Bracknell Forest
Winter Resilience & Preparedness
2023/24

August 2023
Ben Cox & Sarah Van Heerde

Frimley Health and Care

Frimley System
Approach to Winter

The system has a UEC transformation plan

Frimley Health and Care

The demand for Urgent and Emergency Care services has continued to climb steadily throughout 2022/23, as the system emerges from the post-pandemic period.

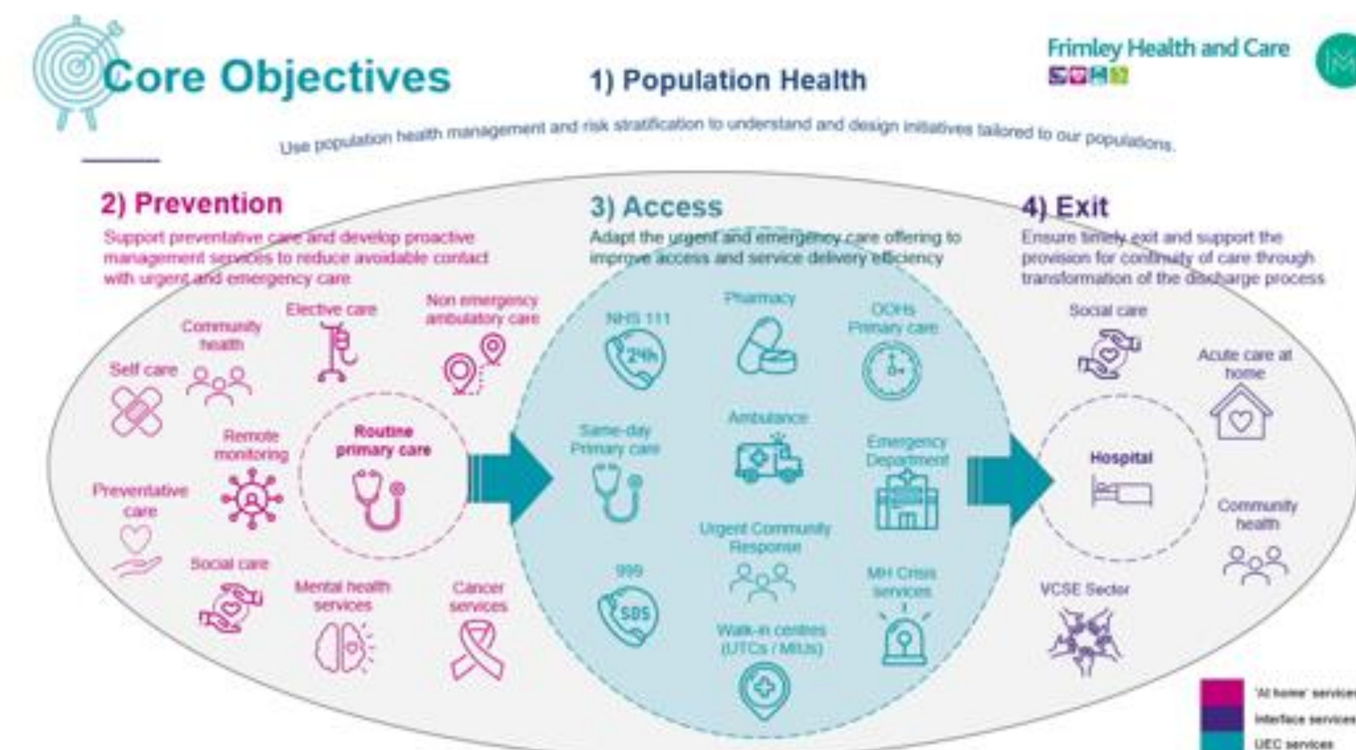
The operational challenge has been exacerbated by several periods of Industrial Action, with more scheduled into 2023/24.

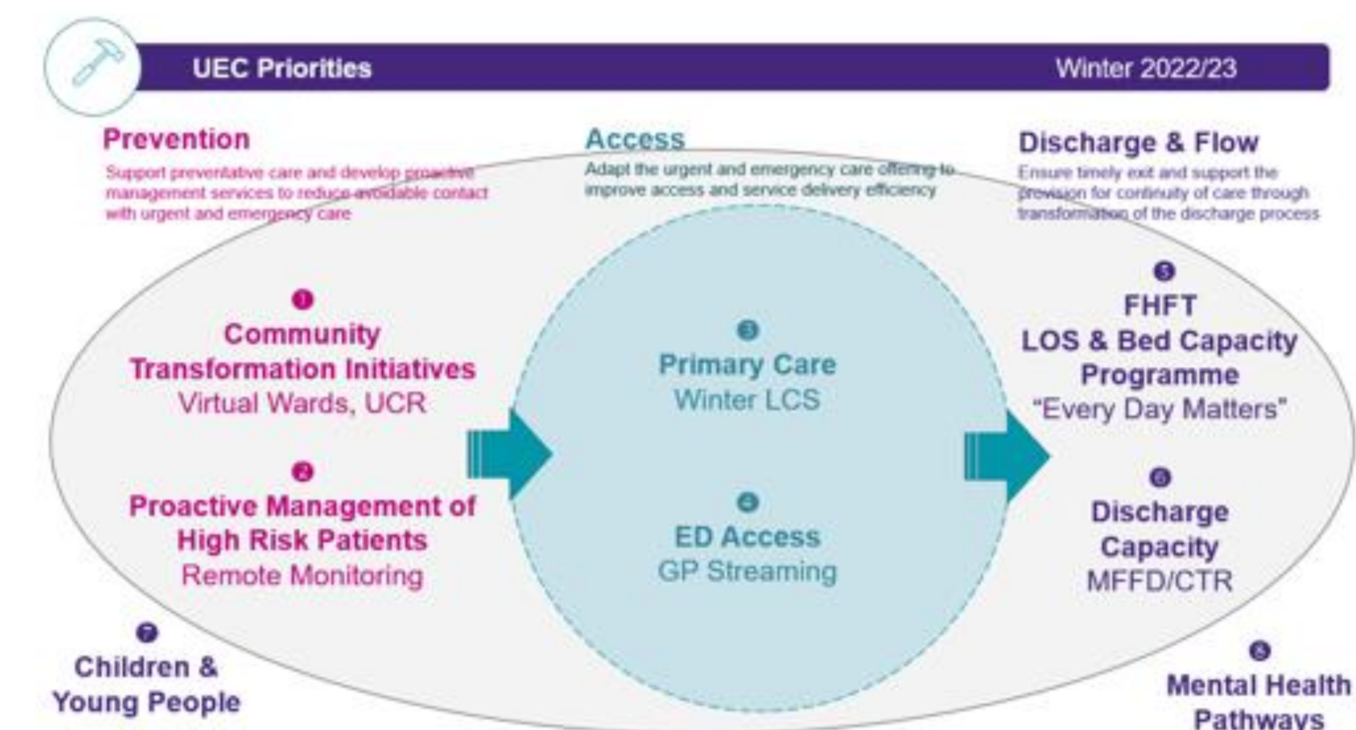
As a system we have come together to develop a detailed Operational Plan for 2023/24, against exceptional financial pressure.

