improved access which meet the seven requirements specified by NHSE

Variation

- Delivery of the GP pillar of the STP urgent and emergency care plan
- Agreed joint plan to co-locate mental health therapists in GP practices
- Cancer - This element of the programme is still be agreed with the Cancer work stream


Frimley ICS 2020 GP Workforce Supply Demand Summary
Estimated Gap = 82 FTE
(16% of 2020 requirement)
GP FTE Assumption
600
500
400
300
200
100
0
-100
409
-82
-28
116
10
507
GPs as at Sep 2016
GP Retirement
GP Mid career leavers
GP New trainees
GP Overseas recruits
Est Requirement 2020 changing demographics allowance extended
Chart one

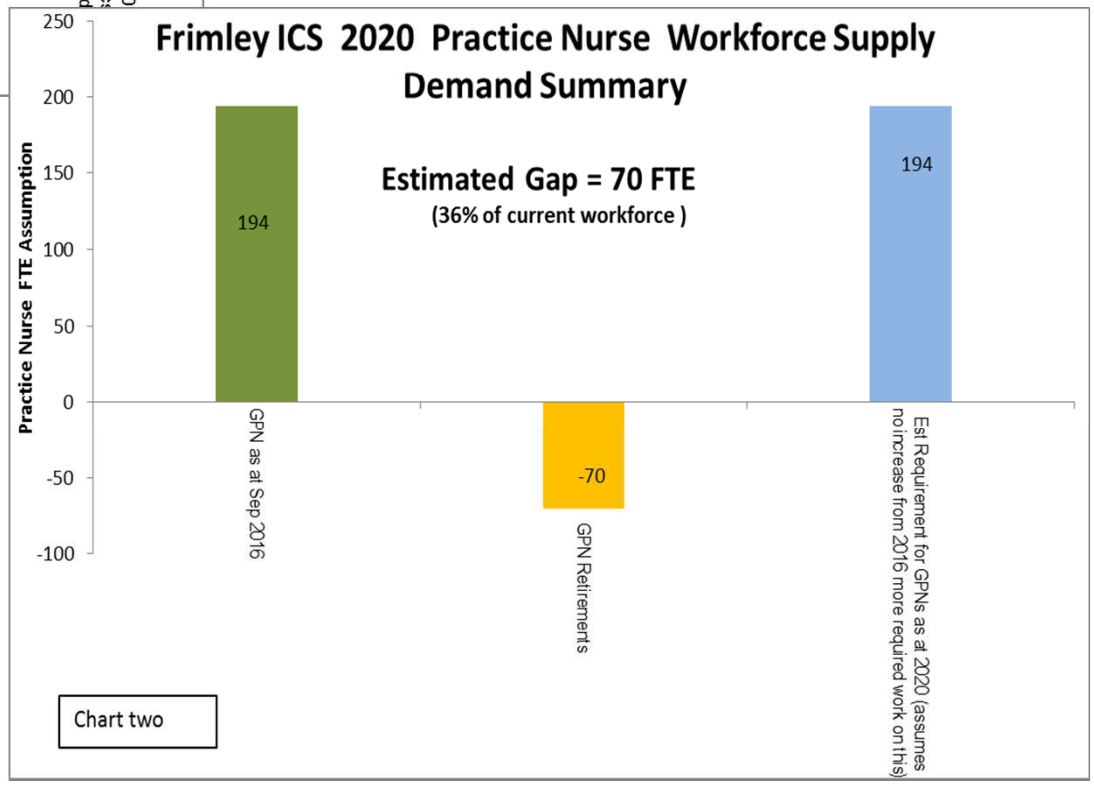

Frimley ICS 2020 Practice Nurse Workforce Supply Demand Summary
Estimated Gap = 70 FTE
(36% of current workforce)
Practice Nurse FTE Assumption
250
200
150
100
50
0
-50
-100
194
-70
194
GPN as at Sep 2016
GPN Retirements
Est Requirement for GPNs as at 2020 (assumes no increase from 2016 more required work on this)
Chart two

Chart one

Releasing Time in General Practice: 10 High Impact Actions

Time to Care Programme

High Impact Action	Examples	EB	Bracknell & Ascot
Active sign-posting / Care navigation Training	online portal and reception navigation	✓	✓ Navigator training available for all practices
New Consultation Types (e.g. eConsult)	telephone, e-consultations, text message, group consultations	✓	✓ Text messages and group consultations (some)
Reducing DNAs	easy cancellation, reminders, patient recording, read-back, reporting attendances, reduce 'just in case'	✓	✓ Text reminders, cancellations online, waiting room messaging
Develop the Team (Paramedics, CPs, etc.)	advanced nurse practitioner, physician associates, clinical pharmacists, medical assistants, paramedics, therapists	✓	✓ Clinical Pharmacists and others
Productive Workflows	matching capacity and demand, efficient processes, productive environment	✓	✓ Productive workflow of medical correspondence
Personal Productivity	personal resilience, computer confidence, speed reading, touch typing	x	
Partnership Working (Federations, ICTs)	productive federation, community pharmacy, specialists, community services	✓	✓ Practice Federation; Berkshire Primary care ✓ Primary Care Network agreed
Social Prescribing	practice based navigators, external service	✓	✓ Asset map available via PH
Supporting Self-care (Access to records)	Prevention, acute episodes, long term conditions (LTC)	✓	✓ HealthMakers commissioned ✓ LTC; patient centred care plans
Develop QI Expertise	leadership of change, process improvement, rapid cycle management, measurement	x	

Primary Care Network development

The benefits

- Working at scale makes it easier to provide a comprehensive range of services in the community, and also offers benefits for practices and staff, including the potential to release pressure on GPs.

Resilience

Services can be more resilient to fluctuations in demand or unexpected changes in staffing. This can be realised through pooling of staff and arranging overflow support.

Skillmix

It is easier to broaden skillmix when working at scale. It is usually easier to employ new staff across several practices than to have part-time roles in each practice. For the staff themselves, working for a larger employer will often be more attractive.

Economies of scale

Economies of scale can be realised in areas such as purchasing supplies and services, shared functions, and more efficient approaches to specialist functions such as HR, finance, clinical governance, IM&T and business intelligence.

Innovation and improvement

Working at scale makes it easier to build expertise and systems for service redesign, patient engagement, analytics and project management. This supports faster and more sustainable improvement, allowing staff to improve through working smarter not harder.

System partnerships

Operating at scale makes it easier to form effective partnerships with other organisations in the health and care system such as acute and community trusts and the voluntary sector, and allow primary care providers to have a significant input into strategic planning.

Staff development

It is easier for larger organisations and networks to provide an enhanced employment experience for staff. Expert HR staff and shared resources enable a strong focus on professional development and create opportunities for a more diverse career.

Most of these benefits are not automatic – leaders need to take action to realise them

P

@robertvarnam #GPforwardview

Frimley Health and Care

ICS Programme: The next 3 months

- **Workforce tool** utilised to provide information to support development of network plans during summer 2018
- **Primary care network plans** to be submitted by September 2018. Plans will be to achieve a minimum of stage 2 in all areas of the maturity matrix by March 2019. Themes will be collated at ICS level and used to inform investment decision in second half of year..
- Finalise **workforce prospectus** mid July 2018
- **Impact of current workforce initiatives** understood by September 2018 and remaining gap quantified.
- Plans to improve **retention of trainee GPs** agreed by September 2018
- Plans for **MH workforce** in primary care agreed by GP and MH work streams.
- **Online consultations** contract awarded and roll out commenced
- **Demand and capacity** modelling framework agreed**.**
- **GP provider voice** on ICS Leadership Board established.

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NHS
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Clinical Commissioning Group

Public conversations – Urgent Care

Introduction

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East Berkshire
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- A conversation with local people **not** a public consultation.
- We will undertake a formal consultation with options if we need to after we have heard what people have to say
- Consultation Institute has advised on best practice
  - Process
  - documentation
- Focus on urgent care
- Service models not estate

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Clinical Commissioning Group

The decisions we will have to take

- The type and location of urgent care services in the future
- Agree the service models that will serve our population in the future and how community buildings can best meet these needs

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Clinical Commissioning Group

What do we mean by urgent care?

- A condition or illness needing attention the same day, but that is not life-threatening or changing.
- Urgent care is NOT emergency care. Emergency care is suitable for people whose life is at immediate risk from severe illness, injury or serious worsening of a condition.

East Berkshire CCG will spend c. £10.44m on urgent care, out of hours care and primary care enhanced access in 2018-19.

What we want to understand

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- Why people choose a particular urgent care service
- What is important to people about who they see for their urgent care needs
- What people would do if they were told an issue was not urgent
- What is important in terms of location of services and would there be support for co-location of services
- What is good about and what can be improved in current services
- Would the use of technology be supported
- What is important when people have urgent mental health issues

What we've done so far

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- We have spoken to over 300 people via:
  - 6 public meetings during the day in Sandhurst; Slough; Bracknell; Maidenhead; Sunninghill; Windsor;
  - Evening meeting in Slough and one is coming up in Bracknell on 19 July
  - 2 online 'Cover It Live' sessions
- Held a provider event
- Visited a number of community groups to understand the views of groups generally and of those who use urgent care more than average, these include Parent and toddler group Great Hollands, Bracknell; Sandhurst Nepalese Society, Polish Saturday School Bracknell, Carers group in Bracknell, Asian women's group in Slough; Slough Youth Parliament attended by young people
- Had face-to-face conversations with our three Patient Groups
- Took the conversation to Community Partnership Forum (CPF)
- Launched the 2nd phase of the 'Big Conversation' via our online survey (10 July – 6 August)

Flavour of early themes

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The insights below are a flavour of some of the things we have heard so far but may change as we have more conversations

- Default to urgent care services if cannot access general practice (experience variable)
- People need to understand more about what is available – they don't know where to go
- Everyone has a different view of urgent care
- Technology is better if it is has a personal interface e.g. live chat
- Some people like the idea of using more technology

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- Travel considerations are important
- Support for some services being together if they are local, there is parking and good public transport
- Confusion about the roles of extended teams
- Mental health important
- Variable experience of NHS 111

Process

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Phase	Purpose	Dates
Conversation (pre-engagement)	To understand what matters to people about urgent care and their experiences of having used it in the past. To understand the views of people in groups that are over represented and who we do not often engage with. To have conversations with local people that will inform the development of options	29 May – 19 July
Survey	To gain a wider reach of people who will not engage through meetings. Particularly to include the working age population and people with caring commitments	10 July – 6 August
Engagement report	To bring together in one place the full picture of who we have had conversations with and what they have told us.	Completed 15 August

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Stakeholder Panel	To consider the outcomes of the engagement and agree 'desirable' criteria for checking options against. This will use the 'Issues Paper' as a framework Consider the possible options for consultation	w/c 27/ August
Options development	Should public consultation be required development of options	16 August – 3 October
Stakeholder Panel	Panel to be involved in reviewing the options against desirable criteria	w/c/ 17 September
Governing Body	Governing Body to review options and case for change	10 October
Consultation if required	To consult with local people on the options that have been developed	15 October – 7 December

