Notice of Meeting

Health and Wellbeing Board
Councillor Dale Birch (Chair)
Fiona Slevin-Brown, Frimley Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard
Philip Bell, Involve
Neil Bolton-Heaton, Healthwatch
Dr Annabel Buxton, Clinical Lead (Bracknell Forest) Frimley CCG
Alex Gild, Berkshire Healthcare NHS Foundation Trust
Jane Hogg, Frimley Health NHS Foundation Trust
Andrew Hunter, Bracknell Forest Council (Place, Planning and Regeneration)
Sonia Johnson, Bracknell Forest Council (Children's Social Care)
Stuart Lines, East Berkshire Public Health
Melanie O'Rourke, Bracknell Forest Council (Adult Social Care)
Dave Phillips, Bracknell Forest Safeguarding Board
Jonathan Picken, Bracknell Forest Safeguarding Board
David Radbourne, South Central Sub Region NHS
Grainne Siggins, Bracknell Forest Council (People)
Heema Shukla, Bracknell Forest Council (Public Health)
Fidelma Tinneny, Berkshire Care Association
Timothy Wheadon, Bracknell Forest Council (Chief Executive)

Thursday 2 December 2021, 2.00 - 4.00 pm
Online Only - Zoom

Agenda

Item	Description	Page
1.	**Apologies**	
	To receive apologies for absence and to note the attendance of any substitute members. **Reporting:** Lizzie Rich	
2.	**Declarations of Interest**	
	Members are asked to declare any disclosable pecuniary or affected interests 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.	

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	Reporting: ALL	
3.	**Urgent Items of Business**	
	Any other items which the chairman decides are urgent. **Reporting:** Chairman	
4.	**Minutes from Previous Meeting**	5 - 12
	To approve as a correct record the minutes of the meeting of the Board held on 8 September 2021, and the extraordinary Board held on 8 November 2021. **Reporting:** Chairman, Lizzie Rich	
5.	**Matters Arising** **Reporting:** ALL	
6.	**Public Participation**	
	QUESTIONS: If you would like to ask a question you must arrive 15 minutes before the start of the meeting to provide the clerk with your name, address and the question you would like to ask. Alternatively, you can provide this information by email to the clerk at committee@bracknell-forest.gov.uk at least two hours ahead of a meeting. The subject matter of questions must relate to an item on the Board's agenda for that particular meeting. The clerk can provide advice on this where requested. **PETITIONS:** A petition must be submitted a minimum of seven working days before a Board meeting and must be given to the clerk by this deadline. There must be a minimum of ten signatures for a petition to be submitted to the Board. The subject matter of a petition must be about something that is within the Board's responsibilities. This includes matters of interest to the Board as a key stakeholder in improving the health and wellbeing of communities. **Reporting:** Lizzie Rich	
7.	**Better Care Fund**	13 - 94
	To approve the Better Care Fund **Reporting:** Julia McDonald	
8.	**Population Health Management**	
	To provide a briefing on proposals on population health management. **Reporting:** Stuart Lines	
9.	**Health and Wellbeing Strategy**	95 - 144
	To agree the next steps for the Health and Wellbeing Strategy	

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	Reporting: Heema Shukla	
10.	**Winter Plan**	
	To provide an update on the Winter Plan. **Reporting:** Grainne Siggins	
11.	**ICS Update**	
	To receive an update on the ICS. **Reporting:** Jane Hogg	
12.	**Agency Updates** **Reporting:** ALL	

Sound recording, photographing, filming and use of social media is permitted. Please contact Lizzie Rich, 01344 352253, lizzie.rich@bracknell-forest.gov.uk, so that any special arrangements can be made.

Published: 25 November 2021

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HEALTH AND WELLBEING BOARD
8 SEPTEMBER 2021
2.00 - 4.00 PM

Bracknell Forest Council

Present:
Councillor Dale Birch (Chairman)
Fiona Slevin-Brown, Frimley Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard
Philip Bell, Involve
Annabel Buxton, Clinical Lead (Bracknell Forest) Frimley CCG
Alex Gild, Berkshire Healthcare NHS Foundation Trust
Andrew Hunter, Bracknell Forest Council (Place, Planning and Regeneration)
Stuart Lines, East Berkshire Public Health
Rafal Nowotynski, Healthwatch
Jonathan Picken, Bracknell Forest Safeguarding Board
Grainne Siggins, Bracknell Forest Council (People)
Heema Shukla, Bracknell Forest Council (Public Health)
Timothy Wheadon, Bracknell Forest Council

Apologies for absence were received from:
Jane Hogg
Sonia Johnson
Melanie O'Rourke
Neil Bolton-Heaton
Karen Buckley

Also Present:
Nurul Aimi Zain, F2 Placement doctor (Public Health)

14. **Declarations of Interest**

There were no Declarations of Interest.

15. **Urgent Items of Business**

There were no Urgent Items of Business.

16. **Minutes from Previous Meeting**

The minutes of the previous meeting held on 8 June 2021 were approved as a correct record.

17. **Matters Arising**

There were no matters arising from the minutes.

18. **Public Participation**

A resident, Sarah Peacey, attended the meeting to ask a question around a particular incident of a resident who was struggling to access mental health services via their GP practice

Fiona Slevin-Brown encouraged Sarah and the resident in question to contact her directly to discuss the matter. To address the question of GP and mental health service access, Fiona commented that Primary Care and General Practice was currently extremely busy. Primary Care practitioners were providing the best service possible and were not making services deliberately difficult to access. Conversations were ongoing with GP surgeries around access issues, and how to make this easier for residents.

Alex Gild, BHFT commented that lots of investment was going into mental health support in the primary care sector. Wexham Hospital had also established a psychiatric liaison service to address the increase in cases presenting to acute services.

It was also recognised that as part of the Frimley ICS changes, the mental health commitment would be reviewed and consulted on. Sarah and any other interested residents were encouraged to take part in the relevant consultation processes.

19. **Actions taken between meetings**

Cllr Birch reported that the Government had confirmed that the status quo of the Frimley ICS footprint would be maintained. Cllr Birch thanked all involved in the consultation process.

20. **Healthwatch survey results**

Raf Nowotynksi presented Healthwatch's What Matters Most survey.

The survey had asked residents for any feedback on health and social care services they had used in the last 12 months. There had been 155 responders, who had given 206 positive experience examples and 133 negative experience examples.

The best performing services were vaccination centres, ambulance services, opticians and pharmacies. The worst performing services had been mental health services (both adult and child), sexual health services and the care of older people. Raf presented a few examples of the reasons why residents had found services easy, normal, or difficult to access.

As a result of the survey, the Healthwatch priorities would be GP services, mental health services, elderly care and dental care. The next steps would be to speak to GP practices to hear about patient access from their point of view.

Raf commented that Healthwatch were looking forward to speaking to GP practices and residents face to face as COVID restrictions allowed.

In response to questions, the following points were noted:

- Partners recognised the importance of having a good front door experience, before patients get to medical treatment.
- It was noted that patient access was a high priority in the CCG.
- The CCG had started work with practices to address challenges raised in the report, however it was noted that there were significant workforce challenges including recruitment and retention of frontline administration and reception staff. Retention of these staff was made more difficult by the increasing levels of abuse experienced by reception staff at GP practices.
- Patients should be reminded to be sure that the GP was the correct service to contact, and to check whether a pharmacy could meet their need.

- It was noted that the different demographics and cohorts within the population would have different needs, and it was important to recognise the differing needs within the community especially when considering patient access. This would include different preferences in accessing services, for example those who were more or less digitally able.
- The CCG would be recruiting health champions to hear the voice of communities who may be underrepresented.
- Partners queried why there had been such varied experiences across GP services, and hoped that the detail of why different practices were easier to access would come out in the work going forward.

21. **Berkshire Suicide Prevention Strategy**

Heema Shukla presented the Berkshire Suicide Prevention Strategy.

The strategy was being written based on a full data report including suicide demographics, a suicide prevention audit, an NHS 0-25 suicide prevention audit, a deep dive into female suicide, and information on the impact of COVID on mental health and self harm.

The areas of focus for the report were children and young people, self-harm, economic pressures, and the bereaved or those affected by suicide. Overarching actions cover all areas of focus were to conduct a Berkshire suicide audit, hold a multi-agency conference to raise awareness of suicide and suicide prevention, monitor the impact of COVID and the wider trends of COVID on mental health, work with other partners to improve cross-topic working, and set up subgroups informed by local intelligence.

Partners noted the draft actions relating to each specific area of focus.

22. **Health and Wellbeing Strategy Update**

Heema presented the Health and Wellbeing Strategy update.

The draft strategy covered six priority areas:

- Give all children the best start in life and support emotional and physical health from birth to adulthood
- Promote mental health and improve the lives and health of people with mental-ill health (term TBC)
- Create opportunities for individual and community connections, enabling a sense of belonging and the awareness that someone cares
- Keep residents safe from COVID and other infectious diseases
- Improve years lived with good health and happiness
- Collaborate, plan and secure funds for local and national emerging new health and wellbeing priorities

The draft strategy had been discussed at stakeholder workshops through the summer, and the key outcomes, actions and indicators for each priority had been developed out of the workshops. The draft structure of the report had been proposed in consultation with the tastk and finish groups.

Partners noted that the strategy would be taken to members for their feedback. The complete draft strategy would be available for partners in mid-October, and would be published for public consultation in November 2021.

23. **Joint Strategic Needs Assessment Briefing**

Heema presented on the East Berkshire Joint Strategic Needs Assessment which was in development. The Health and Wellbeing Board was responsible for the JSNA, which identified future health and care needs and looked for any gaps in local provision.

The East Berkshire JSNA would cover three local authorities, with specific summaries for each local authority. An East Berkshire JSNA steering group would deliver the work, overseen by an East Berkshire Management Group who would feed into each Health and Wellbeing Board.

The JSNA would be produced in the form of an interactive website, and it was hoped that the website could be launched by the end of the year.

Board members welcomed the update on the JSNA website, and agreed that good data was critical.

24. **COVID update**

Stuart Lines updated Board members on COVID, influenza and RSV.

The Bracknell Forest COVID case rates were at 318 per 100,000 which was broadly in line with the South East and national levels. West Berkshire and Reading had slightly higher rates. Partners were reminded that COVID was still being spread in the community. The testing rate remained reasonably high in Bracknell Forest.

Stuart commented on the cost-benefit to schools being open, as although it would likely lead to increased COVID rates in the borough, the socialisation of children would be critical to their development. The JCVI had recommended against vaccinations for 12 to 15 year olds, but the final decision was due to be made by the Chief Medical Officer. The NHS were ready to implement such vaccinations if agreed.

The death rates were low, with no recent recorded COVID deaths in Bracknell Forest. The number of total deaths was in line with the expected rate in a normal year.

There had been a strong take-up of the vaccine in Bracknell Forest, and younger age groups were now taking up their vaccines. Public Health were working to combat any anti-vax messaging.

Public Health were encouraging the uptake of the seasonal flu vaccination, however it was noted that there was some uncertainty over the nature of the flu season due to relative isolation of the population during COVID. Stuart encouraged Board members to make sure healthcare and frontline staff were flu vaccinated, in preparation for winter. It was noted that while it would be useful to co-ordinate flu vaccines with COVID booster vaccinations, the logistics of this may prove challenging.

Stuart also drew partners' attention to the potential spike in RSV (Respiratory Syncytial Virus) amongst young children. Public Health colleagues were aware of the risk due to the sudden increase in social mixing, and were working with colleagues to model all eventualities. Public Health England had created infographics for parents to raise awareness of the virus.

In response to questions, the following points were noted:

- Councillor Birch reminded colleagues that he was the flu champion for the Council, and would be photographed getting his vaccine.

- Partners were encouraged to share any initiatives they had around vaccinations with the Board, so that other partners could promote.
- Public Health England was monitoring the RSV rates, and there was no need for local authorities to monitor this closely on a local level yet.

25. **Winter Planning**

Fiona Slevin-Brown reported on the CCG's winter planning process.

It was noted that health care colleagues were already under a lot of pressure, with high demand and low capacity due to a fatigued workforce. There remained around 80 patients in hospital with COVID across Wexham and Frimley Park hospitals.

Fiona highlighted the following winter planning considerations for partners to be aware of:

- Impact of pandemic and the associated backlog
- Workforce resilience and fatigue
- Conlicting and competing demands
- System recovery and progress
- COVID and flu vaccination programme
- Population health and health inequalities
- Learning, sharing and building on good practice

Fiona also explained the key risks and mitigations faced by the CCG.

In preparation for winter, Fiona recommended that all partners ensure they had clear co-ordinated messaging and communications and refreshed information on their websites.

26. **Frimley ICS update**

Fiona Slevin-Brown and Timothy Wheadon gave an update on the Frimley ICS boundary.

The Government had confirmed that the current Frimley ICS boundary would be retained which was welcome news. The government's whitepaper on ICS' gave further clarity to the scope of the ICS going forward, and the work done so far aligned with the framework included in the whitepaper.

Adverts for Chairs and the Chief Executive roles had gone out and applications were being received.

Partners were reminded that guidance on place-based partnerships was being released regularly from the government, and that the new ICS arrangements were likely to be an iterative process.

27. **Agency Updates**

There were no agency updates.

CHAIRMAN

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HEALTH AND WELLBEING BOARD
8 NOVEMBER 2021
4.15 - 5.12 PM

Bracknell Forest Council

Present:
Councillor Dale Birch (Chairman)
Fiona Slevin-Brown, Frimley Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard
Philip Bell, Involve
Sue Dorling, Berkshire Care Association
Emma Leatherbarrow, Healthwatch
Jonathan Picken, Bracknell Forest Safeguarding Board
Grainne Siggins, Bracknell Forest Council (People)
Timothy Wheadon, Bracknell Forest Council

Apologies for absence were received from:
Neil Bolton-Heaton
Alex Gild
Andrew Hunter
Sonia Johnson
Melanie O'Rourke
Heema Shukla
Fidelma Tinneny

Also Present:
Julia McKenzie, Bracknell Forest Council

28. **Declarations of Interest**

There were no declarations of interest.

29. **Exclusion of Public and Press**

RESOLVED that pursuant to Section 100A of the Local Government Act 1972, as amended, and having regard to the public interest, members of the public and press be excluded from the meeting for the consideration of the following item which involves the likely disclosure of exempt information under the following category of Schedule 12A of that Act:

(3) Information relating to the financial or business affairs of any particular person (including the authority holding the information)

30. **Better Care Fund sign off**

RESOLVED that:

1 The Board reviewed the draft Better Care Fund Plan and gave feedback prior to final submission.

2 Delegated authority be awarded to the Executive Director (People) for clearance of the final Bracknell Forest BCF Plan 2021/22 for submission to Better Care Support England by the deadline of 16 November 2021.

3 The final Bracknell Forest BCF Plan be included on the agenda for the 2 December 2021 Health and Wellbeing Board in order to formally approve the Plan.

CHAIRMAN

To: Health and Wellbeing Board
2 December 2021

Better Care Fund Plan 2021/22
Executive Director of People

1 Purpose of Report

1.1 The Health and Wellbeing Board decided, on 8 November 2021, to delegate authority to sign off the Bracknell Forest Better Care Fund Plan 2021/22 to the Executive Director of People, Bracknell Forest Council and the Managing Director for Bracknell Forest, Frimley CCG. This was to enable the timely submission of the Plan to the regional Better Care Manager in line with national planning requirements.

1.2 Before the submission on 16 November 2021, the Plan was signed off by officers outlined above, and by the Chief Executive, Bracknell Forest Council and the Accountable Officer, Frimley CCG, as well as the Health and Wellbeing Board Chair.

1.3 This report asks the Health and Wellbeing Board to formally approve the Better Care Fund Plan 2021/22.

2 Recommendation(s)

2.1 For the Board to approve the Better Care Fund Plan 2021/22 consistent of: Bracknell Forest Better Care Fund Narrative Plan 2021/22 (Annex 1) and Bracknell Forest Better Care Fund Planning Template 2021/22 (Annex 2).

3 Reasons for Recommendation(S)

3.1 To ensure compliance with the BCF Framework 2021/22 and associated submission and assurance process.

4 Alternative Options Considered

4.1 None

5 Supporting Information

5.1 The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework[1] for the implementation of the Better Care Fund (BCF) in 2021-22. The Framework forms part of the NHS mandate for 2021-22.

5.2 As set out in the BCF Policy Framework, the requirements of the planning process have been kept simple and focused on continuity in 2021-22, while enabling areas to agree plans for integrated care that support recovery from the pandemic and build on the closer working many systems developed to respond to it. Collection of BCF plans will recommence in 2021-22 and plans will be assured at regional level. Use of BCF mandatory funding streams (clinical commissioning group [CCG] minimum contribution, improved Better Care Fund [iBCF] grant and Disabled Facilities Grant [DFG]) must be jointly agreed by CCGs and local authorities to reflect local health and

[1] Better Care Fund policy framework: 2021 to 2022 - GOV.UK (www.gov.uk)

care priorities, with plans signed off by Health and Wellbeing Boards (HWBs).

5.3 For 2021-22, BCF plans consist of:

a) **a narrative plan** – see Annex 1. Key priorities for Bracknell Forest to note:

- Embedding Integrated Care Decision Making for early discharge planning and admission avoidance
- Integrated Care Teams delivering strengths-based and person-centred care
- Ageing Well and frailty support
- Mental health and wellbeing – reducing social isolation
- Joint commissioning and collaborative working
- Building capacity to access quality care and support in the community

b) **a completed BCF planning template** – see Annex 2. Key points to note:

- Total pooled budget of £14,873,334 with main spend areas:
  i. Reablement in a person's own home: £4,252,514 (28.6%)
  ii. Residential Placements: £3,526,910 (23.7%)
  iii. Enablers for Integration: £1,384,181 (9.3%)
  iv. Assistive Technologies and Equipment: £1,198,480 (8.1%)

5.4 Following the submission, a regional assurance and cross-calibration process is underway. Approval letters giving formal permission to spend are expected in mid - January 2022 with the Section 75 to be signed and in place by 31 January 2022.

6 Consultation and Other Considerations

Legal Advice

6.1 Legal advice was sought when planning the approach for agreeing Section 75 for 21/22.

Financial Advice

6.1 Annex 2 was developed with input from the Better Care Fund Finance Leads from the Council and the CCG.

Other Consultation Responses

6.2 The plan was shared for input with stakeholders from housing, social care, community engagement, public health, FHFT, the Place Committee and the Health and Wellbeing Board.

6.3 Consultation was also competed with Berkshire Better Care Fund leads and the regional Better Care Manager.

Equalities Impact Assessment

6.4 No EIA has been completed. However, consideration has been given to equalities and health inequalities in Annex 1.

Strategic Risk Management Issues

6.5 Following key strategic risks / mitigating actions are identified:

Risk	Mitigation
Plan not covering all aspects / not all stakeholders were able to contribute due to short turnaround	• Plan shared with key stakeholders for input in October / November • Recognition by BCF regional team re challenges of completing the plan in very short turnaround / during winter pressures • Engage more widely and more deeply with stakeholders to agree a joint vision, priorities and a strategic approach as part of the development of the Place Integration Strategy in 2022
Metrics estimated at incorrect levels due to unprecedented surge and winter pressures in 21/22, Covid19 outlier data for 20/21	• 'No jeopardy' approach by BCF regional team recognising challenges around forecasting • Targets for 21/22 have been developed to the best of our ability with input from NHS Frimley Health Foundation Trust (FHFT), adult social care teams, and other East Berkshire Better Care Fund leads.
Approval not given by regional BC team / DHSC	• Support available through BCF regional team utilised • Positive initial feedback from BCF regional team prior to final submission

Climate Change Implications

6.6 The recommendation in Section 2 above are expected to have no impact on emissions of CO_2. The reasons the Council believes that this will have no impact on emissions are that the BCF is an overarching plan / funding mechanism.

Background Papers

Annex 1 – Bracknell Forest BCF Narrative Plan 21/22
Annex 2 – Bracknell Forest BCF Planning template 21/22

Contact for further information
Julia McDonald, Commissioning Manager Integration, Bracknell Forest Council - 01344 354045, Julia.mcdonald@bracknell-forest.gov.uk

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Bracknell Forest Better Care Fund Narrative Plan 2021/2022

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1 Introduction

Bracknell Forest Health and Wellbeing Board has overseen the development of the Better Care Fund (BCF) Narrative Plan 2021/2022 and Planning Template.

Partners involved in preparing the plan included Frimley Clinical Commissioning Group (CCG), Bracknell Forest Council's (BFC) leads for Adult Social Care, Community Engagement, Housing, Public Health, Commissioning, Frimley Health Foundation Trust, Local Healthwatch and involve (the local support organisation for voluntary, community and faith groups).

The plan was shared directly with key stakeholders and shared for input and review at a Health and Wellbeing Board and Place Committee meetings. In addition, steer from the BCF regional team and other Better Care Fund leads was incorporated.

2 Executive Summary

Bracknell Forest Council and Frimley CCG are committed to person-centred integrated care, with health, social care, housing and other public services working together to provide better joined up care.

The following document reflects on key activities being delivered in 2021/2022 as well as areas of change and development which will contribute to improved outcomes in the challenging context of managing Covid-19 effects and demographic pressures on the system.

2.1 Our priorities for 2021/22

The Better Care Fund is an essential part of a wider integrated approach for Bracknell Forest. BFC and Frimley CCG work together to implement a collaborative commissioning style as guided by the LGA to ensure a home first approach. Our overarching aspiration is **to support people to remain living independently at home, avoiding unnecessary admissions to hospital and enabling a safe and timely discharge home after a hospital stay.**

The Better Care Fund supports our wider ambitions for integration while also focusing on key priorities, in particular:

- Embedding Integrated Care Decision Making for early discharge planning and admission avoidance
- Integrated Care Teams delivering strengths-based and person-centred care
- Ageing Well and frailty support
- Mental health and wellbeing – reducing social isolation
- Joint commissioning and collaborative working
- Building capacity to access quality care and support in the community

Our joint approach will contribute to:

- reducing avoidable admissions to hospitals
- reducing length of stay in acute settings
- increasing the proportion of people being discharged to their usual residence
- reducing permanent admissions to residential care homes
- continuing to increase the effectiveness of Reablement

This plan is a snapshot of the achievements and work in progress to drive integration. Our aim is to widen and deepen the work across our health, care and community sector partners to progress our wider vision and priorities through the development of an integration strategy in 2022.

2.2 Main changes since 2020/21

We as the Council, the CCG and system partners have a drive and commitment to ensure we are doing the best for residents and communities and seek to continue the preventative approach to integrated care. As in the previous year, 2021 – 2022 has seen the BCF planning approach affected by the pressures of Covid-19. Covid-19 has led to a backlog of non-Covid related care. This means that there are longer waiting lists amid on-going Covid-19 outbreaks ending in hospitalisation, people experiencing long Covid and some changed

health behaviour[1]. While integrated working was accelerated and enhanced during the Covid-19 pandemic, capacity issues are amplified across the system due to ongoing workforce shortages and recruitment difficulties.

This means that we have looked at using the BCF to increase capacity in the system and doing things differently to help alleviate pressures and improve outcomes. Our longer-term ambition is to review the wider system to ensure we use our resources effectively and have in place innovative evidence-led ways of working.

Furthermore, various national programmes and policies have given renewed impetus in 21/22 to focus strategically on integration and offered a structured way to work collaboratively across the system; for example: Integration White Paper, Ageing Well Programme, NHS Comprehensive Model of Personalised Care, NHS SE Community Transformation Programme (to launch early 2022).

[1] Health behaviour changes during COVID-19 and the potential consequences: A mini-review - PubMed (nih.gov)

3 Governance

The **Health and Wellbeing Board** signs off the Better Care Fund Plan.

The main governance hub for decisions and scrutiny around the BCF is the **Bracknell Forest Place Committee** which includes key stakeholders from health, social care, the council and community sector.

The Committee coordinates partnership working to minimise duplication, make best use of resources and maximise the cost effectiveness of services, by:

- Working closely with related boards and committees, including the Bracknell Forest Health and Wellbeing Board and relevant subcommittees of the board.
- Integrating the business action plans of partner organisations.
- Coordinating information sharing across partners
- Coordinating commissioning decisions to reflect the priorities identified by the partnership including the use of joint commissioning and pooled budgets where appropriate

The Better Care Fund is also being supported by the **BCF Delivery Group** which includes finance leads, operational leads from housing, social care the public health, as well as commissioners from the council and CCG. The Better Care Fund Delivery Group's purpose is to drive the delivery of the Better Care programme at Place by:

- Developing a shared view of the BCF in an operational, financial and commissioning context
- Monitoring BCF budget reports and maximising the efficient use of the BCF budget
- Shaping the development of the local BCF programme and managing its delivery
- Understanding and maintaining oversight of local BCF performance
- Managing and escalating system risks
- Identifying opportunities for improvement, development and further integration
- Making recommendations to strategic decision-makers

The **Better Care Fund lead** is responsible for reporting on BCF performance through quarterly dashboards and presenting delivery updates and business cases to the Place Committee. The lead also includes all relevant stakeholders in the development and implementation of the Better Care Fund programme.

Other key programmes such as Ageing Well, Winter Planning or the Heathlands Project are feeding into the Place Committee which provides a useful oversight of developments around integration. A review of the integrated governance structure in light of the new ICS / Place Partnership developments is under way, this will include strengthening the role of the Health and Wellbeing Board and strategic links to Housing.

4 Overall Approach to Integration

An integrated service delivery refers to the process of building connections between services in order to work together as one. This ensures that services are more comprehensive and cohesive, as well as more accessible and responsive to need. The King's Fund describes integration as approaches that seek to address fragmentation of care which should be centred around the needs of the service users.

4.1 Joint Priorities

The BF HWB seeks to continue to enhance integrated person-centred health, social care and housing services for our residents. We build on lessons learnt from the Covid-19 pandemic, consolidating and enhancing existing achievements, while also planning to strengthen our strategic vision and overall system integration. Our Joint Priorities this year are:

- Embedding Integrated Care Decision Making for early planning and admission avoidance
- Integrated Care Teams delivering strength based and person-centred care
- Ageing Well and Frailty support
- Mental health and wellbeing – reducing social isolation
- Joint Commissioning and collaborative working
- Building capacity to access quality care and support in the community

4.1.1 Integrated Care Decision Making

The ICDM programme, which provides an integrated care planning approach and personalised support to minimise emergency interventions for 'at risk' residents with frailty and complex conditions, has recently been reconfigured to align to the PCNs across the area. The Locality Access Point (LAP) provides a single, community-based, multi-disciplinary access point for residents with complex health and care needs. The Primary Care Networks link in with the ICDM Cluster meetings in identifying patients who have had multiple hospital admissions and/or are becoming increasingly frail, as well as patients who are at risk of developing these conditions (anticipatory care planning). The Cluster meetings bring together a variety of professionals across various disciplines in order to create a holistic care plan for a patient, rather than trying to deal with each condition separately.

4.1.2 Integrated Care Teams

Bracknell Forest Council and Berkshire Healthcare Foundation Trust have well established integrated teams – Community Mental Health teams (including a dedicated team for Older Adults, specialising in supporting people with Dementia), as well as teams supporting people with Learning Disabilities and Autism Spectrum Disorders. Integration here includes teams that are comprised of social workers and health professionals such as Occupational Therapists and Physiotherapists and ranges from Integrated management, shared caseloads and some shared use of data management systems. These joint teams provide a person-centred and seamless approach to care and support. In compliance with the Care Act 2014, the teams will also provide assistance and advice to people who are or would be self-funding their care.

4.1.3 Ageing Well and supporting people living with frailty

Ageing Well is a national programme being rolled out at Place to support adults to live healthier and longer lives and avoid premature admission to hospital or residential care.

Main elements of the programme include the delivery of an **Urgent Community Response (UCR):**

- 2 hr face-to-face crisis response in the home (to operate 8am-8pm, 7 days per week from 1/4/22)
- 2-day reablement to be delivered as part of the UCR
- All residents in England to have access to an urgent model of community health & care by March 2023, 7 days per week, 24/7
- **Anticipatory Care**-using a population health management approach, identify those at higher risk of hospital admission and agree personalised care plans of health, care and wellbeing support
- Further **work in care homes** to address inequalities and variation in access to care and reduce risk of hospital admission.

Frailty

- Population-level frailty identification and stratification can help plan for future health and social care demand whilst also targeting ways to help people age well. BF primary care is a pilot site for a **population health management approach**.
- A **hospital @ home pilot** ('virtual ward') is being introduced over the winter which delivers consultant-led hospital interventions in the home or care home. This will form part of the UCR from April 22. The service will use a Multi-Disciplinary Team (MDT) approach where patients are to be treated as though admitted to hospital but managed within their own homes. This is an adjunct or a 'complementary service' to other community-based service aiming to support patients to live in their own home. Referrals can be either 'admission avoidance' (Community/ GP) of an 'early supported discharge' (from acute hospital); depending on the source of referral & clinical pathway. Care should be designed to be patient & family centred in partnership with the team. The hospital @ home team members will include: Consultant Geriatrician, Advanced Nurse Practitioner, Senior Nurses: Band 6 & 5, Pharmacist, Health Care Assistants. The H@H team will be supported by Physio, OT, and will refer onwards as required to LA and social care services.

