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?

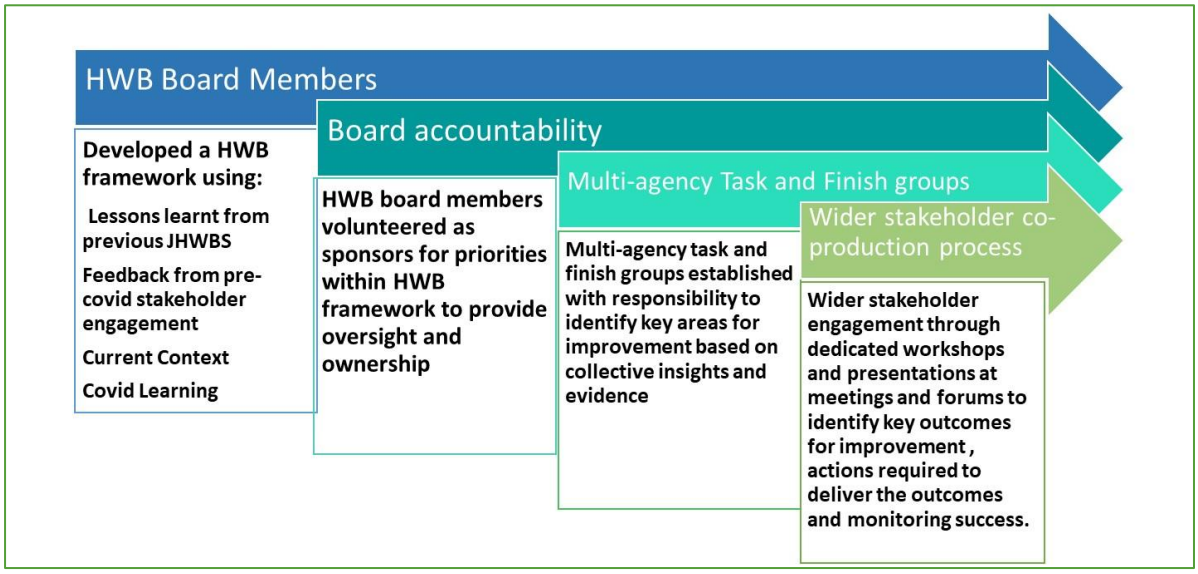
This strategy has been produced within a very different context to anything that has come before. The COVID-19 pandemic has affected all aspects of our lives and, as such, it has also changed the approach taken by the HWB in developing this strategy. Figure 1 shows the process through which this strategy 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

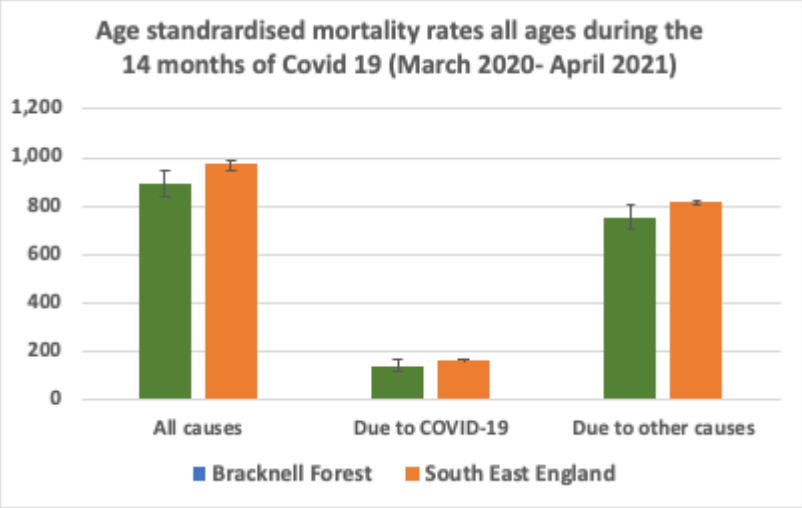
Mortality

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.