Frimley Health and Care

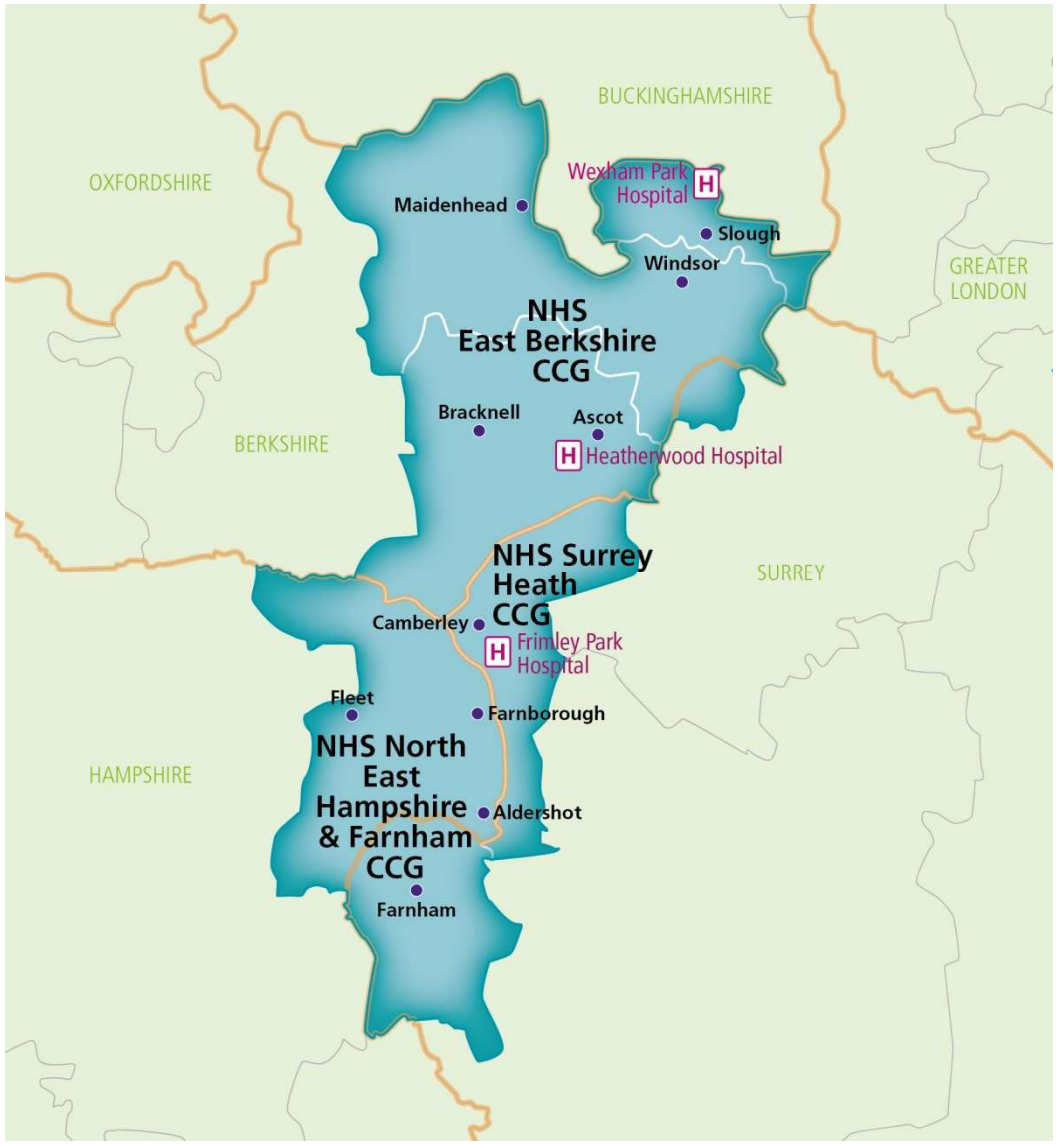
Frimley Health and Care ICS Update
'Creating healthier communities'

Bracknell Forest Scrutiny Panel
July 2018

Frimley Health and Care

Population of **800,000 people** in East Berkshire, North East Hampshire and Farnham and Surrey Heath CCG's.

Involves **30 statutory bodies**. Includes Local Authorities, CCGs, provider Foundation Trusts and others



Frimley Health and Care

Video link

Please click on the hyperlink above to launch the video

Health regulatory changes

- NHS England and NHS Improvement starting to work closer together
- From September 2018 they propose:
  - One national team where possible
  - Integrated regional teams under one regional director
  - Seven national regions
- We already have
  - one regional director, Anne Eden
  - System-level quarterly assurance meetings
  - Ambition to be ‘self-assuring’
- CQC exploring their regulatory role with respect to systems
  - We have a system relationship contact, Ruth Rankine, Deputy Chief Inspector.
  - CQC working with our system as one of two pilot areas

Governance

- The ICS has a System Operating Plan for 2018/19
- An approach to the system control total for health for 2018/19 agreed with NHS England and Improvement
- ICS branding and key messages agreed by HWB Alliance Board
- Discussions underway on appropriate role for non-executives and lay members within our ICS
- Care provider role for ICS under consideration

Workstreams

- All workstreams and enabling elements have clear delivery plan for 2018/19
- Social prescribing is now live across the ICS
- Mental health - cross-system approach to the crisis care pathway in mental health being co-designed
- Integrated Care Decision Making –spreading successful model across East Berkshire
- Workforce strategy - implementation plan agreed with leads across workstreams

Frimley Health and Care

Creating healthier communities – key messages

Your Local Authorities and local health organisations are working together as the Frimley Health & Care System to provide you with a joined up health, care and wellbeing system. This means you will receive the right care at the right time and in the right place.

You and your family will:

- Be supported to remain as healthy, active and independent as you can be
- Know who to contact if you need help and only have to tell your story once
- Have easier access to information and services
- Work together with a care and support team to plan and manage your own care
- Access urgent or emergency care more easily closer to home
- Be treated in the best place for your needs
- Increase your ability and confidence to take responsibility for your own health, care and wellbeing
- Be confident that your care is provided in the best possible way.

Frimley Health and Care

Workstream Aims:

- Prevention and self-care – ensuring people have the **skills**, **confidence** and support to **self-care** and to **stay well**
- Integrated care decision-making – developing integrated teams of **multi-disciplinary** practitioners providing **single points of access** to services such as rapid response and re-ablement
- GP transformation – laying foundations for a new model of general practice provided at scale to offer a **wider range of services** in the community, including development of GP networks to **improve resilience and capacity**
- Support workforce – supporting the care support workforce so that it is **fit for purpose** and offers good career opportunities across the system
- Care and support – transforming the social care support market and **improved management** of the market by health and social care working more closely together. Helping to make the **best use of the money** available across the Frimley Health and Care system and better plan for the future care support needs of local people.
- Reducing clinical variation – ensuring that the population **has access** to the same **high quality of services** across the system wherever they live
- Shared care record – helping people to **tell their story once** by implementing a shared care record that is accessible to professionals across the footprint

Frimley Health and Care

Benefits already being seen:

- Health and care workers working more closely together
- An improved patient experience across the system – more joined up care provided in peoples homes
- Plans are continuing to be rolled out
- A greater community involvement and support in health and wellbeing
- Mental health liaison 24/7 has been rolled out across both Frimley and Wexham Park hospitals
- An increase in staff satisfaction, with retention and recruitment supported by the new roles and opportunities being developed
- More flexible ways of engaging with your GP
- No increase in A&E activity year-on-year.
- 8am-8pm appointments in primary care
- Fewer people with mental health problems having to travel out of the area for treatment.
- There has been greater investment in the local system

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Bracknell Forest Community Network
Progress Update – July 2018

Matthew Clift
Development Manager (Mental Health)
Bracknell Forest Council
Tuesday, 24th July 2018

Network Philosophy

Remain socially engaged

Better understanding of their mental health

Prevent relapse

Develop their confidence, life skills and resilience

Rooted in the mental health recovery principles and using co-production with an asset-based approach, the Network works alongside individuals to develop their support networks and live independently. This will lead to a reduced likelihood of needing secondary mental health support and bed-based provision.

Who's the Network for?

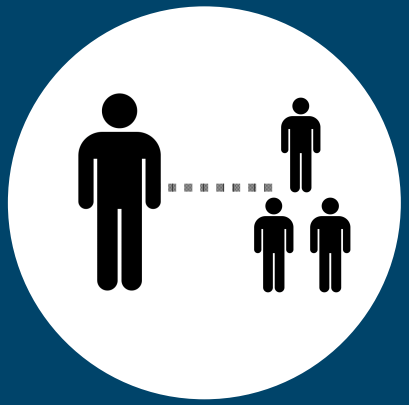
- Bracknell Forest residents aged 18+
- People recovering from an episode of mental ill-health (including people accessing secondary mental health services)
- People stepping down from CMHT/CMHT(OA)
- Those at risk from suffering an episode – preventative
- Support for carers to access community assets

Outline of Network Process

Identify an individual's strengths and aspirations

Identify and develop personal support networks

Support people develop their Recovery Plan



Signpost individuals to community assets

Monitor and support recovery

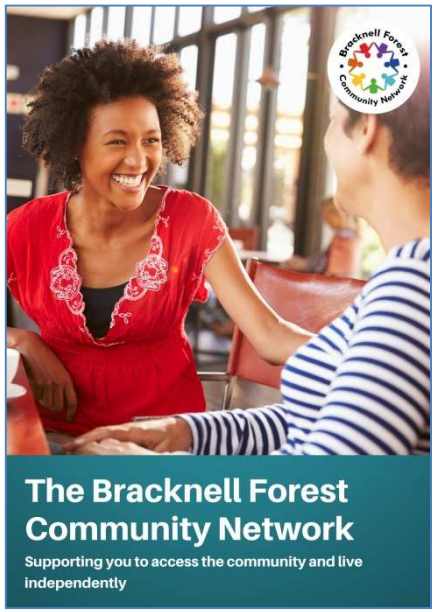
Look to develop the individual into a Peer Mentor

How to make an Introduction

- Email: network@berkshire.nhs.uk
  - Name of individual
  - NHS Number
  - Brief synopsis of individual's situation

- Network leaflet and posters can also be given out to prospective Introductions

- Network staff can go on joint visits with practitioners to engage individuals for Network Support



Network Case Studies and Report

Sandra's Story:

…Since engaging with the Network, Sandra has a much more positive outlook on life and is "very much looking forward to the future" having been discharged from the CMHT. She says "Because of the Community Network I'm doing more things now and keeping more active and because of that I actually want to get up in the mornings as I am enjoying life more!".

Sam's Story:

…Sam says of the Community Network support "It has given me a kick up the butt to volunteer because I have lacked confidence. I enjoy the monthly meetings where I learn about different services and activities. It also helps being around other people with mental health difficulties so it saves me from being socially isolated".

Positive Network Feedback

Please use this space for your feedback and ideas for developing the Bracknell Forest Community Network:

I was very depressed and anxious when I first met Daire, but with her support and encouragement I now feel like a different person. I have much more confidence and my anxiety levels have dropped a lot. I have made some lovely new friends through the Network and have the confidence to contact my old friends that I was too anxious to see before.
I would never have believed getting help from the network could make such a dramatic change to my life and in a relatively short space of time! It is a wonderful service and I feel very lucky to have been able to benefit from it.

Network Case Studies and Report

Sarah Beaumont, Community Psychiatric Nurse, BHFT
"The Community Network has filled a huge gap in the community resource. Before this team was established, clients often saw their options for mental health support in Bracknell as the Community Mental Health Team or nothing. Keeping individuals open to the CMHT for the purpose of the remaining part of their recovery seemed at odds with the aim to empower individuals. This also placed a significant pressure on the CMHT whilst the team was trying to manage a steady flow of referrals in. The Community Network has helped many service users to continue and to enhance their recovery journey and to reach some of their more specific goals within the community. I will continue to readily refer into the Community Network as I strongly believe this team is empowering individuals with mental health difficulties to achieve more."

First year report on Network development and operation produced

2nd Tranche of BFCN Development

- Adults Psycho-Education Sessions
- Older Adults Maintenance Groups
- BFCN Peer-to-Peer Scheme
- Bracknell Forest Mental Health Forum

Adults Psycho-Education Sessions (1)

- Suggested session topics:
  - Managing Difficult Emotions
  - Anxiety Management
  - Coping Strategies
  - Medication Management
  - Sleep Hygiene
  - Depression
  - Intrusive Thoughts
  - Psychosis
  - Wellbeing

Better understanding of their mental health

Develop Peer supporters

Older Adults Maintenance Groups

- Suggested Groups
  - Maintenance Cognitive Stimulation Therapy (MCST)
  - Minor Cognitive Impairment (MCI)
  - Cognitive Behavioural Therapy for Carers (CBT)
- BFCN to provide secretariat
- Test Group to be developed

Prevent relapse and deterioration

BFCN Peer-to-Peer Scheme

- “Peers” to share their experience of mental-ill health and their recovery journey
- Scheme will “dovetail” into the current BFCN process
- Peer Register to be stored on the CMHT shared drive
- BFCN Project Board to provide scrutiny

Bracknell Forest Mental Health Forum

- CMHT Link Officer: Amy Edwards
- Practitioners to attend each session
- Promotional means to be developed
- BFCN providing funding
- BFCN Project Board to provide scrutiny

Thank You!