The Better Care Fund supports the roll out of the Ageing Well Programme by funding key joint teams and posts leading on the main elements, for example the Ageing Well Programme Manager post is funded from the Better Care Fund, as are Integrated Care Teams, the Locality Access Point and Care Home Quality posts. The Better Care Fund Lead and Ageing Well Programme Manager work closely to ensure the programmes and associated funding are aligned and complement each other.

4.1.4 Mental Health and Wellbeing

Bracknell Forest Council continues to develop the **wellbeing / social prescribing** offer to tackle social isolation and support wider determinants of health. This is to encourage and enable residents to get involved in local activities, clubs and groups to combat the social isolation that so many people experience, especially as a result of Covid-19 lockdown and restrictions.

The offer at Bracknell Forest includes Wellbeing Advisors, the Bracknell Forest Community Network, the Recovery College, as well as the social prescribing service provided by Public Health. These schemes work together to improve health outcomes and reduce healthcare costs. In order to maximise the efficient use of resources across the system, Bracknell Forest health and care partners' work includes:

- Review, service development and management of the Social Prescribing Service, including alignment across the system (e.g. PCNs, Community Connectors and Befriending scheme).
- Conduct asset mapping and gap analysis of the community and voluntary services. Gain a better understanding of the community assets which are needed and of most value to those in receipt of a social prescription.
- Develop an evaluation mechanism so that the local impact can be observed.

The Public Health team have also maintained and promoted the **'Warm Welcome' Programme** which lists a host of directories and self-help resources, including the "Community Map" of over 500 local groups that serves as a key resource for social prescribing.

A further offer rolled out in 2021 across East Berkshire includes the **Mental Health Integrated Care Service** (MHICS) to support those with serious mental illness in the community, aligned to Bracknell Forest Community network.

The BCF specifically supports schemes around Mental Health including the Bracknell Forest Community Network, a short-term **CAMHS support** offer and social care **schemes** that recognise the interplay of the 'toxic trio' and holistic support needs of families (Family Safeguarding Model, Homestart).

4.1.5 Joint commissioning and collaborative working

- Ongoing joint work on understanding and identifying needs and gaps at Place; for example, joint development of **Health and Wellbeing Strategy** with co-produced priorities (due end 2021)
- **Joint Working Programme**: Review governance, map joint commissioning and develop joint integration strategy in 2022
- Other key joint projects: **Heathlands** (integrated care facility offering dementia nursing and intermediate care), **Blue Mountain** (community and health centre), CCG and Council community Engagement leads to develop community resilience, **Ageing Well** (health & ASC leading on workstreams around urgent care, enhanced health in care homes and anticipatory care planning)
- **Wellbeing / social prescribing partnerships** to align offer and provide joint up support to those with wider needs
- **Joint Winter Planning** – identifying gaps and possible solutions for admission avoidance, community resilience and discharge and flow. Raising awareness across the system of existing / new schemes that can support residents and to access those during the winter. Coordinating additional funding and resources. Winter Pressure funded delivery models will be considered as pilots for new ways of working / added capacity to consider for future Better Care Funding. *See attached Winter bid summary developed as a system.*

- **Ongoing dialogue** with health and care partners to plan and deliver improvements (e.g. MH Delivery Group, East Berks Commissioning Group, Children's Specialist Support Teams / BHFT, refreshed Learning Disability Partnership Board)
- Realising the benefits of the **Council commissioning** team established 2019 and the Place CCG team (close working relationships, capacity to deliver joint commissioning projects); establishing roles and teams spanning health and care to operationally and strategically drive integration (Programme Support funded by BCF).

  It is our intention to review the wider D2A and ICS pathways as system partners post Covid-19 in 2022/23.

4.1.6 Building Capacity

- We are cognisant of pressures in system and aim to generate capacity to tackle demand pressures and right skill teams (e.g. Enhanced Intermediate Care Service); promoting 'self-help' / self-management through improved use of assistive technology.
- **Community resilience and asset-based approach** is being developed, this includes maximising the community sector's potential. For example, we are reviewing contracts / procuring new services through the commissioning team's work, setting up NHS Charities programmes. Covid-19 specific resources are to be continued for vulnerable residents (e.g. Community Hub).
- The Frimley ICS Strategy, Creating Healthier Communities, is focused on improving the health and wellbeing of the people who live and work here. The council and partners are developing a **community deal approach** to working in partnership with communities to increase self-reliance, focus on prevention, improve health and wellbeing and reduce health inequalities.

4.2 BFC Schemes supporting integration approach

Schemes in the BCF contribute to integration by enhancing joint working, driving the improvement of joint health and care outcomes for residents and developing the capacity and quality of the system to manage increasingly challenging pressures across the system.

Main changes since the previous 2020-21 BCF Plan include:

- Focusing on generating capacity (piloting additional staff to relieve pressure from therapists in our Intermediate Care Service)
- Piloting a new Assessment Suite to ensure people get the right assistive technology / equipment to live as independently and as safely as possible in their own homes
- Piloting a telehealth scheme for people with heart failure to reduce the need to attend ambulant appointments and increase confidence and independence for patients
- Mobilising a new integrated care facility (Heathlands) to offer intermediate care services and dementia nursing care for Bracknell Forest residents
- Funding the Family Safeguarding Model to ensure benefits are fully realised from joined-up support for families in need (domestic abuse, substance misuse, mental health)
- Reviews to ensure efficient use of BCF monies (e.g. de-commissioning of free basic toenail cutting service to refocus funds)
- Developing a joint Health and Wellbeing Strategy for Bracknell Forest that outlines key priorities for our population
- Reprieving drive for strategic integration (joint working programme between the council and the CCG, view to develop a joint integration strategy by mid-2022)

- Embedding of the Ageing Well Programme to deliver joint pathways for urgent care, Enhanced Health in Care Homes and Anticipatory Care
- Focusing on mental health joint work and planning (e.g. roll out of MHICS, wellbeing and social prescriber collaboration)

5 Supporting Discharge

The BCF funds activity to support safe, timely and effective discharges by directly funding joint teams and infrastructure to support discharge and flow (e.g. MDTs, LAPs, Intermediate Care Services, Community Equipment), and by generating capacity in the community to allow for patients to feel confident, safe and supported following their discharges. The risk pool fund also allows for short-term emergency funding so patients can be moved from acute settings prior to long-term funding being agreed.

Our approach to improving outcomes for people being discharged includes:

5.1 Intermediate Care (Heathlands & Enhanced Intermediate Care Service)

- The **joint Bracknell Intermediate Care team** operates using a shift rota with staff available between 8am and 8pm Monday to Friday as well as therapy support over the weekend; to respond to emergencies in the community or to avoid admission to an acute hospital. This multi-disciplinary, joint assessment approach is intended to allow decisions to be made earlier and the right professionals to be involved from the beginning of a person's journey through reablement, making the process smoother and more effective as a whole.
- Introduction of **blended roles** to ensure people's skills are best matched to the task at hand and a better utilisation of lower banded roles. For example, the BCF is funding 3 additional assistant roles in the EICS team to ensure that OTs and PTs can be freed up in the Falls Service (such as home hazard assessments). This allows for a more therapeutic approach and a more efficient delivery to patients minimising waits. We are developing this approach in other teams and services.
- **Heathlands** intermediate care services has provided the opportunity to take a fresh look at how we deliver integrated intermediate care. The aim is to have no boundaries between bed-based and home-based intermediate care.
- The longer-term ambition is to develop a fully **integrated Intermediate Care workforce** working across Heathlands and community settings. Underpinned by an innovative approach to collaborative recruitment, joint working and fully integrated Bracknell Forest intermediate care workforce. Provides the opportunity to look at innovative ways of overcoming workforce challenges, creating new roles and developing the skills needed to keep our BF population healthier at home.
- This is well aligned to the **Ageing Well programme** in delivering community transformation through improved access to reablement, reducing LoS, improving discharges to usual place of residence and reducing risk of readmission.

5.2 Locality Access Point (LAP)

- Building on the success during Covid-19, the LAP continues to support the assessment and coordination of care for the most complex and frail adults. The LAP will play a pivotal role in the delivery of the Ageing Well 2-day reablement response.
- A golden thread across integration will be personalisation, ensuring what is important to the person is captured, and used to empower individuals to make informed decisions.
- The model includes a Community Matron to link efficiently between community health and acutes.

5.3 Joint working

- **Hospital discharge teams** aim to reduce avoidable delays in acute environment and support a safe and timely return into a community-based environment with personalised support programmes to meet individual needs. This includes huddles / **IRIS meetings** to discuss patients for discharge and plan for follow-on care and support
- We keep building on the continued approach of **Trusted Assessments** – especially as social workers / care homes were unable to access acute wards during Covid-19.
- **7-day working** across Enhanced ICS and Social Workers is being developed. This includes working with Commissioning and Adult Social Care providers to ensure placements / care packages can be started on weekends if necessary.

5.4 Community based support

The Better Care Fund supports the ambition that people with long term conditions or those that have recently been discharged from hospital receive the care in the community to gain independence and avoid (re) admissions. This includes:

- Hospital to Home (Red Cross) - Supporting people discharged from hospitals to ensure they are settled at home. Currently reviewing offer and exploring option to enhance service to 7 days a week.
- Carer Support, Stroke Support funding (see below) to ensure patients and families feel supported and have the right information and advice to bets manage their condition.
- Integrated respiratory clinic (AIRS) and developing the telehealth pilot for people with heart failure to keep patients out of hospital.
- Housing adaptations, assistive technology and equipment to promote independent living.

Example: BCF Scheme – Stroke Support

The time following a stroke can be an anxious and often confusing time for stroke survivors and their families to navigate their way through local services. For example, nationally only half of stroke survivors identified with speech and language needs receive the service they require. 44% of stroke survivors suffer from severe anxiety due to impaired communication. The National Clinical Guideline for Stroke published in 2016 recommends a structured programme of support and reviews for all stroke survivors at six months and twelve months; this has been commissioned jointly across East Berkshire and is delivered by the Stroke Association, funded by the Better Care Fund.

Since the launch of the service in 2020 there has been a concerted effort to improve partner relationships to increase the throughput and outcomes; links have been established with local health care providers such as Wycombe Hyper Acute Stroke Unit, Early Supported Discharge (ESD) Unit at Wexham, Frimley Park Hospital and Royal Berkshire Hospital. Starting in the hospital, via remote MDT participation the provider is able to support discharge planning and has found that their involvement at this stage has helped the families of stroke survivors considerably.

The ability to provide in-reach support means many users of the service are assessed earlier and are supported successfully in the transition from hospital to home.

At the end of Q 21/22, the service had 188 active clients and self-reported outcomes included services users 'feeling re-assured', 'enabled to self-manage stroke and its effects', as well as ''increased confidence to care' for families.

5.5 Personalisation

- Frimley ICS is working with partners at system and place recognising the existing work and reviewing the six components of the NHS comprehensive model for personalised care (Shared decision making, Personalised care and support planning, Enabling choice, including legal rights to choose, Social prescribing and community-based support, Supported self-management and Personal health budgets) to identify ways to integrate health, social care, public health around the person recognising the contribution of communities and voluntary and community sector to support people and help build resilience.

5.6 Capacity in the Provider Market

- Commissioners are working with care homes and home care providers through the challenges of the pandemic to ensure **sustainability** (regular forums and ongoing communications).
- We are also refreshing the home care framework in 21/22 to **drive improvement and quality of provision**.
- Additional capacity in care homes and a programme focussing on care home quality are being delivered through the implementation of the **Enhanced Health in Care Homes** framework
- Challenges re workforce shortages persist; different ways to address this as a system and at place are being developed. For example, commissioners are delivering comms and **recruitment campaigns** using Berkshire Opportunities (Health and Care Sector| Berkshire Opportunities) as the main recruitment portal.
- Commissioners are working in **collaboration across East Berkshire** to support the market in a consistent way and join resources to address common issues.

6 Disabled Facilities Grant (DFG) and wider services

Bracknell Forest Council's Housing service is committed to supporting older and disabled people to remain living independently in their own homes for as long as safely possible. Following workstreams contribute to the integration between housing and health and social care partners:

6.1 Housing Assistance Policy

The Council is developing a **new Housing Assistance Policy** which will to offer wider financial support to older and disabled people to enable them to live independently at home for as long as possible.

The new policy framework enables mor**e flexible use of the Disabled Facilities Grant budget**. The mandatory Disabled Facilities Grant (DFG) is seen as one of the main support packages that eligible older people and people with long-term health conditions are able to access to support them to remain living independently in the community.

The Policy utilises the powers available to the Council to extend the support it offers using the DFG funding to ensure effective use of funds and that support is available to as many people as possible.

The policy includes support for people who require more extensive works than the current mandatory DFG limit allows, through new discretionary 'top-up' funding, potential funding support for those people whose means test result would previously have excluded them from receiving support, and support for those whose needs can be more appropriately met by moving home. There are also a range of smaller, bespoke grants to support specific aims such as enabling faster hospital discharge and supporting people with dementia.

6.2 Strategy development

The service is also about to consult on a **new homelessness strategy**. Effective partnership working lies at the heart of all successful homelessness prevention services and includes the involvement of a wide range of public services, including health and criminal justice agencies, housing associations and voluntary sector organisations.

Partnership working overall has been improving. With some partners there is strong joint working, for example with Children's Services and with several partner agencies involved in work on ending rough sleeping. The Covid-19 pandemic has acted as a catalyst to further improve partnership working in some instances, for example with the Probation Service and some health services. There are challenges in accessing local mental health services for homeless people, including rough sleepers, especially for those with a dual diagnosis. This strategy sets out a range of actions including

- building on and **improving joint working** between mental health agencies and the Housing Options Service and Rough Sleeping Team.
- **reviewing single homelessness accommodation pathways** and protocols and specifically, working with the Probation Service and the Berkshire NHS Foundation Trust to improve referral pathways for people leaving either custody or hospital or where mental health is an issue.

Over the coming year the Housing team will also be focusing on developing a **new over-arching Housing Strategy.** The Commissioning Team will be working closely with social care services and housing to develop a care and accommodation strategy for people with support needs.

6.3 Home adaptions for disabled people

Home adaptions for disabled people are an integral part of meeting the health, housing, social care and educational needs of disabled people and their carers. Accordingly, the new policy framework will help to deliver adaptations that not only increase the level of independence for the disabled person but also provide support for carers.

7 Equality and Health Inequalities

7.1 Context

- Bracknell Forest has a population of approximately 123,000 people. Bracknell Forest has a smaller proportion of over 60s compared to the average for the South East and England. This is estimated at just under 25,000 people.
- There is a similar profile of ethnicities in Bracknell Forest compared to the South East, with 91% of the population from a white ethnicity. It's estimated there are just over 10,000 ethnic minority residents in the borough. There are a notably higher proportion of 'other Asian' residents than other areas of the South East and England, this is in part due to a large community of Nepali residents linked to the Gurkha Company Sittang regiment based at the Royal Military Academy Sandhurst.
- In the 2011 census, approximately 7% of households in the borough were single parents with dependent children and a further 28% are one person households. If these proportions have remained similar, this equates to around 17,500 houses with one adult. The impact of the multiple periods of lockdown may be greater for these individuals due to isolation and the knock-on effects for health and wellbeing.
- The level of deprivation is relatively low across the borough with just under half of neighbourhoods in the least deprived 20% of the country. However, there are a further 16% of neighbourhoods considered more deprived than the national average.

7.2 Changes since 2020/21

The impact of the pandemic and associated restrictions has been significant for many groups in Bracknell Forest. A Community Impact Assessment[2] identified the following challenges in Bracknell Forest:

- Unemployment remains high
- Worsening mental health
- Slow recovery for community coal and leaning groups
- Disruption to children's education and support

More specifically, it is recognised that Covid-19 has heightened existing health inequalities, for example for carers, BAME communities, low-income families and older people:

7.2.1 Carers

Evidence suggests that carers have experienced inequalities prior to the pandemic, for example, a 2018 GP Patient survey[3] in England showed 63% of carers reported having a long-term condition, disability or illness themselves, compared to 51% of non-carers. With disrupted access to heath and care support for the cared-fors and carers themselves during the pandemic, these inequalities are expected to have worsened. The ONS states that a larger proportion of unpaid carers than non-carers were worried about the effects that the coronavirus pandemic was having on their life (63% compared with 56%).[4]

[2] Community Impact Profile (bracknell-forest.gov.uk)
[3] What does the GP Patient Survey tell us about carers? - Carers UK
[4] Coronavirus and the social impacts on unpaid carers in Great Britain - Office for National Statistics (ons.gov.uk)

7.2.2 Black, Asian and Minority Ethnic Groups (BAME)

Public Health England's report *Beyond the data: Understanding the impact of COVID-19 on BAME groups* highlighted the rate of infection and mortality as being much higher for those from particular BAME communities than for their non-BAME counterparts.[5]
Prior to the onset of the COVID-19 pandemic, there had been evidence demonstrating poorer health outcomes and experiences for ethnic minority groups compared with the overall population.[2] Examples include (but are not limited to) poor access to services and higher rates of both mental health illness and metabolic illnesses such as type 2 diabetes and cardiovascular disease.[3]

7.2.3 Low-income families

Covid19 has also affected families in Bracknell Forest with growing financial pressures impacting hundreds of households in the borough. The indicators show there is likely to be complexity in the financial situation of residents, with combined financial pressures of housing, income and childcare. [6]

7.2.4 Older People

Older adults are more at risk of mortality if they are infected by coronavirus, although the progress of the vaccination programme significantly limits this. They are also more likely to have wider health conditions where treatments and check-ups may have been postponed during parts of the lockdown restrictions, having negative impacts on health. This group are more likely to have shielded, increasing their risk of isolation and negative mental health impacts. This isolation can also cause further deterioration for conditions such as dementia. Older adults are also more likely to be affected by digital deprivation in skills, confidence and access to online and virtual communication methods.[7]

7.3 Measures at Bracknell Forest to address this

- Utilising NHS Reach Out project to improve access to information and services for local Nepalese and other **BAME groups** this includes:
    - Setting up an advisory group bringing in CCG, LA, Public Health and BAME Community representatives.
    - Supporting the digital Celebrating Culture event delivery, co-produced with young activists from the Bracknell against racism linking PH messaging to different cultural, faith and differences spiritual perspectives
    - Supporting consultation work with the Health and Wellbeing Board strategy workshops (gaining further insights)
    - Supporting Covid/testing joint work with local diverse community groups to gain community insight
    - Setting up plans to promote key Health messages linking with the Diversity Calendar (e.g. Flu messaging in the Muslim Communities
    - Gaining insight of the attitude shifts on Immunisation/Covid/ vaccination from the community leads
    - Working closely with BF Communications and Marketing team to develop PH messaging
- **Carer Support** services being funded out of the BCF to provide information, advice and guidance as well as short term support to unpaid carers. Health, social care and

[5] Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities (publishing.service.gov.uk)
[6] Community Impact Profile (bracknell-forest.gov.uk)
[7] Community Impact Profile (bracknell-forest.gov.uk)

community sector partners working jointly to support carers (e.g. dementia cafe, young carer strategy development). A refreshed **young carer strategy** is also being developed.

- New spend in the 2021/2022 BCF plan includes Families Safeguarding Model providing additional support for **vulnerable families**
- Homestart supporting **families with young children** that need extra support is funded through the BCF
- **Advocacy support** funded by BCF, giving a person support to have their voice heard. It is a service aimed at helping people understand their rights and express their views when planning / receiving health and care services.
- NHS Charities - **Older People** Consortium to ensure older people are engaged digitally and can access information, advice and support through their community groups
- Community Hub work to support **vulnerable residents** / those that have been shielding
- Healthwatch What Matters Most project to understand inequalities in **accessing health and care services**
- **Improving access** to blood pressure monitoring and other aspects of population health. In Bracknell, there are four health pods, each with three types of screening devices at the Waitrose site (Atrial fibrillation, BMI, blood pressure). The screening is opportunistic. The process is that the screening result details are entered onto a patient information leaflet with a tear off slip which then gets returned to our admin hub. The details are checked for any red flags and then entered onto patient's medical records. Any red flags are raised directly with the patient's practice.

Public Health also have a range of initiatives encouraging people to manage their own health and wellbeing particularly around preventative measures; whether that be mitigating the impact of an existing condition or preventing it from occurring in the first place. Particular focus has been placed on reducing the causes of health inequalities across social and population groups as these represent thousands of unnecessary premature deaths every year. Some of the key initiatives are:

- **Smoking cessation** support offered via a telephone support service – Since smoking is more common in more deprived populations, effective preventative support such as that offered through the service also has the potential to narrow smoking-related health inequalities, particularly by preventing smoking related illnesses such as COPD, emphysema and chronic bronchitis that during the colder months can also contribute to winter pressures.
- **Flu campaigns** – promoting the uptake of the flu vaccination both in at-risk groups (children, over 65s etc.) as well as staff providing care to people in those groups (e.g. residential and nursing homes). Flu can have a dramatic impact on NHS pressures, particularly over winter and with ongoing Covid-19 infections.
- **Covid-19** – test and trace work continues; supporting the NHS vaccination programme by messaging residents and providing school nurse support.
- **Fuel poverty** – working with the Sustainable Energy Officer to promote ways of keeping homes warmer and more energy efficient, as well as finding a cheaper energy provider.
- **Drug and Alcohol** – newly re-commissioned Recovery College to support those with substance misuse and mental health issues.

- **Weight management** for adults – face-to-face and virtual support for residents with BMI of 30kg/m2 or above, or 27kg/m2 if they are from an ethnic minority group. This is a 12-week course and will support residents to achieve a healthy weight through a combination of healthy eating, physical activity, behaviour change and peer support.
- **Physical Activity Strategy** and Activity Plan development – looking to draft a strategy by the end of 2021 to shape the physical activity programme to support our residents stay more active. Developing the launch of schemes such as Healthy Walks and ways to support care home residents.
- **Falls Prevention** – planning for needs assessment to start in winter 21/22.
- **Dementia directory** – online and printed versions for residents with dementia and their carers and primary care partners signposting to NHS and community support.

While the Better Care Fund directly supports some of the above schemes, all measures are delivered in a collaborative whole system approach to ensure available funding streams and resources are used as efficiently and system intelligence is shared widely; leads of NHS Charities, Public Health and the community sector are working collaboratively to ensure an integrated approach to tackling health inequalities.

8 Metrics – Supporting Information

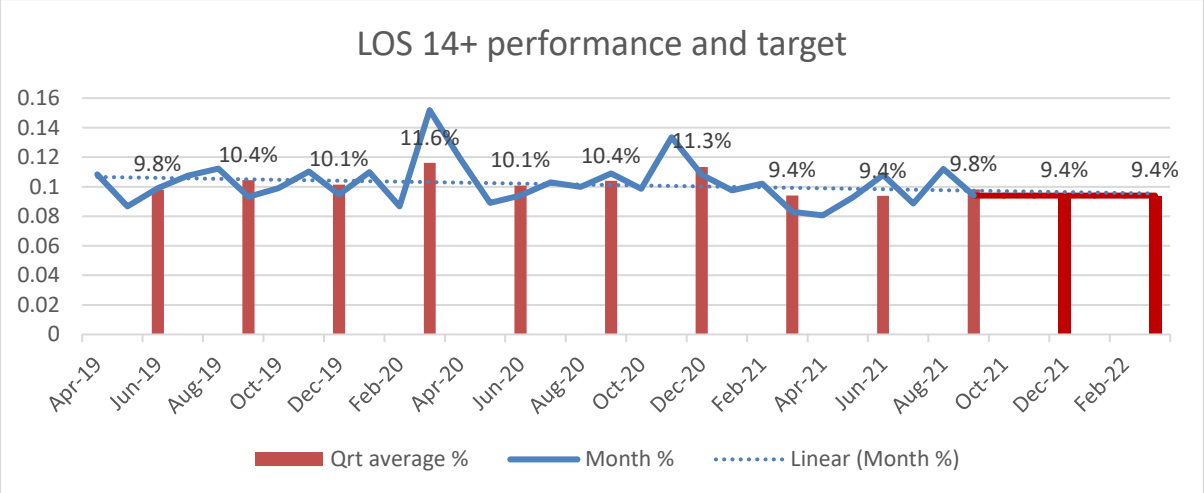
Developing the targets for Q3 and Q4 21/22 has been challenging, as 20/21 data was not available or, when available, presented an extreme outlier due to Covid-19. The system has changed since Covid-19 in that demand pressures and levels of acuity for patients have increased in 21/22, however so have efforts to improve discharge, flow and capacity.

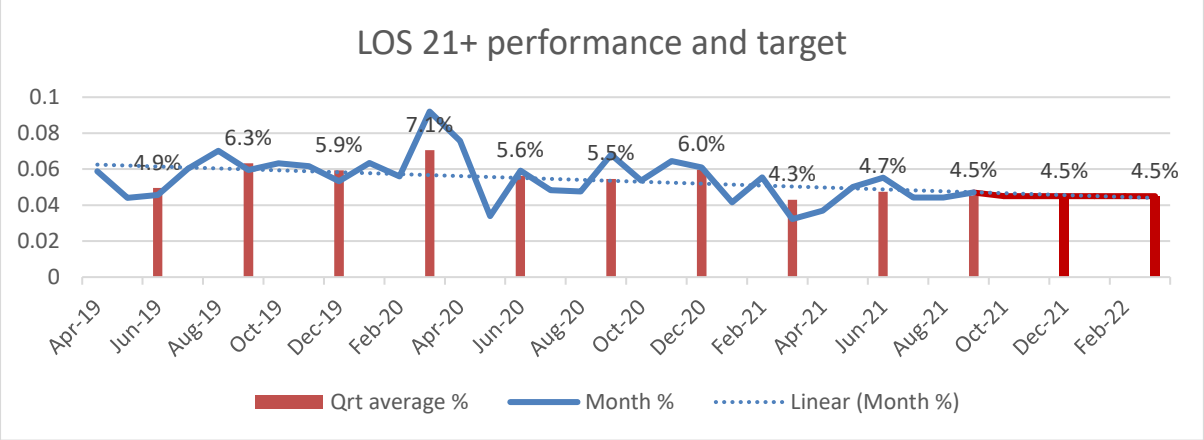
Lessons learnt from the target development process with Frimley Health Foundation Trust and other partners will be applied in the 22/23 planning round to ensure consistent development of regional targets and ongoing performance monitoring. Further we will be able to review the actual performance across the system for Q3 and Q4 21/22 and better understand the impact of winter pressure funded schemes.

Outline of rationale and assumptions are included in the planning template – see below for supporting graphs and tables.

