Bracknell Forest Better Care Fund Narrative Plan 2023-2025

1. Cover

Bracknell Forest Health and Wellbeing Board has overseen the development of the Better Care Fund (BCF) Narrative Plan 2023 – 2025 and Planning Template 2023-2025.

Partners involved in preparing the plan include Frimley Integrated Care Board (ICB), Bracknell Forest Council (BFC) leads and managers for Adult Social Care, Intermediate Care, Community Mental Health and Community Mental Health Older People, Community Engagement, Housing (DFG), Public Health, Strategic Commissioning, Involve (local support organisation for voluntary, community and faith groups), Berkshire Healthcare Foundation Trust and BCF leads across East Berkshire and the wider Frimley ICS.

An integrated Seasonal Capacity planning group meets on a weekly basis. The planning group consists of colleagues across Bracknell Forest Place from Urgent and Emergency Care Lead, Frimley ICB, Housing, Access to Resources, Commissioning (BCF leads) , Team Managers and Head of Service across Adult Social Care Community Hospital Discharge Team, Intermediate Care Service and Mental Health and Integration Project Lead (EHCH lead). There is no set agenda – the group meet informally to discuss system demand, share information across the system, hold workshops to troubleshoot / deep dive service areas, winter and other seasonal planning. Collaborative engagement to review the BCF 22/23 Plan, develop the ASC DF plan 22/23 and ASC DF takes place in this forum as well. All developments are also shared with the Ageing Well Forum for input and comment. In addition, plans for the ASC DF 23/25 were shared with the Frimley UEC for an input and steer. Members of the Health and Wellbeing Board were briefed, including social care provider representation, and had the opportunity to provide input into the development of the plan on the 6th of June 2023.

2. Governance

Please briefly outline the governance for the BCF plan and its implementation in your area:

The Better Care Fund Delivery Group meet once a month to consider performance, business cases and other developments. Membership of the Delivery Group has just been reviewed and consists of colleagues across place to include Frimley ICB, Berkshire Healthcare Foundation Trust (BHFT), Involve, Housing, Mental Health, Community Teams, Public Health, Finance Leads for BFC and Frimley ICB, and Integrated Operational Leads.

Considerations and recommendations from the Delivery Group are then presented at the BCF Strategic Group. The Strategic Group Membership consists of Assistant Directors in Mental Health, Adult Social Care, Commissioning, Head of Commissioning, Divisional Director BHFT, Finance Leads for BFC and Frimley ICB and Director of Operations, Frimley ICB.

Funding decisions and performance reviews are presented monthly at Place Committee. Place Committee membership consists of representatives from Frimley ICB, Primary Care, the Voluntary Sector, BHFT, Finance leads across the ICB and Council and Bracknell Forest Council.

The Health and Wellbeing Board oversees the planning and reporting of the Better Care Fund, with delegated authority assigned to the Executive Director: People, Bracknell Forest Council, to ensure timely authorisation of the planning and reporting cycle.

3. Executive Summary

This should include:

- **Priorities for 2023-25**
- **Key changes since previous BCF plan**

Bracknell Forest Place are jointly committed through effective integrated working to person-centred integrated care. Health, Social Care, Housing and the Voluntary Sector work together to ensure ongoing improvement in our joined-up care.

Priorities 2023-2025

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

The priorities developed for the Better Care Fund 22-23 plan remain key areas of focus for Bracknell Forest Place with work progressing towards better integrated care. They are:

- Build on Integrated Care Decision Making for early discharge planning and admission avoidance
- Improving the pathway from acute to the community
- Ageing well and frailty support
- Develop and enhance a technology first approach
- Improve quality assurance oversight of provider markets
- Integrated Community transformation
- Prevention and Early Intervention collaborative working

Key changes since BCF 22-23 Plan

The 22-23 BCF plan focussed on a recovery and re-setting approach following the Covid pandemic. We are continuing to support our acutes operating at unforeseen sustained levels of black Opal 4 for ongoing periods of time by building capacity across health, social care and the voluntary sector. The following key changes can be noted:

- Understanding demand and capacity across our system. One of the key areas of success we noted in the 22-23 EoY repot is the work that has commenced on shared access to EPIC. This continues to develop with social care staff recently accessing training. Work is underway to improve our data and reporting across the system which will drive forward our planning processes.