Questions?

1st Year Report
January 2018

Matthew Clift - Development Manager (Mental Health)
Bracknell Forest Community Mental Health Teams

Contents

1. Executive Summary

The Bracknell Forest Community Network (BFCN) was formed in 2017 in the wake of the previously commissioned Community Mental Health Service overseen by Rethink finishing on Friday, 1st December 2016. The BFCN set out to support, motivate and connect people with a network of resources in the community that will help them to remain socially connected, better understand their mental health, prevent relapse and develop their confidence, life skills, and resilience so they can live as independently as possible with a reduced likelihood of needing secondary mental health support and bed-based provision.

Rooted in the mental health recovery principles and using co-production with an asset-based approach, the Network works alongside individuals to recognise their strengths, aims and aspirations to develop their support networks and live independently. As of January 2018, the BFCN is funded by Bracknell Forest Council and the Bracknell and Ascot Clinical Commissioning Group, and provides support to individuals meeting the following criteria:

- Bracknell Forest residents aged 18+
- People recovering from an episode of mental ill-health (including people accessing secondary mental health services)
- People stepping down from CMHT/CMHT(OA)
- Those at risk from suffering an episode of mental ill-health (preventative)
- Support for carers of individuals with mental health needs

Based at Church Hill House, the BFCN is integrated within the Bracknell Forest Community Mental Health Teams to offers a different way of working linking up primary care, secondary care services, Bracknell Forest Council and, voluntary and community sector organisations.

The BFCN has been set-up to be more preventative in nature than the previous service, where more people are supported to prevent the deterioration of their health and wellbeing.

This report summarises the BFCN's first year of development and operation as a borough-wide service.

The BFCN has offered 132 people personalized support since starting operation in May 2017 up to and including January 2018.

Key issues that have arisen during the development and implementation of the BFCN are detailed fully within the wider report, notably difficulties in duplication and boundaries of work within the Adult Social Care, Health and Housing department of Bracknell Forest Council, staff recruitment, and developing a model of volunteer and peer support.

Key recommendations for the future of the BFCN focus upon:

- Sustaining the BFCN, its performance and continuing to positively impact the wider health and social care economy in Bracknell Forest.
- Working with primary and secondary care practitioners in a more joined-up way to support individuals holistically.
- Increasing BFCN (and BFCN staff's knowledge of) links with local community assets and networks to encourage more individuals to self-introduce to get the right support at the right time before a crisis ensues.
- Continued development of Network staff's relationship building, graded exposure, confidence building, anxiety management and motivational techniques.
- Setting-up condition specific (including: OCD, trauma, personality disorder, Schizophrenia) Mental Health educational sessions and reminiscence groups in the community, working co-productively with supported individuals, IPT, psychologists and psychiatrists from CMHT/ CMHT(OA) to deliver these sessions and groups.
- Closer working with the CMHT Task Team with the aim of further reducing the list of people awaiting care-co-ordination.
- Development of a Network Individual Placement and Support scheme (IPS) to aid individuals accessing secondary mental health service into competitive employment

2. Introduction and Purpose of the Report

2.1 Purpose of the Report

The purpose of this report is to demonstrate the progress and impact of the BFCN on the wider communities that make up Bracknell Forest, the Community Mental Health Teams and against the Key Performance Indicators that have been agreed by the Project Board. This includes the activity of the BFCN and its outcomes to date. The BFCN's journey of development, the evaluation process and the relationships that the BFCN has and continues to build are also discussed.

Most importantly the report gives feedback from people who have been supported by the BFCN, this is in the form of case studies, compliments and quotes that the BFCN has received and can be found in Appendix A.

The report concludes with the next steps of development for the BFCN and how these could be achieved.

2.2 Background

The Bracknell Forest Community Network (BFCN) became active within Bracknell Forest on 15th May 2017, working with individuals previously supported by the now defunct commissioned Community Mental Health Service overseen by Rethink.

At the time of closing, the Rethink-run service was supporting 23 people with a range of mental health needs. There is no evidence to suggest that the model of support provided by Rethink increased independence and recovery.

In the interim period between the Rethink service closing and the BFCN starting up it was recognised that there was a need to shift towards supporting people in ways that prevent episodes of mental ill-heath that warrant access to secondary care (including bed-based provision), encouraging recovery and resilience. It was also found that the former service encouraged supported individuals to develop a dependence on the service, which affected the individuals' ability to be resilient and independent.

The BFCN is rooted in the mental health recovery principles, focussing on people's strengths and abilities rather than their deficits and needs. Its asset-based approach has been guided using co-production, learning from experiences in other localities, such as Lambeth and Slough, and holding extensive discussions with local stakeholders across the voluntary and statutory sector, but particularly people with lived experience of secondary mental health services and their carers.

Taking this into account the purpose of the BFCN is to:

- Support people to recover from mental ill-health (including PTSD, recovering psychosis, anxiety, depression and agoraphobia) and stay well
- Support people to Identify their strengths and aspirations
- Support people to Identify and develop personal support networks
- “Connect” individuals with community assets
- Move away from a crisis-focussed system and to focus on early intervention
- Reduce the likelihood of needing secondary mental health support and bed-based provision
- Increase the capacity of the Bracknell Forest CMHT and CMHT(OA)
- Provide cost-effective support and better outcomes for individuals with mental health needs.
- Develop supported individuals into Peer Mentors

The development of the BFCN has been led by the Development Manager (Mental Health), appointed in January 2017, with the support of the Project Board (meeting monthly), consisting of senior practitioners and management from the Community Mental Health Teams, Adult Social Care Team and Joint Commissioning Team. A monthly Highlight Report is produced for senior ASCHH management to report progress on the development and implementation of the BFCN. The reports cover progress to date, including an update on key areas of work, as well as issues and risks. It is used to advise the Project Board and ASCHH Departmental Management Team of any potential problem areas where further advice, help and decisions are required.

Based on the Lambeth Collaborative model used by the Lambeth Living Well Network, the BFCN has sought to operate in a wider network of support formed by existing commissioned, mainstream and voluntary sector services, in the context of the person’s own community including their family and friends. Its key aim is to help people identify their skills and assets and the support they could draw upon in the

network when a person is finding things more difficult than usual.

During the recovery journey process Network staff support individuals in the community over an initial period of six weeks. This allows the Network's Recovery Facilitators and supported individuals to build a relationship, engage in graded exposure activities, and confidence building, anxiety management and motivational techniques. Once this initial six week period has concluded the Network assesses the individual's progress using a specifically design Patient Reported Outcome Measures (PROMs) form and liaise with the requesting practitioner to see if further support is required.

The BFCN office base is situated within Church Hill House, Easthampstead in Bracknell Forest. All meetings between BFCN and supported individuals are conducted away from this office base in the community to emphasis the "separation" between CMHT and the BFCN as a way of reducing dependence on secondary mental health support.

Most meetings either take place at Coppers Hill Community Centre or The Bracknell Forest Open Learning Centre. These are in central locations with strong public transport links that are accessible for those people meeting staff in a confidential setting. Importantly, the services offered by the BFCN are provided across the borough, at places that best meet the needs and preferences of supported individuals. The model of service delivery has changed to reflect the community nature of support being provided.

3. Journey of Network Development and Activity

In January 2017, Matthew Clift was appointed to the post of Development Manager on a two year contract to oversee the development of the Network.

The first step in the development process was for Network Staff and key stakeholders (including Joint Commissioning Officers) to visit other localities across the country to see how they approach mental health recovery and learn from their experiences and processes.

Locations visited include:

- Compass Recovery College, Reading (Friday, 3rd March 2017)
- Earley cReCent Resource Centre (Tuesday, 7th March 2017)
- Mind in Bexley Recovery College (Wednesday, 8th March 2017)
- IRiS Peer Mentoring Scheme, Reading (Thursday, 9th March 2017)
- Brighton & Hove Recovery College (Tuesday, 14th March 2017)
- Second Step Recovery College, Bristol (Monday, 20th March 2017)
- Greenwich Recovery College (Tuesday, 28th March 2017)
- Clarendon Recovery College, Haringey (Tuesday, 4th April 2017)
- Lambeth Living Well Network (Wednesday, 5th April 2017)
- Hope Recovery College, Slough (Thursday, 20th April 2017)

Key learning from these visits included:

- The Network's narrative needs to be set around what can the individual do for themselves to regain independence and what assets can they utilise in the community to achieve this.
- The relationship between the Network and the supported individuals needs to be reframed so individuals are seen as citizens and not patients.
- Individuals should be self-motivated to engage and lead their recovery journey not be coerced into entering the Network by practitioners or other agencies.
- The Network should have a different logo from Bracknell Forest Council and Berkshire Healthcare NHS Foundation Trust so as to separate it from them and in turn start to reduce people's dependence on statutory service.
- The Network will benefit from not holding meetings with supported individuals at NHS or Council offices as this may re-enforce any dependence on statutory services.
- The language used by the Network should not be clinical.

To ensure co-production was at the heart of the development of the BFCN, monthly Network Group meetings have taken place on the first Friday of every month in the Honeysuckle room at the Open Learning Centre. All supported individuals, carers and stakeholders are invited to attend. At the meetings attendees have been asked, for example “What does recovery and independence mean to you?” and “How would they like the co-production meetings of the future to be like?”. The answers given to these questions have been fed back into the Network to guide its development, planning and delivery.

At the meetings the Network logo was designed to be displayed on Network related documentation and forms. This was in-line with a lesson learnt from visiting other localities that the Network should have a different logo from Bracknell Forest Council and Berkshire Healthcare NHS Foundation Trust so as to separate it from them and in turn start to reduce people’s dependence on statutory service.

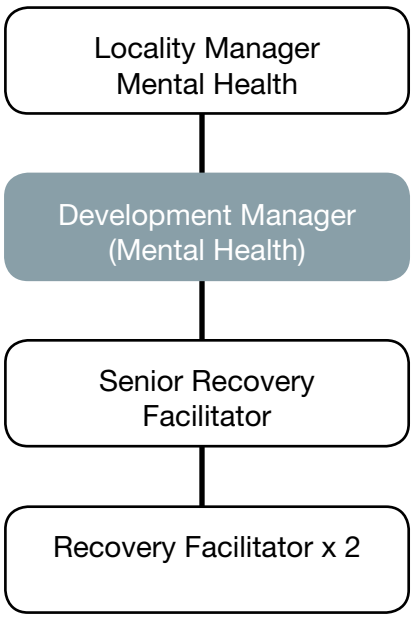
In addition to the co-production activities, attendees requested talks from local community organisations should take place at the meeting to educated and support them with their increasing independence.

Talks have included:

- Changes to benefits - Citizens Advice Bracknell & District (January 2018)
- Community Safety Team (January 2018)
- Bracknell Forest Libraries (December 2017)
- Royal Berkshire Fire and Rescue Service (December 2017)
- Community First (Jealott's Hill Landshare) (December 2017)
- Community Investment Service (November 2017)
- The Acoustic Couch (November 2017)
- Sport in Mind (November 2017)
- Christians Against Poverty (October 2017)
- Involve (September 2017)
- Sport in Mind (May 2017)
- Open Learning Centre and Community Learning (April 2017)

The staffing structure of the BFCN was agreed by the Project Board following co-production activities with supported individuals and community organisations.

The current BFCN staff structure is as follows:



Being situated within Church Hill House has allowed BFCN staff to discuss and receive advice on cases and issues from health and social care practitioners. This has empowered BFCN staff to raise alerts and ensure safeguarding vulnerable individuals is the BFCN's highest priority.

Running parallel to this Network development; research and information gathering on community assets in Bracknell Forest was conducted by Network staff to aid the recovery facilitation process and identify gaps in provision that would need to be addressed in future as the Network's operation expands.

The Development Manager met with local community organisations including Jobcentre Plus, Involve, Open Learning Centre and Sport in Mind to build relationships with them and also find ways, including seed funding, the Network can utilise and develop these assets to the benefit of the individuals it will support.