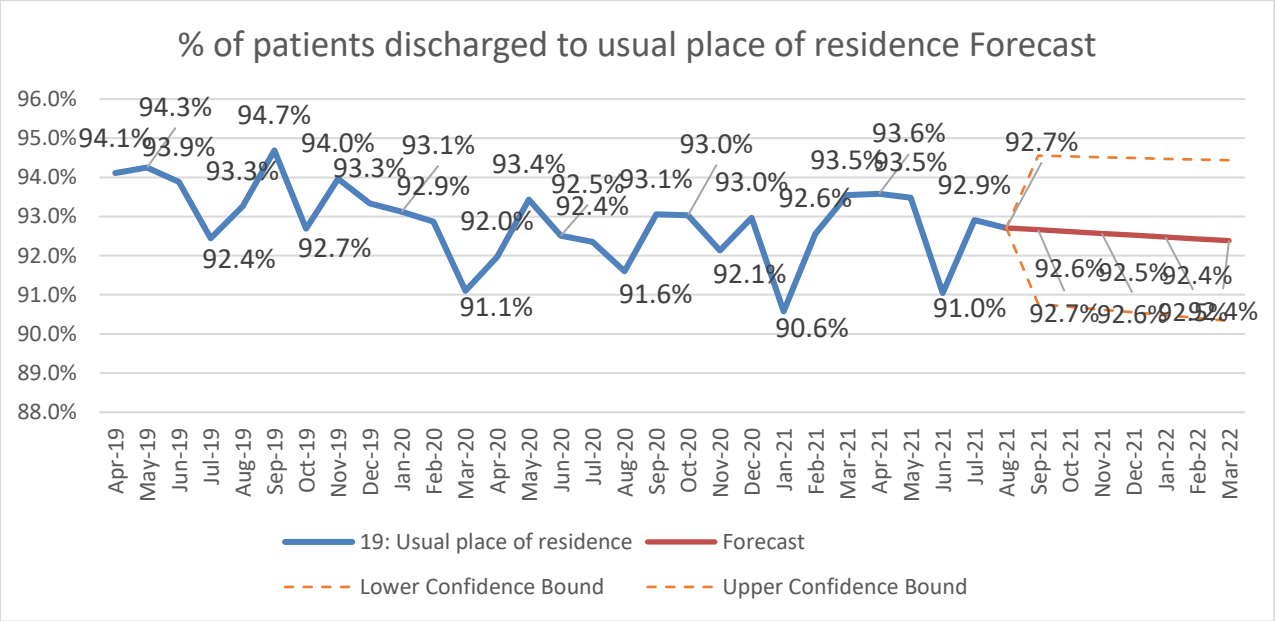
8.2 Length of Stay

	National average Q3 19/20 and 20/21	Q3 19/20 and 20/21 average BF	Q3 21/22 target	National average Q4 19/20 and 20/21	Q4 19/20 and 20/21 average BF	Q4 21/22 target
14+ LOS	11.0%	10.7%	**9.4%**	12.2%	10.5%	**9.4%**
21+ LOS	5.8%	6.0%	**4.5%**	6.6%	5.7%	**4.5%**



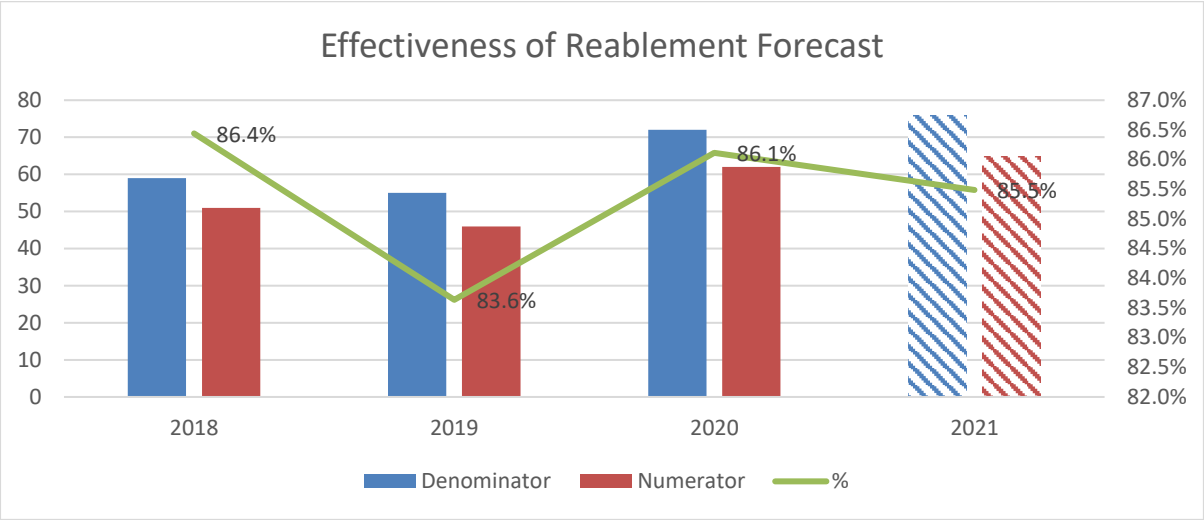


8.3. Discharge to normal place of residence



8.5. Effectiveness of reablement

	Previous years' actuals			Forecast
	2018/19	2019/20	2020/21	2021/22
Annual %	86.4%	83.6%	86.1%	85.5%
Numerator	51	46	62	65
Denominator	59	55	72	76


Effectiveness of Reablement Forecast
80
70
60
50
40
30
20
10
0
87.0%
86.5%
86.0%
85.5%
85.0%
84.5%
84.0%
83.5%
83.0%
82.5%
82.0%
86.4%
83.6%
86.1%
85.5%
2018
2019
2020
2021
Denominator
Numerator
%

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

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- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Bracknell Forest
Completed by:	Julia McDonald
E-mail:	julia.mcdonald@bracknell-forest.gov.uk
Contact number:	01344 45050

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Executive Director People
Name:	Grainne Siggins

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 02/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Executive Member for	Dale	Birch	dale.birch@bracknell-forest.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Fiona	Edwards	fiona.edwards18@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Fiona	Slevin-Brown	f.slevin-brown@nhs.net
	Local Authority Chief Executive		Timothy	Wheadon	Timothy.Wheadon@bracknell-forest.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Grainne	Siggins	grainne.siggins@bracknell-forest.gov.uk
	Better Care Fund Lead Official		Julia	McDonald	julia.mcdonald@bracknell-forest.gov.uk
	LA Section 151 Officer		Julian	McGowan	julian.mcgowan@bracknell-forest.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Bracknell Forest

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£968,392	£968,392	£0
Minimum CCG Contribution	£7,574,813	£7,574,813	£0
iBCF	£1,480,053	£1,480,053	£0
Additional LA Contribution	£4,850,076	£4,850,076	£0
Additional CCG Contribution	£0	£0	£0
Total	**£14,873,334**	**£14,873,334**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£2,237,809
Planned spend	£2,249,262

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£1,907,604
Planned spend	£5,288,331

Scheme Types

Assistive Technologies and Equipment	£1,198,480	(8.1%)
Care Act Implementation Related Duties	£205,000	(1.4%)
Carers Services	£0	(0.0%)
Community Based Schemes	£405,140	(2.7%)
DFG Related Schemes	£968,392	(6.5%)
Enablers for Integration	£1,384,181	(9.3%)
High Impact Change Model for Managing Transfer of	£134,680	(0.9%)
Home Care or Domiciliary Care	£225,000	(1.5%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£577,280	(3.9%)
Bed based intermediate Care Services	£137,456	(0.9%)
Reablement in a persons own home	£4,252,514	(28.6%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£231,346	(1.6%)
Prevention / Early Intervention	£1,020,950	(6.9%)
Residential Placements	£3,526,910	(23.7%)
Other	£606,005	(4.1%)
Total	**£14,873,334**	

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	no data available	630.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SLIS data - available on the Better Care Exchange)	LOS 14+	9.4%	9.4%
	LOS 21+	4.5%	4.5%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SLIS data - available on the Better Care Exchange)	0.0%	92.5%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	473	579

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.5%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Bracknell Forest

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Bracknell Forest	£968,392
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£968,392**

iBCF Contribution	Contribution
Bracknell Forest	£1,480,053
Total iBCF Contribution	**£1,480,053**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Bracknell Forest	£3,029,076	Prior year BCF underspends
Bracknell Forest	£1,821,000	Contibution to the intermediate care team
Total Additional Local Authority Contribution	**£4,850,076**	

CCG Minimum Contribution	Contribution
NHS East Berkshire CCG	£7,574,813
Total Minimum CCG Contribution	**£7,574,813**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£7,574,813**	

	2021-22
Total BCF Pooled Budget	**£14,873,334**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Bracknell Forest

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£968,392	£968,392	£0
Minimum CCG Contribution	£7,574,813	£7,574,813	£0
iBCF	£1,480,053	£1,480,053	£0
Additional LA Contribution	£4,850,076	£4,850,076	£0
Additional CCG Contribution	£0	£0	£0
Total	**£14,873,334**	**£14,873,334**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£2,237,809	£2,249,262	£0
Adult Social Care services spend from the minimum CCG allocations	£1,907,604	£5,288,331	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

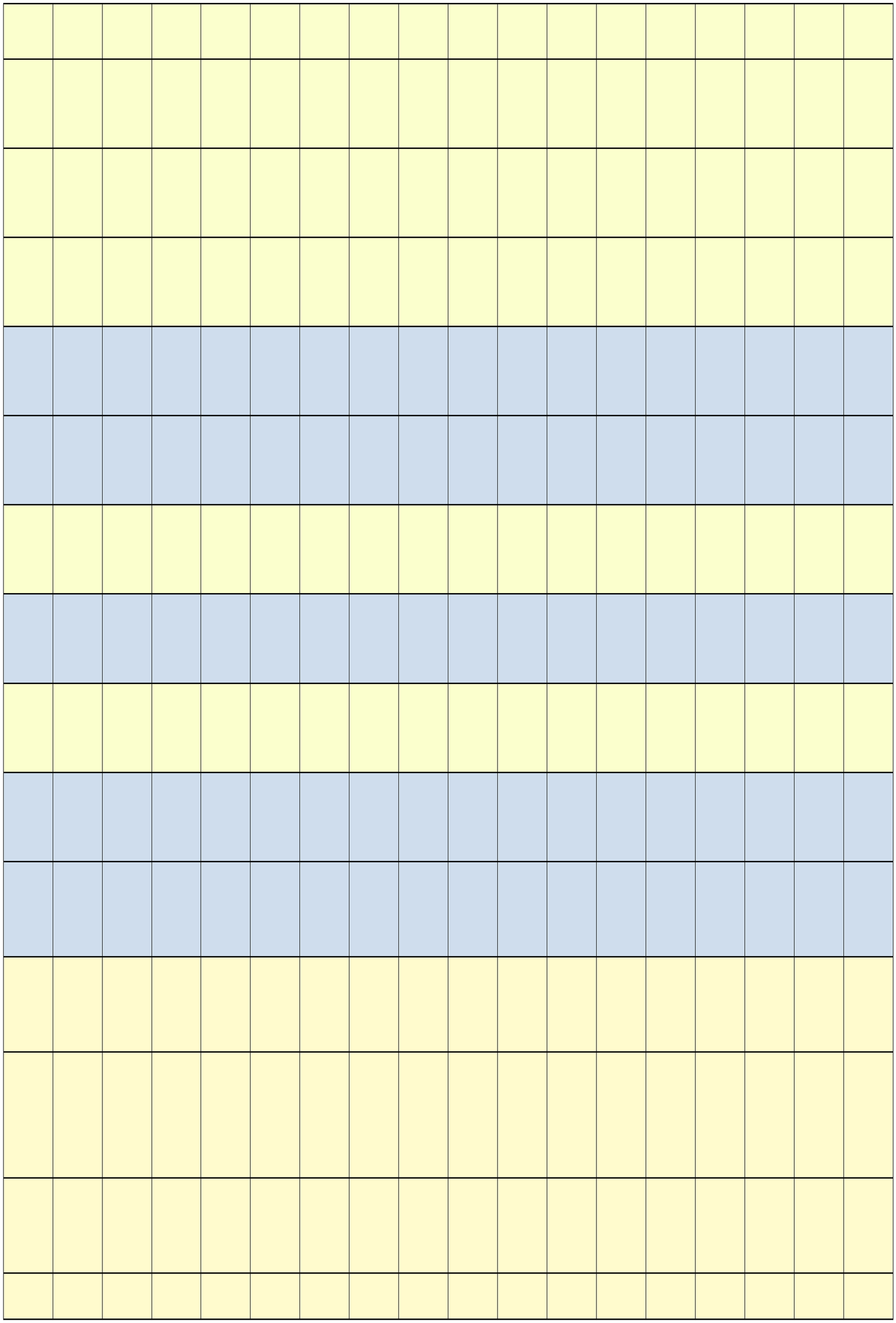
Sheet complete

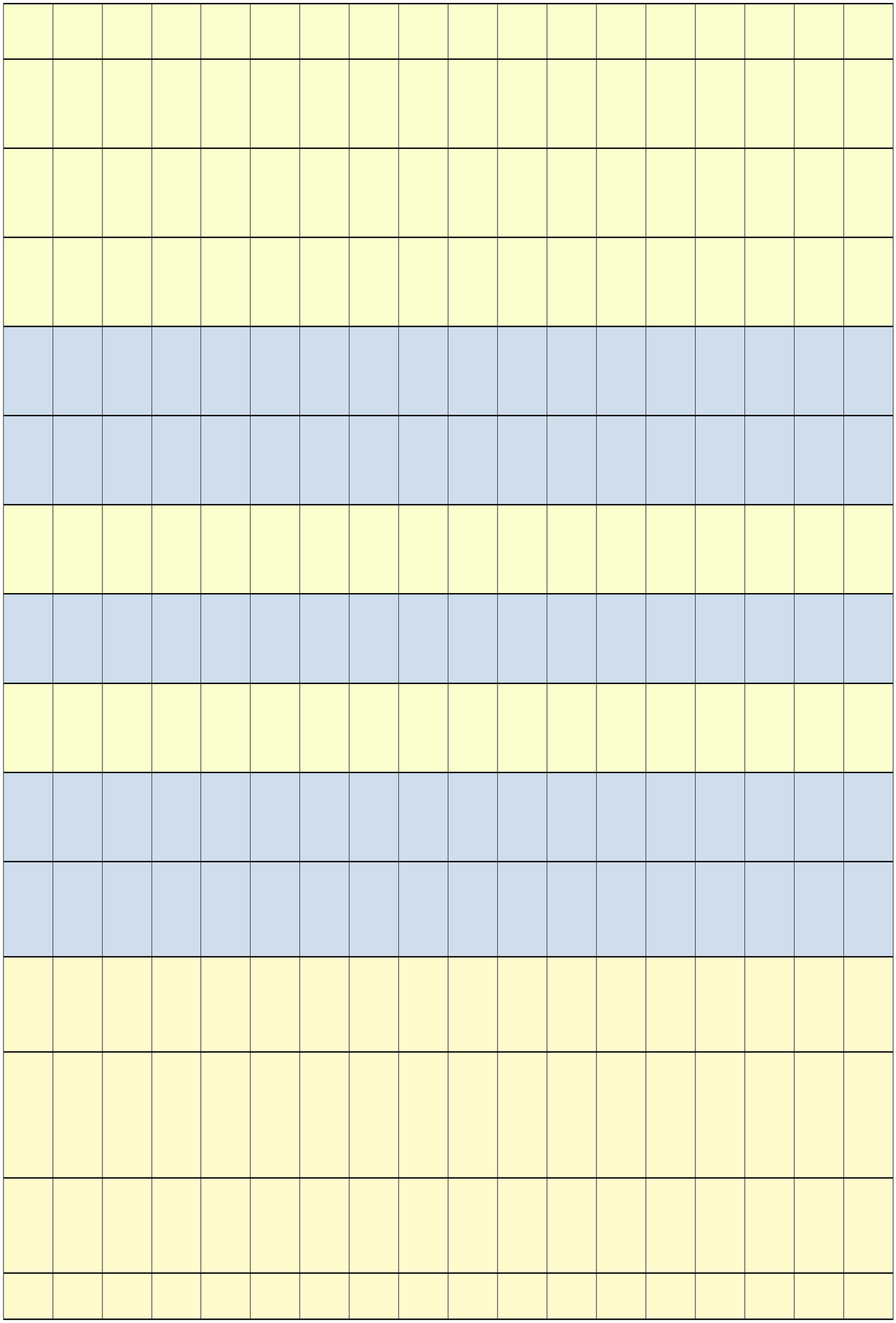
						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Extension of integrated multi-disciplinary care teams	Integrated care team - expansion of clusters (CCG costs): Community Matron post, case co-ordinator post, MH nurse post	Enablers for Integration	Integrated models of provision		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£217,586	Existing
2	Falles prevention advice service and footcare	Basic Toenail cutting - ended in July 2021	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£10,166	Existing
3	Falls Tier 3	Rapid Assessment Community Clinic	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£167,280	Existing
4	Integrated Respiratory Servive	AIRS clinic for provision of home oxygen and pulmonary	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£195,840	Existing
5	Transformation Schemes	Primary and Community Care Transformation	Enablers for Integration	Integrated models of provision		Other	Various	CCG			CCG	Additional LA Contribution	£819,275	Existing

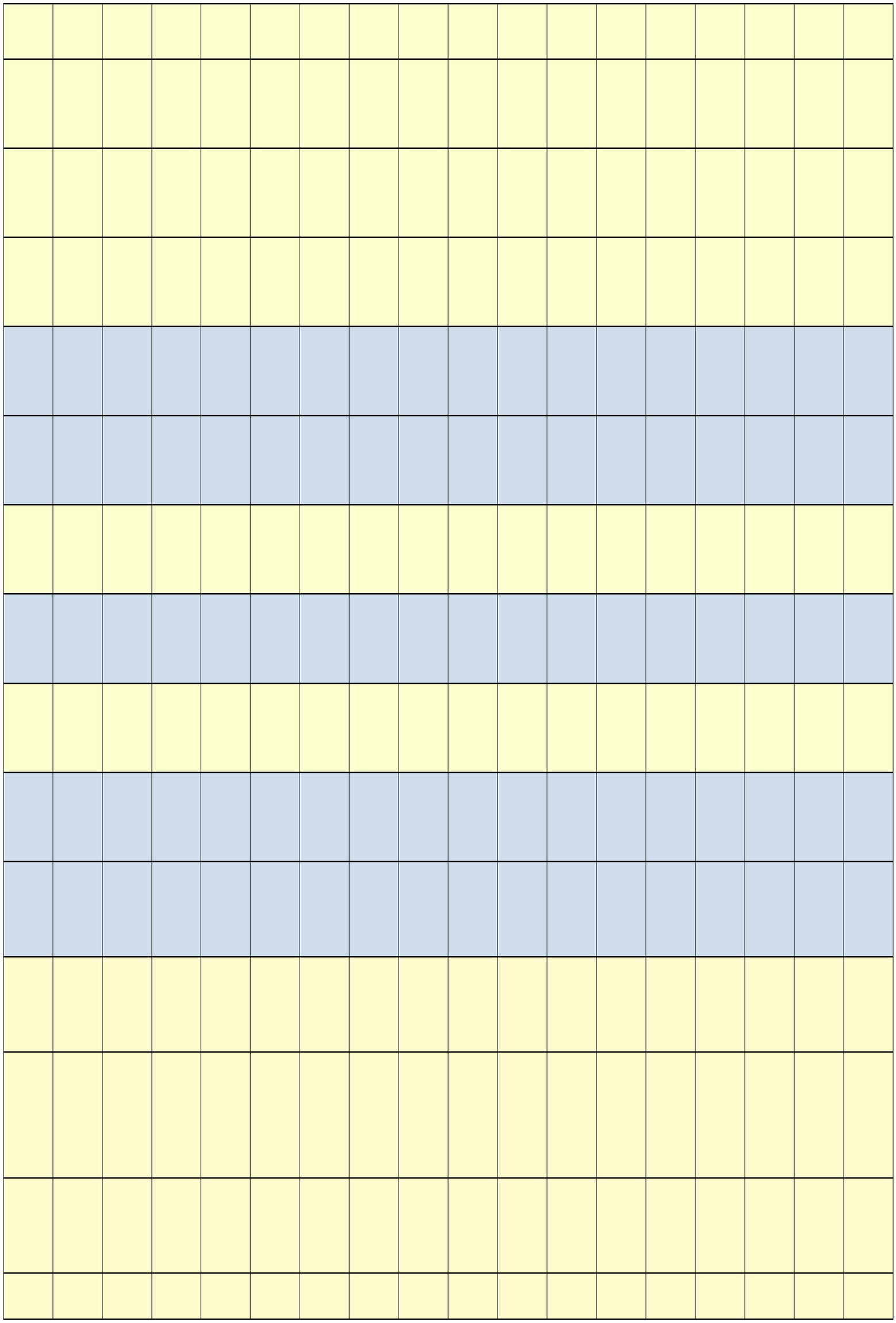
6	Family Safeguarding	Posts for Family Safeguarding Model	Prevention / Early Intervention	Other	Support for Families in Need esp around mental health, substance misuse	Social Care		LA			Local Authority	Additional LA Contribution	£397,450	New
7	Getting Help (CAMHS)	Short-term support for children, young people with low / moderate MH	Personalised Care at Home	Mental health /wellbeing		Mental Health		CCG			NHS Mental Health Provider	Additional LA Contribution	£76,000	Existing
8	Community Equipment (CCG)	CCG equipment - joint funded contract for community equipment	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			CCG	Minimum CCG Contribution	£583,880	Existing
9	Care Home Quality	Care Home Quality post (prevent admission / aid discharge and flow) & Swallowfield	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		Social Care		CCG			CCG	Minimum CCG Contribution	£34,680	Existing
10	Red cross home from hospital	provides up to 6 weeks of support at home after discharge	Community Based Schemes	Low level support for simple hospital		Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£66,300	Existing
11	Integrated Care Decision Making	Thames Hospice Care - end of life 24 hour advice line & night sitting service	Personalised Care at Home	Physical health/wellbeing		Continuing Care		CCG			Private Sector	Minimum CCG Contribution	£155,346	Existing
12	Connected Care	Integrated IT project	Enablers for Integration	Data Integration		Other	Joint IT	CCG			CCG	Minimum CCG Contribution	£200,000	Existing
13	Risk contingency pool	Funding so clients can be moved from acute setting prior to funding being agreed. Part reimbursed.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		Continuing Care		CCG			CCG	Minimum CCG Contribution	£100,000	Existing
14	Programme Support	CSU Analytical Support	Enablers for Integration	Data Integration		Other	Analytical support	CCG			CCG	Minimum CCG Contribution	£6,120	Existing
15	Farnham Rehab Beds	Rehab beds at Farnham Hospital (Virgin contract)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£95,636	Existing
16	St Marks Rehab Beds	Inpatient rehabilitation at St Marks and Upton hospitals	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£41,820	Existing
17	Stoke Support Contract	East Berkshire wide contract with Stroke Association (CCG	Community Based Schemes	Other	Support for stroke survivors in the	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£13,000	Existing
18	Programme Support (CCG funded)	CCG programme support: Integration Programme Mgt Post	Enablers for Integration	Programme management		Other	Programme Support	CCG			CCG	Minimum CCG Contribution	£19,608	Existing
18	Programme Support (LA funded)	CCG programme support: Integration Programme Mgt Post	Enablers for Integration	Programme management		Other	Programme Support	CCG			CCG	Additional LA Contribution	£60,392	Existing
19	Locality Access Points	Senior Integration Manager, Senior Occupational Therapists,	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Community Health		CCG			Local Authority	Minimum CCG Contribution	£342,000	Existing

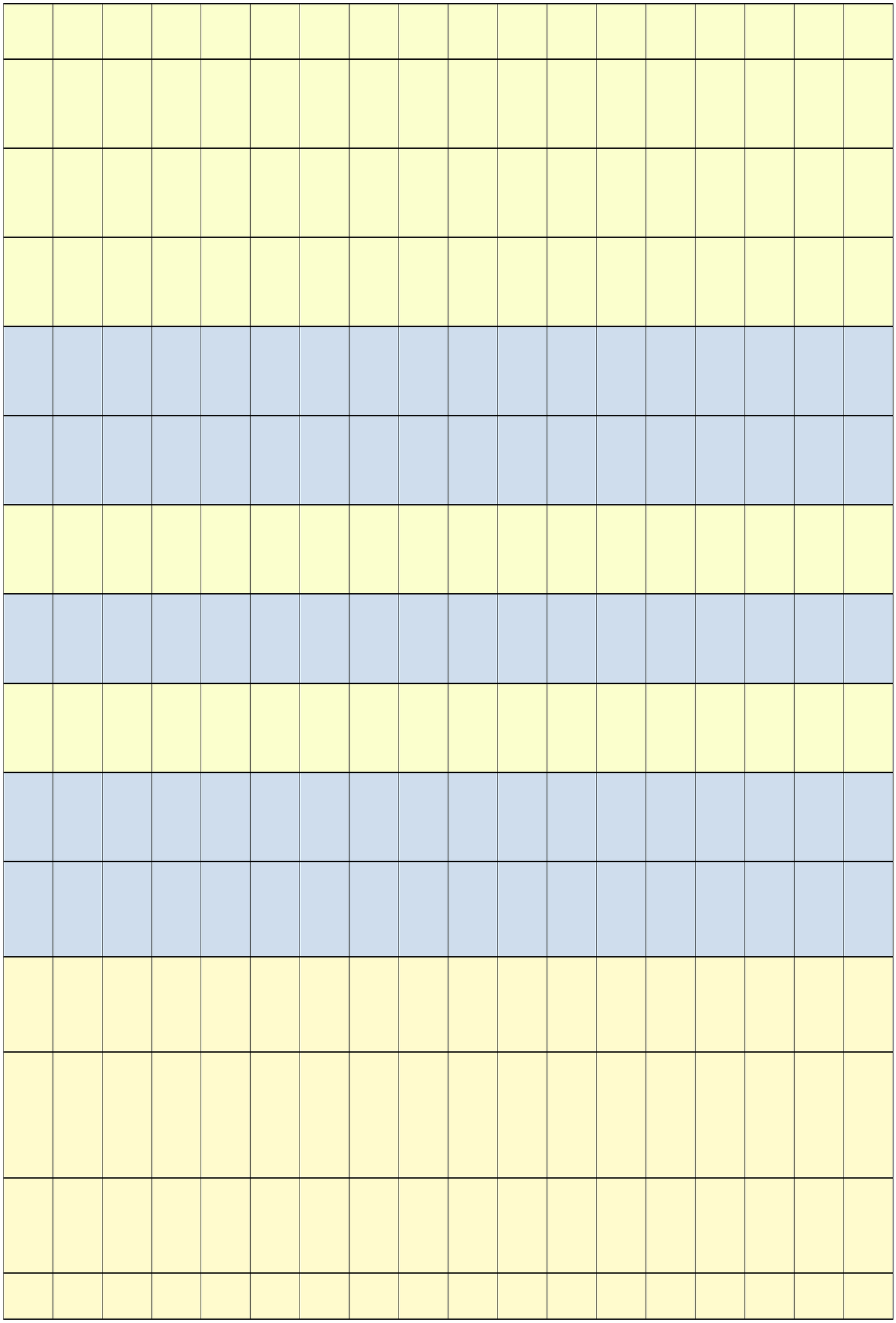
20	Extension of multi-disciplinary care teams	Age UK Berks Coordinator PIC project	Community Based Schemes	Low level support for simple hospital		Community Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£60,000	Existing
21	Carer support	Carers support, Direct Payments to carers	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£100,000	Existing
22	Community Network	MH community support fro step down from secondary MH care	Community Based Schemes	Integrated neighbourhood services		Mental Health		LA			Local Authority	Minimum CCG Contribution	£30,000	Existing
23	Child Development Centre Unit - Early Years	Support for children with SEN	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£68,000	Existing
24	Homestart - Early Help	Support for families with young children	Prevention / Early Intervention	Other	Preventing Mental Health and Wellbeing	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£13,334	Existing
25	Protecting Social Care Services	General support for the Adult Social Care budget	Residential Placements	Other	General support for the Adult Social Care	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,546,857	Existing
25	Protecting Social Care Services	General support for the Adult Social Care budget	Residential Placements	Other	General support for the Adult Social Care	Social Care		LA			Local Authority	iBCF	£1,480,053	Existing
26	Care Act	Advocacy and Deprivation of Liberty Safeguarding	Care Act Implementation Related Duties	Other	Advocacy and Deprivation of Liberty	Social Care		LA			Local Authority	Minimum CCG Contribution	£105,000	Existing
27	Community Equipment (LA)	LA equipment - joint funded contract for community equipment;	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum CCG Contribution	£518,600	Existing
28	Intermediate care	CCG funding - 6 week reablement at home service & Operational Integration Mgr	Reablement in a persons own home	Reablement to support discharge - step down (Discharge to		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,557,560	Existing
28	Intermediate care	Council Funding - 6 week reablement at home service & Operational Integration Mgr	Reablement in a persons own home	Reablement to support discharge - step down (Discharge to Assess pathway 1)		Social Care		LA			Local Authority	Additional LA Contribution	£1,694,954	Existing
29	Increase capacity in the domicilliary care market	Contibution to ASC dom care spend	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£225,000	Existing
30	Programme Support	Commissioning	Enablers for Integration	Programme management		Other	Programme Support	LA			Local Authority	Minimum CCG Contribution	£61,200	Existing
31	Stroke Support Contract	East Berkshire wide contract with Stroke Association (LA	Community Based Schemes	Other	Support for stroke survivors in the	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£40,000	Existing
32	Heathlands Revenue Costs	Contribution to set up Heathlands	Residential Placements	Nursing home		Social Care		LA			Local Authority	Additional LA Contribution	£500,000	Existing
33	Assessment Suite	facilities for assessing needs around equipment & support	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Additional LA Contribution	£91,000	New
34	Disabled Facilities Grants	Note: Excludes prior year balances carried forward	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£968,392	Existing