- A significant piece of work sponsored by the BCF was to develop an all-age integrated carers strategy completely co-produced with all types of carers in the Bracknell Forest Community, health including primary and secondary care, the Frimley ICB and BHFT, the voluntary sector and social care. The key priority outcomes identified are:
    - Recognising and Supporting Carers in the Wider Community
    - Services and Support that work for Carers
    - Employment and Financial Wellbeing
    - Supporting Young Carers
    - Young Adult Carers

  The strategy is in its final stages of completion and will shortly be published. This will see the commencement of a 5-year implementation plan which will drive forward the sustainable changes required to better support our unpaid carers.
  Moving into 2023-2025 The Carers Partnership Board, comprising of representatives from, health including primary and secondary care, the Frimley ICB and BHFT, the voluntary sector and social care, will monitor and report on progress of the implementation plan to the Health and Wellbeing Board and Place Committee. The implementation plan will be delivered collaboratively through our partnerships to provide services such as information and advice, respite, recreation and learning opportunities for carers.

- Joint redevelopment of our Adult Social Care operating model is underway and currently in the consultation process. Colleagues across Health and Care have informed changes to our model which will see improved access to social care with a consistent focus on the needs of the individual with system realignment to support new ways of working.

- 23-25 will see the enhancement of the Integrated Community Mental Health support across Bracknell Place through increasing the capacity for group led support, peer monitoring and drop ins. In addition, the wider community transformation programme will be further enhanced to ensure a seamless pathway for people accessing Mental Health support.

- Over the next two years an increased focus in developing and enhancing our technology first approach across health and care will be prioritised. We are seeking to utilise a wider range of monitoring equipment at the point of discharge and have set aside a fund for people who meet criteria to be financially supported with the

online monitoring of their equipment. The Assessment suite is now underway, and the Better Care Fund has supported the additional purchase of technology for demonstration purposes to social care colleagues and members of the community.

- Ongoing capacity to carry out complex pathway 3 assessments across adult social care and mental health is a priority accessed through the adult social care discharge fund. The additional resource of this fund has supported access to temporary accommodation and home preparation for people ready to be discharged, supporting our system flow. Joint workshops to explore and troubleshoot any system blockages to effective discharge from hospital have resulted in a renewed focus in enhancing our home first approach.

- Improving our preventative approach through anticipatory care supported by Healthwatch and primary care. In addition, the new two years will see the continued utilisation of the UCR and virtual wards to support system flow.

4. National Condition 1 – Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- **Joint priorities for 2023-25**
- **Approaches to joint/collaborative commissioning**
- **How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.**

The vision for the BCF over 23-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Our 2023-25 priorities will build on our existing key areas of focus, developed in collaboration with partners:

- Build on Integrated Care Decision Making for early discharge planning and admission avoidance
- Improving the pathway from acute to the community
- Ageing well and frailty support
- Develop and enhance a technology first approach
- Improve quality assurance oversight of provider markets
- Integrated Community transformation
- Prevention and Early Intervention collaborative working

Bracknell Forest Council and Frimley ICS colleagues work well together to support each organisation's priorities and integrate services through a collaborative approach in order to achieve better outcomes for residents. Our community provider, Berkshire Healthcare Foundation Trust is a key partner in the development and improvement of services. This is evidenced through a range of initiatives from small value contracts through to multi-million-pound ventures. The voice of Bracknell Forest residents is important to health, social care and community colleagues as evidenced in the extensive co-production to develop the Carers Strategy.

Bracknell Forest regularly host integrated provider forums where health and care operational and strategic colleagues meet with local and out of area providers in home-care, supported living and residential care to understand challenges and barriers to delivering effective services. Conversations across these forums which feed into the Market Sustainability and Improvement Fund (MSIF) are integrated into the joint working and planning for the development of the Better Care fund. Demand modelling undertaken as part of the BCF capacity and demand is shared and informs the MSIF conversations and equally, forum discussions are fed into planning meetings for the Discharge Funding and Winter Planning.