From these meetings, visits and discussions, the processes and forms underpinning the daily operation of the Network were formalised and agreed by health and social care practitioners from Community Mental Health Team (CMHT) and the Bracknell and Ascot Clinical Commissioning Group (BACCG). These processes and forms have been refined using lessons learnt as the Network has developed.

In May 2017, a cohort of twenty-eight individuals (later increased to thirty) previously supported by CMHT started to be processed for the first testing stage of the Network. The cohort was made up of individuals with a range of mental health conditions including Emotionally Unstable Personality Disorder (EUPD), Bipolar and Schizoaffective Disorder.

Even in the early stages of Network Development positive feedback was received by the Network:

"The good news is that I have joined Sport in Mind and will fill in the official paperwork on the 11th July. I like the leader and actually had a good time playing badminton and table tennis. I knew lots of people who attended."

"I contacted Kate at Community First and have attended the centre the past two weeks from ten to one. I have really enjoyed it. Made friends with other volunteers. I've been mainly weeding but saved a sunflower which germinated in the vegetable patch. I plan to plant it in my front garden in the next few days."

"I would like to say how much I have enjoyed the activities: Allotment of life, People Bingo and the walk in South Hill Park. Keep up the good work!"

To ensure the BFCN maximised its positive impact on the local community, an Equalities Impact Assessment for the Network's daily operation was carried out. As part of the drafting process, data was collected and analysed from sources including Bracknell Forest Joint Strategic Needs Assessment (JSNA), 2011 Census, Projecting Adult Needs and Service Information (PANSI), Projecting Older People Population Information (POPPI) and the Berkshire Healthcare NHS Foundation Trust Central Database. The completed Equalities Impact Assessment was approved by the Project Board and Chief Officer (Adult Social Care) before being published by Bracknell Forest Council's Community Engagement and Equalities Team in December 2017.

As the first phase of testing with individuals previously supported by Rethink came to its conclusion, Sandhurst Group Practice agreed to act as a test bed for the second stage of Network testing for local GPs to introduce eligible individuals directly into the Network.

This stage of Network testing commenced on Monday, 31st July 2017 across both of the Practice's sites (Sandhurst Surgery and Owlsmoor Surgery). It was hoped this introduction pathway would reduce the number unnecessary referrals to CPE and Secondary Mental Health Care from primary care. In addition it would act in a preventative way to stop people's mental ill-health deteriorating to the point they need the aforementioned services.

Unfortunately over this testing stage there was a disappointing lack of Introductions from either site with a doctor stating that they "had not seen suitable patients who were not already being referred to Talking Therapies etc."

Despite the lack of success in this phase of testing, later in 2017 Waterfield Practice Group, agreed to start using a modified Network Introduction Form for their patients to access Network support. The practice will also in future facilitate Introductions into the Network via its online portal.

After this stage of testing was concluded in September 2017 the Network opened the CMHT Introductions pathway fully and more pathways came online shortly after. These included Talking Therapies, Mencap, the Memory Clinic, Home-Start and Neighbourhood Policing Teams

To encourage self-Introductions into the Network a poster and leaflet campaign was launched at over 250 community locations (the BFCN leaflet can be seen in Appendix D and the BFCN Poster can be viewed in Appendix E). The BACCG Communications Team distributed Network promotional material via its channels including the Weekly Bulletin to all practice staff including GPs as well as their public website, twitter account and Facebook page.

Further promotion of the Network has been arranged with the BFC Communications Team for there to be a half page advert in the March 2018 edition of Town and Country. This publication will go to every household in the Borough.

With the aforementioned pathways opening ahead of scheduled meant the Network could maintain a suitable number of Introductions into the Network on a consistence basis whilst not over burdening Network staff.

As the Network developed further throughout 2017, Network staff started attending activities with individuals to help overcome their initial anxieties of attending something new and unfamiliar alone.

This approach has already seen positive results with the Recovery Facilitators attending a badminton and table tennis session organised by Sport in Mind at the local leisure centre with a supported individual and their parents. Here the parents were able to learn more about the Network, community activities and how to get involved. This has led to the individual's mother signing up to train to become a Walk Leader for Sport in Mind.

Since the opening of the CMHT and self-Introduction pathways, the Development Manager has worked with the Community Services Manager (CMHT(OA)) on the Network's expansion to support individuals in the Older Adults age range. Highlighted area of this work has included how the CMHT(OA) functions and what challenges there maybe when introducing recovery facilitation into the team. At the time of this report being published the CMHT(OA) pathway is still under development with a limited number of Introductions being accepted. A working group of Network staff and CMHT(OA) is being setup to look into improving the Network forms and processes (including the Network Risk Assessment and Recovery Plan format) to ensure Older Adults supported by the Network have the help they need to stay independent for longer.

World Mental Health Day took place on Tuesday, 10th October 2017 and focussed on wellbeing in the workplace. To support this, the Bracknell Community Network working with the Dementia Action Alliance Co-ordinator of Bracknell Forest (CMHT(OA)) offered local businesses and organisations free on-site relaxation taster sessions to help improve their staff's wellbeing. Ten organisations signed up for these sessions.

To further enhance the partnership working between the BFCN and CMHT(OA), the Development Manager has worked with the BFC Dementia Advisor, Karen White to organise the bi-annual Dementia Forum for May 2018 in the style of a "marketplace". Local organisations will be invited to promote the support available for people with dementia and their carers. This will be an excellent opportunity to promote the Community Network to stakeholders of the Older Adults age range.

The BFCN initially set out to develop a peer support network. Peers with experience of mental ill-health who have already developed their ability to self-manage their own mental health, would provide inspiration, encouragement and support to others during their journey to strengthen their resilience and ability to self-manage.

However, this was reviewed and it was decided that this would have to be delayed until enough suitable candidates had successfully gone through their recovery journey. In the early stages of the development of the Network it may be more appropriate to have Recovery Champions instead of Peer Mentors.

Despite this, the development of Network Peer Support (volunteer) forms and processes have been completed and approved by ASCHH HR, training of Network staff to manage volunteers and production of volunteer recruitment material has been undertaken.

There are more general issues facing the Network in relation to the recruitment and running of volunteers, due in part to the Council not having an agreed volunteering policy for the majority of 2017.

Late 2017, the Project Board has had to work to alleviate confusion amongst practitioners coming from the lack of clarity over the difference between the Bracknell Forest Community Network, Involve's Community Choices scheme, Friends in Need the new Connections Hub (Community Connectors) and new Public Health Social Prescribers. In 2018 the BFCN will look to build good working relationships with all of the aforementioned services for the benefit of improve support for individuals in the community.

With the BFCN becoming more settled, the Project Board started to provide seed funding in January 2018 for the benefit of improving current and building up new community assets. Sport in Mind received the first grant, guaranteeing five additional sports sessions a week for one year in Bracknell Forest

4. Evaluation and Presentation of Key Performance Indicator Data

The Key Performance Indicators (KPIs) by which the Network's operation is measured and how they are presented on a monthly basis was agreed in mid-2017 by the Project Board.

These include (with monitoring periods):

- Number of people supported by Network (Monthly)
- Number of new introductions(Monthly)
- Reduction of secondary MH care activity levels (Quarterly)
- Reduction of other services activity levels (Quarterly)
- Number of people disengaging from network (Six-monthly)
- Routes of disengagement (Six-monthly)
- People involved with mentoring others in the network (Annually)
- Sustainability Review (Annually)
- Reduction of costs in secondary MH care
- Reduction of other services costs
- Improvement of outcomes for Individuals

The CMHT Business Performance and Development Manager produces a monthly report focusing on the agreed KPIs, which is distributed to the Project Board and the Director and Chief Officers of BFC ASCHH. In future the Networks operation statistics will be displayed on the Adult Social Care Health and Housing Dashboard.

2.1 Activity Overview

The BFCN has received 132 Requests for Introduction since it opened borough wide in May 2017. Figure One shows the monthly Requests for support since the BFCN came online.

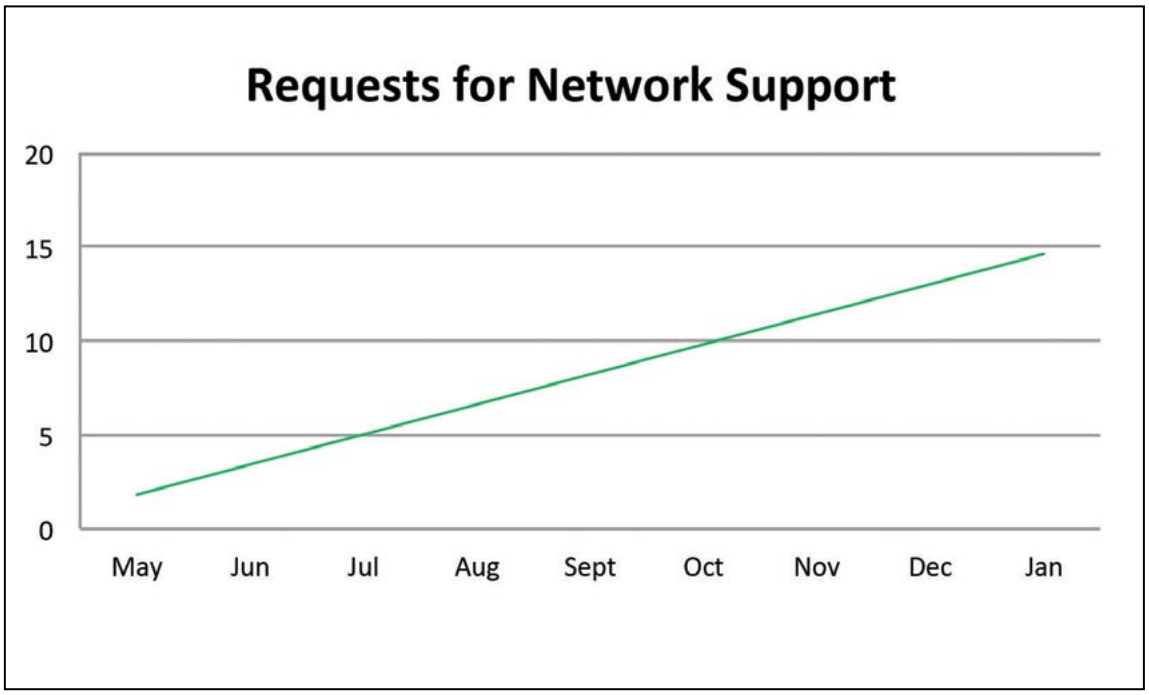


Figure One. BFCN Requests for support by month (trend line given)

The BFCN receives introductions from a variety of different sources, for example CMHT, CMHT(OA), GPs, Talking Therapies, ASCHH and Self-Introductions. Figure Two shows a percentage breakdown of where the Introductions into the Network have been received from.