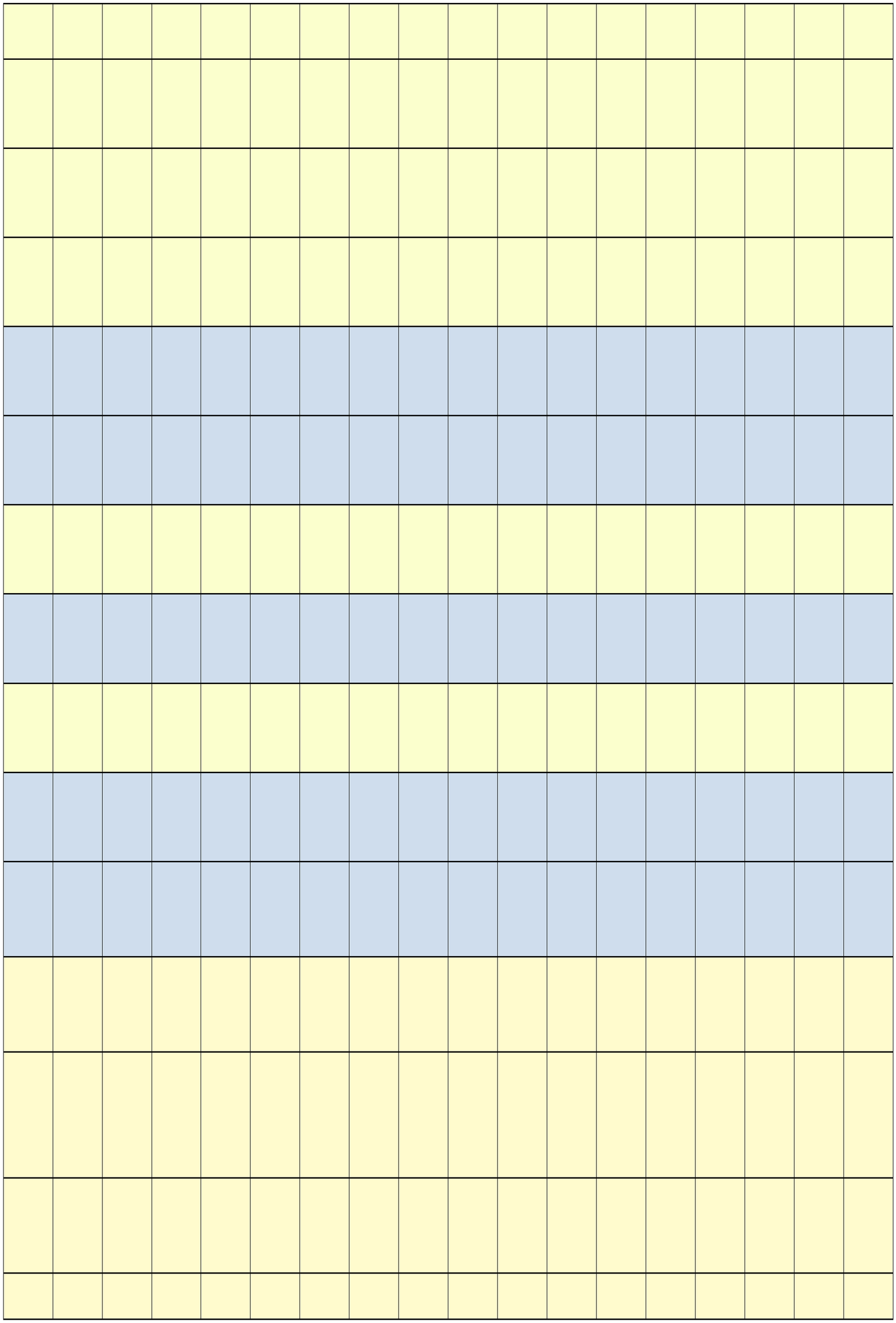
35	Telehealth Pilot	for people with heart failure - joint with Slough	Assistive Technologies and Equipment	Telecare		Community Health		LA			NHS Community Provider	Additional LA Contribution	£5,000	New
36	Contingency	Planning for 22/23 spend priorities (incl placeholder for additional Heathlands capacity in 22/23; continuing winter pressure schemes with proven outcomes beyond Q4 21/22; extra capacity to complete strategic review in 22/23)	Other		Funds supporting 22/23 onwards	Other	various	LA			Local Authority	Additional LA Contribution	£606,005	Existing
37	Earmarked contingency	Posts for Family Safeguarding Model in 22/23	Prevention / Early Intervention	Other	Support for Families in Need esp around	Social Care		LA			Local Authority	Additional LA Contribution	£600,000	New

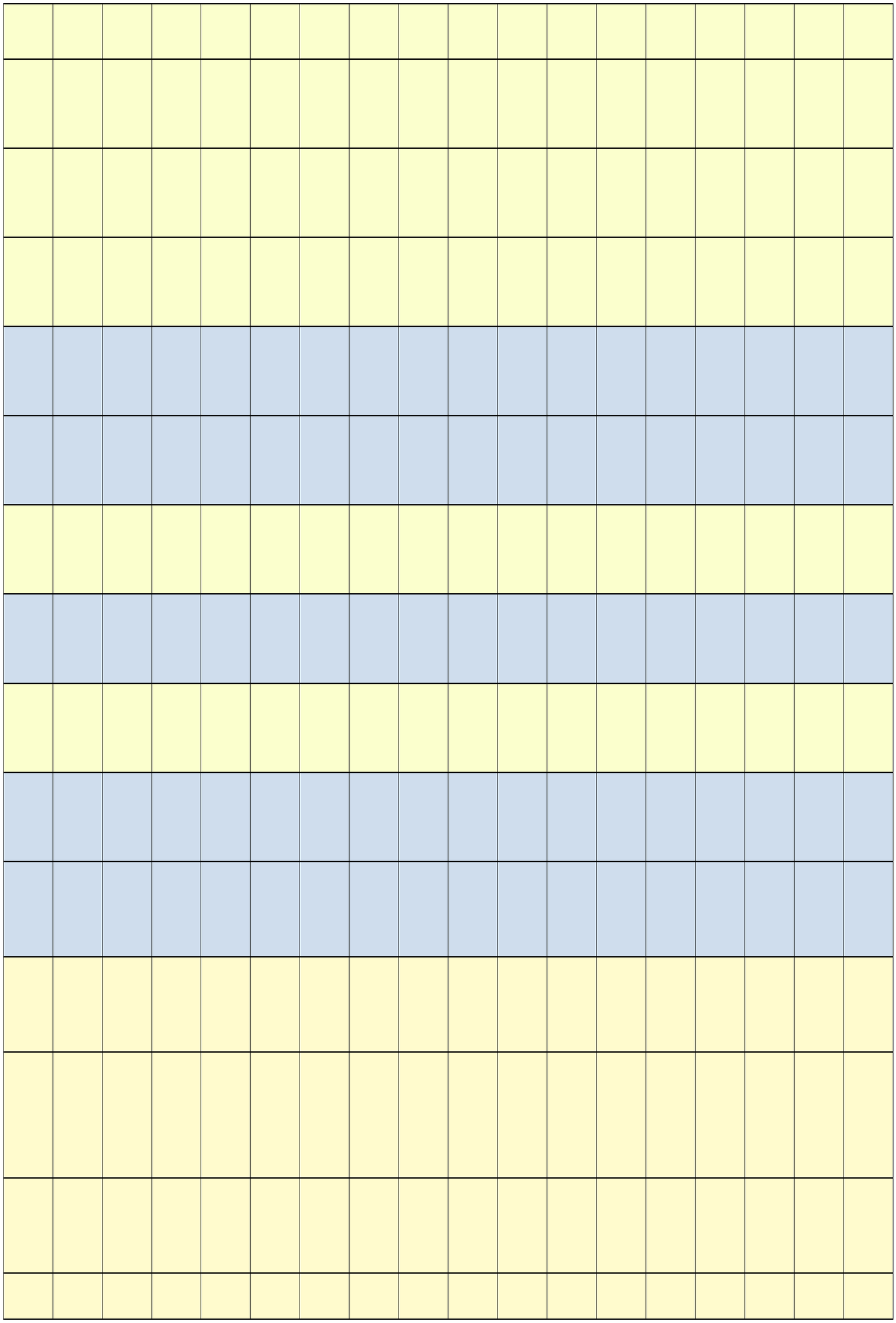


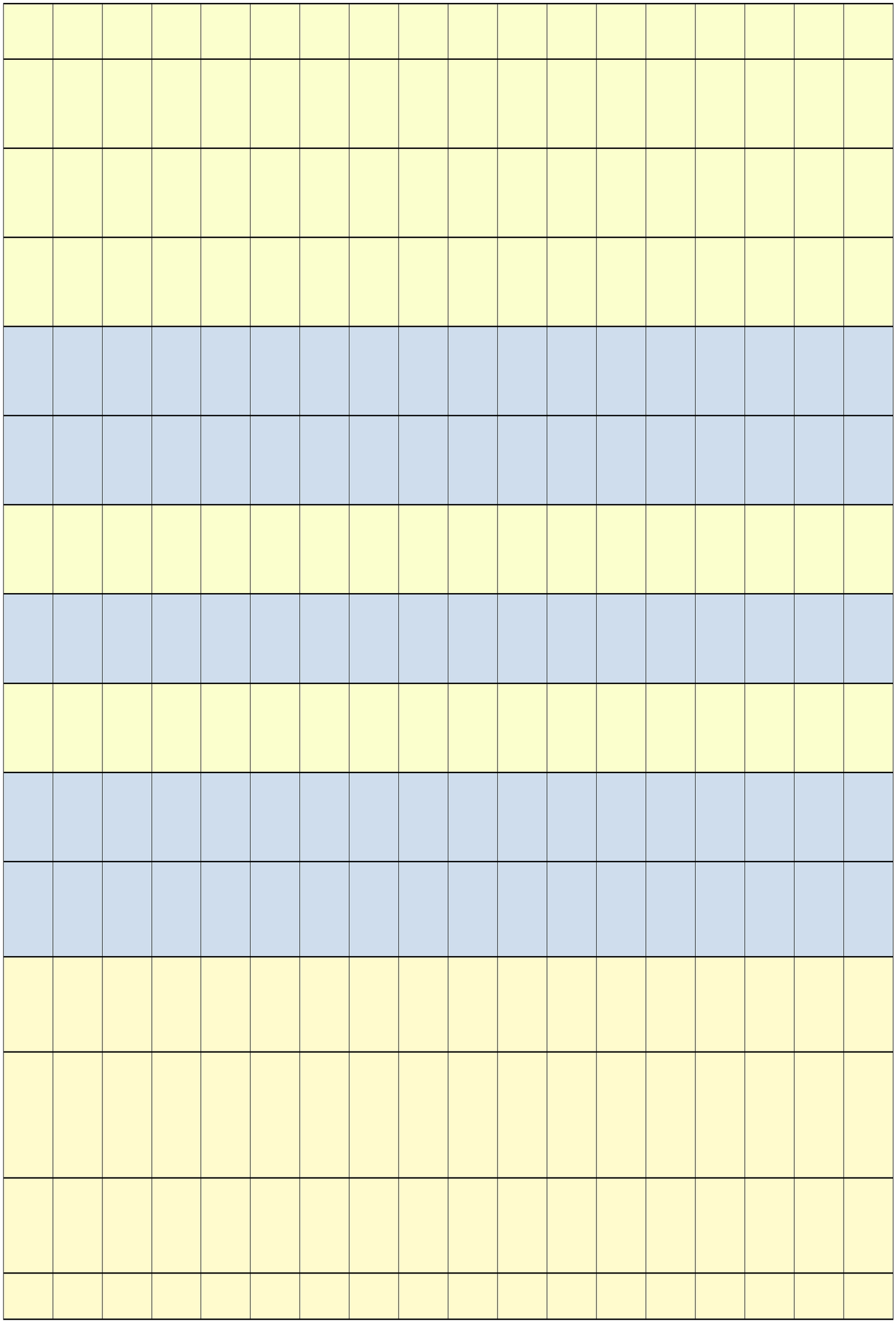


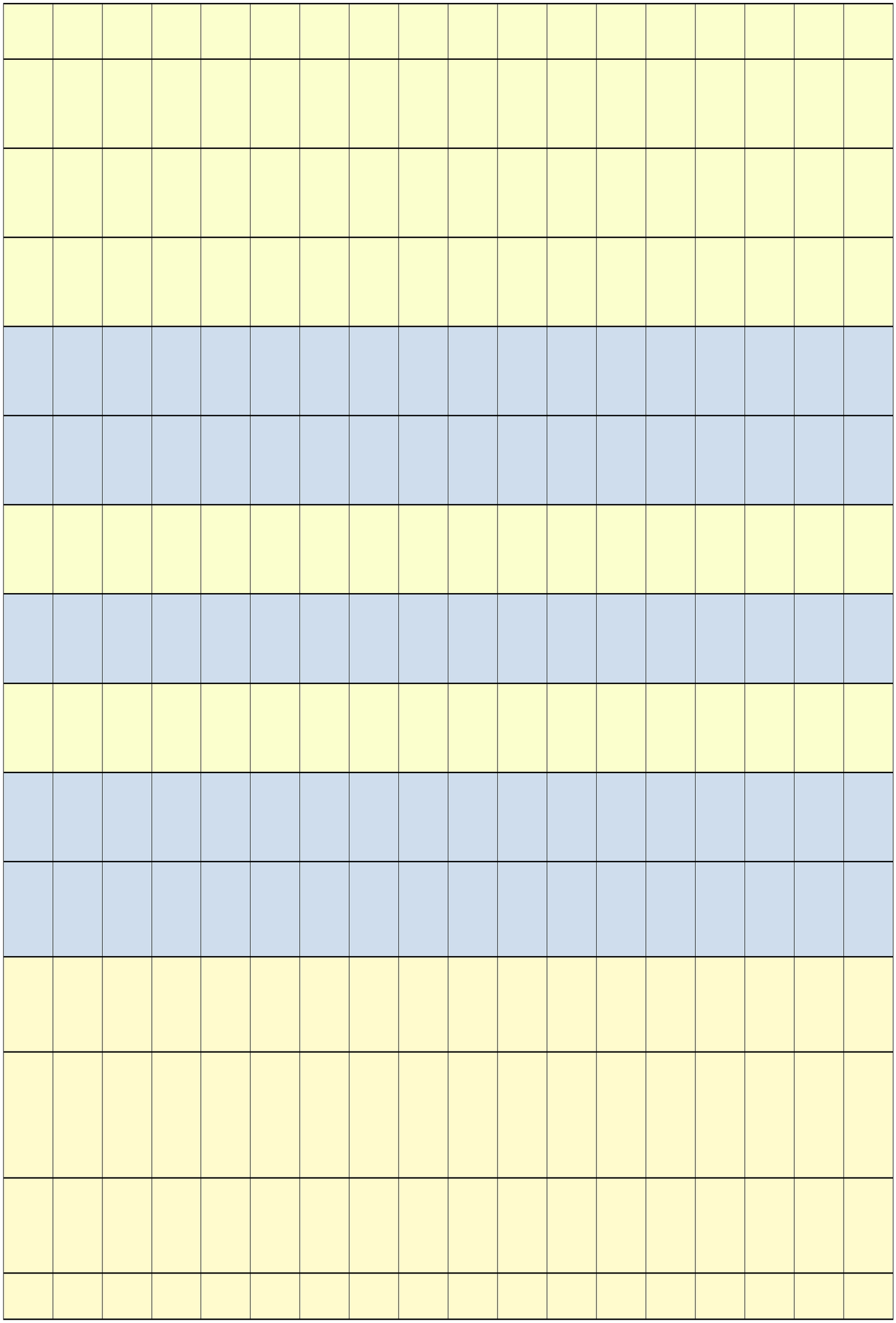












2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other
1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other
1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other
1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Bracknell Forest

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	no data available		630.0	•2020-21 data is unpublished at HWB area level. Anecdotally all hospital admissions were lower than previously for large portions of 21/22. •Having spoken to the local NHS Trust we anticipate that 2021/22 will be closer to 2019/20 (615.5) in terms of activity with a sligh increase. NEL admissions for FHFT

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	9.4%	9.4%	•The NHS Trust ambition is clearly to reduce LOS by 20% across the board which is the right thing for our patients – but also materially improves our ability to maintain elective work and reduce ambulance handover delays. •Analysis of the longer stayers (14+/21+ days) showed that Length of Stay increases with the higher number of co-morbidities and the complexity of health needs for these patients. Whilst as a system the community can support with reducing excess bed days (time beyond
	Proportion of inpatients resident for 21 days or more	4.5%	4.5%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.5%	•FHFT completed a system dynamic model to understand pathways post-discharge (P0, P1, P2, P3). Data indicates that c90% are discharges on P0 (home without support) and P1 (home with extra support). •According to SUS, the average discharge to home rate for Bracknell Forest for Apr – Aug 21 was 92.7%. The

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	643	738	473	579	•2020 – atypical admission numbers due to Covid-19 •April to October 2021 are already fixed – 59 in total so far; we expect to see a seasonal increase in March 2022. •Planned annual rate of 579 compared to 19/20 actual of 738 means we are aiming for a real terms reduction (decreased numerator and increased denominator
	Numerator	115	133	88	110	
	Denominator	17,872	18,011	18,616	18,994	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.3%	83.6%	85.5%	•Last three years, BFC have performed well against 81% target set in 2018 •Only officially reported based on one quarter's data (anyone discharged from October to December followed up between January – March as 91 days). Not tracked throughout the year. Monitoring Q performance
	Numerator	65	46	65	
	Denominator	80	55	76	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Bracknell Forest

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	FICS Winter funding bids 21/22 (p8) Community Impact Assessment (p16)		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

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COVID Community Impact Assessment

Recognising the impact of COVID-19 on Bracknell Forest residents

July 2021

Introduction

Purpose

The coronavirus pandemic and subsequent measures to control transmission has impacted every part of life. There is a significant amount of data being collected at a national and local level to track the changes in perceptions, behaviours and environment. The community impact assessment brings together information from a range of sources to provide a local narrative on how residents in Bracknell Forest have been affected by the virus.

Understanding these impacts and the emerging opportunities and challenges will inform the council's decision making and future planning to make sure priorities best address the current environment. This work also supports wider actions to recognise the disproportionate impacts of the virus for some groups.

This report is not intended to provide the answers or solutions to the impacts of coronavirus, however the evidence gathered is an important step in identifying the key issues that must addressed.

An extensive assessment has been conducted and examined to guide strategic work and this report is a summary of the most significant issues for ongoing action. This document aims to highlight the areas where evidence indicates significant impact on the community. It also describes how the COVID pandemic is likely to affect the delivery of the Council Plan. Finally this document raises current areas of priority for recovery and renewal work.

We hope this will inform residents about the direction of the council's work with partners in addressing the emerging impacts from the pandemic.

Methodology

This report is based on data broadly up to the 1st May 2021. This builds on the previous community impact assessments to compare the changing trends over time. It aims to capture a snapshot of the impacts emerging from the new environment. Whilst further changes have since occurred and some newer data is available, the 1st May has been used to provide a consistent time point.

It is recognised that the impact of coronavirus will continue to change over the coming months and years therefore, there is broader work monitoring live data. There are also a very broad range of impacts and there continues to be new data available, therefore this report has focused on highlighting the most salient issues.

The narrative provided has been based on a range of local and national evidence sources.

- Local statistical sources and dashboards
- National transparency data
- Analytical primary research from local partners
- Stakeholder and partner insight

When reference is made to the 'first lockdown' period this refers to the restrictive measures put in place from the 23rd of March to the 1st June 2020. The 'second lockdown' period refers to the 5th November to 2nd December 2020 and the 'third lockdown' period refers to 5th January to 12th April 2021.

Community Profile

Within Bracknell Forest there is a diverse community. It has been widely reported that coronavirus affects some groups more than others with an increased risk of catching the virus and a higher chance of mortality. Therefore, the prevalence of these groups must be recognised to understand the potential health inequalities and impact for the borough.

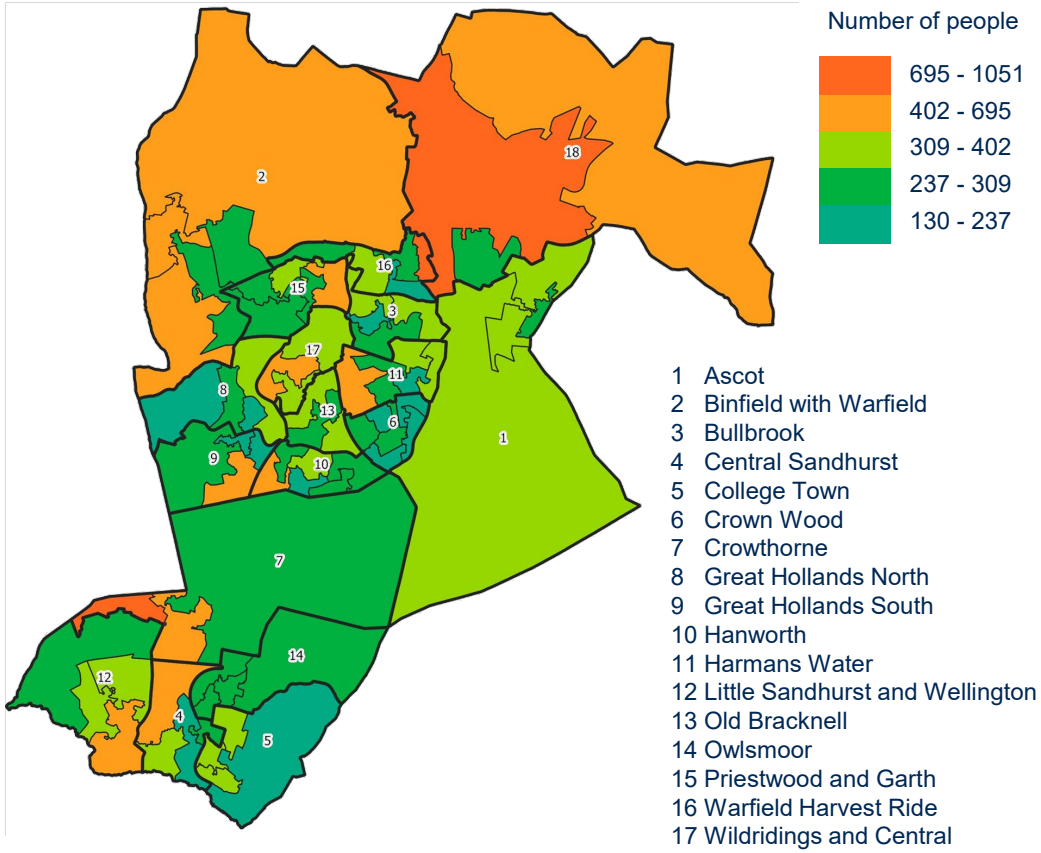
Age and Gender

Bracknell Forest has a population of approximately 123,000 people. Of these, just under half (49.7%) are male. Of confirmed cases, men have been more at risk of needing intensive care and have a higher mortality rate.

Bracknell Forest has a smaller proportion of over 60s compared to the average for the South East and England. This is estimated at just under 25,000 people. There is a significantly higher risk of mortality for older adults, particularly those over 80 years. There are approximately 4,700 residents over 80 in the borough, this is 3.8% of the population and a smaller proportion than the SE (5.5%) and England (5.1%)

Ward level information is available on the over 60 population. Some parts of the borough have higher proportions of adults over 60 living there, this is particularly noticeable in the north of the borough. There may be a greater impact on these communities if the virus becomes more widespread in the borough, as those over 60 have more negative outcomes.

Population aged 60 and over
2019



Source: Public Health England Disparities Report and Berkshire Observatory

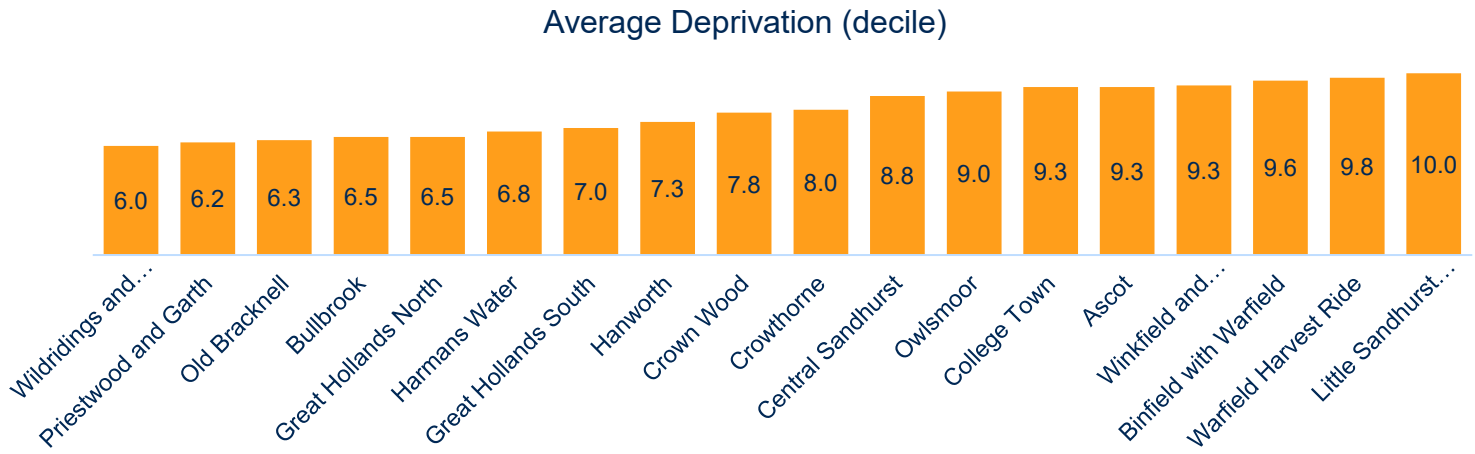
Community Profile

Deprivation

The level of deprivation is relatively low across the borough, with just under half of neighbourhoods in the least deprived 20% of the country. However, there are a further 16% of neighbourhoods considered more deprived than the national average. The evidence to date shows that more deprived areas have a higher rate of deaths related to coronavirus.

Parts of Crowthorne and Wildridings and Central are the most deprived in the borough, therefore the impact of coronavirus may be greater for these communities.

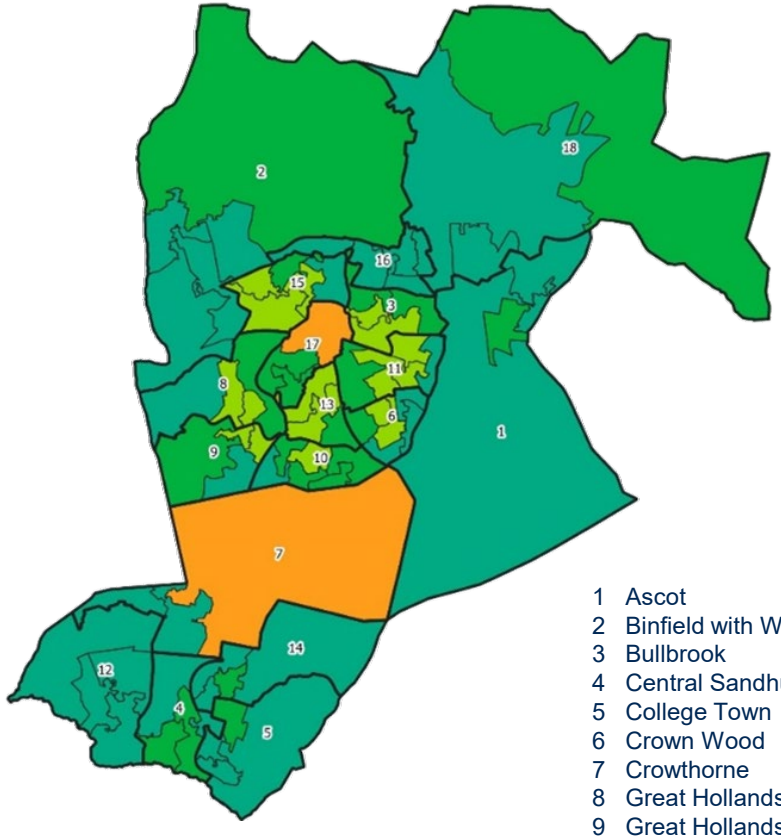
The map implies that a large proportion of Crowthorne is more deprived, however it should be noted that this is a single neighbourhood (Lower Layer Super Output Area). All neighbourhoods represent approximately 1500 people, regardless of geographic size. When evaluating the deprivation of whole wards, it shows that Crowthorne has an average level of deprivation for the borough, as highlighted in the graph below. Wards nearer to Bracknell town centre are, on average, more deprived.



Source: Public Health England Disparities Report and Berkshire Observatory

Index of Multiple Deprivation

2019



Community Profile

Ethnicity

There is a similar profile of ethnicities in Bracknell Forest compared to the South East, with 91% of the population from a white ethnicity. It's estimated there are just over 10,000 ethnic minority residents in the borough. There are a notably higher proportion of 'other Asian' residents than other areas of the South East and England, this is in part due to a large community of Nepali residents linked to the Gurkha Company Sittang regiment based at the Royal Military Academy Sandhurst.

A number of more negative impacts of the pandemic have been reported for non-white ethnicities. Including that Black ethnic groups are disproportionately affected by coronavirus as more likely to be diagnosed with COVID-19 than white ethnicities. Some ethnic minority groups are also more likely to need more intensive treatment.