The 30 plus schemes located within the Bracknell Forest BCF are all jointly developed, evaluated and agreed. Six of these schemes are jointly hosted. Integrated evaluation panels are formed with key service leads across health and care for the development and evaluation of services through the procurement process. Several BCF funded posts are for operational Integration Managers, integrated commissioning, and support for the BCF and these will continue as key elements of our integrated working. These posts sit across the council, within our providers or within the ICB.

Considerable effort is made to jointly develop all schemes jointly regardless of whether the scheme is hosted within the NHS or Local Authority, with a governance structure through which BCF proposal are developed, consisting of a BCF Delivery Group, then a Strategic Group that reports to the Place Committee, in turn reporting to the Health and Well Being Board. As a unitary authority, we have the DFG Lead and the Housing Lead as part of this governance structure, ensuring alignment of services delivered with the funding. All of these meetings have a joint membership and a quoracy requirement for joint input on decisions, with General Practice and Primary Care attending Place Committee. This ensures that the BCF is a focal point for joint commissioning, supported by an Integration commissioning team and BCF lead hosted in the local authority.

A review of the Bracknell Forest Better Care Fund was undertaken in late 2023 to inform planning for 23-25. This enabled accurate prioritisation and ensured up to date information was available for each scheme. Concurrent with this review, a review of the operating procedures around the Adult Social Care Community Teams and associated services, such as Intermediate Care, is underway.

The review has led to the development of a reporting system, trialled in Q3 and Q4 22/23, that will enable robust monitoring and reporting of all schemes, through the governance structure, including progress, metrics, incidents, whether active, risks and issues.

Changes to the ASC operating model will see a more resourced focus around hospital discharge. This approach is currently in the planning stages and will be supported by the Better Care Fund 23-25 and Adult Social Care Discharge Fund 23-25.

In order to further align priorities and enhance strong integration partnerships, 2023 – 2025 will see a refresh of the Bracknell Forest Health and Care Plan, jointly developed to align with the Frimley ICS Health and Care Plan. The plan will refresh work already undertaken and will outline further plans to drive forward areas supported and facilitated by the BCF 23-25. i.e., Better Health and Wellbeing through prevention, Thriving Communities, Strength Based approaches, unpaid carers, anticipatory and personalised care, primary care transformation, enhanced health in care homes, assistive technology, urgent care, enhanced home first approach, intermediate care, people living with dementia and mental health transformation. This document outlines work to be undertaken and built on over the next 2 years across these areas which are aligned to the BCF local priorities 2023-2025.

The voice and inclusion of Bracknell Forest residents is essential to health and social care All commissioned services include the voice of the service user group through co-production, engagement and consultation. Our Health and Wellbeing Strategy looks to support joint working to enable older and vulnerable people to live independently in good health in their own homes for longer..

The 2023-25 BCF has funds carried forward from last year, allocated for understanding and addressing health inequalities across the system. This will inform the targeting of initiatives, linked with the Bracknell Forest Health and Wellbeing Strategy and Frimley ICS Health and Care Plan.

The HWB Strategy identifies some key challenges impacting people and potentially increasing health inequalities post covid, notably around Mental Health and children. The BCF for 2023-25 will provide additional resource to expand the Mental Health Network and for Homestart work, in response to both seeing demand exceed capacity.

In 2022/23 a three year “Thriving Communities Programme” was instigated and funded from the BCF. With a focus on community involvement and engagement, this will be targeted initially in areas of highest deprivation or where other health inequalities are identified. It will commence in 2023/24 with the aims of:

- Reducing health inequalities, maximising wellness through a focus on prevention and increasing self-care and community resilience through community development. Supporting and enabling an increase in individual’s agency, community action, activities, and asset development. ‘People helping people to remain well’.
- Supporting the start of a transformation of the relationship vertically between organisations/the system and communities founded on listening and collectively acting on the voices of people with lived experience, co-design, and co-production. This involves a significant cultural shift across the system to be enabled by organisational development.