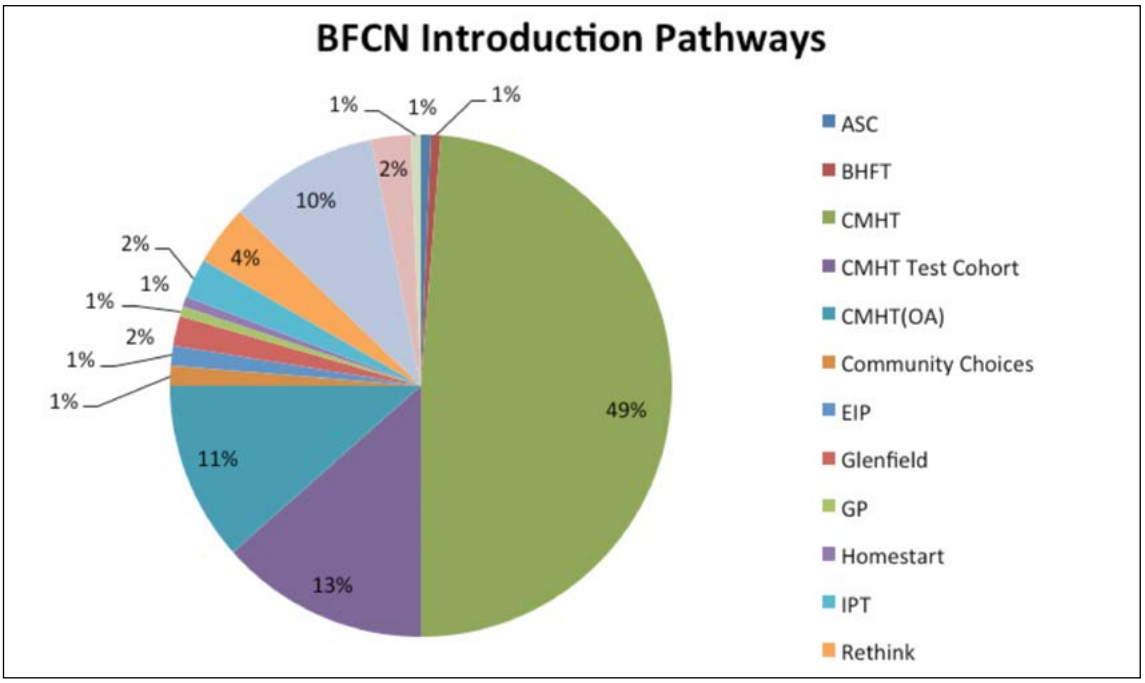


Figure Two. BFCN Sources of Introduction

If required the BFCN will make onward referrals to secondary care (BHFT/BFC) or if the person needs a crisis response. This may be on receipt of the Introduction, or at any time during the period when an individual is being supported by the BFCN.

The method by which supported individuals' recovery journey progress is measured is carried out by BFCN staff using a modified PROM form (Appendix D)

The success of the BFCN can also be seen qualitatively from the selection of quotes below:

Sandra, supported individual:

"Because of the Community Network I'm doing more things now and keeping more active and because of that I actually want to get up in the mornings as I am enjoying life more!".

Sam, supported individual:

"It has given me a kick up the butt to volunteer because I have lacked confidence. I enjoy the monthly meetings where I learn about different services and activities. It also helps being around other people with mental health difficulties so it saves me from being socially isolated".

Sarah Beaumont, Community Psychiatric Nurse, BHFT

"The Community Network has filled a huge gap in the community resource. Before this team was established, clients often saw their options for mental health support in Bracknell as the Community Mental Health Team or nothing. Keeping individuals open to the CMHT for the purpose of the remaining part of their recovery seemed at odds with the aim to empower individuals. This also placed a significant pressure on the CMHT whilst the team was trying to manage a steady flow of referrals in. The Community Network has helped many service users to continue and to enhance their recovery journey and to reach some of their more specific goals within the community. I will continue to readily refer into the Community Network as I strongly believe this team is empowering individuals with mental health difficulties to achieve more."

The full case studies can be viewed in Appendix A.

5. Conclusion and Next Steps

5.1 Conclusion

The Bracknell Forest Community Network has been operational in the borough since May 2017 and opened to general self-introductions in September 2017. The BFCN utilises the principles of mental health recovery and coproduction to deliver an asset based approach when supporting people back to independence from an episode of mental ill-health.

The activity of the BFCN has demonstrated an immediate and significant impact on mental health services in Bracknell Forest.

The BFCN has offered 132 people personalised support since starting operation in May 2017 up to and including January 2018.

There have been considerable challenges in the past year which have been discussed in the report. These are:

- Working with similar type local services
- Staff recruitment and retention
- Developing a Recovery Champion and Peer Support Scheme

5.2 Next Steps

Consolidation and improvement

As the Network has taken shape, three areas of development have emerged across both the Adults and Older Adults age ranges:

- Daily Network Operation
- Improving the effectiveness of the Network
- Increasing the number of Introductions into the Network

The daily Network operation for supporting individuals in the CMHT age range is on-going with only minor amendments being made. Amendments to the daily operation for supporting individuals in the CMHT(OA) age range are on-going and more significant as this Introduction pathway has only recently come online and still in the development phase.

The Network's effectiveness to support individuals on their recovery journey will be boasted with the further development of Network staff attending the initial sessions of their chosen activities to have a higher likelihood of achieving their recovery goals.

The number and consistency of Introductions into the Network will be increased as more Introduction Pathways become operational, for example more GP surgeries etc.

In addition to the three area mentioned the Project Board will look to achieve the following in 2018:

- Expand Network capacity and operation
- Increasing CMHT/CMHT(OA) capacity
- More Seed Funding to build and develop community assets
- Continued development of Network staff's relationship building, graded exposure, confidence building, anxiety management and motivational techniques.
- Setting-up condition specific (including: OCD, trauma, personality disorder, Schizophrenia) Mental Health educational sessions and reminiscence groups in the community, working co-productively with supported individuals, IPT, psychologists and psychiatrists from CMHT/CMHT(OA) to deliver these sessions and groups.
- Closer working with the CMHT Task Team with the aim of further reducing the list of people awaiting care-co-ordination.
- Development of a Network Individual Placement and Support scheme (IPS) to aid individuals accessing secondary mental health service into competitive employment.

Local organisations and venues will be encouraged to become more "mental wellbeing aware/friendly", which could be formalised into a Safe Places style scheme. Existing resources, such as toolkits and training resources from Time to Change and other mental health organisations will be used to support community assets to be more accessible for people with mental health needs and to help set up projects and initiatives.

A critical next step will be to set up an alliance contract across BACCG, BFC, BHFT, and other relevant partners, that will enable resources to be pooled and risk to be shared across organisations.

Appendix A - Case Studies (supported individuals and practitioners)

Case Study of Sandra's Supported Recovery Journey

Sandra's story

Sandra has been living with a diagnosis of Schizophrenia for the past 16 years. She was Introduced into the Bracknell Forest Community Network from the Bracknell Community Mental Health Team (CMHT) after a relapse saw her health and wellbeing deteriorate.

Sandra found she had isolated herself from her family and the local community, and was struggling to cope with simple activities of daily living that most people take for granted. Sandra found it particularly hard coping with the bereavement caused by the loss of her close friend as she did not have a regular support network to talk things over and fall back on. It was at these difficult times negative thoughts to harm herself would manifest and she would often contact the out of hours CRISIS team for support. All of which could have been prevented if Sandra had some initial help to access support tailored to her needs available in the local community.

Once Sandra met with Network staff she was able to talk about herself, her illness, likes and dislikes and together they co-produced a Recovery Plan, which was goal-orientated and put Sandra at its heart.

Sandra's short-term goals were based around gaining work experience and the right employment advice for her. Sandra was signposted and supported by the Network's Recovery Facilitator to access a local job club at the Kerith Centre and drop-in employment workshops provided by Bracknell Forest Homes for advice. From this Sandra was able to achieve her longer-term goal of permanent part-time employment at a local car hire firm.

Sandra was also keen to widen her support networks and social interactions by following her love of arts and crafts. Sandra was supported to attend a local knitting group where she has attended regularly since, and made new friends. From this, Sandra has set herself a new goal of knitting Snoods for her loved ones and new friends for Christmas.

Sandra has contributed to the development of the Network at the monthly Network Group Meetings, by giving feedback and engaging in the development activities on the Network's forms, processes and logo.

Since engaging with the Network, Sandra has a much more positive outlook on life and is "very much looking forward to the future" having been discharged from the CMHT. She says 'Because of the Community Network I'm doing more things now and keeping more active and because of that I actually want to get up in the mornings as I am enjoying life more!'.

Case Study of Sandra's Supported Recovery Journey

Sandra's story

Sam has been living with a diagnosis of Bipolar disorder with generalised anxiety and depression for the past 25 years. Sam's rapid cycling causes her to have periods of mania followed by periods of deep depression and exhaustion where she struggles to get out of bed. She was introduced into the Bracknell Forest Community Network from the Bracknell Community Mental Health Team (CMHT) after Sam had spoken to her doctor about some of her daily difficulties.

These difficulties included being socially isolated as Sam lives alone, trouble motivating herself to connect to the community as well as routine activities such as cooking, taking her medication and completing daily tasks. Sam said "When I'm depressed all I want to do is sleep as I have trouble concentrating on tasks like cooking.".

Earlier in 2017, Sam met with Community Network staff at Coopers Hill Community Centre and was encouraged to talk about her goals and aspirations for the future. Sam mentioned her love of physical activity and how being active helped her mental illness. She also mentioned how volunteering would help her feel part of the community and make her feel like she is giving back.

From this discussion a Recovery plan was produced by Sam and a Recovery Facilitator. Sam's recovery plan focused around resuming her old volunteering job at Sandhurst Military Academy working with the horses, which she previously enjoyed. Sam also wanted to focus on ways to overcome her depression including keeping physically active.

Sam was supported by the Network to attend weekly Sport in Mind yoga sessions as well as encouraged to try her hand at boxing sessions. Sam said 'The Boxing through Sport in Mind I would never have heard of without the Community Network'. Sam now attends the boxing on weekly basis and is thoroughly enjoying this increased level of physical activity.

Sam has contributed to the development of the Network at the monthly Network Group Meetings, by regularly attending, Sam has engaged in the development activities focussed on the Network's forms, processes and logo. Sam has also been involved on service user panels for Network staff interviews which she has thoroughly enjoyed. This make Sam feel like her voice is being heard and that service users are part of the decision making process when the Network hires new staff members.

Since engaging with the Community Network, Sam's contact with secondary mental health services has decreased. She still sees her psychiatrist for quarterly medication reviews but Sam has reported an increase in her mental wellbeing, has seen marked improvement when coping with difficulties in her life and has increased her support networks by developing friendships within the community.

Sam says of the Community Network support "It has given me a kick up the butt to volunteer because I have lacked confidence. I enjoy the monthly meetings where I learn about different services and activities. It also helps being around other people with mental health difficulties so it saves me from being socially isolated".

Case Study of a Practitioner's Experience

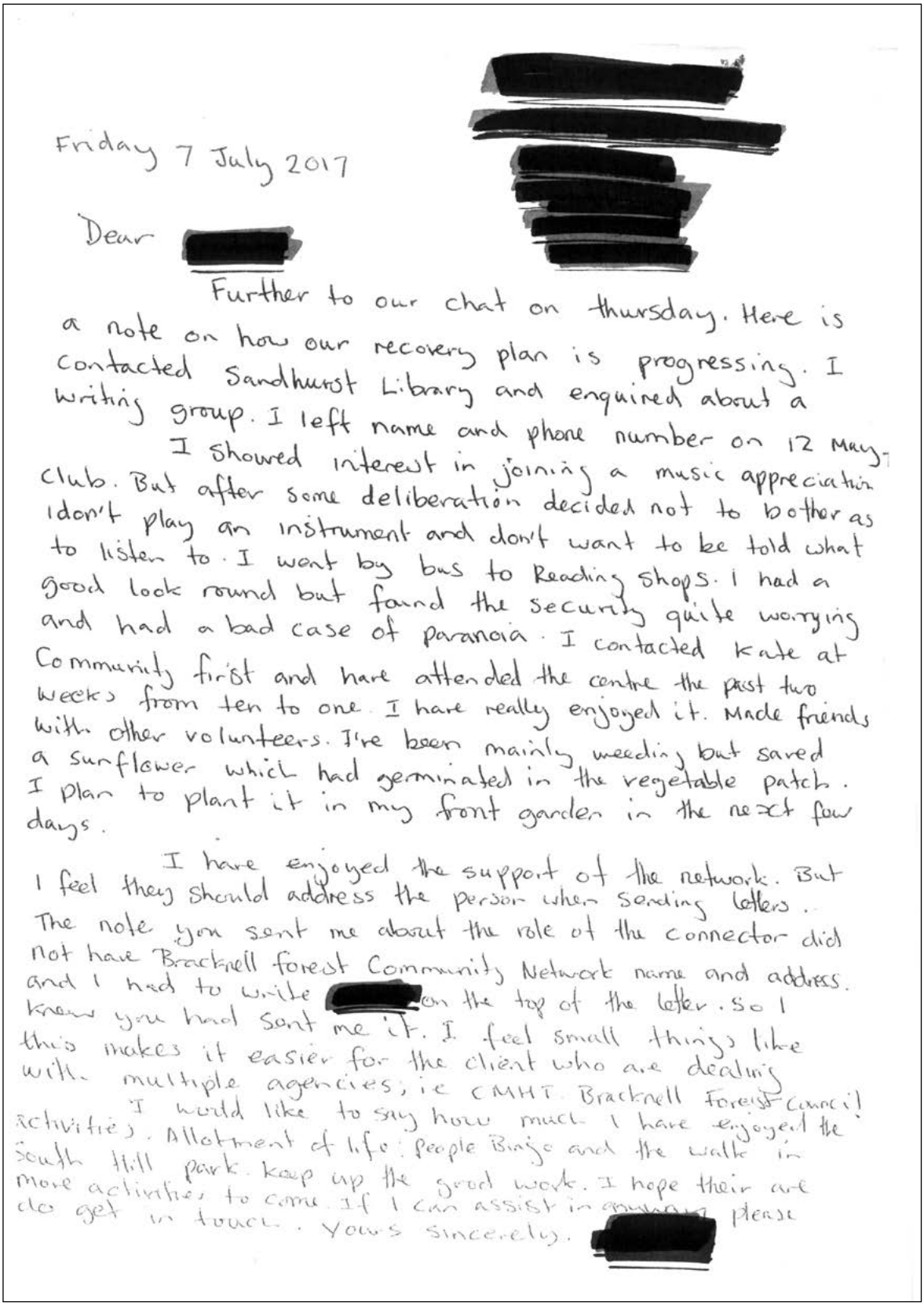
Sarah Beaumont is a qualified psychiatric nurse who has been practicing for almost three years and working in the local community for a year a half. In Bracknell Forest, the Community Mental Health Team, which Sarah works within, supports individuals with varying mental health issues ranging from psychotic illnesses such as schizophrenia through to difficulties including personality disorders. The Team's role in the community is to provide care for individuals whose mental ill-health is preventing them from living to their full potential and desire. Ultimately, the Team are working towards enabling these individuals to become independent and to ensure recovery and positive mental health.