Meanwhile, we continue to roll out our long term UEC Strategy, which was endorsed by the ICB Board in February.

Key System Challenges

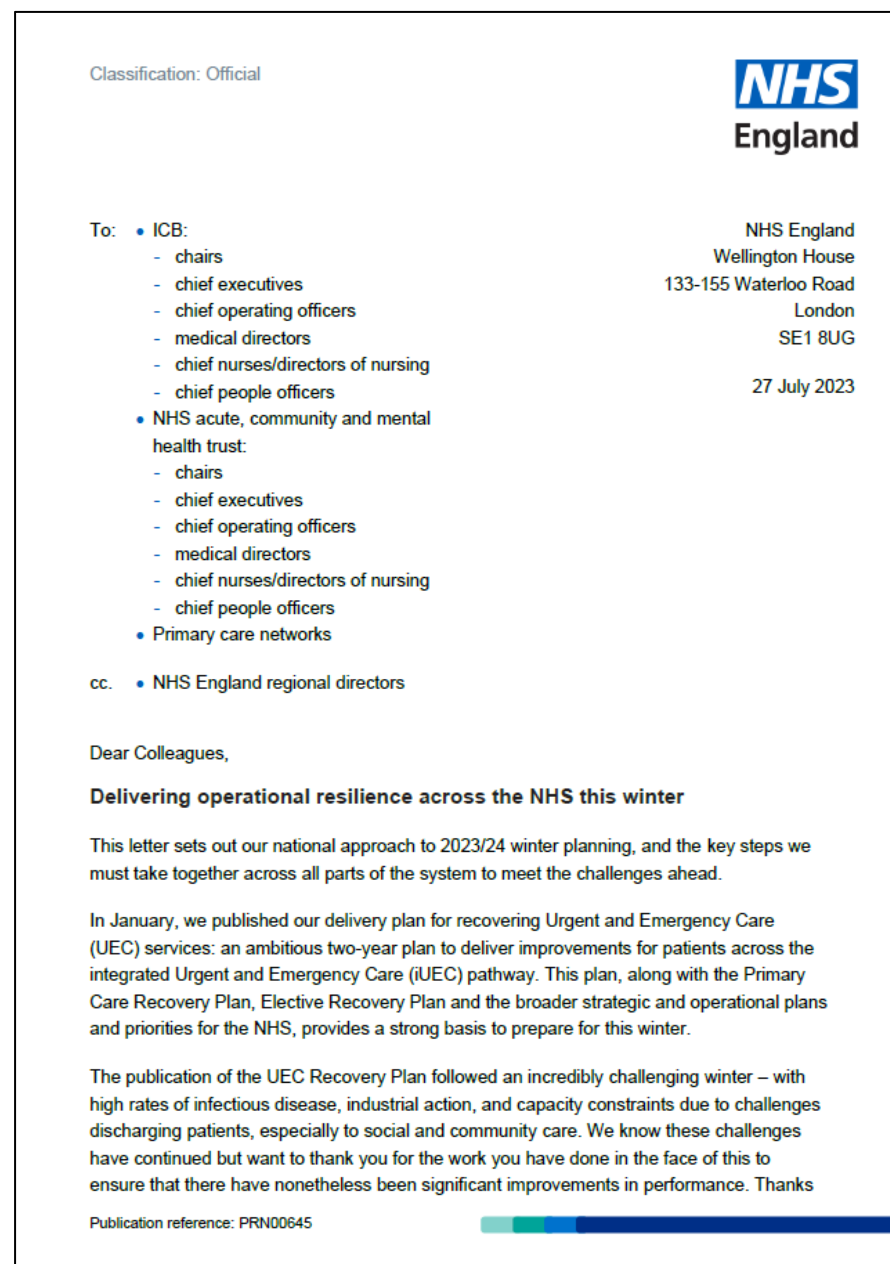
- Demand for services continues to increase
- Disruption from continued Industrial Action
- Planning for 23/24 against financial challenges
- Delivery of UEC Strategy for the long term





Frimley Health and Care

Delivering Operational Resilience across the NHS this Winter



Classification: Official

NHS England

To: • ICB:
- chairs
- chief executives
- chief operating officers
- medical directors
- chief nurses/directors of nursing
- chief people officers

• NHS acute, community and mental health trust:
- chairs
- chief executives
- chief operating officers
- medical directors
- chief nurses/directors of nursing
- chief people officers

• Primary care networks

cc. • NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

27 July 2023

Dear Colleagues,

Delivering operational resilience across the NHS this winter

This letter sets out our national approach to 2023/24 winter planning, and the key steps we must take together across all parts of the system to meet the challenges ahead.

In January, we published our delivery plan for recovering Urgent and Emergency Care (UEC) services: an ambitious two-year plan to deliver improvements for patients across the integrated Urgent and Emergency Care (iUEC) pathway. This plan, along with the Primary Care Recovery Plan, Elective Recovery Plan and the broader strategic and operational plans and priorities for the NHS, provides a strong basis to prepare for this winter.