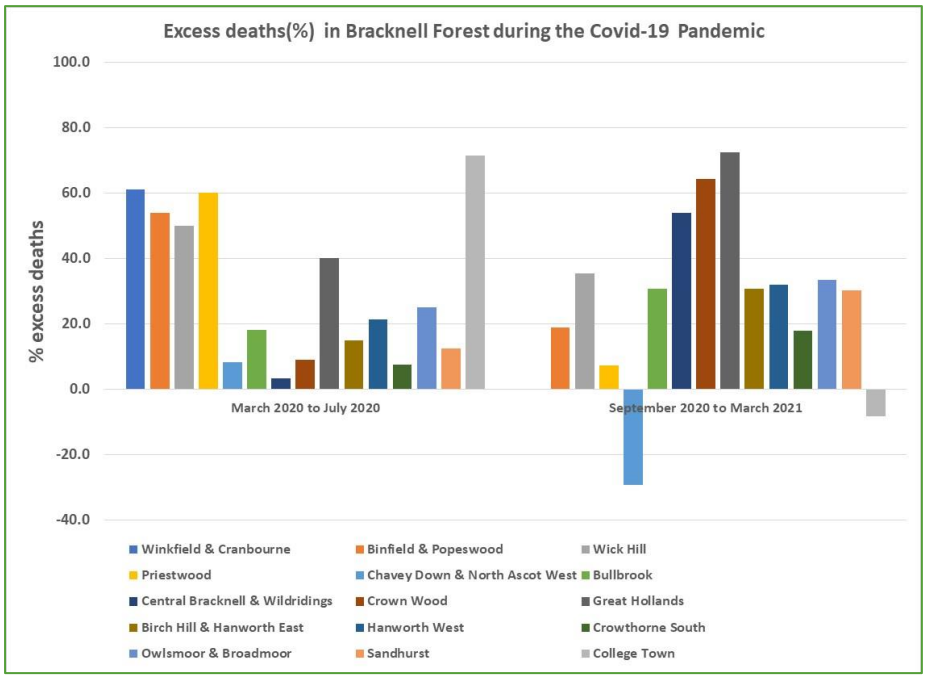
Figure 3 details excess deaths in Bracknell Forest and shows that the impact of COVID-19 across Bracknell Forest was not uniform. This is not surprising given that national evidence suggests that some communities had been more severely affected than others. Factors include age, gender, ethnicity, occupation,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

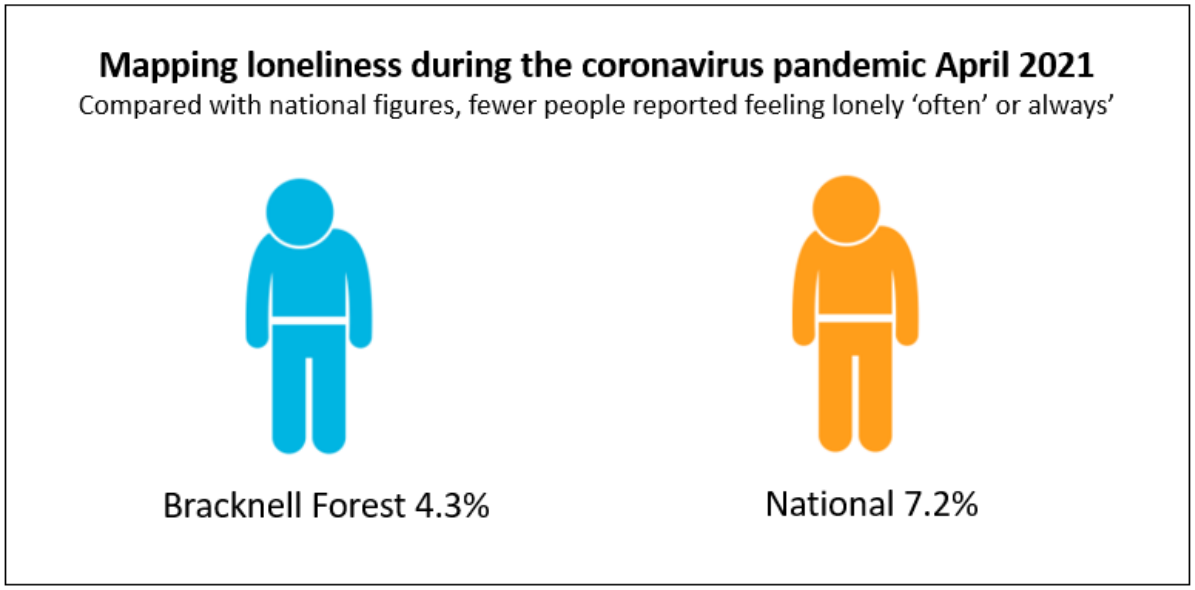
3.1.6 Social connections and loneliness

[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].