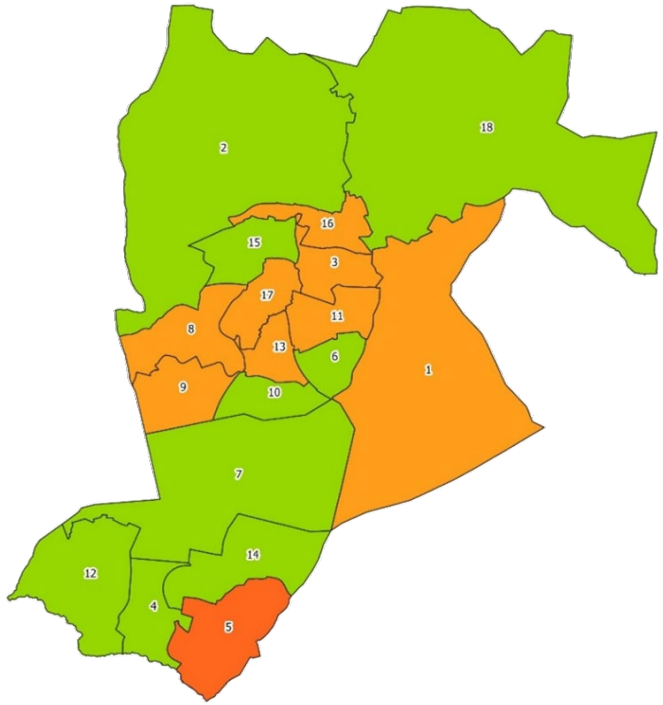
Bracknell town centre wards generally have a higher proportion of residents from ethnic minority communities. However, there is also a significantly higher proportion living in College Town where there is a large Nepali population. Therefore, the impact of the virus may be greater in these areas.

Household environment

In the 2011 census, approximately 7% of households in the borough were single parents with dependent children and a further 28% are one person households. If these proportions have remained similar, this equates to around 17,500 houses with one adult. The impact of the multiple periods of lockdown may be greater for these individuals due to isolation and the knock on effects for health and wellbeing.

Source: Public Health England Disparities Report and Berkshire Observatory

Percentage of ethnic minority population



An estimated 6% of households are considered overcrowded, where there are increased risk of transmission and where it may be more difficult to work or study at home.

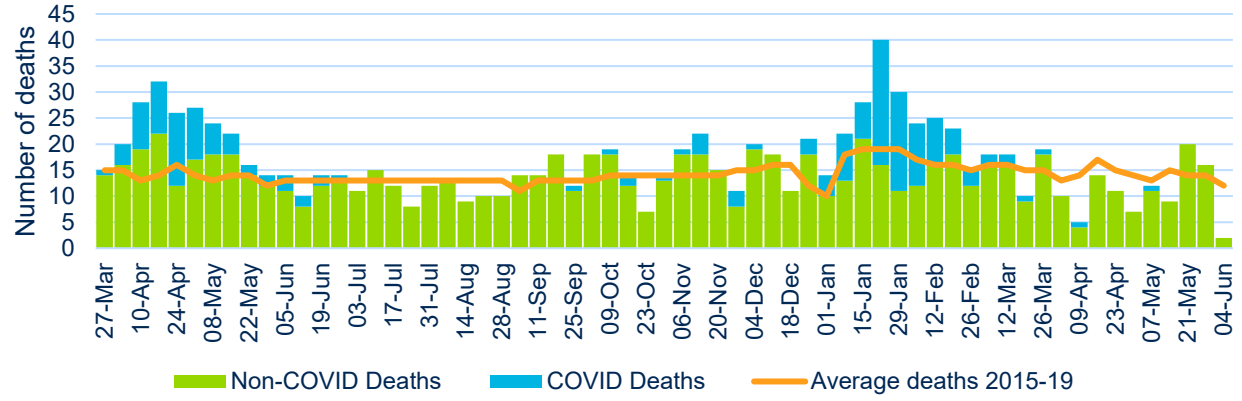
Similarly, the risk of isolation may be higher for those who are not as able to connect through technology and with their community. It was estimated in 2019 that 2.4% of the Bracknell Forest adult population have never used the internet and 0.7% do not speak English well or at all. Within the over 65 population around 12% report not to speak English well.

Community Profile

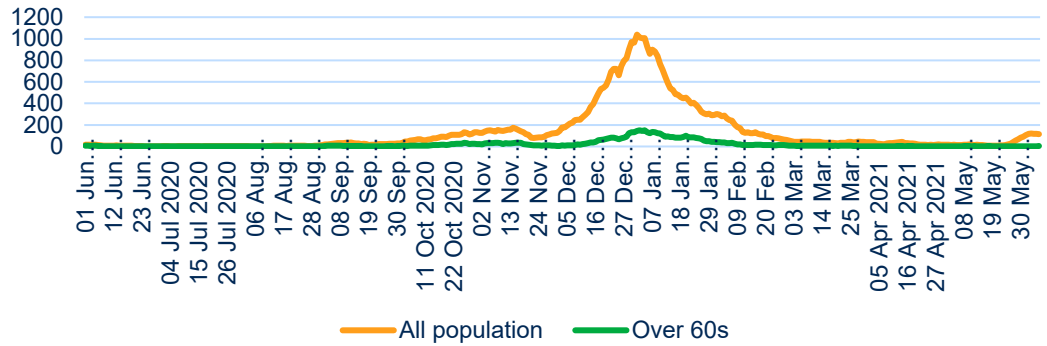
Surveillance Data
On the 30th April 2021 in Bracknell Forest, there was an average case rate of 25 new cases per week, around 8% of cases were in the over 60s age group. There is a slow but continued reduction in cases.

Mortality
Up to the week ending 30th April, there had been 186 deaths of Bracknell Forest residents registered as related to COVID-19. This is an increase of 115 people, since the last report (end of September) and reflects the 'second wave' that occurred over the winter. The pressures on healthcare and different environmental circumstances have also been reported to have contributed to more deaths. There has been approximately an 18% increase overall in the number of deaths of Bracknell Forest residents in the last 13 months, compared to the expected average. This is substantially higher than the previous report and reflect the high impact of the second Winter wave.

Weekly mortality in Bracknell Forest

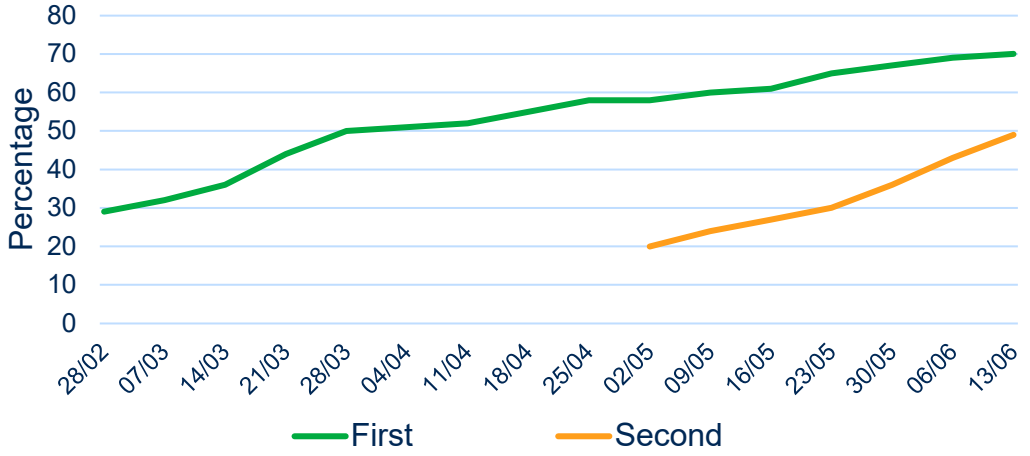


Weekly number of confirmed cases:
7-day moving average



Vaccinations
Up to the week ending 13 June, 70% of residents had received at least one dose of a COVID vaccination and almost 50% had received both doses. Broadly this is in line with the rates for England and across CIPFA neighbours.

Percentage of residents with a COVID vaccine



Source: LG Inform and Fingertips PHE

Since this report, the rate of new cases has increased. There is a surveillance tool from the Berkshire Public Health team with real time reporting. This can be accessed at: www.berkshirepublichealth.co.uk/covid-19-dashboard

Community Profile

Shielding residents

The shielding programme was introduced during the first lockdown to provide additional protection to those defined as clinical extremely vulnerable. The NHS initially advised 2,218 residents in Bracknell Forest to follow the shielding guidance. By the 1st June 2020 this had doubled to 4,139 residents. Of those advised to shield, 2,502 registered themselves for support online or over the phone.

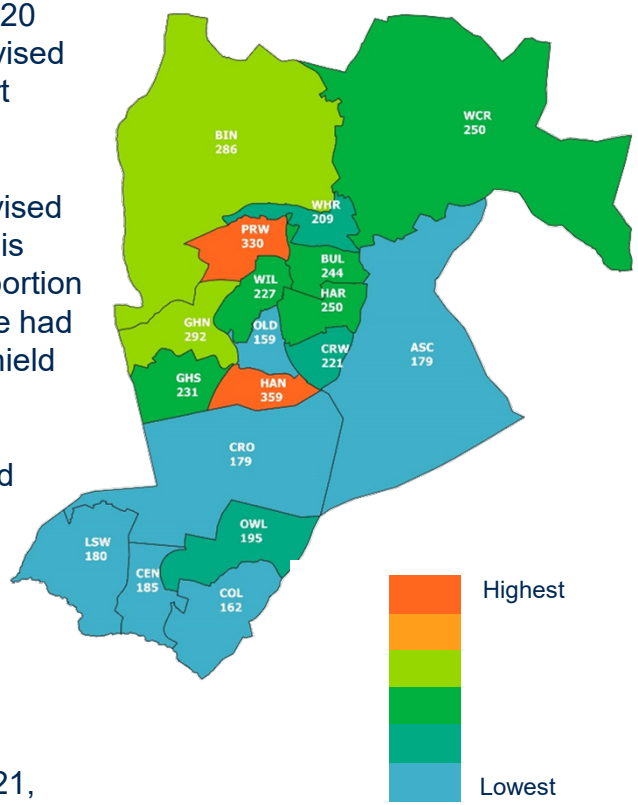
The ward with the greatest number of people advised to shield was in Hanworth, with 359 people. This is approximately 4.4% of that community. As a proportion of the ward population, Winkfield and Cranbourne had the highest percentage of residents advised to shield at 5.1%.

The lowest numbers advised to shield were in Old Bracknell with 159 people (2.6%).

This shows which areas may have the greatest health needs and potential wellbeing needs linked to the longer and stricter isolation recommendations.

The second shielding phase ended on 1 April 2021, were a total of 5,906 had been advised to shield.

Advised to shield



Health

Other health conditions have also been linked to different outcomes for coronavirus. Most notably diabetes has been reported in one in five COVID-19 deaths. The health profile of the borough is relatively similar to the rest of England as around 62% of the local population classed as overweight and there is a diabetes prevalence of 7%.

Community Profile Summary

The community profile of Bracknell Forest residents suggests that the impact of coronavirus may not significantly differ for the rest of the South East. Of note are the lower number of the over 60s population and lower levels of deprivation which may slightly reduce the risks and consequent negative impact on the community. However, there are over 10,000 residents in the BAME community who are more at risk of the COVID-19.

Within the borough, the ward level information also shows that there may be greater impact for some specific communities. This may be particularly apparent where there are compounding risks for example in some of the central Bracknell Town wards where there is greater deprivation and higher numbers of the BAME community.

This may be relevant to consider in the context of the council plan and associated recovery planning as it identifies where more targeted resources may be needed to support specific communities.

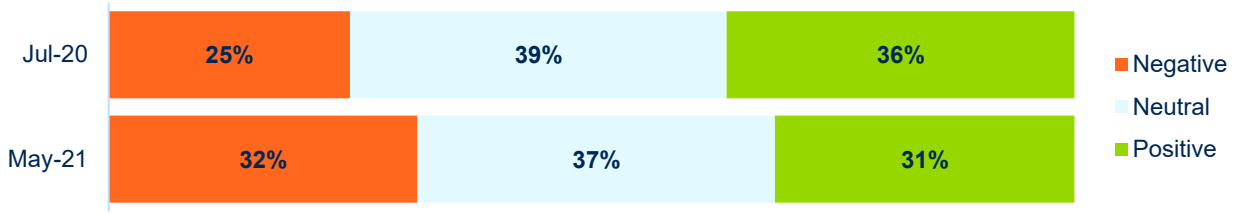
Emerging trends – Challenges

The impact of the pandemic and associated restrictions will have been significant for many and this report aimed to understand some of these key areas. The data and insights from services, partners and residents identified several areas where the patterns suggest negative impacts. These have also been explored in further detail beyond this summary to further understand the impact on Bracknell Forest.

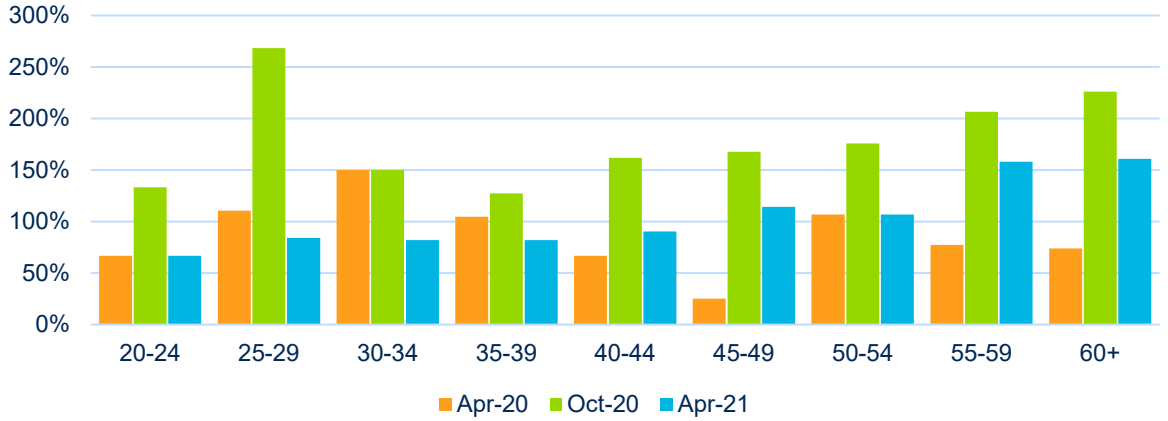
Unemployment remains high
National data shows that unemployment in the borough has significantly increased since the pandemic. Whilst this was initially more apparent for younger people, it now appears to be over 55s where the unemployment is more sustained. This will have significant knock on effects, including stable but increased use of foodbanks, Citizens Advice and financial support claims. Looking to the coming months there are also concerns that the end of the furlough scheme will further increase unemployment.

Worsening mental health
In the council's May 2021 independent survey, one third of residents reported that the pandemic has negatively affected their mental health. This was a higher number than in the July 2020 survey. Partners have also shared their concern about the increasing prevalence and complexity of mental health needs. However it is also important to note that around one third also reported a positive impact for their mental health, and for many, household and caring relationships have improved.

Residents Survey: Mental Health Impact



Change in number of JSA claims compared to 2018/19 average



Slow recovery for community social and learning groups
The booking and use of community spaces has remained substantially lower than last year. The significant reduction in the use of these spaces demonstrates how many community groups have had to operate in alternative ways. Some groups may be able to operate online however many will also have stopped. This reduces the opportunities for support, personal development and active lifestyles for the community.

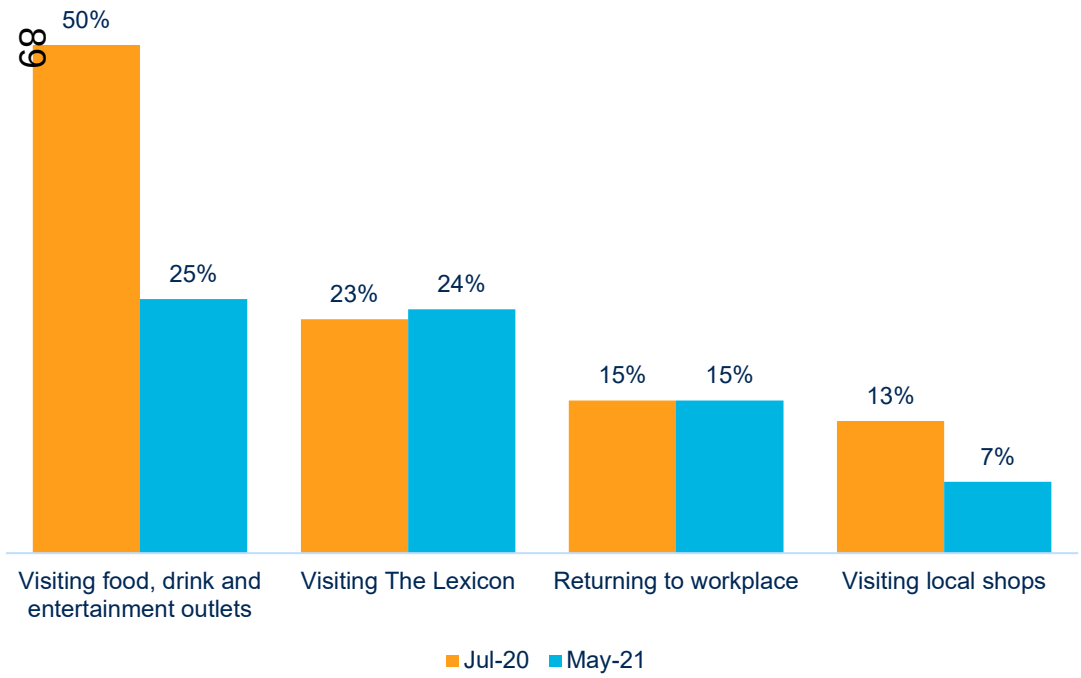
Disruption to children's education and support
Schools have significantly changed how they provide support and education to their pupils. Despite this, it has been widely reported that the pandemic has increased the inequalities in attainment and learning. 58% of parents reported that the pandemic has negatively affected their child's education. There is still significant uncertainty for the longer term effects of tis.

Residents Survey: Impact on Child's Education

Emerging trends – Improving

Town centre recovery
Several indicators, including car park visits, suggest that town centre activity is increasing as restrictions continue to ease and as more people get vaccinated. This was also supported by the residents survey, which particularly indicates recovery of local shops and retail. There has also been a significant increase in confidence for visiting food and leisure outlets.

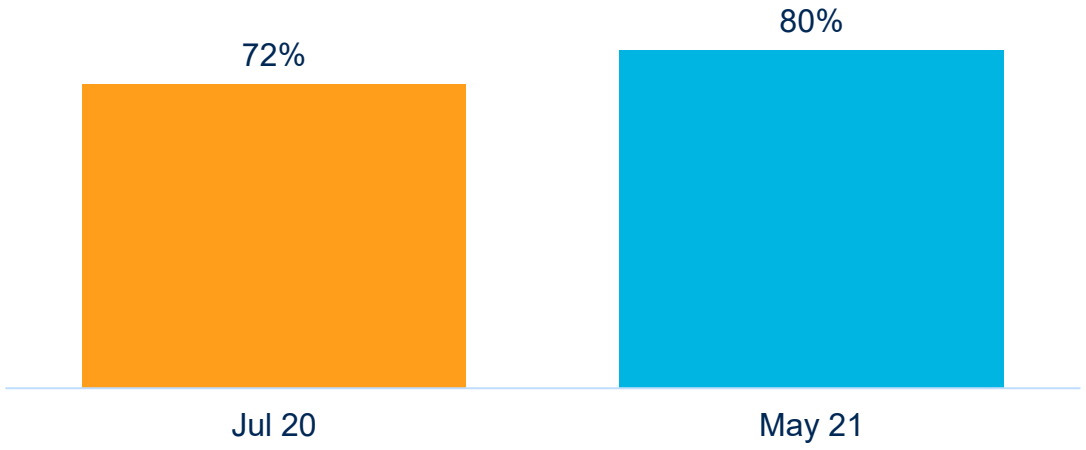
Residents survey: Activities not likely to return to soon



Climate friendly action
Throughout the pandemic there has been positive changes for the environment, particularly linked to reduced driving. In the recent residents survey, three quarters of residents agreed that the pandemic was a good opportunity for people to be more environmentally friendly. More people reported taking actions to reduce their carbon footprint than in July 2020, suggesting a greater desire to be environmentally conscious.

In comparing the two resident's surveys, it shows that residents are now more likely to be walking and cycling and to be traveling less in general. This implies that positive habits may be forming. The introduction of the food recycling service is also increasing the opportunities to be environmentally friendly.

Percentage of residents who have made changes to reduce the carbon footprint

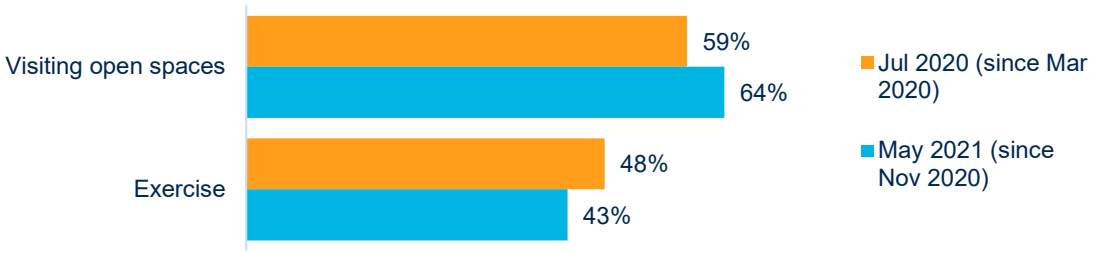


Emerging trends – Opportunities

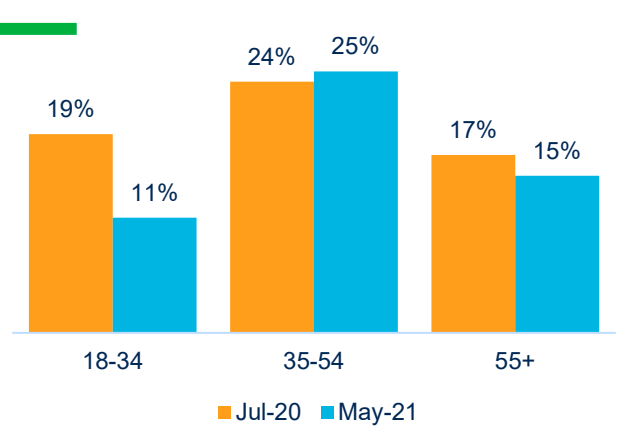
Increased volunteering and community engagement
During the pandemic lockdowns, the community excelled in supporting the local community response. Over 7,500 tasks were completed by the community response volunteers. Around one in five residents undertook some form of volunteering, including informal activities. Those aged 35-54 were the most likely to volunteer and reported a greater intention to continue in the future. This increase in active engagement within the community demonstrates a positive impact of the pandemic and shows how vital strong community networks are.

Increased exercise and use of open spaces
Whilst there has been a mixed impact for overall physical health, reports in local surveys suggest that many residents have been able to do more exercise during the lockdown than previously. In many cases this was reported as linked to having more time. Many residents also report accessing local parks and open spaces more often. Promoting healthy lifestyles is an important commitment within the council plan and so the current changes in behaviour suggest positive progress towards this and an opportunity to be sustained.

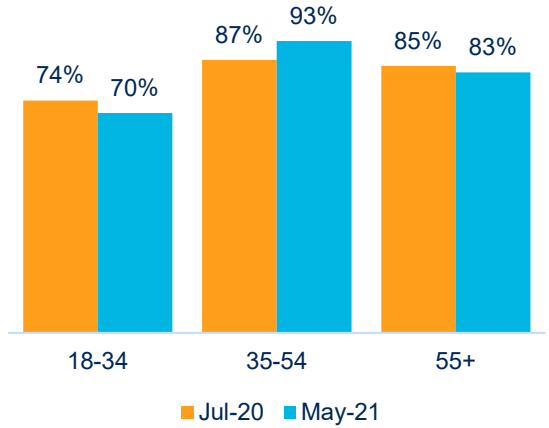
Residents survey: More frequent activities



Volunteering during the pandemic*

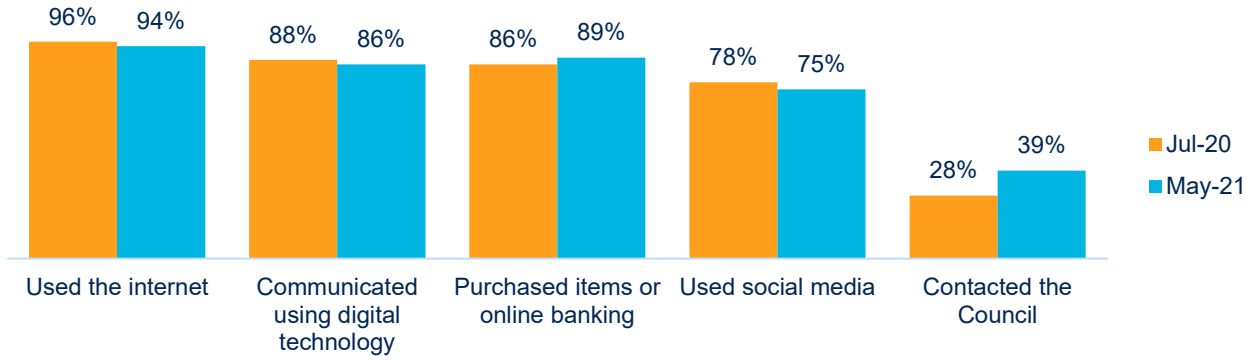


Intention to keep volunteering



Greater digital engagement and confidence
Many activities had to move to digital operating methods during the pandemic restrictions. Health partners have reported greater preference from many patients for using these online services. There were also many more visitors to the council website and increased engagement on social media platforms, all indicating changing communication habits. Most residents reported using the internet, particularly for communication, more often than before the pandemic.

Using online services



Accumulated impacts

Through this report, evidence had been gathered identifying some of the key impacts for residents. These have been grouped into themes related broadly to the council plan, however there are also cross cutting and accumulated impacts that do not fit into a single theme. The impacts of COVID have widened health inequalities, disproportionately affecting certain groups of our local population, therefore this page briefly summarises some of the most significant overarching issues where there are multiple compounding impacts. This broadly remains the same as the previous CIA.

Young people

There has been a slight reduction in the rate of young people seeking employment support, since the previous CIA. This is a positive indication of recovery in employment rates. Of those school aged, there are emerging indications of increasing gaps in education attainment, compounded by deprivation and lack of technology for home-schooling. There is also likely to be an increasing cohort of young people leaving school into a limited jobs and training market. However broadly, there is confidence in young people in accessing the economy and support as restrictions ease.

Older adults

Older adults are more at risk of mortality if they are infected by coronavirus, although the progress of the vaccination programme significantly limits this. They are also more likely to have wider health conditions where treatments and check-ups may have been postponed during parts of the lockdown restrictions, having negative impacts on health. This group are more likely to have shielded, increasing their risk of isolation and negative mental health impacts. This isolation can also cause further deterioration for conditions such as dementia. Older adults are also more likely to be affected by digital deprivation in skills, confidence and access to online and virtual communication methods.

Low income families

There are an increasing number of people affected by multiple deprivations. For example, those already on lower incomes are also more often working in jobs in sectors most affected by redundancies, therefore they are at more risk of unemployment. These groups may also be more reliant on the VCS for support, for example through foodbanks. There has been a lot of financial support schemes in place for low income families, which may be masking and delaying some of the impacts.

Ethnic minority communities

It is already widely reported that COVID-19 is exacerbating the pre-existing inequalities in health. Ethnic minority communities are particularly affected with negative outcomes related to COVID-19 however this will be minimised with the vaccination programme. They also are more likely to live in areas of deprivation, to use public transport for work and to avoid seeking healthcare.

Council plan impacts

Value for money

The evidence indicates increasing financial hardship for residents, so the need for council tax support is likely to be greater. The evidence also suggest greater confidence and use of technology which supports the council plan objective to increase digital technology/self-service. Although some groups are still relatively excluded from digital methods such as older adults and some of those with learning disabilities. Business stability and economic evidence indicates a risk for the objective to generate income through commercial property investment.

Economic resilience

One fifth of the local population reported in the resident's survey that the council should prioritise supporting the local economy and businesses for the borough's recovery. However the economic environment means several objectives may be affected. This includes the development of The Deck, retaining and attracting businesses in the area and maintaining the viability of shopping and employment areas. Although indicators for these sectors suggest they may also 'bounce back' relatively quickly. There has also been positive impacts for council plan delivery such as strengthening the relationships with businesses and delivering infrastructure improvements with minimised disruption to residents.

Education and skills

The evidence indicates it will be now more difficult to create opportunities for care leavers and to increase the number of apprenticeships and training programmes. The impact of limited education and support groups may mean more resources are needed to increase the percentage of children achieving good levels of development in communication and language. The objective for new youth services may also need to be considered in the context of new needs and operating models post-pandemic.

Council plan impacts

Caring for you and your family

One sixth of the local population reported in the resident's survey that the council should prioritise supporting vulnerable people. The impacts highlight the importance of council plan objectives such as using social prescribers in reducing isolation, the need for new mental health services and the value of working closely with the CCG and primary care network. However achieving some objectives, such as promoting a range of sport and leisure activities have been more difficult under the social distancing restrictions and could contribute to more negative health impacts emerging later.