The publication of the UEC Recovery Plan followed an incredibly challenging winter – with high rates of infectious disease, industrial action, and capacity constraints due to challenges discharging patients, especially to social and community care. We know these challenges have continued but want to thank you for the work you have done in the face of this to ensure that there have nonetheless been significant improvements in performance. Thanks

Publication reference: PRN00645

The UEC Recovery plan focuses on two key objectives:

1. **76% of patients will be seen within 4 hours by March 2024**

2. **Ambulance response times for C2 mean will be under 230 minutes**

Delivering Operational Resilience across the NHS this Winter

Four areas of focus:

1. Continue to deliver on the UEC Recovery Plan by ensuring **high-impact interventions** are in place
2. Completing operational and **surge planning** to prepare for different winter scenarios
3. ICBs should ensure effective **system working** across all parts of the system
4. Supporting our **workforce** to deliver over winter

10 High Impact Interventions

	Action
1.	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2.	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3.	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10.	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Frimley Health and Care

System roles and responsibilities

Each sector's responsibilities are specified in the 15pp guidance document:

Adobe Acrobat Document

Classification: Official

NHS

Working together to deliver a resilient winter

System roles and responsibilities

The NHS England operating framework describes the roles that NHS England, integrated care boards (ICBs) and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

As we continue planning for winter it is important that we are clear on the actions that each part of the NHS system must now take to ensure that we are collectively pulling in the right direction to deliver for patients.

To support this, we have developed a set of recommended winter roles and responsibilities for each part of the system, which are included in this document, largely taken from existing guidance and recovery plans. These build on the core objectives outlined in the winter letter and provide a platform for systems to be clear on how actions are taken in all areas to deliver a resilient winter period.

The roles and responsibilities are designed to be supportive and provide clarity but are by no means exhaustive – each system should use these to develop their winter planning return and consider how these relate to the circumstances within their individual system.

Publication reference: PRN00645

27 July 2023

Roles	Lead the delivery of high-impact interventions
Integrated care boards	5-10
Acute and specialist NHS trusts	1-4
Primary care	
Children and young people (CYP) services	
Community trusts and integrated care providers	4-6
Ambulance trusts	
Mental health provider pathways	3, 4 and 9 across mental health provider pathways
Local authorities and social care	

ICBs should lead on delivery of Care Transfer hubs, Intermediate care demand and capacity, virtual wards, ARI hubs, UCR, Single Point of access

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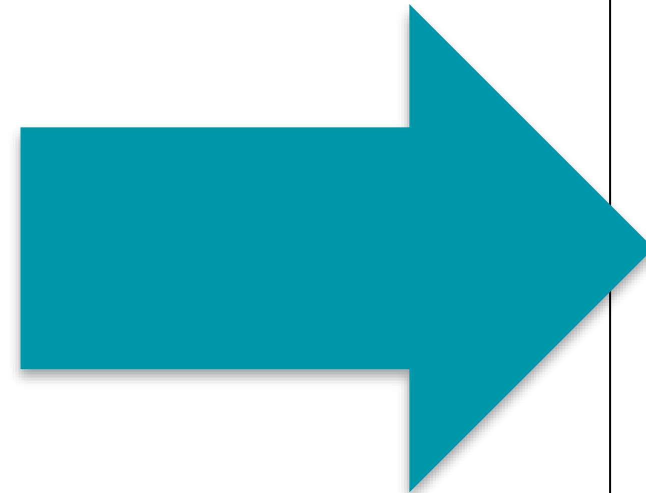


Working together to deliver a resilient winter: System roles and responsibilities

Local authorities and social care

Local authorities should continue to work with ICBs to ensure an integrated approach across health and social care.

This includes:

- commissioning intermediate care services that help keep people well at home, prevent avoidable hospital admissions and support timely and effective hospital discharge.
- areas keeping under review their Better Care Fund (BCF) capacity and demand plans for intermediate care, in line with the BCF Policy Framework and planning requirements, considering trends in demand.
- improving data flows where the BCF capacity and demand plans showed limited data or insights available to support local areas' ability to accurately forecast demand for these services throughout the year.
- supporting NHS winter surge planning, including considering contingency arrangements for a significant flu or COVID-19 wave.
- deploying this year's Discharge Fund in ways that have greatest impact in patient safety and experience and in reducing delayed discharges, both to improve outcomes following hospital admission and help prevent avoidable A&E and ambulance delays for patients who need emergency care, alongside planning how to deploy next year's discharge funding.
- systematically embedding good practice in the use of care transfer hubs to manage discharges for patients with more complex needs, focusing on nine priority areas that will be set out as part of the upcoming support offer for the UEC Recovery Plan.
- ensuring systematic involvement of social care and community health providers in planning discharge services and in improving the operation of care transfer hubs.