"Even before the Community Network was officially established, their staff made themselves readily available within the Community Mental Health Team for discussions around what their team would be providing. The staff were extremely friendly and approachable and demonstrated a real care and passion for the goals of the new service. The referral process has evolved as the service has become better established but it has been simple and user friendly throughout. There have been no demands on practitioners to complete lengthy referral forms and risk assessments duplicating information already available on the systems we use. The Community Network have contacted care co-ordinators where necessary for extra information or to share information when needed.

"I referred P as soon as the service was set up as I had previously thought of them during Introductions from the Community Network. P has been open to the Community Mental Health Team for many years as they require on-going treatment. They have a reasonable level of independence; they did not require more intensive involvement from CMHT but had some unmet potential and some personal interests which could be further explored in the community. P needed more support to make this happen due to the negative symptoms of their illness. P also thrives in peer settings and can be very supportive of others known to have mental health difficulties. P has been using the Community Network now since it began and reports back regularly of how much they enjoy it. P is now accessing and doing more in the community and has a support network separate to the CMHT. The next stages for P would be continuing to maintain their recovery and to take on more responsibility for their involvement in the community.

"The Community Network has filled a huge gap in the community resource. Before this team was established, clients often saw their options for mental health support in Bracknell as the Community Mental Health Team or nothing. Keeping individuals open to the CMHT for the purpose of the remaining part of their recovery seemed at odds with the aim to empower individuals. This also placed a significant pressure on the CMHT whilst the team was trying to manage a steady flow of referrals in. The Community Network has helped many service users to continue and to enhance their recovery journey and to reach some of their more specific goals within the community. I will continue to readily refer into the Community Network as I strongly believe this team is empowering individuals with mental health difficulties to achieve more."

Appendix B - Redacted Letter of Thanks from a Supported Individual



Friday 7 July 2017

Dear [redacted]

Further to our chat on thursday. Here is a note on how our recovery plan is progressing. I contacted Sandhurst Library and enquired about a writing group. I left name and phone number on 12 May. I showed interest in joining a music appreciation club. But after some deliberation decided not to bother as I don't play an instrument and don't want to be told what to listen to. I went by bus to Reading shops. I had a good look round but found the security quite worrying and had a bad case of paranoia. I contacted Kate at Community first and have attended the centre the past two weeks from ten to one. I have really enjoyed it. Made friends with other volunteers. I've been mainly weeding but saved a sunflower which had germinated in the vegetable patch. I plan to plant it in my front garden in the next few days.

I have enjoyed the support of the network. But I feel they should address the person when sending letters. The note you sent me about the role of the connector did not have Bracknell forest Community Network name and address. and I had to write [redacted] on the top of the letter. So I knew you had sent me it. I feel small things like this makes it easier for the client who are dealing with multiple agencies; ie CMHT Bracknell Forest Council

I would like to say how much I have enjoyed the activities. Allotment of life; People Bingo and the walk in South Hill park. keep up the good work. I hope their are more activities to come. If I can assist in anyway please do get in touch. Yours sincerely. [redacted]

Appendix C – Example of a BFCN Recovery Plan

Next steps, your goals…	
Short-term (one - two months from 20/03/2018):	
1.	**Goal: Attend a monthly book club**
	Action: Catrin and Sharon to research a local book club and send information to Joe (please see below). • Ascot Heath Library has a book club 1st Monday of every month 10.30am. Ring 01344 884030 to ask about creative writing group, book club and other adult activities. • Crowthorne Library 01344 776431 also have creative writing group, ring or drop in to enquire about this. • Sandhurst library 01252 870161 have creative writing groups Friday 10.30-11.30 (however they require a financial donation to attend) • Binfield Library Benetfeld Road, Binfield, RG42 4JZ Tel: 01344 306663 have a drop in book group. This can further be researched on a computer in your local library on the Bracknell forest website under 'libraries'. **Action:** Joe to decide which of the above he would like to pursue, and contact them himself within 2 weeks.
2.	**Goal:** Attend a music appreciation club
	Action: Joe to attend Acoustic Couch (01344 483 861) to enquire about their events, jam sessions and music appreciation within the next 3 weeks.
3.	**Goal:** Attend/volunteer at a gardening club.
	Action: Catrin and Sharon to send Joe leaflets about Community First and Bracknell Conservation Volunteers (please see enclosed). **Action:** Joe to contact enclosed community assets to enquire about their service/times etc.
4	**Goal:** Attend an Astronomy club
	Action: No current Astronomy club in Bracknell, however Joe to research his interests in Natural History and Astronomy at his local library. Please try www.astronomy.com or www.astronomyforbeginners.com
5.	**Goal:** Visit Reading to attend shops and explore town centre.
	Action: Joe to go by Bike or bus to Reading to widen his horizons by exploring town centre and see what Reading has to offer within 3 weeks.
Next time this will be reviewed:	Approximately 1 months' time to review progress.

Appendix D - BFCN PROM (monitoring form)

Monitoring Form

Name	
Completed with	
Date	

1. Hope for the Future

- Do you see a future for yourself that meets your aims and aspirations?

None of the time (0)		Rarely (1)		Some of the time (2)	
Often (3)		All of the time (4)			

Comments

2. Control in Your Life

- Do you feel that you are able to take control of difficulties in your life?

None of the time (0)		Rarely (1)		Some of the time (2)	
Often (3)		All of the time (4)			

Comments

Bracknell Forest Community Network
51 - 52 Turing Drive, Bracknell, Berkshire, RG12 7FR
Telephone: 01344 823300 Email: network@berkshire.nhs.uk

3. Developing Support Networks

- Are you able to develop and support relationships with friends and family?

None of the time (0)		Rarely (1)		Some of the time (2)	
Often (3)		All of the time (4)			

Comments

4. Mental Wellbeing

- How do you feel your mental wellbeing is currently?

Poor (0)		Struggling (1)		Ok (2)	
Good (3)		Very good (4)			

Comments

5. How often do you use the following services?

GP		CMHT	
Substance misuse service		Social services	
CRISIS		Probation	
Talking Therapies		Police	
Other			

Bracknell Forest Community Network
51 - 52 Turing Drive, Bracknell, Berkshire, RG12 7FR
Telephone: 01344 823300 Email: network@berkshire.nhs.uk

Appendix E - BFCN Promotional Leaflet

The Bracknell Forest Community Network

Supporting you to access the community and live independently

What is the Bracknell Forest Community Network?

The Bracknell Forest Community Network connects people aged 18+ experiencing stress, anxiety or low mood to develop confidence, interests and hobbies, life skills, and resilience. This will help you to remain socially connected, and better understand your health and wellbeing so you can live as independently as possible.

Who can the Community Network support?

Community connection could help if you are experiencing any of the following:

- Recovering from an episode of mental ill-health
- Social Isolation or looking to get out in the community more
- Lacking confidence
- Needing practical support and information to get back to independence

Joe's Story

Joe has been feeling anxious and depressed since he lost his job a couple of months ago. He has been prescribed medication but would like to get back into work and regain his independence.

The Network's Community Connectors helped Joe to set goals and make plans to improve his wellbeing and take steps to move forward with his life. These included:

- Supporting Joe to access a local Job Club
- Attending a local landshare to maintain Joe's practical skills
- Attending a weekly Ranger Walk at South Hill Park for exercise and to meet people

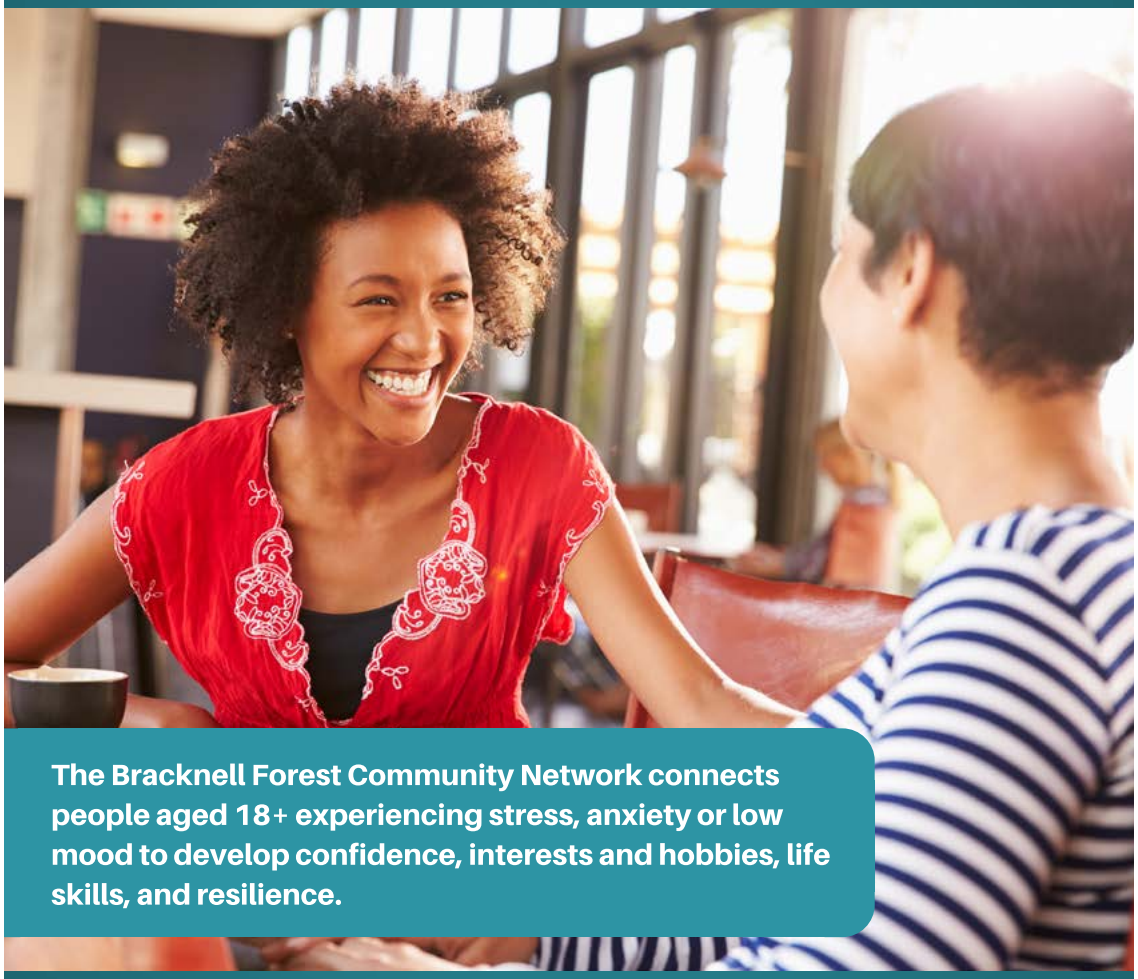
What happens next?