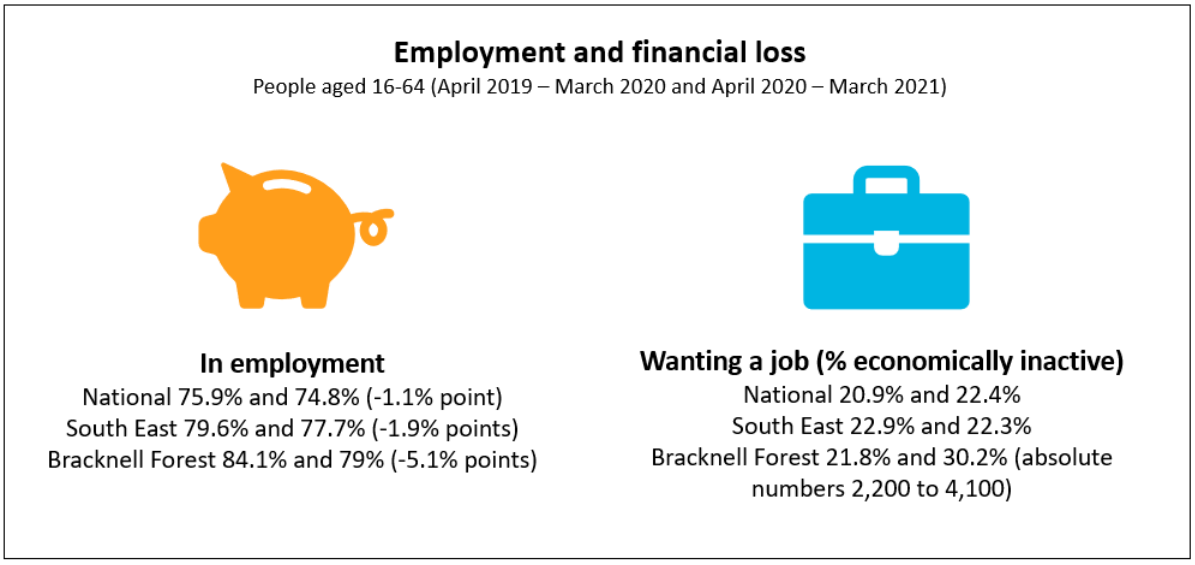
3.1.7 Wider determinants of health

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.

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[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

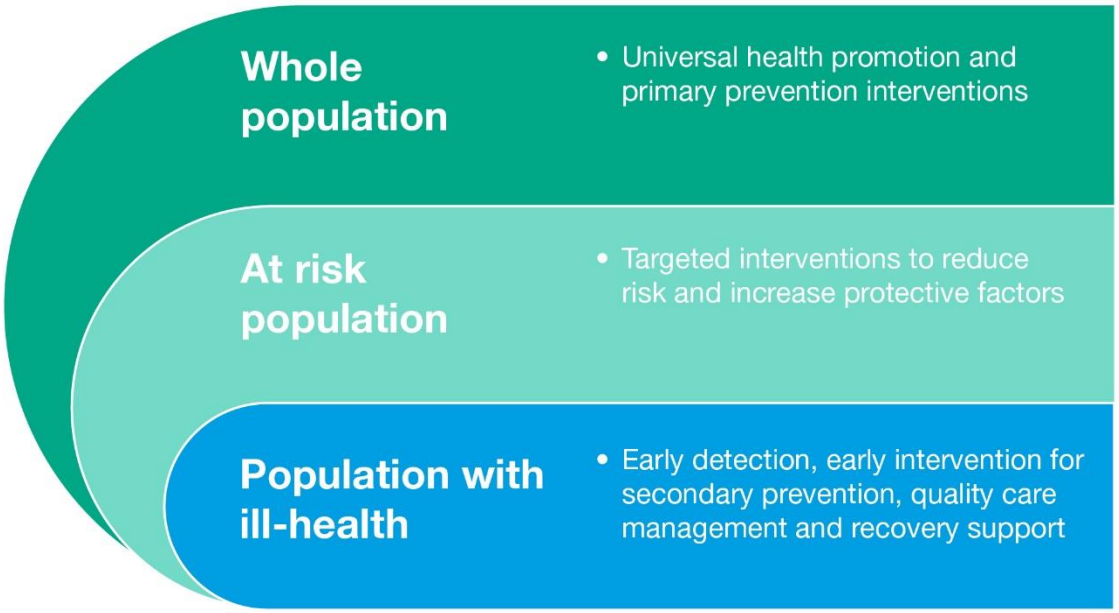
Compared with individual and personalised care provided by frontline practitioners, a population health approach explores the health status and outcomes for either the whole population or sub-populations. It allows strategic planning by identifying where improvements can be made by taking a system-wide 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