Protecting and enhancing your environment

The residents survey feedback would indicate support on council objectives to become carbon neutral, protect green spaces and promote more use of cycle ways. However the impact assessment findings suggest the objective to encourage greater use of public transport will be more difficult to achieve and in the context of the pandemic, may not be appropriate to promote. The impact of more people using local parks has also added pressure to the maintenance of popular outdoor spaces such as Horseshoe Lake and the Look Out.

Communities

Objectives such as supporting community centres and libraries will be extended through working with partners, to ensure services are integrated and accessible to residents. There has been a positive impact for the council plan delivery where the pandemic has encouraged a greater focus on recognising and supporting the diversity in the community and relationships with partners have strengthened such as with the police and the VCS, supporting the delivery of community objectives.

Recovery and renewal priorities

Since the last report it is clear that the recovery and renewal principles agreed in 2020 are still highly relevant. However the latest data provides more detailed insights into understanding the effects.

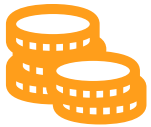
Mental health
There continues to be a sustained impact for mental health. Slightly more people are reporting negative impacts than earlier in the pandemic, perhaps demonstrating fatigue and reflecting growing financial pressures. There is growing pressure on mental health services, with more complex presentations. This is also affecting a range of services beyond the increased demand for health and social care services.

Physical health
Early in the pandemic there were many positive indications that physical health for many had improved. However this appears to have reduced slightly, suggesting habits of walking and exercising more may not be sustained as restrictions ease. Some residents, particularly older people, have reduced confidence accessing health services which could also lead to later physical health difficulties. Long COVID effects are still relatively unknown but may cause further pressures related to health.

Business and employment
Whilst the national economy is still relatively unstable, businesses appear to be recovering well each time restrictions are eased. Employment continues to be a challenge, this appears particularly to be the case for older people, with many now seeking more financial employment support. Earlier in the pandemic, young people were also significantly affected however the evidence suggests that this has reduced slightly, perhaps supported by schemes such as Kickstart.

Voluntary and community sector (VCS)
There continues to be significant uncertainty for the state of many VCS groups. It is positive that many residents report continuing their volunteering roles and particularly 35-54s have a strong intention to continue volunteering longer term. There is likely to need to be a shift in roles for volunteering to reflect the changes in the community and the reduced profile of older volunteers.

Carbon reducing activity
Many positive changes to the environment occurred during the restrictions, notably the reduced use of vehicles and increased cycling and walking. These changes are now returning to pre-pandemic behaviours and so work will focus on sustaining positive changes for the environment.



Financial principles
The emerging trends indicate there is likely to be increasing need for support from the council and pressure on services. A number of one-off measures to support recovery have been introduced addressing many of the areas of impact recognised through this CIA. It will be a priority to continue maximising the resources available to make sure the council can support the community recover.

To: Health and Wellbeing Board
2 Dec 2021

Health and Wellbeing Strategy
Director of People, Place and Regeneration

1 Purpose of Report

1.1 The purpose of the report is to present the Joint Health and Wellbeing Strategy prior to consultation. The health and wellbeing board members have been engaged in developing the strategy along with wider stakeholders. This report seeks to confirm the vision for the strategy, agree the strategy for consultation and confirm the consultation arrangements.

2 Recommendation(s)

2.1 The Board is requested to formally agree a vision for the HWB strategy from the two options;

Option A: Bracknell Forest is one of the healthiest place to live, work, study and play, providing our residents with the opportunities to be happy, healthy and productive. We will support this by taking a health in all policies approach with a focus on reducing health inequalities

Option B: Bracknell Forest is one of the healthiest place to live, work, study and play, providing our residents with the opportunities to be healthy, resilient, and productive. We will support this by taking a health in all policy approach with a focus on promotion of health, prevention of ill-health and reduction in disparities in health outcomes between our communities

2.2 To agree the Draft Joint Health and Wellbeing Strategy for public consultation (Appendix A)

2.3 To agree the consultation arrangements as set out in paragraph

3 Reasons for Recommendations

3.1 The Health and Wellbeing Board (HWB) as a formal committee of local partners is tasked with developing and publishing a local Joint Health and Wellbeing Strategy (JHWS) this is a statutory duty. The JHWS is a mechanism through which the HWB delivers its key role in improving the health and wellbeing of the local population. The JHWS should demonstrate how the local council and the NHS deliver their statutory duty in improving the health and wellbeing of the local population and reducing health inequalities. The is not about taking action on everything at once, but about setting a small number of key strategic priorities for action, that will make a real impact on people's lives.

4 Alternative Options Considered

4.1 Not to produce a Health and Wellbeing Strategy and rely on strategies from the different agencies and partners to deliver health and wellbeing initiatives for the local

community. As the Board has a duty to prepare a strategy this option has been discounted.

5 Supporting Information

5.1 The draft HWB Strategy as attached has been developed over a number of months by members of the Health and Wellbeing board, partners and stakeholders, via a process of co-production.

5.2 The draft strategy identifies six priority areas and four cross cutting themes which are set out below and contained within Annex A.

Priority areas

- Give all children the best start in life and support emotional and physical health from birth to adulthood
- Promote mental health and improve the lives and heath of people with mental-ill health
- Create opportunities for individual and community connections enabling a sense of belonging and the awareness that somebody cares
- Keep residents safe from Covid-19 and other infectious diseases
- Improve years lived in health and happiness
- Collaborate, plan and secure funds for local and national emerging new health and wellbeing priorities.

Cross Cutting Themes

- Reducing health inequalities
- Creating healthy environments
- Enhancing experience of seamless care
- Community development for wellness.

5.3 The above priorities and cross cutting themes have been agreed at the Health and Wellbeing Board and have been further developed with a number of workshops including agencies, and stakeholders to develop a series of outcomes, actions and indicators which can be monitored once the strategy is formally signed of following public consultation.

5.4 Once agreed the draft Health and Wellbeing Strategy will be made available for a four-week public consultation to take place in January. The document will be made available online for comment, will be shared with key agencies and stakeholders, hard copies will be made available on request. All agencies will be asked to advertise the consultation to their user groups and stakeholders. The consultation will also be publicised via press releases and on the council's social media platforms, to try and reach as many groups as possible and individuals who may wish to comment on the consultation.

5.5 Following consultation, a summary of the consultation and suggested changes to the strategy will be presented back to the Board prior to final sign off, of the Strategy.

6 Consultation and Other Considerations

Legal Advice

6.1 The Health and Wellbeing Strategy is a statutory requirement for the HWB Board.

Financial Advice

6.2 The Health and Wellbeing strategy is expected to be delivered within the existing financial envelope of partner organisations, seeking to sues resources collaboratively to meet value for money objectives.

Other Consultation Responses

6.3 The strategy was co-produced with wider stakeholders. The list of stakeholders engaged during the process is attached as part of annex A.

Equalities Impact Assessment

6.4 Reducing health inequalities is a key cross-cutting theme of the strategy. It is expected that the strategy will have a positive impact on all communities. An equalities impact screening will be available prior to the board meeting.

Strategic Risk Management Issues

6.5 None identified currently

Climate Change Implications

6.6 The recommendations in Section 2 above are expected to:

Reduce emissions of CO_2

The reasons the Council believes that this will reduce emissions as the strategy healthy environment cross-cutting theme and improving years lived with good health promotes active transport.

Background Papers
Appendix A – Draft Joint Health and Wellbeing Strategy

Contact for further information
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Appendix A

Bracknell Forest Health and Wellbeing Strategy 2022-2026

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1 Forward

1.1 Forward by Chair

For the past two years our lives -how we live, work, study and play has been affected by the Covid-19 Pandemic. On one hand the spread of the virus in our communities made many people severely ill whilst on the other hand the social restrictions imposed to stop the spread of the virus affected our health and wellbeing. During this time we have also seen that all our frontline services have done a heroic job of transforming services to respond quickly to respond to the pandemic and support those who were affected. We also saw many of our residents

As the population wide vaccination programme is helping to get us back to some sort of normalcy, we know that we are having to respond to the pandemic and its aftermath. It was therefore, more important than ever to use a co-production process to develop this strategy. This allowed the Council and its partners at the Health and Wellbeing board to work with a range of organisations and people to agree the priorities based not only on the quantitative data but on the lived experiences of people. Bracknell Forest is a healthy place with our residents enjoying longer life expectancy than the national average, and post Covid-19 we want to continue our joint efforts to use our combined assets to ensure that our borough is one of the healthiest place to live, work, study and place. The past two years have taught us that health is everyone's business and we want to maximise health gains from all we do by taking a health in all policies.

Improving emotional and mental health, supporting people to remain physically healthy, creating opportunities for social connections and continuing to keep our residents safe from the Covid-19 virus are key priorities that we will focus our joint efforts. We know that some communities have suffered more than others during the pandemic and the strategy therefore advocates a health population management approach in all that we do, thereby allowing service providers to provide both universal and targeted services to meet the needs of our diverse communities.

This year we have also taken an outcomes driven approach and have committed to monitoring the progress by a set of success indicators.

I look forward to working with all our partners and resident in implementing the actions in the strategy to improve the health and wellbeing of all of us, leaving no one behind.

1.2 Forward by Co-Chair

The pandemic years have put tremendous pressures on the health and care system and continue to do so. Colleagues across the system have risen to this challenge and provided quality services during a rapidly changing public health emergency which we have not witnessed in the last century. We are continuing to face these challenges and are acutely aware that we are yet to see the longer-term impacts of the pandemic on the physical and mental health of our population.

Whilst our services continue to provide treatment and care services to those who need them, the pandemic has brought to the fore that we need to shift our culture to working with our communities to promote health and prevent ill health. Covid-19 affected those with underlying preventable conditions such as obesity and hypertension. We also know that some communities were affected more because of where they live and work. This health and wellbeing strategy provides us the framework to shift that culture whilst our health and care

service plans continue to improve and deliver quality services for our patients and service users.

Taking the opportunities provided by the implementation of population health management and health in all policies approach in this strategy, allows us to combat the wider determinants of health and make decisions for universal and targeted approaches more effectively. The direct and indirect impact of Covid-19 on mental health of our population is already being witnessed through the demand on our services. This strategy rightly focuses on taking actions to improve and support the emotional and mental health of the population. Our frontline services are having to support people who have become more vulnerable and socially isolated and lonely. Creating opportunities in the community for people to feel connected will help our frontline services support the clinical need of these people more effectively.

We heard during the co-production process that whilst we provide many services, people found it difficult to navigate the system. We have therefore committed to work with our communities to improve the information on the services we provide and make it easier for everyone to navigate the system.

The Covid-19 pandemic has been a difficult journey and has emphasised the importance of population health alongside clinical individual services. We cannot afford to miss the opportunity provided through this health and wellbeing strategy to make that cultural shift in maximising health gain from every policy and every contact.

2 Introduction

2.1 About us

The Health and Wellbeing Board (HWB) is a formal committee of the local authority that brings together local organisations that play a key role in improving the health, care and wellbeing of local residents. The membership of the Bracknell Forest HWB is listed in Appendix 1. It is chaired by a democratically elected member and, together with representatives from local patient involvement and voluntary sector organisations, it assures there is a resident perspective to its function of improving the health and wellbeing of its population.

The HWB does not have budgetary or scrutiny powers – these are functions of other boards or committees. However, it does play an important role in identifying key strategic needs and priorities for improving health and wellbeing in the borough. To deliver its role, the HWB has a responsibility to produce a Joint Strategic Needs Assessment (JSNA) and a health and wellbeing strategy. The JSNA is a process that collates and analyses a range of quantitative and qualitative data on the health and wellbeing status of local communities. It identifies key priorities and makes recommendations for improvements that support local commissioning and planning. The JSNA for Bracknell Forest can be found here.

The health and wellbeing strategy is a joint plan that sets the priorities for improvement based on the current understanding of the health and wellbeing profile of the population. In addition to the findings from the JSNA, it considers insights from topic experts, service providers, service users and residents. It sets out the actions that local system partners (commissioners, service providers, service users and residents) should jointly take to achieve the improvement outcomes. Furthermore, it describes how progress on improvement will be monitored. Past strategies that the Bracknell Forest HWB produced can be found here.

2.2 How did we develop the strategy?

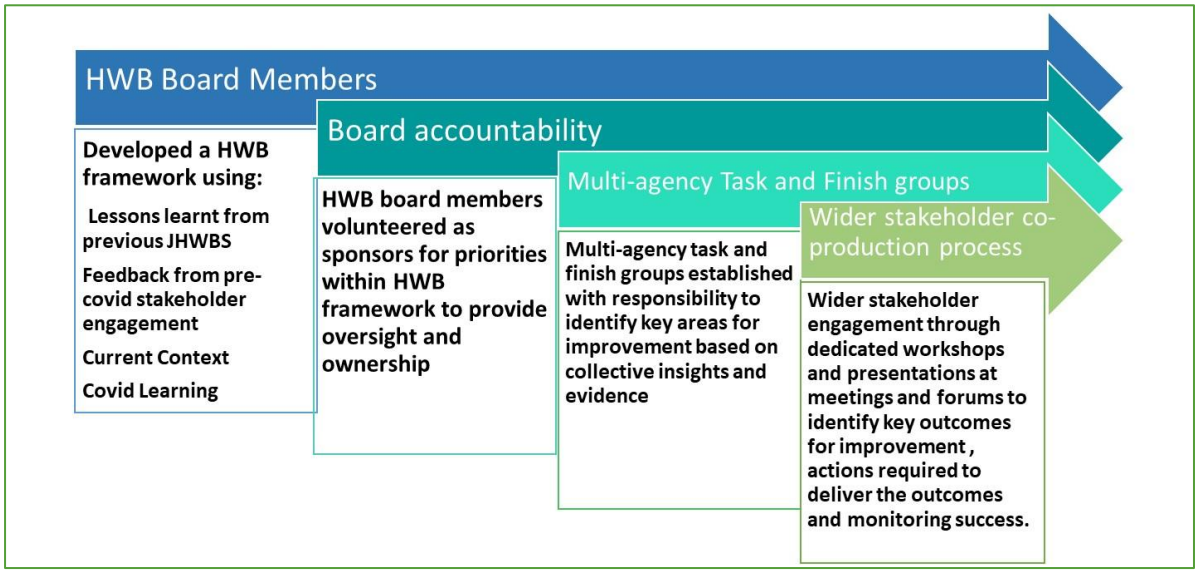
This strategy has been produced within a very different context to anything that has come before. The COVID-19 pandemic has affected all aspects of our lives and, as such, it has also changed the approach taken by the HWB in developing this strategy. Figure 1 shows the process through which this strategy was developed. It includes a framework which allows outcomes driven action planning and the flexibility to review and update the action plans on a yearly basis in response to nationally dictated structural changes and local need.

The framework consists of six principles, six priority areas and four cross-cutting themes. These are owned by partners and their members to take joint responsibility as sponsors for each of the priority areas.

A list of sponsors, task and finish groups and terms of reference are listed in Appendix 2. Using a co-production approach, each of the task and finish groups has undertaken wider

stakeholder engagement to agree the outcomes, the actions to achieve the outcomes and the indicators to monitor the progress. The stakeholder list is in Appendix 3.

Figure 1: Process used to co-produce the strategy



3 Context

3.1 COVID-19 and its impact on population health and wellbeing

COVID-19 has had a direct impact on population health due to it being an infectious disease (ranging from a mild illness to a more severe disease and death). Illness (morbidity) and death (mortality) from COVID-19 has placed tremendous pressure on the NHS, public health services and social care, which has resulted in reduced access to services for routine non-urgent care.

The measures to control the virus implemented in March 2020, both nationally and globally, affected every aspect of our daily lives, including social contact, work, education, finance, leisure and transport.

By the end of 2020, vaccines (a key tool in the fight again infectious diseases) for COVID-19 became available. A national immunisation programme was then launched which was advised by the Joint Committee on Vaccination and Immunisations (JCVI). The programme resulted in the easing of COVID-19 measures, and by 19 July 2021 all mandatory restrictions had been lifted. Transmission of the virus continued, however, the emphasis shifted away from government mandates to personal and workplace responsibilities, including handwashing, social distancing and wearing face coverings – or the new normal.

As the national public health surveillance shifts its focus to detecting and understanding any new variants of concern resulting from higher transmissibility or immune response escape, local public health partners may have to play a greater role in the control of local transmission and outbreak management.

Planning across the health and care system is currently transitioning from the reactive phase of the pandemic to the recovery phase. As some sort of normality returns, several factors will come to the fore that will affect the health and wellbeing of the local population. These include changes in health behaviours due to lockdown, the impact of loss of family and friends, reduced opportunities for social connections, worsening of both physical and mental health due to reduced self and managed care of long-term conditions, and the impacts on the wider determinants of health, such as employment and housing.

The real time national studies and surveys that were conducted during the pandemic provide a rich source of information on the effect these factors have had. The section below describes data from two types of studies – a cross-sectional survey which is a snapshot of a specific time and longitudinal studies which surveyed people over longer periods of time. In Bracknell Forest a Covid 19 resident survey was undertaken during 14 to 30 July 2020.

3.1.1 Mortality and morbidity during the pandemic

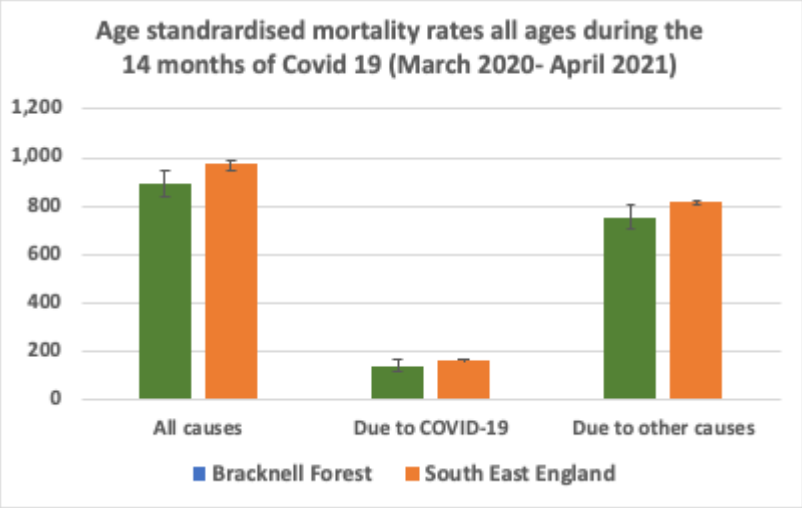
Mortality

Figure 2 shows all-age mortality due to all causes, COVID-19, and all other causes for Bracknell Forest compared with South East England for the 14 months covering the pandemic (March 2020 – April 2021). Rates in Bracknell Forest were not significantly different from rates for South East England.

Nationally, there have been two periods during the pandemic when weekly and monthly registrations of deaths from all causes were consistently higher than the five-year average – also known as 'excess deaths'. Excess deaths are the clearest way to compare the likely impact of the pandemic over time.

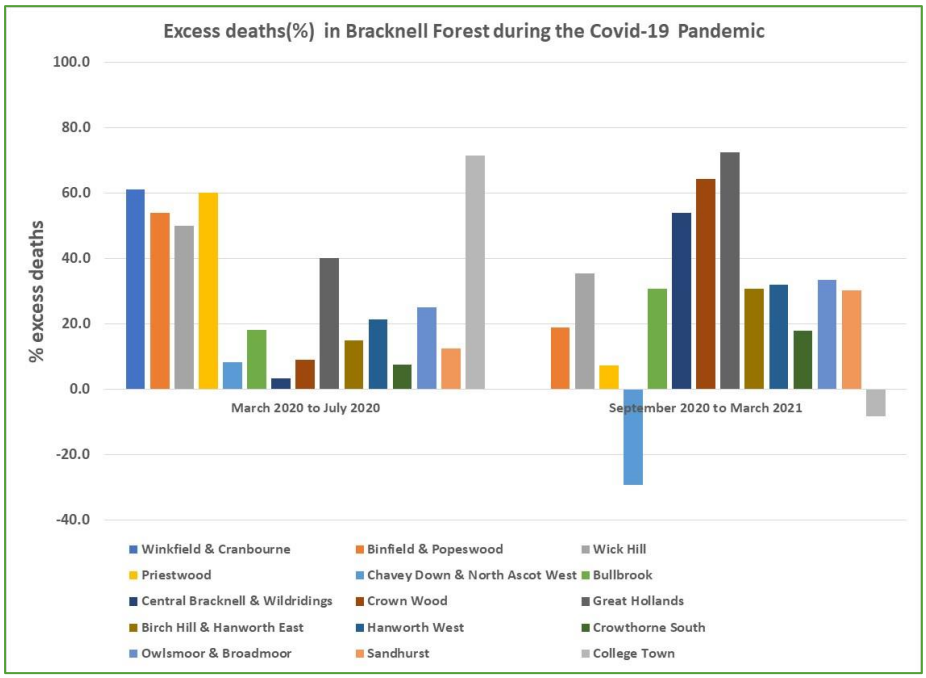
Figure 3 details excess deaths in Bracknell Forest and shows that the impact of COVID-19 across Bracknell Forest was not uniform. This is not surprising given that national evidence suggests that some communities had been more severely affected than others. Factors include age, gender, ethnicity, occupation, and deprivation – all of which underlie established health inequalities.

Figure 2: Age standardised rates (14 months from March 2020 – April 2021)



Data Source: ONS Age-standardised mortality rate, deaths from all causes per 100,000 population and adjusted for age, per month by local authority district, March 2020 to April 2021, England, and Wales

Figure 3 Excess deaths during the pandemic in different areas of Bracknell Forest



Data Source: ONS Deaths registered by MSOA each month, March 2020 to April 2021, compared with the average for the same month between 2015 and 2019, England and Wales

3.1.2 Access to health care and other services during lockdown

A study[1] of primary care contacts between 2017 and July 2020, based on about 13% of the UK population aged 11 years and above and registered with a GP, found that there were substantial reductions in primary care contacts for acute physical and mental conditions following the introduction of restrictions, with limited recovery by July 2020. These findings indicate that except for unstable angina and acute alcohol-related events, contacts for all conditions had not recovered to pre-lockdown levels. The largest reductions were observed for contacts for diabetic emergencies, depression and self-harm. A small study[2] of people with obesity reported reduced access to (44%) and insufficient information from (49%) their clinical service providers. As the pandemic progressed, many services were only offering virtual and online services.

3.1.3 Changes in healthy behaviours during lockdown

During the lockdown, people could go outside for exercise, aside from those who were shielding or self-isolating.

Physical activity

In a snapshot survey[3] with a response from over 9,000 people, around 37% of participants reported a change in their physical activity levels. The results were based on analysis of over 5,000 people who were filtered for case completion. The key findings were that around 1 in 4 reported a reduction in their physical activity levels, while 1 in 10 reported an increase in their physical activity.

In a longitudinal study, physical activity was measured using the International Physical Activity Questionnaire (IPAQ). In this study, 16% of people increased their physical activity levels, while 18% reduced their physical activity levels. The largest drop was in the age group 16-34 years.

In Bracknell Forest, 16% of the people who responded to the Covid 19 resident survey reported doing less physical activity whilst 48% reported increasing their physical activity.

Who were at higher risk?

A study[4] in England based on the self-perceived impact of lockdown on health behaviours found that key independent predictors of negative impacts were a lower education level, being white, having been diagnosed with a psychiatric condition, having class II obesity and above (BMI ≥35 kg/m2), having a high-risk medical condition and having had a case of

[1] Mansfield KE, Mathur R, Tazare J, et al Indirect acute effects of the COVID-19 pandemic on physical and mental health in the UK: a population-based study Lancet Digit Health 2021; 3: e217–30 Published Online February 18, 2021 https://doi.org/10.1016/ S2589-7500(21)00017-0

[2] Brown A, Flint SW, Kalea AZ Negative impact of the first COVID-19 lockdown upon health-related behaviours and psychological wellbeing in people living with severe and complex obesity in the UK EClinicalMedicine March 17, 2021DOI:https://doi.org/10.1016/j.eclinm.2021.100796

[3] Rogers NT et al. Behavioural change towards reduced intensity physical activity is disproportionately prevalent among adults with serious health issues or self-perception of high risk during the UK Covid-19 lockdown (prepublication not reviewed) https://www.medrxiv.org/content/10.1101/2020.05.12.20098921v1

[4] Robinson E, Boyland E, Chisholm A, et al. Obesity, eating behavior and physical activity during COVID-19 lockdown: A study of UK adults. Appetite. 2021;156:104853. doi:10.1016/j.appet.2020.104853

suspected/diagnosed COVID-19. There were some differences for individual health behaviours.

The factors that were all (independently) significantly associated with lower physical activity levels were lower income, being non-white, having a high-risk medical condition, higher BMI, experiencing negative mental health and increased physical health symptoms since lockdown.

The factors that were all (independently) significantly associated with having an unhealthier diet during lockdown were lower income, being non-white, having a high-risk medical condition, higher BMI, experiencing negative mental health and increased physical health symptoms.

Alcohol consumption

A global survey[5] of the impact of COVID-19 on alcohol intake during the pandemic reported that the UK was one of three countries with the highest proportion (around 20%) of participants who reported an increase in the frequency of drinking alcohol. The other two countries were Ireland and New Zealand. It should be noted that the authors have stated that the samples were not representative. They found that 24% of people had reduced their alcohol intake while 44% had increased the frequency at which they drank. The top reasons given for this were:

- Boredom (42%)
- More time (42%)
- Stressed with what is going on (feeling anxious) (20%)
- Taking
- Feeling lonely (19%)
- Feeling depressed (19%).

People who claimed they were drinking more reported that it was affecting their physical health (35%), mental health (22%) and relationships (10%). 44% also wanted support to reduce their drinking.

A snapshot survey[6] commissioned by the charity Alcohol Change UK found that out of 2,000 participants, about 30% had either reduced their drinking or stopped drinking completely (6%). Overall, 20% of drinkers said that they were drinking more frequently and 50% said they were drinking the same as before. Changes in drinking behaviour during the pandemic were, however, related to previous drinking habits. Those who drank daily were more likely to have increased their drinking during lockdown.

Findings from longitudinal studies using the Alcohol Use Disorders Identification Test (AUDIT) tool, compared pre-pandemic drinking to drinking during lockdown and found that 5% of people increased risky alcohol use and 18% of men and 11% of women reduced risky

[5] GDS https://www.globaldrugsurvey.com/wp-content/themes/globaldrugsurvey/assets/GDS_COVID-19-GLOBAL_Interim_Report-2020.pdf

[6] Alcohol Change UK. Drinking during lockdown: headline findings April 2020 https://alcoholchange.org.uk/blog/2020/covid19-drinking-during-lockdown-headline-findings

alcohol use. This reduction in risky alcohol use occurred to the greatest extent in the youngest age group.

In Bracknell Forest, 24% of respondents to the Covid-19 residents survey reported increasing alcohol consumption.

3.1.4 Personal wellbeing

Personal wellbeing is measured routinely in the UK by the Office for National Statistics (ONS) and in many other national surveys. Worries about income, food insecurity, fear of the virus and bereavement are all likely to have had an impact on personal wellbeing. There are four measures of personal wellbeing used by the ONS:

- Life satisfaction
- Worthwhile (to what extent do people feel the work they do is worthwhile)
- Happiness
- Anxiety.

The impact of COVID-19 on personal wellbeing can be observed by comparing data from a survey ending March 2019[7] (which may be used as reference for population personal wellbeing in the UK before the pandemic), with a survey taken just before entering lockdown and a survey taken the last week in May 2020[8], just before the phased exit. The mean scores for all four indicators fell during the pandemic but the largest reductions were seen in the mean scores for happiness and anxiety. The percentage of people reporting high anxiety increased from 20% pre-pandemic to 46-56% during lockdown. The life satisfaction and worthwhile indicators had fallen less overtime but remained subdued through lockdown.

The most common issue that affected wellbeing continued to be feeling worried about the future (63%), followed by feeling stressed or anxious (56%) and feeling bored (49%). The data from the economic wellbeing and food insecurity studies discussed in the above sections reported that the following populations had higher levels of anxiety due to COVID-19:

- People whose income had reduced in employment
- People who were facing food insecurity

The increase in anxiety levels may put a higher burden on health services. A study[9] that investigated COVID-19 related anxiety and somatic symptoms found that there was a strong positive correlation with anxiety for all somatic symptoms except cardiopulmonary symptoms. This correlation remained even after adjusting for generalised anxiety disorder suggesting that the pandemic had impacted anxiety levels. The strongest correlation was between COVID-19 anxiety and fatigue.