Frimley Health and Care

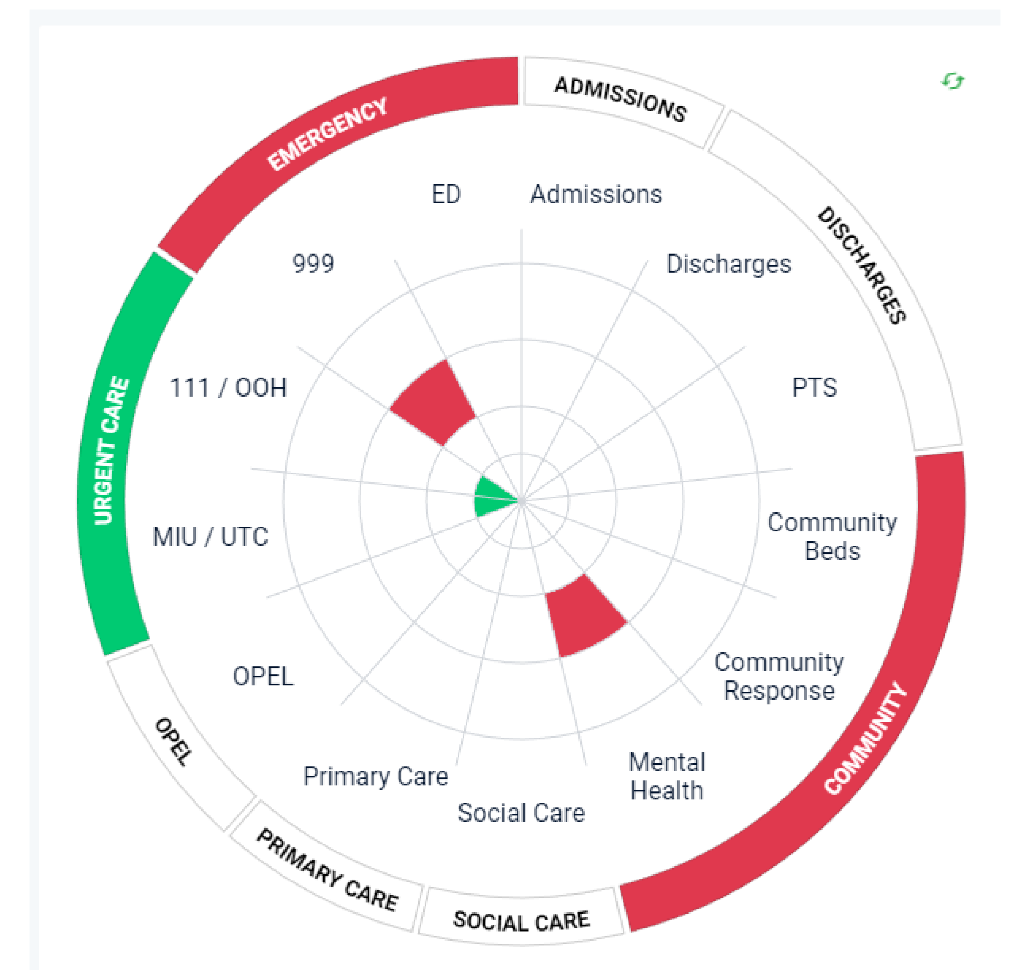
Preparing for winter

System Co-ordination, Surge and Resilience

- Frimley SCC - full implementation underway in line with NHSE required operational standards and timescales with real time visibility of operational pressures and system risks.
- Increased requirement for operating hours aligned to collaboration discussions with neighbouring ICB partners
- Key aim to take prospective actions ahead of demand and activity peaks using informatics tools
- Design principle is to proactively manage clinical risk and mitigate emerging system issues impacting patient safety and flow
- SHREWD platform in place to act as primary decision support tool and single version of truth for system pressures

Escalation and responsiveness

- Adoption of new OPEL framework to ensure consistency across regional landscape
- Revision of surge plans and policies to reflect acute focussed model
- Underpinned by mature existing arrangements for escalation with senior oversight
- Mutual aid and interventions at pace - ensure focus on priority areas
- System wide Winter Summit scheduled for early September
- Stress test our plans and ensure surge and super surge capacity is responsive
- Linked to EPRR framework and integrated incident management models



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Frimley System

Winter Planning & Assurance Framework

Winter 2023/4 planning submission and process timeline

7th August	KLOEs received by SOC
10th August	KLOEs and planning template reviewed with ICB and providers
14th August	NHS Frimley planning group review
17th August	Review of progress against template with Systems during Winter Preparedness
w/c 28th August	NHSE calls with individual ICBs to review progress
31st August	**Initial draft of KLOE answers**
6th September	Drop-in session with Region
11th September 10:00	**Systems submit signed off plans to National with Region – KLOE narrative plus a numerical return**
12th September – 22nd September	Regional SME review of plans
25th September	ICBs submit final plans (if changes are required)

Frimley Health and Care

NHSE Key Lines of Enquiry

- **System roles**
  - KLOE1.1 How has each part of the system been engaged?
  - KLOE1.2 How will you assure that each part of the system is delivering
  - KLOE1.3 How will the system deliver
    - Integrated Care Boards
    - Acute and Specialist NHS Trusts
    - Primary Care
    - Children and Young People services
    - Community Trust and Integrated Care Providers
    - Ambulance Trusts (where the ICB is the lead commissioner)
    - Mental Health
  - KLOE1.4 How will the ICB lead the system
  - KLOE1.5 Infection Prevention and Control
  - KLOE1.6 Support for care homes
  - KLOE1.7 Christmas and New Year
- **High impact interventions**
  - KLOE 2.1 Self-assessment of 10 high impact changes / 4 prioritised areas
    - SDEC, VW, UCR/RM, Placed based discharge
  - KLOE 2.2 improvement capability and capacity / Recovery champions

NHSE Key Lines of Enquiry (continued)

- **Discharge, intermediate care and social care**
  - KLOE 3.1 Effective joint working with relevant local authorities
  - KLOE 3.2 Better Care Fund (BCF) intermediate care capacity and demand plan
  - KLOE 3.3 Community hospital and Intermediate Care capacity
- **H2 numerical submission**
  - KLOE 4.1 Demand assumptions
  - KLOE 4.2 Supply assumption
- **Escalation plans**
  - KLOE 5.1 Describe system escalation plan
  - KLOE 5.2 Describe early warning systems (SHREWD)
- **Workforce**
  - KLOE 6.1 How will you ensure adequate staffing levels?
  - KLOE 6.2 How will the system work together on workforce
  - KLOE 6.3 How will staff wellbeing be prioritised
  - KLOE 6.4 How are you maximising the role of VCSE partners?