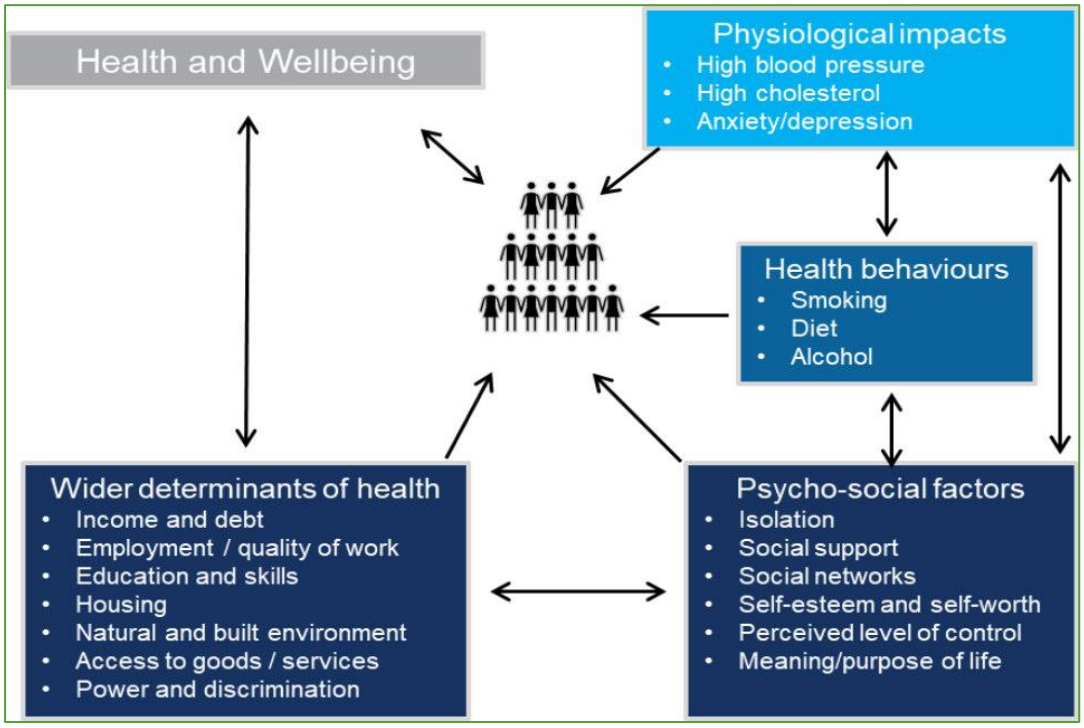
The Health in All Policies (HiAP) approach considers the wider environment and its influence on people's health. It is a label for a larger concept rooted in the fact that the environments in which people are born, live, study, work, play and grow old shape their health outcomes. These wider determinants 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

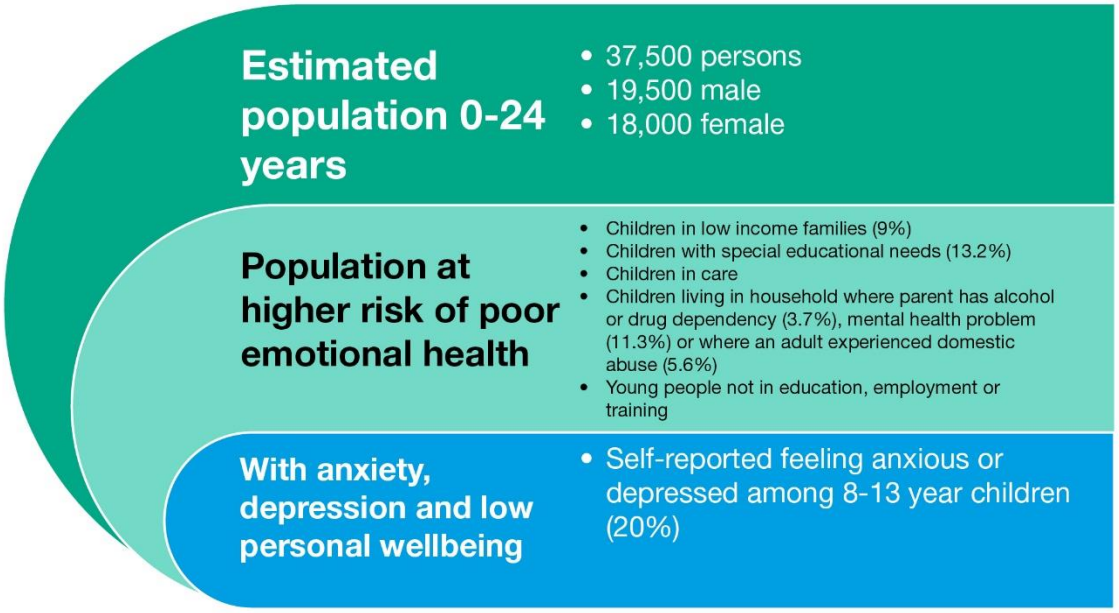
Three key areas emerged that need to be addressed through this strategy