3.1.5 Mental health

Psychiatric distress was associated with the 2003 SARS pandemic, as well as the isolation of populations during other disasters. Therefore, COVID-19 was expected to result in similar

[7] ONS Annual Personal Well-Being Estimates Published 6th Feb 2020
[8] ONS Personal and economic well-being in Great Britain: June 2020
[9] Gibson J et al. COVID-19-related anxiety predicts somatic symptoms in the UK population. British Journal of Health Psychology (2020) DOI:10.1111/bjhp.12430

psychiatric distress[10]. Findings from the UK longitudinal studies[11] found that psychological distress increased one month into lockdown, particularly among women and young adults.

In the Bracknell Forest Covid-19 resident survey, 25% of the respondents reported that the pandemic had a negative impact on their mental health.

A systematic review[12] explored the mental health impact of COVID-19 and categorised them under the following headings:

Mental health impact on patients with COVID-19

In a study of 714 hospitalised but stable patients, post-traumatic stress symptoms were reported in 96% of patients. In another study, 29.6% of newly recovered patients had depression which was significantly higher than patients in quarantine (9.8%). There was no association found with anxiety in COVID-19 patients.

Mental health impacts on people with existing mental health conditions

In a study into patients with eating disorders, it was found that 37.5% reported worsening in their eating disorder symptomatology and 56.2% reported additional anxiety symptoms. Another study found 20.9% people with pre-existing mental health disorders reported worsening of their symptoms.

Mental health problem in health care workers

Some studies reported depression and anxiety amongst front line workers compared with administrative staff while other papers found no difference in symptoms between front line staff and the public or other workers. No study found post-traumatic stress in health care workers.

Mental health impacts on general population

There were conflicting findings on psychiatric impact with reports of increased depression and anxiety by some authors and no significant difference by other studies. Parents of children admitted to hospital during the pandemic had higher psychiatric symptoms of depression and anxiety compared with parents of children admitted pre-pandemic.

The longer-term impacts of COVID-19 on the mental health of the population is expected to be due to the wider determinants of health.

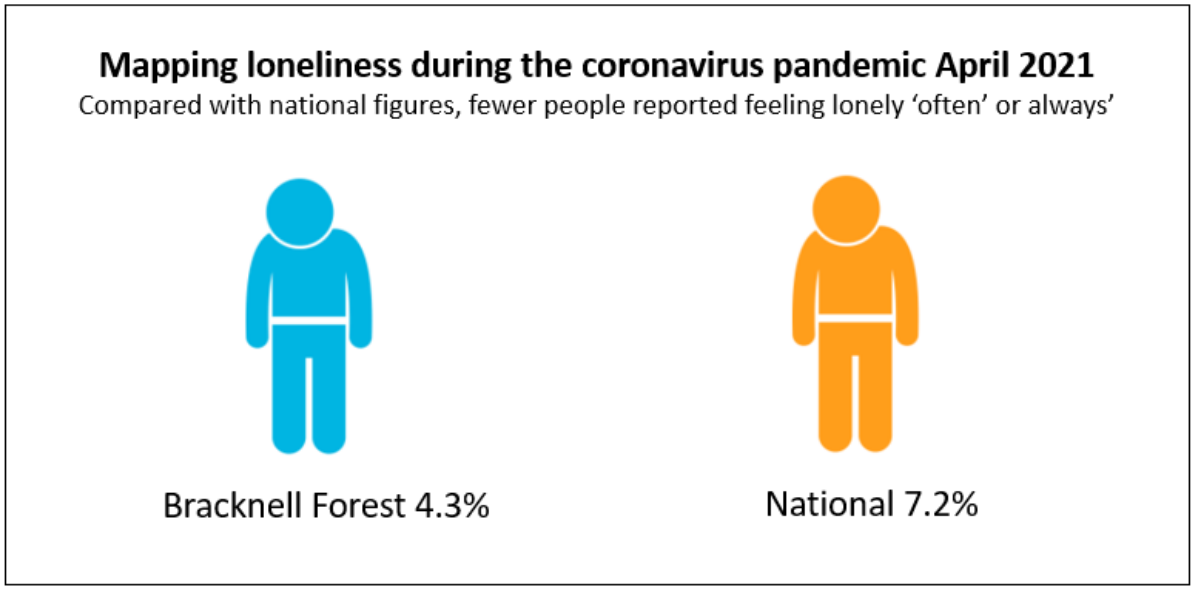
3.1.6 Social connections and loneliness

[10] Torales J et al. The outbreak of Covid-19 coronavirus and its impact on global mental https://journals.sagepub.com/doi/pdf/10.1177/0020764020915212

[11] Niedzwiedz CL, Green MJ, Benzeval M*, et al* Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown: longitudinal analyses of the UK Household Longitudinal Study *J Epidemiol Community Health* 2021;**75:**224-231.

[12] Vindegaard N and Benros MV COVID-19 pandemic and mental health consequences: Systematic review of the current evidence Brain, Behavior, and Immunity accepted for publication in press 2020

Social connections and interactions with family, friends, neighbours and colleagues, are well established factors that influence health and wellbeing. Loss of social connections and physical contact with other people/peers was one of the key impacts of the pandemic for many families and individuals. For others, the pandemic was an opportunity to spend more time together and strengthen family bonds or give time volunteering. Loss of health due to long-COVID or a long stay in hospital and bereavement increased the risk of loneliness.



Data on loneliness from the national opinion and lifestyle survey from October 2020 to February 2021[13]

Who was at greater risk of loneliness during the lockdown?
There was an estimated 5% prevalence of loneliness nationally prior to the pandemic. Lockdowns affected many people who were not chronically lonely. The prevalence of 'lockdown loneliness' was estimated to be 14.3% of the national population. Working-age adults living alone, those in 'bad' or 'very bad' health, those in rented accommodation and those who were single, divorced, separated or a former or separated civil partner were at greater risk of lockdown loneliness[14].

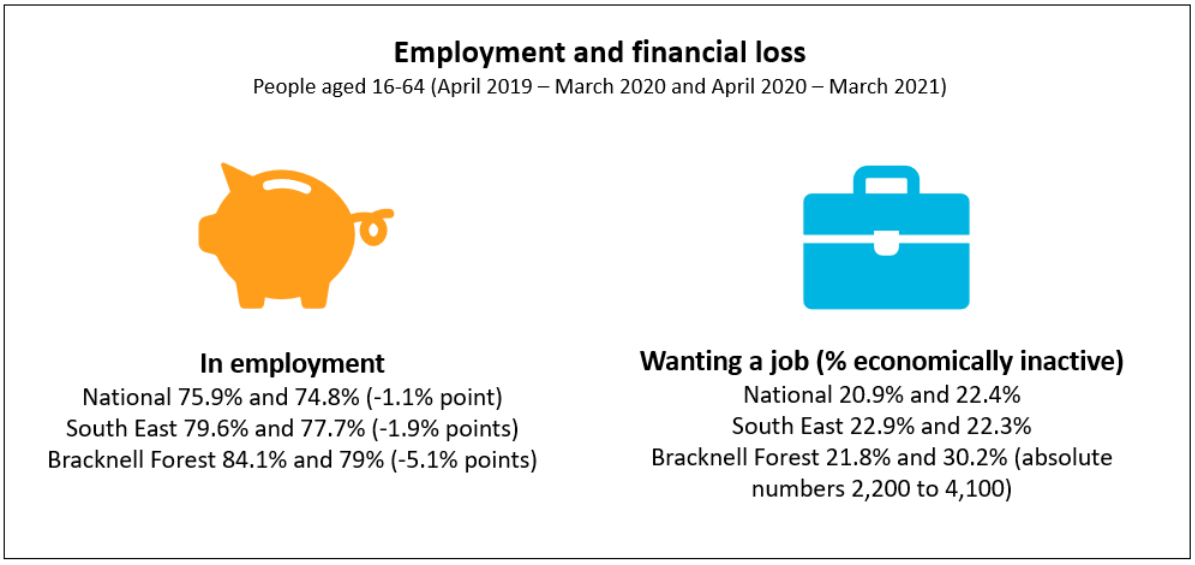
3.1.7 Wider determinants of health

Employment and financial loss
Trend data from labour workforce and real time PAYE information showed a decrease in people in employment during March 2020 and in median pay.[3] The key impact was on positive hours worked and earnings.[4] Between 43-58% of employees were furloughed whilst for the self-employed the figure was 7.4%. On average employees with zero-hour contracts and the self-employed saw the largest reduction in positive hours and earnings (nearly half the pre-pandemic levels). Young people (those aged 16 to 24 years) had been particularly

[13] ONS Mapping loneliness during coronavirus pandemic April 2021 Mapping loneliness during the coronavirus pandemic - Office for National Statistics (ons.gov.uk) accessed 29 sept 2021
[14] ONS Coronavirus and loneliness, Great Britain: 3 April to 3 May 2020 Coronavirus and loneliness, Great Britain - Office for National Statistics (ons.gov.uk) accessed 29 sept 2021

affected with their employment rate decreasing and unemployment and economic inactivity rates increasing (more than for those aged 25 and over).

In recent months, growth in payroll employees and median pay has risen with levels reaching pre-covid levels. However, this growth is not uniform across all the regions.



Out of work benefits

By May 2020, the working age population claiming out of work benefits increased from the baseline in February 2020 then stayed steady until April 2021.Since then it has been decreasing but is still above the pre-pandemic lockdown figures.

Data for February 2020, May 2020, August 2021 (February to May change)

- National 3.0%, 6.4 %, 5.3% (x2)
- South East 2.1%, 5.3%, 4.2% (x2.5)
- Bracknell Forest 1.5%, 4.5% 3.2% (x3) Absolute numbers (1,220, 3,610, 2,590)

Housing

The government's 'Everyone In' initiative to temporarily house the rough sleeping population and homeless people in shelters who could not self-isolate at the outbreak of the virus ensured that 90% had been offered accommodation.

Education and training opportunities

The long-term impact of the pandemic on educational attainment and opportunities is yet to be known, but studies on the short-term impact and associated public health measures indicate that around 7% of children were not able to access online learning due to limited or no internet access. Findings from different studies are mixed with some suggesting a negative impact on both progress of at Key Stage 1 of covid-cohort compared with pre-covid cohort other studies suggesting that the impact was negligible in most high-income countries including UK.

A small study (58 self-selected schools) on the impact of COVID-19 on those starting school found that schools had to provide more for students than previous years.[15] Schools reported that children struggled in three key areas of development:

- Communication and language development (96% schools)
- Personal, social, and emotional development (91% of schools)
- Literacy (89% of schools).

Most parents/carers had concerns about their child starting school, particularly about their social and emotional development.

Domestic abuse and exploitation

Domestic abuse is a pattern of controlling, threatening and coercive behaviour. It can be physical, emotional, economic, psychological or sexual. Abuse is a choice a perpetrator makes, and isolation is used by many perpetrators as a tool of control. In some households, isolation and an increase in the frequency of alcohol consumption during the pandemic created an environment conducive to domestic violence and abuse. In the UK, statistics[16] released by Refuge indicate a 25% increase in calls to its domestic abuse helpline, with visits to its website showing a 150% increase. Similarly, Women's Aid reported a 41% increase in those using its live chat service since the pandemic began.

Health inequalities

The data from all surveys and studies highlight that existing inequalities had widened during the pandemic. This has meant that proportionally, the highest burden of the pandemic, was seen in communities that were already struggling or had the poorest health outcomes. A key report from Public Health England (PHE)[17] presents findings based on surveillance data available to PHE at the time of its publication, including through linkage to broader health data sets. It confirmed that the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them. The largest disparity found was by age. Among those already diagnosed with COVID-19, people who were 80 or older were 70 times more likely to die than those under 40. Risk of dying was also higher in males, those living in more deprived areas and for Black, Asian and Minority Ethnic (BAME) groups. These inequalities largely replicate existing inequalities for mortality rates from previous years, except for BAME groups as mortality was previously higher in white ethnic groups. These analyses include age, sex, deprivation, region and ethnicity, but they do not take into account underlying health conditions, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences.

[15] Tracey l, Boyer-Crane C, Bonetti S et al; The impact of Covid-19 on School Starters: Interim briefing 1: Parent and school concerns about children starting school University of York, The National Institute of Economic and Social Research (NIESR) and the Education Policy Institute (EPI).

[16] J Wilde Research in Practice https://www.researchinpractice.org.uk/all/news-views/2020/april/domestic-abuse-in-the-coronavirus-epidemic/

[17] PHE 2020 Research and analysis overview: COVID-19: review of disparities in risks and outcomes - GOV.UK (www.gov.uk)

3.2 Key local plans

3.2.1 Frimley ICS Strategy 2019-2025[18]

Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It aims to remove traditional divisions between hospitals and family doctors, physical and mental health and the NHS and council services. Integrated Care Systems (ICSs) are new partnerships between these organisations that meet the health and care needs across a specific area, coordinate services and plan ways to improve population health and reduce inequalities between different groups.

The NHS Long-term Plan confirmed that from April 2021, all parts of England would be served by an ICS, building on the lessons of the earliest systems and the achievements of earlier work through sustainability and transformation partnerships and vanguards. The Frimley ICS was one of the vanguard sites and has done pioneering work on integrated care.

In 2019, the Frimley ICS published its five-year strategy 'Creating Healthier Communities'. It has two overarching strategic goals which are to be achieved by 2025:

- Healthy life expectancy at birth to improve by two years
- The gap in healthy life expectancy between the least and most deprived communities will be reduced by three years.

The strategy has six ambitions as shown in Figure 3 below.

Figure 3: Frimley ICS Strategy 2019-2025

The strategy aims to ensure that all children get the best possible start in life by:

- engaging children and young people in a different way, working with education and building on young people's creativity and energy

[18] Frimley Health and Care Organisation: Plans (frimleyhealthandcare.org.uk)

- providing targeted support for children and families with the highest needs and those who are the hardest to reach
- supporting women to be healthy before pregnancy
- ensuring births are safe
- expanding life choices and opportunities
- increasing happiness and decreasing anxiety.

The strategy aims also include:

- Wellbeing – to provide opportunities for people to live healthier lives, no matter where they live. It will prioritise improving the health and wellbeing of those who are most economically disadvantaged and in poor health.
- Our collective agreement - (as organisations, individuals and families) about how healthier communities can be created to support healthier choices and to design and deliver new ways of working to improve the health and wellbeing of residents.

  Community development for wellness is a cross cutting theme in this strategy. Within Bracknell Forest over the next 3 years, we will work alongside communities taking a population health and assets-based approach to address health inequalities and facilitate increased empowerment of communities focusing on the health and wellbeing issues that are important to them. Starting with pilot work with one or two geographical or demographic communities in year one to enable and support community action and assets. The communities will be identified based on data analysis drawn from local health needs assessments and intelligence.

- Healthy work environment – maintain a healthy workforce and attract local people to careers in the health and care system.

The strategy further provides a platform for leadership and cultural change to enable people to work together to encourage co-design, collaboration, inspiration and a chance to contribute. This approach includes:

- Integrating teams at place and targeting care
- Knowing our communities and being part of them
- 'With' our residents, not 'to' – co-designing all our work
- Listening to what is important locally

It also aims to use NHS resources to offer the best possible care, treatment and support, where it is most needed in the most affordable ways and using the best available evidence. By working together to maximise the impact of the skills and capacities of staff, making decisions based on good intelligence, utilising digital capabilities, the 'Frimley pound' and local buildings and facilities, it aims to shift resources to increase benefits.

3.2.2 The Bracknell Forest Council Plan[19]

The council plan sets out the key objectives for 2019 to 2023. It delivers the commitments made to residents in the 2019 local election. The plan focuses on the things that matter most

[19] Bracknell Forest Council The Council Plan | Bracknell Forest Council (bracknell-forest.gov.uk)

to residents, which is at the heart of everything the council does. This is based on a narrative which recognises Bracknell Forest as 'the borough of opportunity'.

The plan aims to prioritise spending based on clearly identified needs, such as:

- reducing our impact on climate change
- making sure help is available for our most vulnerable residents to keep them safe and help them remain independent while avoiding loneliness and isolation
- reducing homelessness
- developing all age learning and life skills
- maintaining value for money.

To deliver the objectives and make sure that Bracknell Forest remains a good place to live, work and play, the plan has six strategic themes as shown in the Figure 4.

Figure 4: Strategic themes, Bracknell Forest Council Plan

The key themes of economic resilience, education and skills and protecting and enhancing your environment address the wider determinants of health.

Caring for you and your family
Bracknell Forest is one of the heathiest places to live. It aims to support people to live longer in good health, both physical and mental.

The Council will continue to invest in preventing people from needing health and care services in the first place and pledge to buy the best possible services that meet the needs of residents.

3.2.3 Population Health Management

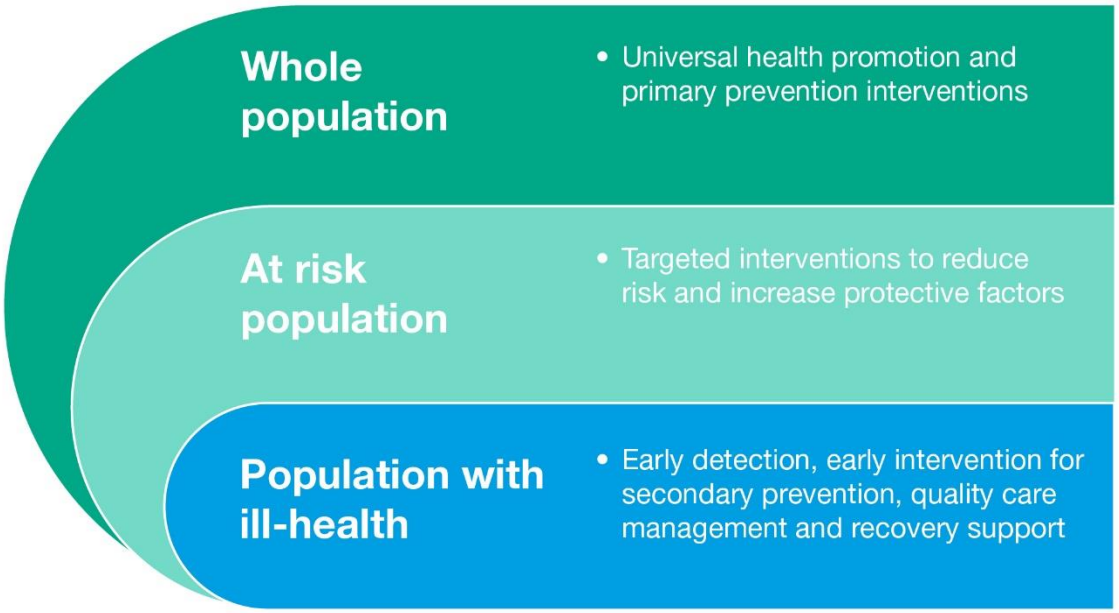
Compared with individual and personalised care provided by frontline practitioners, a population health approach explores the health status and outcomes for either the whole population or sub-populations. It allows strategic planning by identifying where improvements can be made by taking a system-wide approach. For example, a nurse may provide an individualised care plan for a person with diabetes, but population health provides a strategy to both prevent diabetes by identifying key risks and protective factors in the whole population and improve the care and management of the diabetic population (a sub-

population of the whole population). Figure 5 shows how population health approaches can be used to segment populations and make decisions for interventions.

While population health approaches are not new, one of the problems with implementing them has been the use of different data collecting systems which do not talk to each other. This prevented the data from being analysed collectively and, therefore, for partners to make decisions based on collective analysis. NHS England (NHSE) and NHS Improvement (NHSI) are currently implementing a programme which allows the exploration of different populations (whole population and sub-populations) so that decisions can be made to improve the management of care at different levels – system level, place level, primary care network level or at individual practice level. This programme is called Population Health Management.

The NHS Frimley Clinical Commissioning Group (CCG) is a place-based pilot site for the Population Health Management programme in the Frimley ICS.

Figure 5: Population health management concept



3.3 Health in All Policies

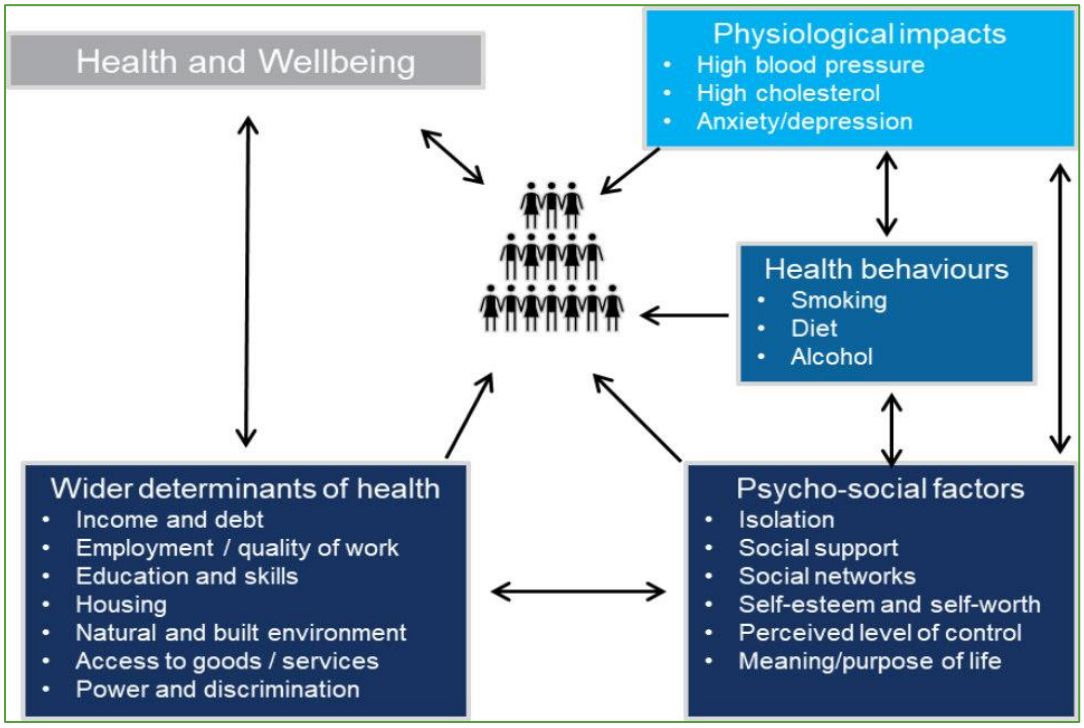
The Health in All Policies (HiAP) approach considers the wider environment and its influence on people's health. It is a label for a larger concept rooted in the fact that the environments in which people are born, live, study, work, play and grow old shape their health outcomes. These wider determinants of health are important as they look beyond factors that only relate to the individual. If environments matter for health, then it is important to consider health outcomes in making decisions that shape these environments.

The environmental frame can be obscured by the fact that many people still hold individuals accountable for their own health outcomes, especially in relation to lifestyle choices, such as smoking, diet and physical activity. While it is true that the decisions we make as individuals affect our health, our environments also matter– individual decisions are usually made in the

context of economic, social and physical environments. To make the case for HiAP most effectively, it is important to provide an alternative to the default frame of individual choice.

The Dahlgren and Whitehead (1991) model of public health has long served as a framework within which a public health approach to population health has been delivered. It describes the wide range of external factors which can influence an individual's health. These include employment, living and working conditions, work environment, health care services, housing and education. It also considers social and community networks and individual lifestyle factors. The consideration of these wider determinants forms a core foundation to a HiAP approach. The Labonte model diagram (Figure 6) illustrates the importance of the wider determinants and their interaction with other individual factors including psycho-social, behaviours and health. The HiAP approach looks more closely at how these wider influences can be altered so that they have a positive impact on an individual's health behaviours.

Figure 6: Labonte Model (1993)



HiAP allows for a shift in focus from these individual factors to environmental and wider influences – this will be a golden thread which will run through the work undertaken by this strategy. Thus, for each of the six components, the wider determinants will be considered along with ways in which the objectives can be fulfilled by embedding health into other parts of the council and wider system.

Defining the HiAP approach

The HiAP approach will cover the following broad areas:

1. **Creating healthy settings** – a focus on the built environment so that the healthy choice is the easy choice for all. This includes supporting others to create healthy settings such as workplaces, High Streets, schools and hospitals.
2. **Creating healthy communities** – supporting communities by taking an asset-based approach to health and wellbeing and targeting key health inequalities. This aspect of the

work will be driven by local data drawn from local health needs assessments and intelligence.

3. **Embedding health in council policy and service delivery** – HiAP will enable the council to maximise the health gains for the population and to promote the ethos that *Health is Everybody's Business*.

Figure 7 provides an overview of the HiAP approach in East Berkshire, which will be considered alongside the delivery of the objectives in this strategy.

Application of the three areas of the HiAP approach to this strategy

Embedding health through building capacity

This is a cross-departmental approach to maximise the health gains for the population and influence health through strategies, services and programme delivery. Many of the objectives of this strategy will rely on the health and wellbeing aims being embedded into other directorates, services and programme delivery as well as policies. Examples of how the HiAP approach will support others across the council to achieve this include:

- Training and funding opportunities to embed health into other work of the council, ensuring health features in criteria and guidance to be included in the procurement processes
- Health Impact Assessment training to be embedded in the planning process
- Training in Making Every Contact Count.

Creating healthy settings

This will use local intelligence to identify places/settings to review assets, the built environment and green space. It will be important to determine what changes are required to the environment to drive healthier behaviours and priorities e.g. smoke-free, easy active travel and healthy retailers. These include:

- Workplaces and employers to promote employee health and wellbeing
- Highstreets, local retailers, night-time economy (future High Streets work)

- Education and healthy schools
- Leisure centres e.g. food and drink and range of activities to suit all
- Hospitals/GP practices
- Care homes and day centres
- Wider infrastructure creating healthy buildings and areas which facilitate walking and cycling and use of local open spaces to support health and wellbeing.

This approach will consider how creating healthy settings can support the relevant objectives of the strategy as they are being delivered.

Creating healthy communities
This will look into the key wider determinants of health that impact on specific population groups or communities including:
- Housing
- Employment including meaningful employment and workplace health
- Local infrastructure and physical access to services
- Access to open space
- Social connections

This approach will focus on working with communities and residents who have the poorest health and, therefore, form the basis of the audience which link to the strategy objectives (e.g. children and young people and their families, adults with mental ill-health).

Overall, the HiAP approach provides a wider lens through which to view and address the objectives of the strategy. It will prompt decision makers in the council to consider the influences of the wider determinants on health and wellbeing and examine what actions can be taken from this wider vantage point to improve the health of its residents.

4 The health and wellbeing framework

The health and wellbeing framework consists of a vision, six guiding principles, six priorities and four cross-cutting themes.

4.1 Bracknell Forest health and wellbeing vision

Or

4.2 Bracknell Forest health and wellbeing guiding principles

The six guiding principles shown below were used in developing the strategy and will support its implementation.

4.3 Bracknell Forest health and wellbeing priorities

The six priorities are interlinked, and four cross-cutting themes are embedded within each of the priority areas to reflect the health in the all policies approach.

5 Give all children the best start in life and support emotional and physical health from birth to adulthood

5.1 Why is this a priority?

Foundations of a healthy life start early from the time of conception and continues through to adulthood. This is the time physical and emotional health is developing, health behaviours are set and social skills are formed. From a physiological perspective, the time of development is the only window of opportunity for ensuring optimum health and wellbeing. From a social perspective, this provides the future agency to reach its full potential and contribute to society as an adult. Social and emotional wellbeing is important, as it also provides the basis for future health and life chances.

5.2 Policy context

The importance of this priority is recognised in evidence-based guidance and a number of national policies. Many of these policies are implemented through commissioned services or plans and even though they support the delivery of the strategy, they also have a wider scope so not all are listed here.

0-19 Healthy Child programme[20]

The Healthy Child programme offers every family an evidence-based programme of interventions, including screening tests, immunisations, developmental reviews and information and guidance to support parenting and healthy choices. It also outlines all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

The Bracknell Forest Public Health team is working with East Berkshire colleagues to produce a health needs assessment for 0-19-year-olds to support the commissioning of the new model of delivery. (Link to HNA)

NHS Long Term Plan

The plan states that by wrapping care around the mother and her family, the NHS will ensure every child has the best possible start in life, from birth through to their transition into adulthood. In addition to the transformation of maternity services, it includes a children and young people transformation plan. The programme focuses on a wide range of priorities in relation to children and young people, from improving care for children with special educational needs, supporting integration and development of new models of care, improving mental health services, to improving transition to adult services. The key areas are as listed below:

- Childhood asthma
- Mental health

[20] PHE May 21 Health visiting and school nursing service delivery model https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model

- Learning disability and autism
- Safeguarding
- Special educational needs and disability
- Children's health data and digital strategy
- Oral health
- End of life and palliative care
- Specialised commissioning
- Health and justice

There are already plans in place locally through the Frimley ICS and hence are not included in this strategy. (LINK to ICS children services plan)
Some of the elements, such as the school mental health teams, will support the delivery of the improvement in outcomes.