If you would benefit from some additional support to improve your health and wellbeing simply get in touch with us using the details listed below to get started.

Bracknell Forest Community Network
Tel: 01344 823300 or
Email: network@berkshire.nhs.uk

Appendix F - BFCN Promotional Poster

Feeling low or anxious? Needing support to get back to independence?



The Bracknell Forest Community Network connects people aged 18+ experiencing stress, anxiety or low mood to develop confidence, interests and hobbies, life skills, and resilience.

Contact the Bracknell Forest Community Network by:

Tel: 01344 823300 or

Email: network@berkshire.nhs.uk

A summary of this document can be made available in large print, easy read, Braille or on audio cassette. Copies in other languages may also be obtained. Please contact customer services on 01344 352000.

Nepali

यस प्रचारको सक्षेपं वा सार निचोड चाहिं दिइने छ ठूलो अक्क्षरमा, ब्रेल वा क्यासेट सून्नको लागी । अरु भाषाको नक्कल पनि हासिल गर्न सकिने छ । कृपया सम्पर्क गनूहोला ०१३४४ ३५२००० ।

Tagalog

Mga buod/ mga hango ng dokumentong ito ay makukuha sa malaking letra, limbag ng mga bulag o audio kasette. Mga kopya sa ibat-ibang wika ay inyo ring makakamtan. Makipag-alam sa 01344 352000

Urdu

اس دستاویز کے خلاصے یا مختصر متن جلی حروف ، بریل لکھائی یا پھر آڈیو کیسٹ پر ریکارڈ شدہ صورت میں فراہم کئے جا سکتے ہیں۔ دیگر زبانوں میں اس کی کاپی بھی حاصل کی جا سکتی ہے۔
اس کے لیے براہِ مہربانی ٹیلیفون نمبر **01344 352000** پر رابطہ کریں۔

Polish

Streszczenia lub fragmenty tego dokumentu mogą być dostępne w wersji napisanej dużym drukiem, pismem Brajla lub na kasecie audio. Można również otrzymać kopie w innych językach. Proszę skontaktować się z numerem 01344 352000.

Portuguese

Podemos disponibilizar resumos ou extractos deste documento em impressão grande, em Braille ou em audiocassete. Podem também ser obtidas cópias em outros idiomas. Por favor ligue para o 01344 352000.

The Bracknell Forest Community Network

Supporting you to access the community and live independently

What is the Bracknell Forest Community Network?

The Bracknell Forest Community Network supports people aged 18+ experiencing stress, anxiety or low mood to develop their confidence, interests, hobbies, life skills and resilience. The Community Network has dedicated Recovery Facilitators who support individuals on their recovery journey using relationship building, graded exposure, confidence building, anxiety management and motivational techniques to access and attend appointments around benefits, housing, education, volunteering, employment, social activities, appointments and life after Network support.

Who can the Community Network support?

Our Recovery Facilitators could help if you are experiencing any of the following:

- **Recovering from an episode of mental ill-health**
- **Social Isolation or looking to get out in the community more**
- **A carer of somebody living with mental ill-health wanting to access the community**
- **Needing practical support and information to get back to independence**

Joe's Story

Joe has been feeling anxious and depressed since he lost his job a couple of months ago. He has been prescribed medication but would like to get back into work and regain his independence.

The Network's Recovery Facilitators helped Joe to set goals and make plans to improve his wellbeing and take steps to move forward with his life. These included:

- Supporting Joe to access a local Job Club
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- Attending a weekly Ranger Walk at South Hill Park for exercise and to meet people

What happens next?

If you would benefit from some additional support to improve your health and wellbeing simply get in touch with us using the details listed below to get started.

Bracknell Forest Community Network
Tel: 01344 823300 or
Email: network@berkshire.nhs.uk

healthwatch
Bracknell Forest

Annual report 2017/18

Message from our Project Lead Mark Sanders

There have been challenges during the year. Despite a cut in funding of almost 40% we have needed to represent the public during the local changes to the health and social care landscape. The three East Berkshire Clinical Commissioning Groups decided to become one, the accountable care system became the integrated care system and local Healthwatch now has to work within wider parameters to ensure local peoples' voices are heard. Bracknell Forest was also one of the first local authorities to undergo a Local Area Review and, as well as providing our feedback to the Care Quality Commission, we arranged focus groups so patients and carers could share their stories directly.

But there has also been a great deal of work done resulting in positive changes for the local community. We are particularly proud of being instrumental in increasing access to primary care for the homeless and rough sleepers during the winter months, the launch of our Information Bus and our collaborative work with other local Healthwatch concerning hospital discharge and the Enter and View report on Prospect Park Hospital.

> It is important that local people have a voice in the changing landscape of health and social care

Highlights from our year

We have reached **89,549** people on social media *

Represented the patient and public voice at **135** meetings

We gather views from the whole community and have focused on engaging with those that are seldom heard

We have collected **939** pieces of feedback and views on local services

We've visited **34** community groups and events to meet local people

We've given **1725** people information and advice

* This does not include those reached through re-tweets and re-posting by others

Who we are

Healthwatch Bracknell Forest is the local independent champion for people who use health and social care services.

Our purpose

We find out what people like about services and what they think could be improved.

We use this information to encourage those who run and make decisions about services to act on what matters to you.

We give people information, advice and support about local health and social care services.

People's views come first – especially those who find it hardest to be heard.

We also share information and ideas with other local Healthwatch groups, Healthwatch England and the Care Quality Commission (CQC).

Your views on health and care

Listening to people's views

+ Visited community groups and events

+ Outreach in the community with the 'Information Bus'

+ Social Media. As well as our own posts we engage in conversations about health and social care on online community forums and groups who have also helped us to promote public meetings and surveys

+ Website

+ Online surveys (available in other accessible formats if required)

Championing the seldom heard

We are committed to hearing the experiences and views of all members of the community. Some people's voices may be seldom heard because:

+ They have limited contact with services, or
+ They have a disability or long-term condition, or
+ English is not their first language

(This list is not exhaustive)

Case study

We were contacted by a young man with autism who was researching the support available he could purchase with his social care direct payments. He had found a company providing support locally but he was unhappy with how they described autism on their website. The descriptions were very clinical and used words such as 'retarded language development' and focused on perceived deficits of people with autism and did not acknowledge differentiation between individuals with the same condition. He found this very upsetting.

We contacted the care company with his concerns and, within a week, they had updated their website to take account of the gentleman's comments.

Patients who cross borders

Berkshire is a county with 6 local authorities so therefore has 6 local Healthwatch. Patients travel between authorities to access services. As part of the local Healthwatch network we all collect and share relevant information but we also meet with our county colleagues regularly.

Making sure services work for you

With the other Berkshire Healthwatch we carried out 11 Enter & View visits at Prospect Park Hospital in Reading over a week long period. The hospital provides services for people with mental health conditions and is run by Berkshire Healthcare NHS Foundation Trust.

A number of recommendations * were made to the Trust and, as a member of the Trust's patient experience group, we will be able to monitor if these have been acted upon.

Enter & View representatives have also assisted in Patient Led Assessments of the Care Environment (PLACE) at St Mark's Hospital and Prospect Park Hospital.

* To read the full report please visit our website

Helping you find the answers

We help the community to access the information they need to make decisions about their wellbeing, care and find the support they need by:

+ Providing information and advice to individuals. This can be at drop-in sessions or events, enquiries received by letter, telephone, email or online and, if needed, home visits

+ Developing a community map resource which details the support available from the community and voluntary sector

+ Referring people to services and groups, including advocacy services

+ Providing bulletins of important health and social care information – drawn from local and national sources

+ Hosting 4 public information and awareness events about the introduction of the Integrated Care System.

These events also gave the public the opportunity to ask questions of the senior members and decision makers of East Berkshire Clinical Commissioning Group and Frimley Health NHS Foundation Trust

+ Taking part in media interviews around current health and social care topics

Making a difference together

The health and social care sector is vast, inter-linked and ever-changing. Healthwatch Bracknell Forest's approach to representation of the patient and public voice is to have a member of staff who attends the Health & Wellbeing Board and other strategic boards and committees. They then have a complete overview of services; how they are linked and the impact decisions in one area have in another.

This approach ensures the patient and public voice is heard at all levels and stages of the decision process to commission and evaluate services. It allows us to champion for patient and public representation by our volunteers, or others, on tendering panels, forums and partnership boards.

We record the feedback and experiences of the public and have developed a knowledge database. Members of staff draw on this when attending meetings therefore it is **essential** we continue to focus on collecting the stories of people who use services.

Here are a few examples of our work with others:

Joint Adult Safeguarding Board (Bracknell Forest and Windsor & Maidenhead)

As a member of the board we have been particularly involved in the workstreams to increase public involvement in the board's work and activities. This will continue next year when the board will also expand to include children's safeguarding.

East Berkshire CCG

In April 2017 the 3 separate CCG groups located in East Berkshire merged to form one clinical commissioning group. They are responsible for the commissioning of the majority of health services.

The East Berkshire CCG values the positive relationship with Healthwatch. in particular the CCG want to highlight a few of the key areas of work that Healthwatch undertakes:

+ *Working with the CCG and Patient Reference Groups (PRGs), especially where there have been contentious issues*
+ *Willingness to support CCG GP Member meetings and providing updates to Members*
+ *Crystallisation and organisation of public to explore the Integrated Care System (ICS) and emerging thoughts about care outside hospital*
+ *Appropriately challenges unreasonable patient issues and concerns*
+ *Provides the CCG with a useful triangulating link with Health and Wellbeing Boards*
+ *Constructive challenge on the CCG engagement agenda*
+ *Willingness to take part in different group work*
+ *Knowledge of the area and issues facing local people*
+ *Membership at CCG and ICS key meetings such as quality committee, primary care quality, equality and diversity and the mortality review group - providing both support and critical challenge*
+ *Sharing intelligence to help us sensitively challenge and support improvement in providers especially primary care*
+ *Sharing skills (such as supporting the CCG to produce documents in 'Easy Read' format)*
+ *Providing access to panel of experts by experience in disability*

Sarah Bellars, Director of Nursing & Quality - East Berkshire CCG

Healthwatch England

One of the ways we have worked with Healthwatch England this year (in addition to sharing information) is by regularly inputting and contributing to the design of a new website being created by Healthwatch England for use across the whole local Healthwatch network.

Care Quality Commission

We have regular conference calls with the Inspectors that lead on the work in our area. This allows them to discuss the inspection schedule and collect any local evidence and feedback we have and also allows us to raise any concerns about services the public have alerted us to. We also played a proactive role in the Local Area Review.

I think it is very useful to have the HW opinion of how a service is performing and for voicing the patient view. As our decisions to inspect become more risk based, the relationship we have is even more important in advising on these decisions and for highlighting other risks or concerns we would not always be privy to.

Ali Robson, Inspector (Thames Valley Team) - Care Quality Commission

Berkshire Healthcare NHS Foundation Trust

The Experts by Experience (EBE²) group, part of Healthwatch Bracknell Forest, are involved with the communication work stream around people with learning disabilities with Berkshire Healthcare Foundation Trust (BHFT) following their CQC inspection. It was agreed that materials and a video would be co-produced to demonstrate to professionals the good and the bad way to communicate with people with learning disabilities.

EBE² have discussed and shared with a team from BHFT the issues they had encountered with health and social care professionals and these were used to produce ideas for a short film which they also agreed to be in.

I could see how strong the feelings were and how indifferently they have been treated. I really hope we can use this film to help people behave differently.