NHSE Winter Operating Model

- Winter will be managed through the South-East Regional Co-ordination Centre (RCC)
- UEC Winter operating model likely to run 9am-5pm 7 days a week (TBC:MPV 8/8/23)
- There will be a UEC lead 7 days a week
- A daily rhythm will be established to support the ICS which will include joining system calls as required
- All communication with the ICS's will be through the South-East Regional Co-ordination Centre (RCC)
- SHREWD will become the pan-system single operational decision support tool that underpins the revised surge approach.
- The UEC triggers/tiering metrics as focus for national and regional narrative & support include
    - ED 4-hour clinical performance standard:
    - ED Time in department – 12+ hour from arrival
    - Ambulance category 2 response times
    - >14-day LoS
    - ambulance handover delays >60 minutes

Frimley Health and Care

Bracknell Forest Place
Integrated Winter Plan

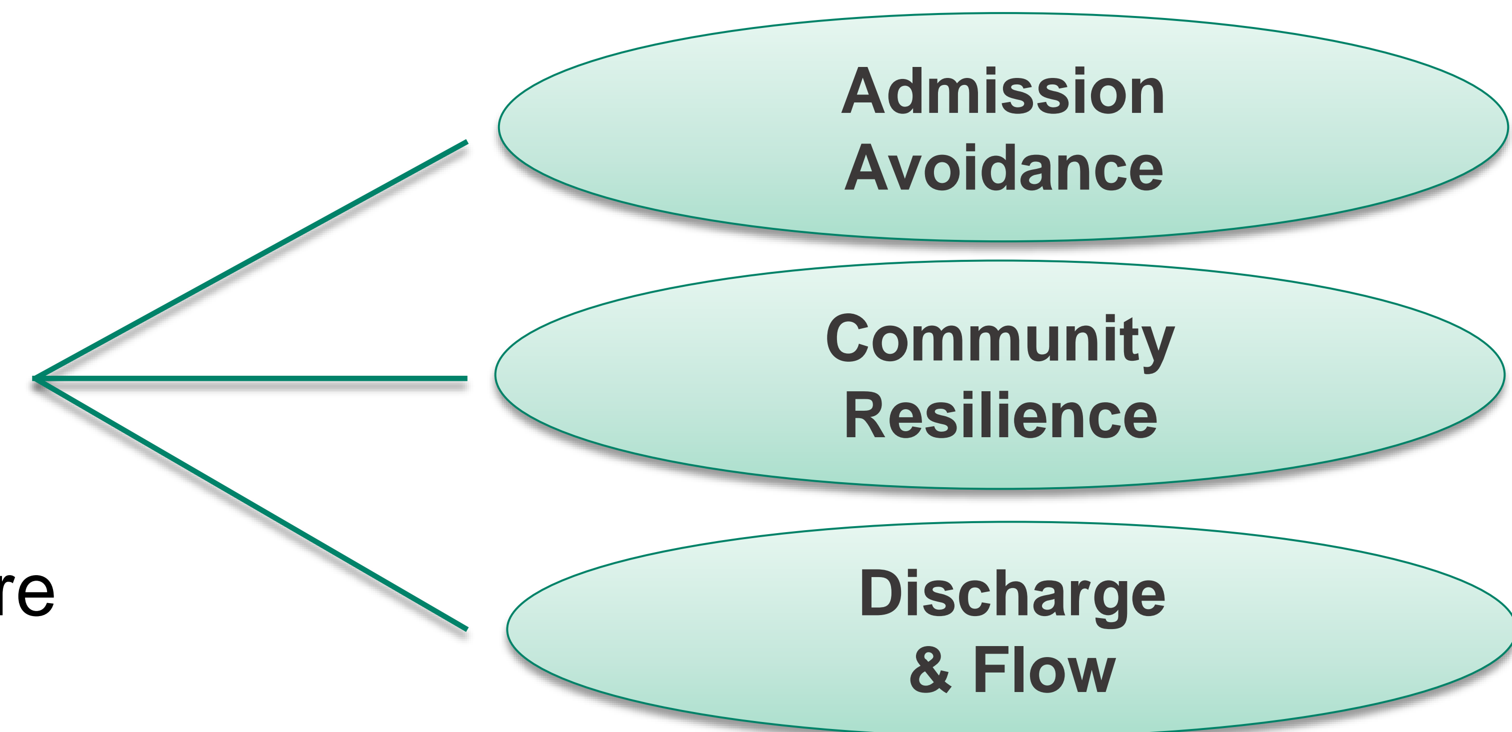
Considerations and Challenges

- **'The unknowns'**
  - Potential impact of new strains of Covid and / or other severe outbreaks of disease (flu)
- **Workforce**
  - Finite workforce and resilience across all partner organisations; vacancies & sickness could limit ability to reliably plan and flex capacity
- **Community resilience**
  - Increased pressure on community resources to keep people out of hospital and support an earlier discharge home
- **Conflicting and competing demands**
  - Multiple priorities and demands on our staff and resources
- **Population Health**
  - Recognising health inequalities, mitigating the ongoing and future impact on local communities
- **Communications**
  - Ensuring a comprehensive Winter Comms Plan – updating and refreshing information on public facing websites, social media and literature
  - Clear messaging on how to prevent ill-health & clear signposting to self-care resources and tools
  - Coordinated communications to help with signposting to services, for example, "Know Where to Go"
- **Building on good practice**
  - Using the learning from the Covid experience and the positive impact of working collaboratively during previous Winters

Winter Framework, the approach

- Winter plans from all organisations attributed
- to these <u>3 key domains</u>

- Winter planning to be delivered using an
- integrated approach across Health & Social Care



- <u>Winter plans will include:</u>
- Schemes / initiatives / pathway's in place & planned to come online in 2023/24
- Aims of the plans (how do they link with other services)
- Anticipated outcomes
- Patient cohorts that the plans will benefit
- How the schemes / initiatives / pathway's are referred into
- Lead within the organisation for each scheme / initiative / pathway
- RAG rating – to understand risk and assurance / mitigation