[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

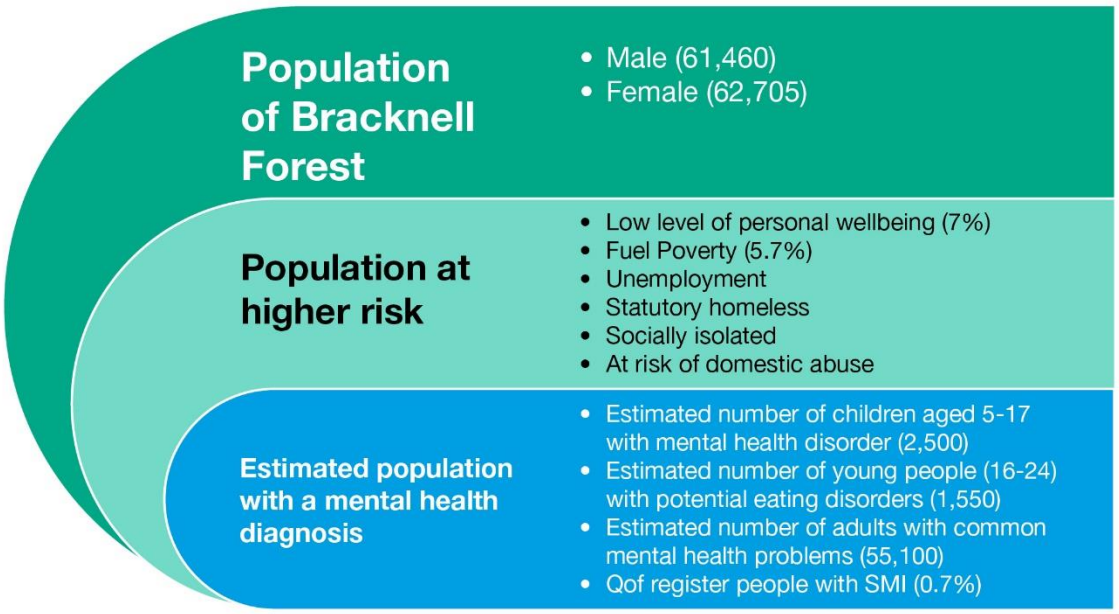
The plans are locally led by the Frimley ICS and can be found here (Link).

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.

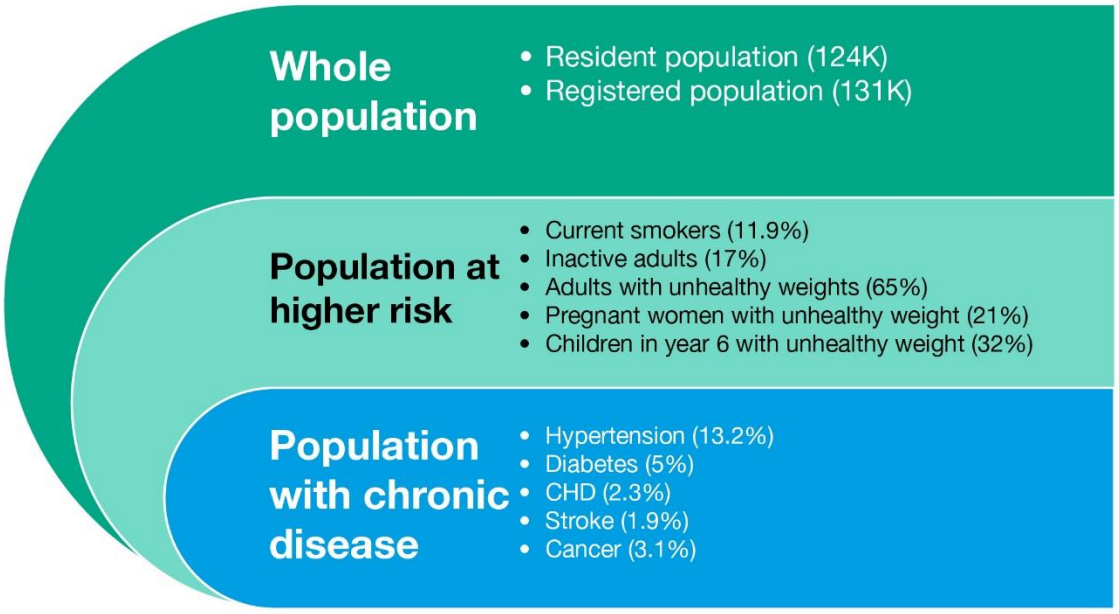
9.2 Policy context

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