Bracknell Forest Better Care Fund Narrative Plan 2021/2022

Contents

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

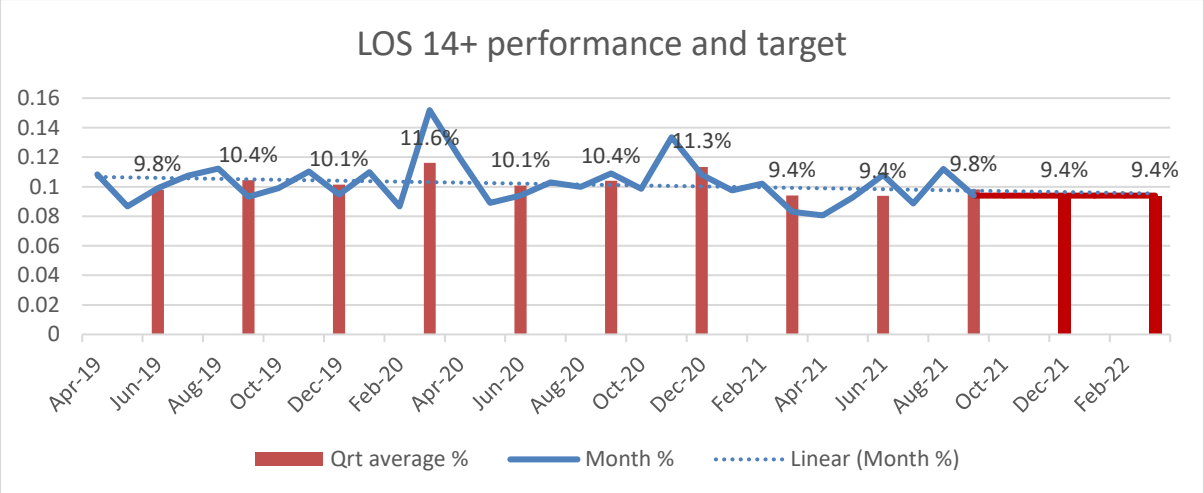
Developing the targets for Q3 and Q4 21/22 has been challenging, as 20/21 data was not available or, when available, presented an extreme outlier due to Covid-19. The system has changed since Covid-19 in that demand pressures and levels of acuity for patients have increased in 21/22, however so have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

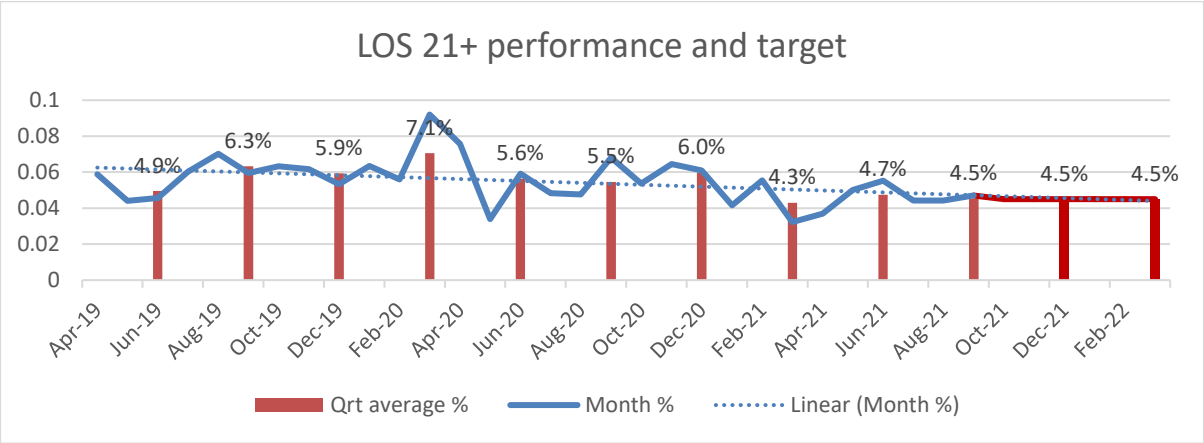
Lessons learnt from the target development process with Frimley Health Foundation Trust and other partners will be applied in the 22/23 planning round to ensure consistent development of regional targets and ongoing performance monitoring. Further we will be able to review the actual performance across 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.