Integrated Winter Planning

Cohort 1.1 Children & Young People					
Scheme (including brief description)	Aims & outcomes, capacity (including surge plans) and interdependencies	Referral pathway (including contact details, where necessary)	Status (Live or planned start date)	RAG rating (Red / Amber / Green) - see tab for details	Key organisation contact (name & details)
Community Equipment Service	To access required equipment for children with disabilities and complex health needs	through CSST OT (Marianne Mowczak)	ongoing	Green	Catherine Lloyd (CSST, BFC)
CSST BAU	Working with chidlren with complex health needs open to CHC funding (incl dual packaging)	BAU - meet with health colleagues; CYP are open to CSST (Children in Need, Child Protection, Children Looked After)	ongoing	Green	Catherine Lloyd (CSST, BFC)
Dynamic Support register for LD, ASD (or both)	Early indentifiction of people at risk of admission to offer community care and treatment reviews	eastberksccg@dynamic			
Temporary Alternatives to Admission Funding – Intensive and Specialist support for Children and Young People with a learning disability and/or autism who display behaviour that challenges	To spot purchase specialist assessments and short-term interventions where they cannot currently be sourced through existing local provision. This funding does not relate to admissions for physical health conditions. It cannot be used for assessment of autism or ADHD	baswamccgs.fundingre			
Self Harm communication campaign	Produce guidance for professionals and promotional camapaign for schools, parents/carers and primary care	n/a			
Frimley Healthier Together	Maintaining children and young people in their normal enviroment	Online Platform			
Clinical Pathways-viral illness, D&V, viral wheeze	Consistant advice and treatment	DXS and Frimley Health			
Gastro-enteritis pathway	Prevent admission to hospital. Training in use of Ondansetron in Children	DXS and Frimley Health			
Consultant Hot Line	Consultant advice for GPs Mon-Fri 0900- 1800	GPs can call the Paedia Consultant Paediatricia			

Cohort 2.2 Mental Health					
Scheme (including brief description)	Aims & outcomes, capacity (including surge plans) and interdependencies	Referral pathway (including contact details, where necessary)	Status (Live or planned start date)	RAG rating (Red / Amber / Green) - see tab for details	Key organisation contact (name & details)
Sandhurst Counselling	Counselling	Self-referral / signposting from social care teams	Live	Green	Sandhurst Counselling
Bracknell Forest Community Network	Support those recovering from an episode of mental ill-health	CMHT or any service offering support to 18+residents in Bracknell Forest	Live	Green	Sheetal Tanna (BFC)
Sport in Mind	MH support through Activity Programme	Self-referral or signposting from other services			
Recovery College	Is recovering from a diagnosed mental health related illness or more	Self-referral Any voluntary or statutory service can			
Social Prescribers - Public Health	18+ and resident in Bracknell Forest Benefit from becoming more socially,	GP Practices Adult Social Care teams/LA Teams			
MHICS - Community Connectors	18+ and experiencing significant mental health problems that are impacting heir life and wellbeing Too complex for IAPT, but dont meet secondary care thresholds. Where established mental health services are not accessible	GP Surgery Gateway			
Link Project: Children & Young Person's (CYP) Mental Health and Neurodiversity GP Lead Training. Including Eating disorders, emotional dysregulation and self harm. GPs from Braccan health and Bracknell and district	•Improve links between Primary Care and CAMHS services in East Berkshire •Improve knowledge and confidence in supporting CYP within Primary Care •Enable a better patient experience ensuring the right support at the right time •Recognise barriers to seeking support including for neurodivergent patients	cypmhtraining.eastberks@nhs.net			
Roll out of Little Blue Book of Sunshine Ebook for secondary school age children	To support CYP, Families and Professionals across Health, Education and Social care with signposting for emotional and	Google- https://play.google.com/store/books/details?id=dvcOEAAAQBAJ; Apple- https://books.apple.com/us/book/the-little-blue-book-of-			

Cohort 3.3 Adults					
Scheme (including brief description)	Aims & outcomes, capacity (including surge plans) and interdependencies	Referral pathway (including contact details, where necessary)	Status (Live or planned start date)	RAG rating (Red / Amber / Green) - see tab for details	Key organisation contact (name & details)
Additional D2A bed capacity over and above current baseline	3 Bed D2A block Contract at Sandown 3 Bed D2A block Contract at Kings Lodge	To be detailed	Live Nov 1st - March 31st	Green	Ben Sladden (BFC) ben.sladden@bracknell-forest.gov.uk
In-reach Advance Nurse Practitioner	Proactively working within FPH and IRIS to activly identify and support the discharge of Bracknell Forest Patients to the most appropriate destination coordinating, communicating and navigating to the right services i.e. LAP, ICTs and BHFT community wards	Based in FPH Monday - Friday. Contact details to be confirmed	Bid approved. Recruitment in progress for a seconded post	Green	Integrated Services and Inpatient Lead (BHFT) Mob: 07919 591058 joanne.blackburn@berkshire.nhs.uk
VSO Winter Pressure Community Pressure navigator (The ARK Trust)	This post will support early discharge for those needing support at home. This post would work with the Locality Access Point and work in partnership with the BHFT In reach nurse above, to ensure support and care coordination is joined up	Contact details and working relationships to be detailed	The ARK Trust notified of successful bid	Green	Aimee Knight (Involve) aimee.knight@involve.community
Hospital discharge Social Worker (includes mental health as per Hospital SW in 3.2)	Working across the hospital discharge team & within ACT/ICS and CMHTOA – improve capacity and flexibility of the Intermediate Care Service (ICS) acting as trusted assessor and completing conversation 3 to support transition from ICS to Long Term Packages of Care (POC)	How this role works with FPH to be articulated	Bid approved. Recruitment in progress	Green	Anna McCafferty (BFC) anna.mccafferty@bracknell-forest.gov.uk
Improving the flow of the Discharge to Assess process	Ensuring the flow of the D2A period is consistently managed moving people from placements to home or appropriate care setting. 1WTE will support all D2A placements facilitating early intervention at the start of the D2A process and discharge planning within the 4-week D2A period	To be detailed			Anna McCafferty (BFC) anna.mccafferty@bracknell-forest.gov.uk

These are examples of the type of content in the detailed Bracknell Forest Integrated Winter Plan, that will be developed over the next couple of months, as part of the planning process

Winter Pressures – supporting Bracknell Forest residents

Adults

The Adult Social Care Discharge Fund (ASCDF)

- Since the pandemic, we have seen consistently high levels of demand on acute hospitals throughout the year, with less seasonal variation and traditional 'Winter' levels being seen all year. This is partially due to delayed intervention or prevention during the pandemic, now leading to higher levels of acuity amongst people seeking Hospital care. Accordingly, we have prioritised allocation of ASCDF funding on initiatives with an impact throughout the year to both manage the current levels and avoid the lack of earlier intervention creating higher demand in future. Successfully implemented schemes to date include:

- Discharge to Assess Social Worker – to support with complex pathway 3 / Discharge to Assess discharges within the Adult Community Team
- Care Homes Physiotherapy Pilot – to provide physiotherapy and reablement to people returning to a care home placement following Hospital discharge
- Assistive Technology Grab Bags – to provide people with monitoring equipment at the point of Hospital discharge
- Temporary Accommodation and Home Preparation – to provide temporary accommodation for a person who is medically fit for discharge, whilst their home is prepared for safe habitation

Better Care Fund (BCF) – supporting Admission Avoidance work

- The Bracknell Forest Integrated Intermediate Care Service (ICS) is recognised for being flexible and responsive ensuring people receive the right care at the right time, including pro-active interventions to avoid admissions. The rapid response and ability to provide holistic care and therapy, from a multi-disciplinary team, is effective at preventing avoidable admissions
- Unpaid carers provide critical support to friends, family and loved ones who would be unable to manage in their everyday lives without their help. The work they do reduces demand on some of the services we provide and plays an important part in helping prevent avoidable hospital admissions. Bracknell Forest have just co-produced an All-Age Integrated Carers Strategy which will identify how we can best support carers in their caring role and plan the right types of support and services to meet the needs of carers going forward
- Forestcare is Bracknell Forest's Assistive Technology service, offering a wide variety of alarms and sensors from basic 'pull cord pendant' alarms to specialised sensors and supportive technology. This monitoring with a 'safety net' provides reassurance to family/carers, helps avoid hospital admissions and helps people them stay in their own home
- One option used extensively across Bracknell, is that of a 'step-up' bed. Where someone might require a period of reablement or care that is difficult to provide at home they can be admitted to a community bed or a rehabilitation bed in several locations across the area. A pro-active admission of this type can prevent a situation from escalation (which can often be quite rapid) that would otherwise result in an avoidable admission and/or longer-term deterioration in their well-being. It also allows for a focused provision of more specialised care that would be challenging or impossible to provide at home

Winter Pressures – supporting Bracknell Forest residents

Adults

Market Sustainability Fund (MSF)

- Funding is being made available that will be used to sustain the cost of existing placements (not funding for new initiatives)

New Adult Social Care Target Operating Model – focussed around system and flow

- The council has invested around £750k to deliver transformation across Adult Social Care, to improve access to services and strengthen integrated working with health partners across the Community and Hospital
- The resultant new target operating model is designed for people to have a common point of access and consistent, quality experience throughout their interaction with services. This will improve discharge and patient flow from Hospital, with a focus on strengthening the Home First and reviewing our Discharge to Assess approach
- As part of the transformation, a new Hospital Community Services Manager post has been created, to provide sufficient oversight, professional and management cover to ensure effective discharge and flow, in order to strengthen management support and resilience for hospital discharge and to manage significant system pressures

Dedicated resource & expertise to continue to support system and flow

- Delivering an intensive period of accelerated activity focussed on the below schemes:
  1. Consider the national specification for transfers of care from hospital and what would work for Bracknell and the Frimley system and interfaces
  2. Improve infrastructure aspects to improve discharge and flow to align with Frimley system and new operating model in Bracknell Forest
  3. Managing choice and complexity on discharge – system discharge challenges, complex decision making, brokering of care provision and funding arrangements
  4. Development of integrated dashboards to monitor discharge and flow across Bracknell and wider Frimley ICS
- This work will be across the ICS as a system and deliver a robust integrated approach across Bracknell Forest and the broader Frimley system to improve hospital discharge and flow

Strong links with the Voluntary Sector

- Schemes to support Bracknell Forest residents who are deemed Clinically Extremely Vulnerable (CEV)
- Bracknell Forest Happiness Hub – a collaboration of support services offering mental health and wellbeing advice for people aged 18 and over who live in Bracknell Forest (and the surrounding areas)

Winter Pressures – supporting Bracknell Forest residents

Mental Health

Learning Disability and Autism

- Planned recruitment of a Learning Disability & Autism Support Manager to address local need within the Primary Care setting. The role will plan, deliver and innovate programmes of work for Learning Disabilities and Autism alongside Bracknell Forest Primary Care Networks and the Integrated Community Team for People with a Learning Disability

Crisis Alternatives

- Extending the period that the Safe-Haven in East Berkshire operates from 4 to 7 days. This service is for all East Berkshire Places and the team have been working on increasing access to Bracknell Forest. This extra capacity is planned to start pre-Winter to enable more people to have access to out of hours, same day Mental Health crisis support

Children & Young People (CYP)

Frimley Healthier Together

- Maintaining children and young people in their normal environment – including integration of the HT app into Bracknell Forest PCN systems

Paediatric Consultant Hotline

- Consultant advice for GPs, Mon-Fri, 0900 – 1800

Psychiatric Liaison Nurse

- 24/7 access to a PLN being developed in Frimley

Paediatric Virtual Wards

- Priority pathway to support admission avoidance, across Bracknell Forest and the Frimley system

Bracknell Forest Primary Care

Supporting Primary Care, Bracknell Forest already has a very well established Integrated Urgent Care (minor illness) Pathway providing up to 93 same day bookable appointments from Bracknell Urgent Care Centre (including a Home Visiting Service)

Integration into Community services that include Urgent Community Response (UCR) & Frailty Virtual Wards (FVW), and the Community Pharmacist Consultation Service (CPCS)

Ideas being explored to further support Winter pressures:

- Training for PCNs (Care Navigators) to achieve Capacity & Access Plans
- Additional same day appointments – either via GP Practice or the Integrated Urgent Care (minor illness) Pathway
- Proactive Case Management – sprint work allowing PCNs to deploy additional resource to potentially focus on Diabetes and Hypertension & Lipid Lowering Therapies
- Remote monitoring of high-risk patients

Winter funding sources being explored:

- PMS (Personal Medical Services)
- Transition Cover & Transformation Support Funding
- IIF (Investment & Impact Fund)
- Digital First