The programme will have a focus on community development and enhancing both engagement, co-design and co-production skill in health, social care and the VCS. By engaging and empowering communities, we will promote individual and community assets

(skills, relationships, groups, social connections, physical e.g., community meeting space) increasing people's agency and sense of control and self-care.

It will work as a catalyst for cultural change towards a system that is increasingly focussed on prevention and enables innovative approaches to engaging and supporting people to be more active and collaborative participants in managing their own health and wellbeing.

The Health and Well Being Strategy also informs our Home First approach, which is embedded in the services that support flow around local acute hospitals.

The development of new services to enhance our Home First approach is enabled by using the Better Care Fund, or the Adult Social Care Discharge fund, to set-up and evaluate new services, for example for Winter Planning, which if successful, are then moved to 'business as usual' and part of our mainstream offering. This approach has the advantage of providing a joint, integrated evaluation of proposals (and advice on improvement) through to ensuring they are socialised and work seamlessly alongside other services.

As a unitary authority, we involve our housing department in key meetings including planning for the BCF and Discharge Fund. Bracknell Forest Council's Housing Assistance policy sets out a range of financial assistance that the Council can make available to improve living conditions for vulnerable residents in our community. The policy framework enables more flexible use of the Disabled Facilities Grant budget providing new forms of support including assisting people to move to a more suitable property and to support specific aims such as enabling faster hospital discharge, relieving pressures on accident and emergency services, and reducing the need for residential care.

Some key commissioning considerations are under way and planned for completion in 23-25. For example:

Stroke Support services – this is an integrated health and care jointly commissioned service across East Berkshire. Current work is underway to consider whether a Frimley ICS service would provide our residents with improved support.

Community Equipment Contract - This is a Berkshire-wide integrated health and care contract. The Partnership are currently in discussion to determine the best route to market effective from April 2024. Consideration is being given to working closely with the Buckinghamshire Framework which supports residents of the BOB ICB and working in an integrated way across Buckinghamshire and Berkshire

Home From Hospital Service – Current consideration is being undertaken in terms of whether residents across the Frimley ICB will find better support from a system wide contract as opposed to a local service.

Thames Hospice - current engagement and consultation with key partners across health and social care to review the current service provision.

An all-age integrated carers strategy 2023-2028 is being finalised – coproduced across health, social care, the voluntary sector and carers. Driving forward the delivery of the strategy, an integrated delivery plan will ensure sustainable changes and improvements to the support of our unpaid carers. Whilst the strategy still has to be formally approved, it has identified areas where support for carers could be improved (such as access) contributing to better health outcomes for carers.

All commissioning undertaken across health and care work in a collaborative, integrated way ensuring joint development and evaluation of the services. With a new council and lead councillor for Social Care, The Health and Well Being Board have delegated approval of this plan to the Bracknell Forest Executive Director of People in order to allow timely approval.

5. National Condition 2

Use this section to describe how your area will meet BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- **Steps to personalise care and deliver asset-based approaches**
- **Implementing joined up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches**
- **Multi-disciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake**
- **How work to support unpaid carers and deliver housing adaptations will support this objective**

In Bracknell Forest we take a strengths-based approach to how we work with people – taking a personalised view of the person and focussing on their assets (including personal strengths and social and community networks) and not on their deficits or what they can't do. It means working with the individual (as the Fuller stocktake says: "what matters to me, not what's the matter with me"), to work with people, promoting their overall wellbeing and resilience in a holistic way, demanding an integrated and multidisciplinary response.

The pandemic drove change and increased integration across our community teams (both health and social care) and following an extensive review, we will be introducing a co-produced structure and way of working – the "Target Operating Model" building on the findings of that review. This has taken into account data covering capacity and demand for all services, including intermediate care, hospital discharge and community referrals. In parallel with this we are working with SCIE (Social Care Institute of excellence) to enhance our practice and develop the way we use the 'three conversations' to ensure a more asset based and personalised approach. Many of the new roles as well as the project management of this work will be funded from the BCF.

A critical part of our holistic approach is the involvement and leadership input of General Practice and other Primary Care services and GP/PCN representation is a key element of our BCF governance, which following a comprehensive BCF review, has been strengthened for 23-25 with a view to leveraging the full potential of working together.