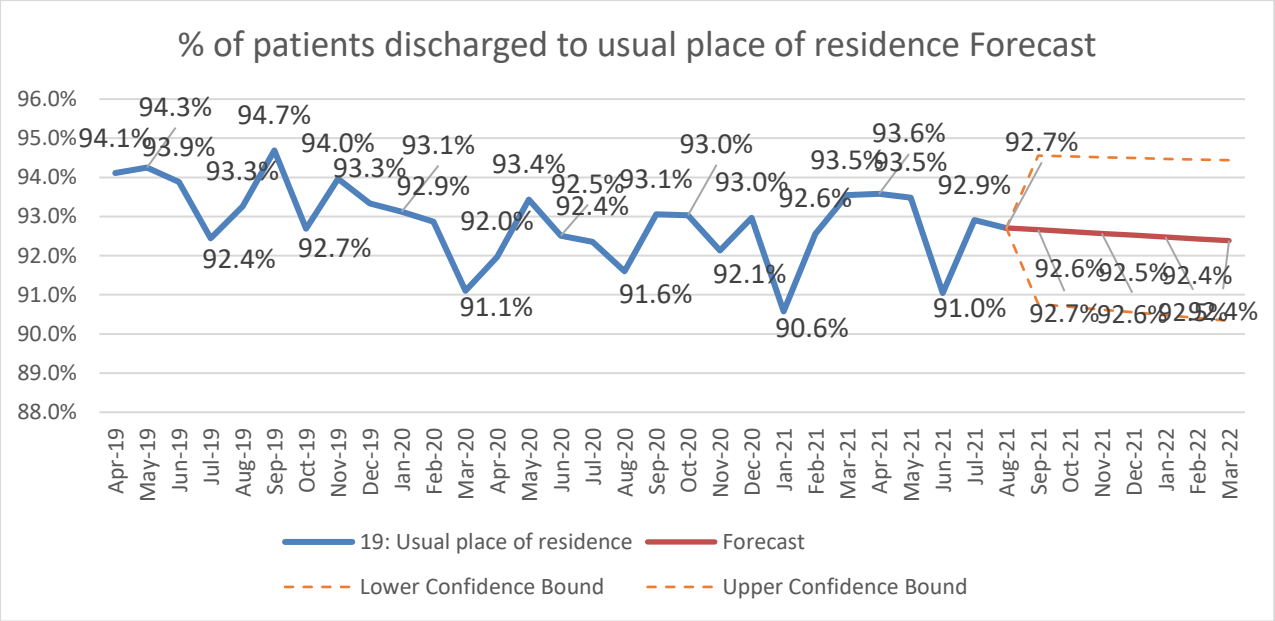
8.2 Length of Stay

	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%**



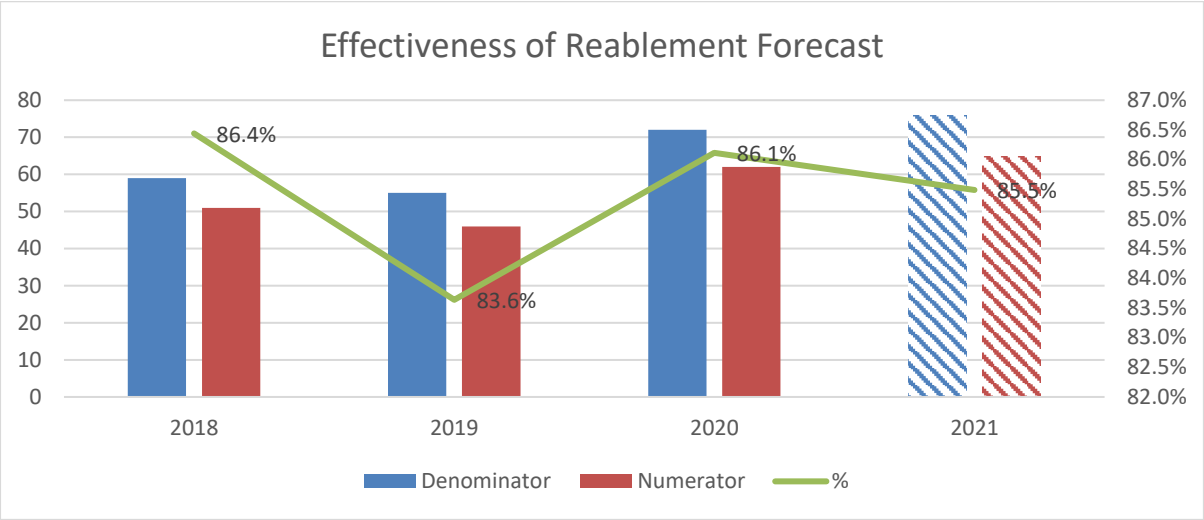


8.3. Discharge to normal place of residence



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
%