Dr Catherine Evers, Consultant Clinical Psychologist Lead (East) - BHFT

Mental Health Forum

With funding from the Community Mental Health Team we are now running the independent Mental Health Forum for the area. As well as collecting people's stories, professionals are invited to give presentations on topics chosen by the forum members.

People

We want everyone to feel able to take an active role in their health and wellbeing. As well as volunteering for Healthwatch Bracknell Forest we promote other opportunities where people can get involved - from membership of GP surgery Patient Reference Groups to Healthmakers (a local peer support project for people with long-term health conditions). We promote consultations and opportunities for 'experts by experience' patients.

Chris Taylor (HWBF staff member) with volunteers Nigel and Muriel

Volunteers are essential to the delivery of Healthwatch Bracknell Forest. All of our volunteers receive, as a minimum, training in Safeguarding, Data Protection, Confidentiality and the Mental Capacity Act. Volunteers who have been involved since the early days of local Healthwatch are currently undergoing refresher training programmes. We have different roles including Project Support Board member, Enter & View Representative, Community Champion and administrative roles. We also have representatives from other community and voluntary sector groups working with us.

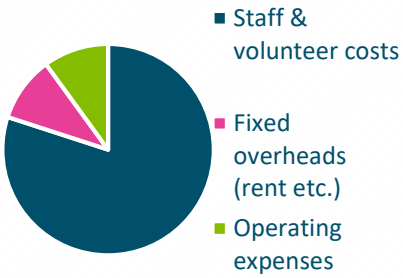
We continue to support the placement of a student from Bracknell and Wokingham college. The students that attend are from the Health and Social Care course and they report that they find it useful to carry out placements which show them a wide variety and exposure to more of health and social care than their usual care home placements.

Going forward....

Finances and funding

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	65,000
Additional income	720
Total income	65,720

Expenditure



Funding from the local authority will remain at the same level (65k) for 2018/19

Our top priorities for next year

1. Mental Health Services

2. Issues with access to primary care for marginalised groups

3. Social care

4. Services working together particularly around hospital discharge

Our annual report will be publicly available on our website by 30 June 2018. We will also be sharing it with Healthwatch England, CQC, NHS England, East Berkshire Clinical Commissioning Group, BF Overview and Scrutiny Committee and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us.

Healthwatch Bracknell Forest is delivered by The Ark Trust Ltd, a charitable company limited by guarantee. Registered Charity number: 1098204, Company number: 04504955. It's registered office is: The Space, 20/21 Market Street, Bracknell, Berkshire, RG12 1JG

Contact us

enquiries@healthwatchbracknellforest.co.uk

01344 266 911

@HealthwatchBF

HealthwatchBF

The Space, 20/21 Market Street, Bracknell, Berkshire, RG12 1JG

TO: ADULT SOCIAL CARE HEALTH AND HOUSING OVERVIEW AND SCRUTINY PANEL
24TH JULY 2018

HOMELESS REDUCTION ACT
Director of Adult Social Care, Health and Housing / Borough Treasurer

1 PURPOSE OF REPORT

1.1 The purpose of the report is to advise the Adult social care health and housing overview and scrutiny panel of the impact of the Homeless Reduction Act and the response the Council has taken.

2 RECOMMENDATIONS

Adult Social Care Health and Housing Overview and Scrutiny panel are asked to,

2.1 Note the new obligations from the Homeless Reduction Act 2017.

2.2. Note the response to the new obligations the Council has implemented.

3 REASONS FOR RECOMMENDATIONS

3.1 On the 3rd April 2018 the provisions of the Homeless Reduction Act 2017 came into force. This brought new obligations for the Council in terms of homeless prevention and relief. There has been additional funding available to assist Council's in meeting these new obligations.

4 SUPPORTING INFORMATION

4.1. The Homeless Reduction Act 2017 introduced two new elements for Council's to provide in relation to homelessness. Firstly, if a household is threatened with homelessness within 56 days the Council is obliged to help them prevent becoming homeless regardless of whether they have a local connection with Bracknell Forest or whether they are in priority need. The Council will work to develop a personal housing plan with the household with a set of actions that are agreed with the household to help them avoid becoming homeless.

4.2. If it has not been possible to prevent homelessness the Council has a duty to relieve homelessness for 56 days. If there is reason to believe that the household is in priority need (has dependent children as part of the household or vulnerable) then the Council is required to provide temporary accommodation. At the end of the 56 days, if it has not been possible to relieve homelessness then the homeless duty must be met. If the household has a local connection to another local authority area then a referral to that Local Authority can be made. If the household is eligible (immigration status), homeless, has a local connection, unintentionally homeless and has a priority need, the Council will provide temporary accommodation pending the offer of a suitable home in the private rented sector or a housing association property.

4.3. Based on the approaches in April and May 2018, a total number of 29 single/ adult couple households were owed a relief duty. This could be equivalent to 174 cases under relief duty in the financial year of 2018/19. It is estimated that the council could

owe an accommodation duty to 50% of the total number of cases owed a relief duty as it may have reason to believe they are in Priority Need. Thus there could be a requirement to provide accommodation for 87 additional households compared to those the Council accommodated in previous years.

4.4. The Housing service had estimated that there could be in the region of 500 additional customers who would receive the homeless prevention and relief duty in the year. If that demand presents as an average of 10 customers a week with an average of 3 hours per customer(pathfinder LA who have already adopted the approach suggest 3 hours is a reasonable amount of time to assess and set up and case manage plans) it should be possible to contain this new demand within the released capacity resulting from introduction of Universal Credit and the proposal to recruit an additional Welfare and Housing Caseworker The additional Welfare and Housing Caseworker post is funded from new burden funding received to accompany the new requirements stemming from the Homeless Reduction Act. In addition, the service has appointed an Accommodation Officer from within existing resources. That officer will procure properties in the private rented sector to be offered to homeless households requiring family size accommodation. It is estimated that they should be able to secure at least 40 properties in a twelve month period.

4.5. The Council has been awarded the Flexible Homeless Support Grant for 2018/19 and 2019/20.The Following table sets out the confirmed flexible homeless support grant and estimated costs of how it will be used. The Flexible homeless support grant as the name suggests, can be defrayed on expenditure to address homelessness. However, it is not possible to carry the grant forward between the years.

Proposal	Flexible homeless support grant 2018/19	Flexible homeless support grant 2019/20	Total
Housing benefit subsidy loss on temporary accommodation	120,000	120,000	240,000
Accommodation finder	80,000	80,000	160,000
Floating support	20,000	20,000	40,000
Redevelopment of Tenterden lodge or alternative accommodation	129,073	155,230	284,303
Total grant	349,073	375,230	724,303

4.6. Housing benefit subsidy loss is the consequence of the change in the maximum amount of housing benefit that can be paid to tenants in the Council's accommodation. Prior to 2017/18 the maximum housing benefit was 90% of the relevant 2011 Local housing allowance (LHA) plus £60 per week management fee. Thus BFC set rents at that level. Post 2017/18 the Government set the maximum housing benefit that could be paid at the relevant LHA. This means the current temporary accommodation rents are set higher than the maximum housing benefit that could be paid. The options to the Council were to reduce rents and lose income or to pay housing benefit up to the current rent levels and as housing benefit subsidy would not be paid to that level, pay the loss of subsidy from the flexible homeless support grant. The latter was chosen as it maximises income for the Council, and maximises provision of affordable temporary housing. There is an existing proposal

to be reported to Corporate Management Team which would remove that subsidy loss and generate a revenue surplus by disposing of the Council's temporary housing stock to Downshire Homes Ltd.

4.7. It is proposed to offer to the market two year funding to an organisation that can procure private rented sector properties for the Council. The requirement will be for an organisation to offer a number of properties as close to local housing allowance levels as possible for which they will receive a fee from the Council. The organisations could offer management services to landlords and it is hoped that the two years funding will help the organisation achieve a level of self-sufficiency. Organisations will be asked to commit to provide at least 30 private rented sector units a year.

4.8. Discussion has taken place with a Registered Provider Places for People, who have committed to purchase houses to act as shared accommodation for ex-offenders. The accommodation will be leased to a specialist registered provider Langley Trust. Following soft market testing to identify the provision of intensive housing management to high risk offenders only, Langley Trust are the only Provider that *solely* provide this service and who already work with one of Bracknell Forest Council Specialist Providers namely Places for People, who provide accommodation for this purpose. Although, Langley Trust are the only service who solely provide intensive housing management support for high risk ex-offenders in this area, there is a need to provide floating support to help the ex-offenders into employment and to ready themselves to move into alternative accommodation otherwise the properties will not be able to be re-let. It is proposed to offer £ 20,000 a year to be match funded by the National Probation Service to fund the floating support service. If the NPS are not able to match fund then it will be in the Council's interests to employ the floating support itself. It is estimated that this proposal will enable at least 6 units of accommodation to be made available.

4.9. It is recommended that the remaining funding of £ 284,000 is made available to redevelop room 10 at Tenterden Lodge. A number of feasibility studies have taken place at Tenterden Lodge to establish whether it was possible to install modular buildings. This has been shown not to be cost effective due to the constraints of the site. It is therefore proposed that room 10 at the back of Tenterden lodge is redeveloped to provide four self-contained one bedroom units. If those units are re-let at local housing allowance one bed rates of £150 a week, it will generate a gross annual rent of £ 31,200. If management and maintenance of 16% and bad debt / voids and arrears at 5% is deducted it will provide ongoing revenue of £ 24,648 a year. The net income can be used to finance the other proposals in this report thus making them sustainable longer term if the flexible homeless support grant is no longer available. If it is possible to provide 4 units it will in effect only provide 3 due to the loss of the original room 10.

5.10. The following table sets out the summary of the proposals

Proposal	Units provided annually
Accommodation finder	30
Floating support	6
Tenterden lodge redevelopment	3
Net new demand due to relief duty	(47)
Unmet housing demand	8

5.11. A model called Housing First is being employed by a number of Local authorities. This requires accommodation to be available for homeless households which they can directly access and then with the help of floating support they can be helped to secure a long term sustainable housing solution**.** As a non- housing stock owning local authority it is difficult for the Council to adopt this approach. The approach would require agreement from the social housing providers in the area to provide suitable housing and this is unlikely to be forthcoming. Therefore, at this point in time this approach cannot be recommended although the recommendations in this report will go some way towards establishing a housing first approach through property procurement in the private rented sector and provision of necessary support

6. STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal issues are addressed within the report.

Borough Treasurer

6.2 As set out in the report, the costs associated with the proposals will be met from the Flexible Homeless Support Grant.

Equalities Impact Assessment

6.3 Not applicable.

7 CONSULTATION

7.1 Not applicable

Background Papers

Contact for further information

Simon Hendey, Adult Social Care, Health and Housing - 01344 351688
Simon.hendey@bracknell-forest.gov.uk

ADULT SOCIAL CARE & HOUSING OVERVIEW & SCRUTINY PANEL

EXECUTIVE WORK PROGRAMME

REFERENCE:	I077498
TITLE:	Downshire Homes Ltd
PURPOSE OF REPORT:	Executive is asked to consider extending the range of households that are nominated to Downshire Homes and also to receive a report from Downshire Homes Ltd on their operations to date.
DECISION MAKER:	Executive
DECISION DATE:	17 Jul 2018
FINANCIAL IMPACT:	Within existing resources.
CONSULTEES:	Not applicable
CONSULTATION METHOD:	Not applicable.

REFERENCE:	I077411
TITLE:	Adult Complaints Annual Report
PURPOSE OF REPORT:	To present the annual report of Adult Social Care and Health to the Executive Member for Adult Services, Health & Housing.
DECISION MAKER:	Executive Member for Adult Services, Health and Housing
DECISION DATE:	25 Jul 2018
FINANCIAL IMPACT:	No financial implications
CONSULTEES:	None
CONSULTATION METHOD:	Not applicable

REFERENCE:	I076397
TITLE:	Safeguarding Adults Annual Report 2017/18
PURPOSE OF REPORT:	To endorse the Annual Report in relation to Safeguarding Adults within the Borough.
DECISION MAKER:	Executive
DECISION DATE:	13 Nov 2018
FINANCIAL IMPACT:	No financial implications
CONSULTEES:	Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board
CONSULTATION METHOD:	Meeting(s) with interested parties