Consistent with the principles of the Fuller Stocktake, we have already introduced, and through 23-25 will be building on, targeted local meetings focussing on more cases at risk of escalation or those that would benefits from more integrated planning and response.

The ‘Locality Access Point’ (LAP) is a daily, multidisciplinary meeting (typically a Senior OT, Senior SW, CPN, Community Matron) where complex cases (inc. Complex Discharges, Referrals from Community Matrons inc. from others e.g., Dietician, SW Duty Referrals, MH Referrals) are brought for discussion about the best approach. It works closely alongside other community support, especially Urgent Care Response (UCR) and helps coordinate a holistic, individual response including joint visits.

The Cluster Meetings are monthly meeting, including GPs, to examine the most complex cases and try to create an integrated holistic care plan and coordinated approach moving forward. Many referrals come from the Locality Access Point and the wider team engagement helps enable a more intensive, holistic, integrated approach.

The Cluster meetings and LAP are both designed to provide care that enhances both the support provided and an individual’s self-management, helping keep them as well as possible and helping avoid unnecessary admissions.

To inform prevention we have been using Population Health Management, initially looking at Mental Health support, with a focus on young adults (18-25) including medicines optimisation. The learning from this work will be extended in 23-25 with new priority areas identified.

2023-2025 will see an extensive period of development in supported living for people with learning disabilities. Work is currently being undertaken to ensure we are bringing people back into the Bracknell Forest community where appropriate and suitable for the Transforming Care Partnership cohort. This will be developed through joint engagement with health partners including CHC funded circumstances. This work will also include the development of an Independence, Support and Supported Living Flexible Framework to ensure excellent packages of care and support are commissioned for people to support them to live independently and remain in their homes. The ambitions are for the framework to commence on the 1st of January 2024 for an initial period of 3 years.

Bracknell Forest has an ageing Learning Disabilities population and extensive consideration will continue into 23-25 to ensure adequate housing is provided which can accommodate ageing needs. Current accommodation is limited, and adaptations have been made where possible. Therefore, the Bridgewell project which is in its planning stage will seek to provide new build suited to meet the needs of up to 20 people with Learning Disabilities enabling people to remain safe and independent in their home.

Bracknell Forest Community Network (BFCN).

We have used BFCN to spearhead our latest local MH integration work. The BFCN has also created the Happiness Hub which connects all local MH services under one umbrella structure. Mental Health inequalities were identified in our Health and Well Being plan as being a post-covid priority and leveraging the network, with local voluntary and community groups involved, provides a more effective return on funding than direct support services, with improved accessibility in groups that we have found difficult to engage.

BFCN currently receives funding from the BCF, and this is soon to increase to offer the outcomes below.

The BFCN Recovery Facilitator roles have broadly changed to offer a more collaborative and integrated model to service provision with other mental health community-based services in Bracknell and now offers more group led support, peer mentoring and collective drop-ins to residents to aid their awareness of the wide range of recovery/ wellbeing focused statutory and community resources available to them to support their mental health and wellbeing.

BFCN has pioneered some excellent pieces of work from the Happiness Hub collaborative to understanding the current increased trends with young adults and working with partners to try and establish key projects to support the MH population.

The funding will support us to aim to reduce 999, 111 and A&E usage by providing an alternative in the community for this cohort of people with moderate to significant mental health needs that are not being met in the Bracknell system. This business case is crucial in improving mental health care in Bracknell as with this intervention it will meet our aim of using the happiness hub as a focal point so once someone contacts one community service, they will have access to all.

Alongside this we also have an Anticipatory care approach. This is proactive, personalised, and coordinated health and care planning for people who may have multiple long-term conditions, moderate/ severe frailty. It aims to improve outcomes by focusing on what matters to the individual and offering earlier intervention, helping keep people at home and avoid unnecessary admissions. It is part of “Population Health Management” – a strategic aim across the Integrated Care System to improve wellbeing and reduce health inequalities across an entire population, with a specific focus on the wider determinants of health (things like housing, employment, education), helping predict current and future needs across Bracknell Forest

Connected Care is in daily use, providing access to a thorough Shared Care Record via seamless integration into a practitioner’s normal line-of-business system (e.g., LAS for Social Care). This is underpinned by some of the most comprehensive Information Sharing Agreements in the country, across all partners. Our use of Connected Care for both the provision of Direct Care and as a data source for Population Health Management and Proactive Care will be further developed over the next two years.