Monitoring the impact of the Bracknell Forest Winter Plan

- Joint weekly meetings (Seasonal Capacity Planning) provide planning and oversight
  - Collaboration between Bracknell Forest Place & Bracknell Forest Borough Council
- Adult Social Care Discharge Fund bids monitored
  - What progress is being made with schemes and tracking of finances
- Better Care Fund oversight of BAU and newly implemented schemes
- Alignment with UEC system priorities through Winter
  - As per previous Frimley system slides
- Winter Plan updates to be brought to Bracknell Forest meetings as required
  - Place Committee, GP Council, Health & Wellbeing Board
- Regular reporting submissions to NHSE
  - Submissions made via the BCF, on a fortnightly basis to monitor impact of Adult Social Care Discharge Fund schemes

Bracknell Forest Public Health

- ## Warm, Safe and Well programme
  - The Council through its public health grant funds the warm, safe and well programme – which is based on the NICE (National Institute of Clinical Excellence) evidence-based guidance on reducing excess winter deaths and illness and the health risks associated with cold homes
  - An assistance scheme for residents who have major health issue and are living in homes in need of heating or safety improvements. Examples include people with cancer, stroke, heart condition, disability and mental health illness

- ## Community Winter Hubs
  - These aim to offer a warm, safe and welcoming community space. Our approach is based on the following principles:
    - *Using existing quality community assets to encourage a thriving community*
    - *Be open and accessible to all, including offering discreetness*
    - *Provide a safe place with staff and volunteers aware of safeguarding support*
    - *Offer a space for self-directed and social activities*
    - *Join up with wider community activities and health initiatives, and broader hardship support*

- ## 5 ways to Winter wellness campaign

As the temperatures fall and we settle into winter, it is even more important to look after our health.

To support residents, Bracknell Forest Council's Public Health team has launched the **Five Ways to Winter Wellness** campaign, providing a variety of free activities across the season to support your wellbeing.

All sessions are free to attend and are led by qualified instructors.

Details of the sessions and a timetable of activities running in November and December are shown in this leaflet.

An updated timetable for January 2023 onwards will be published separately.

Venues include selected spaces from the **Community Winter Hubs** network in Bracknell Forest.

www.bracknell-forest.gov.uk/winter-hubs

Get protected
Self-care
Wellbeing and welfare
Mental health
Get active

What do the activities cover?

Energy efficiency
How to save energy and insulate your home.

Social prescribing
Meet our social prescribers to find out what they do and how they can support your wellbeing.

Fire safety
Fire risks in the home and what you can do to reduce risk.

Nutrition workshop
Suitable for the whole family. Covers everything from cooking on a budget, sugar, fat and healthy snacking.

Stop smoking
Meet a Smokefreelife Berkshire advisor and find out how they can support you to quit smoking.

Stepping Stones Recovery College
Find out about Stepping Stones offers, what course might be suitable for you and where you can access help.

Wellbeing sessions
Discover ways to support your wellbeing using the Five Ways to Wellbeing.

Making Every Contact Count
Learn skills to support your own wellbeing, or the wellbeing of those you interact with through healthy conversation skills.

Drug and alcohol support
Meet the New Hope team and find out how they can support you to reduce your alcohol intake.

Craft session with Bracknell Forest Community Network (BFCN)
A friendly chat and craft session including mindful colouring, journaling and more.

Happiness Hub drop-in
Meet the Happiness Hub at their monthly coffee morning and chat to the team about how they can support your wellbeing.

Winter walks for wellness
A series of walks in local parks and green spaces, making use of the network of footpaths in the town. Each walk is about 40 minutes and is suitable for beginners.

Date	Start time	Session topic	Venue
Monday, 28 November	10am	Energy efficiency	Sandhurst Library
	10am	Adult college	Bracknell Library
	10am	Stop smoking	Crowthorne Library
	2pm	Energy efficiency	Bracknell Library
	2pm	Social Prescribers	Binfield Library
Tuesday, 29 November	10am	The Recovery College	Whitegrove Library
	1pm	BFCN wellbeing sessions	Crowthorne Fire Station
	2pm	MECC	Sandhurst Library
Thursday, 1 December	10am	Stop smoking	Bracknell Library
	10am	Fire safety and smoke alarms	Community Hub Time Square
	10am	Drug and alcohol advice	Community Hub Time Square
	2pm	Social Prescribers	Bracknell Library
	2pm	The Recovery College	Birch Hill Library
	3.30pm	Healthy eating	Whitegrove Library
Friday, 2 December	10am	Winter walks for wellness	Community Hub Time Square
	10am	Adult college	Community Hub Time Square
	10am	Drug and alcohol advice	Crowthorne Library
Monday, 5 December	10am	Stop smoking	Sandhurst Library
	10am	Social prescribers	Community Hub Time Square
	10am	The Recovery College	Bracknell Library
	2pm	Adult college	Binfield Library
Tuesday, 6 December	9.30am	Winter walks for wellness	Crowthorne Library
	11.30am	Energy efficiency	Birch Hill Library
	12.30pm	Winter walks for wellness	Community Hub Time Square
	2pm	Fire safety and smoke alarms	Bracknell Library
	2pm	Energy efficiency	Crowthorne Fire Station
	2.30pm	Winter walks for wellness	Birch Hill Library
Wednesday, 7 December	10am	Drug and alcohol advice	Community Hub Time Square
	11am	Craft session with BFCN	Community Hub Time Square
	2pm	Adult college	Community Hub Time Square
Thursday, 8 December	9.30am	Winter walks for wellness	Bracknell Library
	10am	Stop smoking	Birch Hill Library
	1pm	Winter walks for wellness	Binfield Library
	2pm	The Recovery College	Sandhurst Library
	2pm	Social Prescribers	Birch Hill Library
	3pm	Winter walks for wellness	Whitegrove Library
	3.30pm	Healthy eating	Birch Hill Library
Friday, 9 December	10am	MECC	Bracknell Library
	11am	BFCN wellbeing sessions	Community Hub Time Square
	3.30pm	Healthy eating	Sandhurst Library