Department for Education (DfE) policy
One of the key policies within the education sector is the Relationships and Sex Education and Health Education (England) Regulations 2019 [21], made under sections 34 and 35 of the Children and Social Work Act 2017. This statutory instrument makes Health Education (HE) compulsory in all schools except independent schools. Personal, Social, Health and Economic Education (PSHE) continues to be compulsory in independent schools. The rationale for the legislation is to provide children throughout school life the opportunities to build health competencies and resilience, to understand and build positive relationships within family and peers and to recognise and report abuse when it arises. Building health and social competency and resilience at a young age enables better health and wellbeing outcomes in adult life. Although schools can choose their own method of delivery, the national statutory guidance[22] sets the topics and learning outcomes.

5.3 What we heard in the co-production workshops

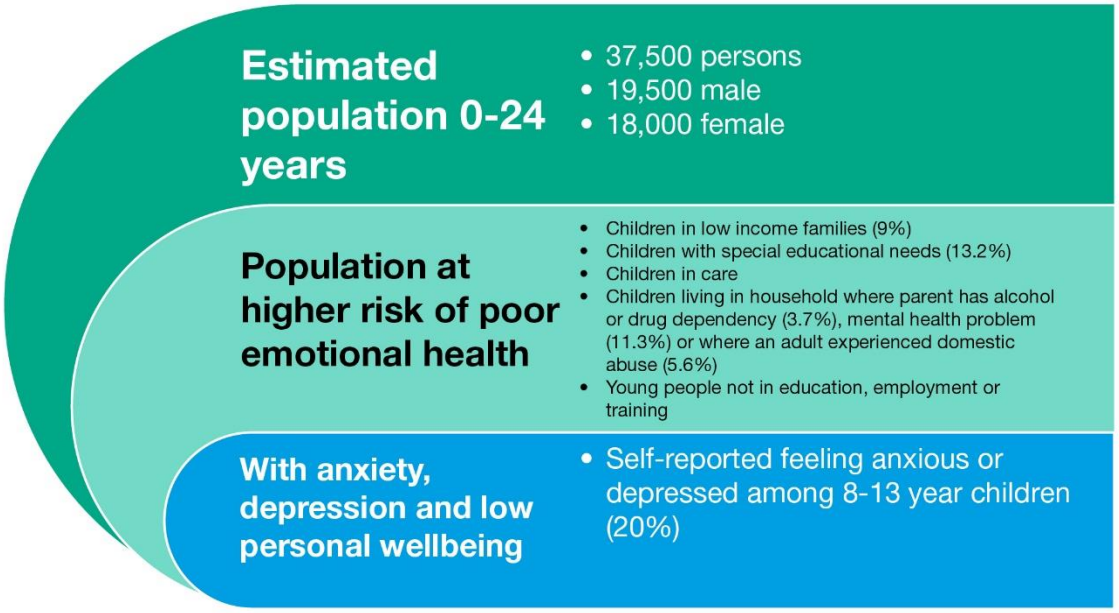
Three key areas emerged that need to be addressed through this strategy

[21]Statutory Instruments no 924 (2019) https://www.legislation.gov.uk/uksi/2019/924/introduction/made
[22] DfE Relationships Education, Relationships and Sex Education (RSE) and Health Education Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers (2019)

- Educational attainment gap
- Bracknell Forest Council's education department is developing the plans for improvements in educational attainment (Link).

5.4 Population health management high level information

Figure 8 provides an estimate of the populations for universal promotion and prevention and those that are at higher risk of poor emotional health due to either adverse living conditions or vulnerability.



Data source: Figures are from PHE fingertips, Children commissioner report, OxWell Survey

5.5 What outcomes do we plan to deliver?

1. Improve personal wellbeing/happiness
2. Reduce anxiety and depression in all children and young people
3. Reduce the feeling of being alone and excluded
4. Increase the number of commissioned services that have performance matrices measuring improvement in emotional wellbeing
5. Improve the experience of children, young people and their parents in navigating the system and services
6. Increase number of peer support groups for children and young people
7. Improve awareness of emotional health, self-help and services among children, young people and their families
8. Reduce stigma associated with emotional health

5.6 What actions will we take to deliver the outcomes?

1. Work in partnership with residents and community groups/organisers to develop age appropriate creative and physical activity opportunities outside school to support health and wellbeing
2. Improve the public health portal 'Thrive', by working with all stakeholders taking on board the lived experiences to enable children and their families to navigate the system with ease
3. Work with the East Berkshire 'Be Well' campaign to ensure links are made with the local public health portal, providers and communities
4. Work with schools, mental health support teams and school nurses to develop peer support groups that enable children and young people to speak about emotional problems without fear of stigma
5. Work with early years, health visitors and voluntary services to develop peer support groups and activities to reduce feelings of loneliness and anxiety in new parents
6. Review and improve the Make Every Contact Count (MECC) training to include appropriate material for emotional and mental health promotion, detection, and early intervention
7. To develop a costed service model to meet the gap between general wellbeing, IAPT and CAMHS
8. Make services inclusive by considering the role of a male parent and the relationship between dads and young boys.

5.7 What success indicators will we use to monitor progress?

1. Indicators on happiness and wellbeing from the ONS survey and the local survey on mental health and wellbeing of school children in Years 5-13 conducted by Oxford University (OxWell Survey)
2. Insights from service performance reports
3. Feedback from service users
4. Increase in participation in creative and physical activity groups outside school
5. Number of peer support groups formed
6. Findings from annual evaluation of application of emotional health MECC training to practice
7. Increase in reach and utility of the Thrive portal and Be Well campaign
8. Decrease in unmet need for services that do not fall in general wellbeing, IAPT or CAMHS services.

5.8 Cross-cutting themes

HiAP approach

Healthy environments at home, school and neighbourhood plays an important role in providing the best start in life and supports emotional and physical health of all children. Actions to support whole school approaches to enable schools to be healthy settings are included in the delivery of the outcomes

Health inequalities

'No Child Left Behind'[23] and the Children's Commissioner reports highlight that inequalities start early in life with many children being vulnerable and this will impact their current and future health and wellbeing.

PHE, NHSE and partners have developed a framework for vulnerability to support 'child and young person-centred recovery' for three broad groups, which are:

- Children who may be more clinically vulnerable to COVID-19 because they have underlying health conditions, or the pandemic has in some way delayed or curtailed their access to health services.
- Children and families who are at increased risk due to family and social circumstances where there is a statutory entitlement for care and support (Education, Health and Care Plan and those with a social worker)
- Children who may be at higher risk due to being negatively impacted through wider determinants of health and/or family stressors and social circumstances and may not be known to services.

Children may be in more than one group, and children not previously identified as vulnerable may become so, as the economic and social impact of the pandemic are felt in the family.

In delivering improved outcomes, this strategy will ensure that the health inequalities within the agreed outcomes are reduced.

Seamless care

The general view is that there are many services, but information on these services is not readily available. Therefore, we will work with partners to update the Thrive portal as a one-stop shop for information and resources. It will also link to the Be Well portal.

Community development for wellness

Young Health Champions

The Young Health Champions programme is a national initiative accredited by the Royal Society of Public Health. It aims to give young people the skills, knowledge, and confidence to act as peer educators by empowering them with knowledge about their community, support groups and where to access health advice. The programme is delivered across secondary schools in Bracknell Forest.

[23] PHE 2020 No Child left behind – A public health informed approach to improving outcomes for vulnerable children https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/913764/Public_health_approach_to_vulnerability_in_childhood.pdf

6 Promote mental health and improve the lives and health of people with mental ill-health

6.1 Why is this a priority?

Mental health is essential to our overall wellbeing and is as important as physical health. When we feel mentally well, we work productively, enjoy our free time and actively contribute to our communities. One of the main impacts that COVID-19 had on our residents, both in the short and long-term, was to their mental health. It also had a greater impact on people living with mental illness.

6.2 Policy context

COVID-19 mental health and wellbeing recovery action plan[24].
The aims of the national mental health recovery plans are three-fold:

- To support the general population to take action and look after their mental wellbeing
- To prevent the onset of mental health difficulties, by taking action to address the factors which play a crucial role in shaping mental health and wellbeing outcomes for adults and children
- To support services to continue to expand and transform to meet the needs of people who require specialist support

Prevention Concordat for Better Mental Health[25]
The Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health has been shown to make a valuable contribution to achieving a fairer and more equitable society. The concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. The sustainability and cost-effectiveness of this approach is enhanced by the inclusion of action that impacts on the wider determinants of mental health and wellbeing.

The concordat is intended to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across:

- Local authorities
- The NHS
- Public, private, voluntary, community and social enterprise (VCSE) sector organisations
- Educational settings
- Employers

It also acknowledges the active role played by people with lived experience of mental health problems, individually and through user-led organisations.

The NHS Mental Health Implementation Plan[26]

[24] HM Government March 2021 Policy paper overview: COVID-19 mental health and wellbeing recovery action plan - GOV.UK (www.gov.uk)
[25] PHE Dec 2020 Prevention Concordat for Better Mental Health - GOV.UK (www.gov.uk)
[26] NHS July 2019 NHS Long Term Plan » NHS Mental Health Implementation Plan 2019/20 – 2023/24

The plan details a new framework at the local level to help deliver on the commitment to pursue the most ambitious transformation of mental health care. Within this plan, a ringfenced local investment fund worth at least £2.3 billion a year, in real terms by 2023/24, will ensure that the NHS provides high quality, evidence-based mental health services to an additional 2 million people. The plan has set ambitious goals to improve mental health services. By 2023/24, 370,000 adults and older adults with severe mental illnesses will have greater choice and control over their care including dedicated provision for groups with specific needs, such as adults with eating disorders or a personality disorder diagnosis. An additional 345,000 children and young people will access support via NHS-funded mental health services and school- or college-based mental health support teams. The current, targeted suicide prevention programme will be rolled out to every local area, and all systems will provide suicide bereavement services for families and staff. Importantly, the shift towards more integrated, population-level health systems will support more localised and personalised responses to health inequalities across the prevention and treatment spectrum.

The Community Mental Health Framework for adults and older people[27]
The Community Mental Health Framework describes how the NHS Long-term Plan's vision for a place-based community mental health model can be realised, and how community services should modernise to offer whole-person and whole-population health approaches, which are aligned with the new Primary Care Networks

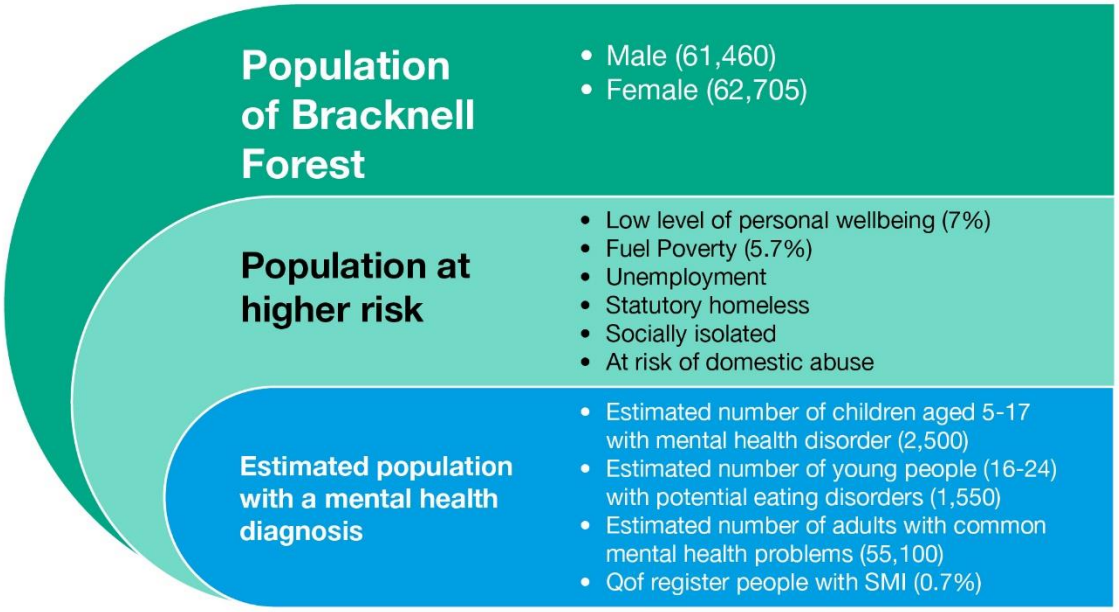
The plans are locally led by the Frimley ICS and can be found here (Link).

6.3 What we heard in the co-production workshops

Three aims were proposed by the multi-agency group.

6.4 Population health management high level information

[27] NHS July 2019 NHS England » The community mental health framework for adults and older adults



6.5 What outcomes do we plan to deliver?

1. Reduce eating disorders and disordered eating at population level
2. Reduce self-harm in children and young people
3. Increase in number of schools promoting mental health and wellbeing
4. Improve social, educational, and physical health outcomes for children and young people with a diagnosis of mental illness
5. Improve the experience of children, young people, and their parents in navigating the system and services
6. Reduce stigma associated with mental health
7. Increase in awareness of service provision by need among all frontline workers and the public
8. Increase in ease of access of appropriate services
9. Reduce smoking in people with mental illness
10. Reduce obesity in people with mental illness
11. Increase the number of people with mental illness who are supported with recovery

6.6 What are the actions will we take to deliver the outcomes?

1. Plan and implement an action plan to reduce risk factors such as low self-esteem and body dissatisfaction targeting at-risk populations
2. Increase awareness of disordered eating/eating disorders among frontline staff working with children
3. Develop and implement multi-agency self-harm protocol
4. Embedding mental health support teams (MHST) principles in all schools
5. More collaborative working to create a shared culture and joined up service offer e.g partnership working between school nurses and MHST

6. Improving the ‘front door’ to current emotional health and wellbeing
7. Develop a joint bespoke Bracknell Forest pledge to reduce mental health stigma
8. Develop and offer mental health awareness training to all staff across the system
9. Explore the development of an easy access, needs-based service directory and a public facing marketing and communication campaign to raise awareness of services available and how to access them
10. Develop and implement a plan for an integrated healthy behaviour outreach service in mental health services
11. Expand recovery service provision to meet existing and future demand

6.7 What success indicators will we use to monitor progress?

1. Decrease in hospital admissions for self-harm (PHOF indicator)
2. Number of children supported by MHST
3. Number of children with mental health illness diagnosis with physical health plans
4. Feedback from children and parents on their experience of accessing services and support
5. Number of organisations and workplaces that have signed the local mental health pledge
6. Number of staff trained in mental health awareness
7. Number of smokers who have successfully quit among people with mental illness
8. Number of people with mental illness supported for weight management
9. Proportion of people with mental illness supported to recover

6.8 Cross-cutting themes

HiAP approach
The wider determinants of health are important to consider and relevant for mental health in ensuring individuals have opportunities for meaningful employment, stable and appropriate housing. Access to open and outdoor space is also important for promoting positive mental health and wellbeing. A healthy settings approach will also ensure that every opportunity is made to create healthy physical environment for residents so that the healthy choice is the easy choice. Health in all Policy approach will also seek to influence planning and place, again so that every opportunity is made to maximise health and wellbeing in new housing developments and civic infrastructure.

Healthy environments
Physical activity is known to improve not only physical but also mental health. Bracknell Forest has open and accessible green spaces for outdoor activities. Public health is working with partners to develop a physical activity strategy. Sport in Mind is a local charity providing physical activity for people with mental health problems. Workplaces play an important role in supporting mental health of employees and as part of HiAP, training and resources will be available to all workplaces in Bracknell Forest.

Health inequalities
People with mental health problems have poorer physical health outcomes compared with the general population. Reducing this gap on health behaviours and physical health is a key focus of this strategy (through this priority and the priority on increasing years lived in good health and free of disability).

Seamless care

The local mental health transformation plans are addressing improvements in patient journey and access, in particular during transitions.

Community development for mental health wellness

MECC training on mental health and mental health awareness training will be rolled out to all frontline staff and the community and voluntary sector. A local charity, Stepping Stones, and the community mental health network provide a user and peer led recovery model.

7 Create opportunities for individual and community connections, enabling a sense of belonging and the awareness that someone cares

7.1 Why is this a priority?

Good social connections and a sense of belonging are important protective factors for physical and mental health. Studies have shown that people with good quality social connections have, on average, longer life expectancy compared with those who lacked social connections. COVID-19 has had an impact across all ages on social isolation and loneliness.

7.2 Policy context

A Connected Community[28] was the first strategy published in 2018 to address loneliness. In 2020, an updated plan was published with three key objectives

- Reducing stigma by building the national conversation on loneliness, so that people feel able to talk about loneliness and reach out for help.
- Drive a lasting shift so that relationships and loneliness are considered in policymaking and delivery by organisations across society, supporting and amplifying the impact of organisations that are connecting people.
- Playing our part in improving the evidence base on loneliness, making a compelling case for action, and ensuring everyone has the information they need to make informed decisions through challenging times.

7.3 Population health management high level information

7.4 What outcomes do we plan to deliver?

1. Increase number of different types of activities that provide opportunities for all ages to connect with other people in their neighbourhoods and across the borough
2. Improve the awareness of the community assets map among all providers and provide training on how to use it in their work to connect people to local activities
3. Increase awareness of community map and its use by residents
4. Increase non-GP referrals to public health social prescribing
5. Increase the awareness of services offered that supports collaborative practice for appropriate referrals

7.5 What are the actions will we take to deliver the outcomes?

1. Review and relaunch an improved version of the current community map working with wider stakeholders

[28] Department for Digital, Culture, Media and Sport 2018 A connected society: a strategy for tackling loneliness - GOV.UK (www.gov.uk)

2. Develop a marketing and training strategy for community map
3. Transform the public health social prescribing service to a community model
4. Support creation of a network of community of practice

7.6 What are the success indicators will we use to monitor progress?

1. Quarterly reports on community map engagement (number of active assets, hits and use)
2. Establish a baseline as part of the review and monitor incremental increases in participation numbers from providers on the community map
3. Feedback from providers on numbers connected to neighbourhood activities through the map
4. Progress on collaborative practice feedback from network of community practice
5. Increased number of non-GP referrals to public health social prescribing services
6. Reduction in number of adults reporting feeling lonely often or always (PHOF indicator)
7. Indicators from social care user survey reported in PHOF
8. Increase in percentage of adult social care users who have as much social contact as they would like (18+ years)
9. Increase in percentage of carers who have as much social contact as they would like (18+ years)

7.7 Cross-cutting themes

HiAP approach
The Health in all policy element to this objective will link to the influence of the wider environment to support social connections and that where appropriate health and wellbeing will be embedded into wider council services for example promoting Making Every Contact Count training to ensure that all frontline staff can recognise when individuals may be at risk of, or currently experiencing, feelings of loneliness and isolation and can be put in touch with relevant services and support to improve social connections.

Health inequalities
Some of our communities were more affected by the impact of COVID-19 restrictions – people living with disabilities, carers and those who they were caring for became more socially isolated. In addressing loneliness and isolation, we will make greater efforts to support them by working with them.

Community development for wellness
Volunteers are an important asset, the numbers of which increased during the pandemic. Working with the voluntary and community sector and local business, we will develop a structured volunteering programme for Bracknell Forest providing opportunities for people of all ages and communities to participate and benefit from the programme

8 Keep residents safe from COVID-19 and other infectious diseases

8.1 Why is this a priority?

The pandemic is not yet over and community transmission has continued. Whilst the severity of the disease has reduced due to the protection offered by the vaccines, there are still risks – those that have not been vaccinated spreading the virus and the virus mutating and becoming more infectious (variants). In addition, other respiratory viruses are in circulation during the winter so we need to ensure the populations are fully vaccinated to prevent these diseases.

8.2 Policy context

The national policy on control and management of COVID-19 in England is regularly updated based on the current epidemiology and scientific advice. Whilst the policy is nationally set, local areas are responsible for implementing it.

National immunisation policies including childhood vaccination[29]
The population vaccination programme in the UK is well established with the JCVI providing evidence-based advise on policy. The commissioning of the programme is delegated to NHSE with oversight from PHE, and the local Director of Public Health having an assurance role.

Prevention of sexually transmitted disease updated PHE guidance[30]
This focuses on the prevention of five common sexually transmitted infections (STIs):

- Gonorrhoea
- Chlamydia
- Syphilis
- Genital herpes
- Genital warts.

It also covers the public health challenge of antimicrobial-resistant STIs.

Infectious diseases in pregnancy screening (IDPS) programme[31]
The IDPS programme currently screens for:

- HIV
- Hepatitis B
- Syphilis.

Each infection has a clear pathway to care. Healthcare professionals should be familiar with these pathways and the timeframes in which to refer patients.

8.3 What outcomes do we plan to deliver?

1. Reduce and manage outbreaks (e.g. COVID-19 weekly case rates per 100,000) across Bracknell Forest

[29] Complete routine immunisation schedule - GOV.UK (www.gov.uk)
[30] PHE 2019 Health matters: preventing STIs - GOV.UK (www.gov.uk)
[31] PHE update 2021 Infectious diseases in pregnancy screening (IDPS): programme overview - GOV.UK (www.gov.uk)

2. Reduce (COVID-19) infectious disease-related morbidity and mortality with reduced numbers of related deaths and hospital admissions and inpatients
3. An engaged community that not only informs local communication and action but also takes responsibility for reducing the transmission of COVID-19 and other communicable diseases
4. High-risk settings for transmission are engaged and take responsibility for their role in reducing the risk of communicable disease infection
5. Reduce winter-related morbidity and mortality

8.4 What are the actions will we take to deliver the outcomes?

1. Review and relaunch the Local Outbreak Management Plan following the Contain Framework update in Autumn 2021
2. Deliver the plan's action plan, including actions around:
    - Engagement and communication
    - Data integration and surveillance
    - Testing, contact tracing, self-isolation and outbreak management
    - Legislation, compliance and enforcement
    - Vaccination
3. Scope the local health protection response so as to align with national public health system reforms
4. Plan and deliver COVID-19 vaccinations to eligible populations, working with partners to ensure high uptake across all ages and communities
5. Feedback from local communities on how best to engage and communicate the ongoing pandemic response in Bracknell Forest
6. Update the joint winter plan based on national guidance and local modelling

8.5 What are the success indicators will we use to monitor progress?

1. Low weekly case rate per 100,000
2. High testing rate per 100,000 and positivity
3. Reduced number and effective management of outbreaks
4. Vaccination uptake of eligibly cohorts (dose 1, dose 2 and booster vaccination) is high

8.6 Cross-cutting themes

Health Inequalities
Disparities related to COVID-19 were described in a previous section. Health inequalities for other infectious disease will be addressed through increasing uptake of the vaccination programme, screening and testing.

Seamless care
Detecting infectious disease through testing and screening should be followed up by referral for appropriate treatment and care in a timely manner. We will ensure that our referral pathways and failsafe mechanisms are in place.

Community development for wellness

One of the key areas for improvement is on improving health literacy and working with communities to develop campaigns which are universally understood by diverse communities.

9 Improve years lived with good health and happiness

9.1 Why is this a priority?

Chronic conditions such as heart disease, stroke, diabetes, cancer and chronic lung disease are the main cause of ill health and disability in the adult population. Due to advances in healthcare, life expectancy has increased with people living, on average, 80+ years. However, as shown in the Figure XX life lived in good health or free from disability is, on average, 15-20 years less. Thus, it is important that we work together to increase years lived in good health.

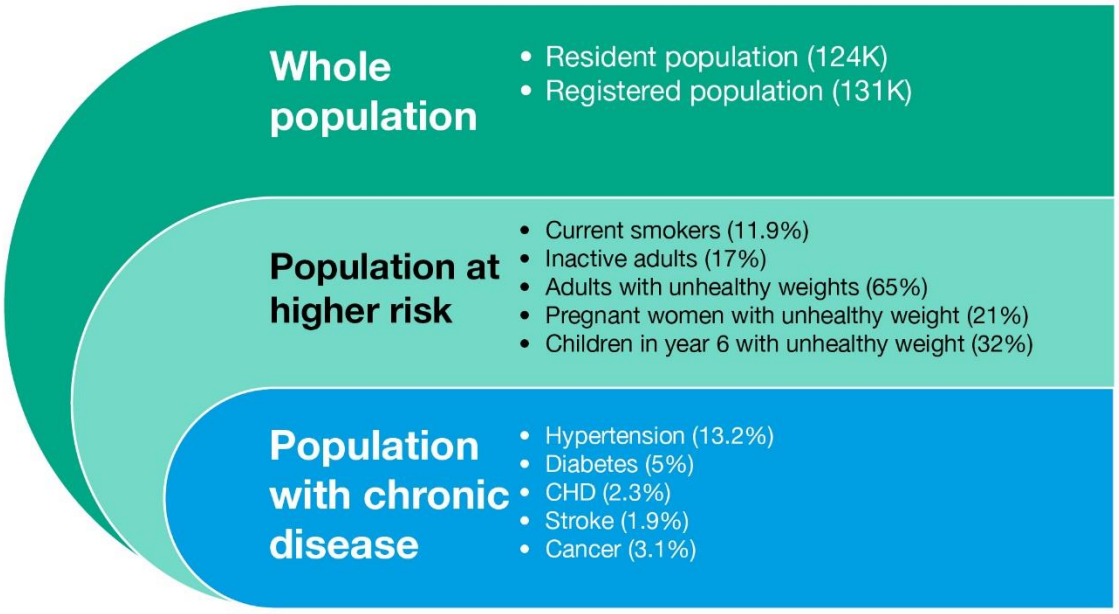
9.2 Policy context

Prevention is better than cure[32] is the national policy that sets out the government's vision for:

- Stopping health problems from arising in the first place
- Supporting people to manage their health problems when they do arise.

The goal is to improve healthy life expectancy by at least five extra years by 2035, and to close the gap between the richest and poorest.

9.3 Population health management high level information



[32] DHSC Nov 2018 Policy paper overview: Prevention is better than cure: our vision to help you live well for longer - GOV.UK (www.gov.uk)

9.4 What outcomes do we plan to deliver?

1. Improve health literacy of cardiovascular risk in target population
2. Increase in offer and uptake of NHS health checks in target population
3. Increase in offer and uptake in smoking cessation in target populations
4. Increase in offer and uptake in weight management in target populations
5. Increase universal offer of physical activity and healthy eating opportunities offered across all population
6. Establish a system-wide joint Bracknell Forest healthy workplace programme
7. Establish a whole-school approach to health in Bracknell Forest
8. Reduce the variance in early detection, management and treatment for hypertension, diabetes and atrial fibrillation.

9.5 What are the actions will we take to deliver the outcomes?

1. A community-led healthy conversations plan developed and implemented.
2. At-risk target groups identified, using population health management
3. Undertake health equity audits across lifestyle services
4. Undertake audit of NHS health checks and develop an improvement plan
5. Develop and implement a system-wide approach to addressing obesity
6. Develop and implement a healthy settings programme as part of the HiAP approach
7. Use right care pathways to support practices to level up detection, care and management

9.6 What are the success indicators will we use to monitor progress?

1. Number of people engaged in self-care due to healthy conversations
2. Increase in number of at-risk people supported by smoking cessation and weight management services
3. Increase in the proportion of people from target populations that have been offered and have completed an NHS health check
4. Findings from the system-wide approach translated into an action plan
5. Number of settings signed up as health promoting places.

9.7 Cross-cutting themes

HiAP approach

The Health in all policy element to this objective will link to the influence of the wider environment to health and wellbeing and that where appropriate health and wellbeing will be embedded into wider council services for example promoting Making Every Contact Count training to ensure that all frontline staff are able to make the most of interaction with residents and signpost to relevant services and support to improve health and prevent ill-health. This will also include healthy settings and Healthy Communities components of the Health in All Policies framework so that, to help understand the influence of the wider determinants on health and specifically those communities which may experience poorer health outcomes and how wider determinants can be addressed to improve long term health outcomes.

Health inequalities

The evidence for health inequalities in the prevalence of chronic conditions and outcomes is well established. In Bracknell Forest, whilst the gap in life expectancy between the least deprived areas and most deprived areas is 1.7 years for females and 7 years for males, the health-related life expectancy gap is 7.8 years for females and 10 years for males.

Seamless care

The care pathways for chronic disease management are well established and we will work to ensure that transitions and care for people with multiple morbidities are particularly well integrated to ensure better experience for patients. We will integrate our healthy behaviour services into a single hub of wellness that will operate across the borough to provide services and health promotion nearer to where people live and work.

Community development for wellness

Bracknell Forest Community Asset Map

The Community Asset Map provides a platform to promote local community groups, clubs, societies, events, and activities that are run by local people for local people. Available online, residents can browse the map but is also used by the social prescribers in finding local activities for their clients. Searchable by categories such as 'Get Active', the total number of groups currently displayed on the map is 465. This includes everything from walking groups through to woodwork, knitting, reading, chess and signing groups. An extensive review of the community assets hosted on the map will be completed to ensure information on local groups is kept up to date. The map will also be expanded to include a children and young people's offer.

10 Governance and accountability for delivery of the improvement

Figure 1 shows the governance and accountability for the joint delivery of the improvement outcomes.

To be added

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