Supporting Unpaid Carers

The BCF continues to fund the Carers Support contract through our provider Signal4Carers. Signal4Carers provide a range of support including

- Information, Advice and Guidance
- Encouraging carers to enjoy activities outside of their caring responsibilities, providing carers with opportunities to engage with other carers over lunch, and small groups.
- A range of training opportunities
- Monitoring and supporting the well-being of carers, assessing the level of support they may require.

The BCF also funds our Stroke Support service which supports carers of stroke survivors. Health, social care, and community sector partners work jointly to support carers e.g., the Alzheimer's Memory Café.

The BCF has resourced the development of an Integrated, All-Age Carers Strategy that sets out joint ambitions across health, social care and the voluntary sector for carers living in Bracknell Forest. The development of the strategy included primary and secondary research. This strategy and priorities have been co-produced with our partners in health, our providers in the Voluntary and Community Sector (VCS) and carers from:

- Berkshire Health Foundation Trust
- Frimley Integrated Care System/Integrated Care Board
- Primary Care Network
- Signal4 Carers/The Ark
- Parent Carer Forum
- Promise Inclusion
- New Hope
- The Wayz
- The Community and Mental Health Team
- Dementia Service

The strategic group initially met monthly to scope out the plan of work, determine what should be included in the survey questions, share intelligence, and agree roles. When data started to be collected, they met more frequently (fortnightly). All meetings were hybrid to enable access to as many people as possible. Times and days were varied also for this reason. In between meetings documents were circulated for discussion.

Carers groups during the day and evening time were visited and over 150 adult and young carers were consulted. In addition to this we consulted with carers via a survey, facilitated a young carers workshop in school and facilitated a carers focus group to determine priorities going forward.

The survey was directly sent to 728 adult carers, 275 completed surveys were returned this is a response rate of 37%. The survey was also sent to 242 parent carers and 194 parents of young carers. It was promoted via all members of the steering group, provider groups, community engagement team and newsletters. Bracknell Forest's social media platforms and schools advertised it widely in an attempt to reach carers not known to the Council or engaged with any of the VCS. The Council also included a question about carers in its' annual staff survey.

The priority outcomes that have been co-produced are:

1. Recognising and supporting carers in the wider community
2. Services and support that work for carers
3. Employment and financial wellbeing
4. Supporting young carers
5. Young adult carers

Whilst 2022/23 saw the development of the strategy, 23-25 will see the development and implementation of a delivery plan which will drive forward the priority outcomes. The delivery plan will be owned by the new Carers Partnership Board, who will monitor progress of delivery and report to the Health and Wellbeing Board and Bracknell Place Committee. The strategy and implementation plan are currently going through the final stages of local governance and approval. Once formally adopted, it will provide the basis for planning support for carers over the next few years.

The Integrated, All-Age Carers Strategy aligned to the Council Plan Priorities: Ensuring help is available for our most vulnerable residents to keep them safe and to help them remain independent, whilst avoiding loneliness and isolation. The strategy considers a carers experience and role in both acute, primary healthcare settings as well as in the community.

The strategy is aligned to and reflects:

- Berkshire Healthcare Strategy
- NHS Long Term Plan commitment to carers
- BFC Health and Care Plan 2022-2025
- Health and Wellbeing Strategy 2022-2026.

Following a successful winter initiative whereby carers were given additional payments in order to support the care of family members coming out of hospital, the BCF 22/23 plan has continued to fund this arrangement for the duration of 22/23.

Adaptations

The Disabled Facilities Grants Service, have, with the implementation of a 5 year Housing Assistance Policy in April of 2021, widened the scope of possible intervention by introducing 6 areas of discretionary funding including, Hospital Prevention & Discharge Assistance, and a Dementia, Cognitive and Behavioural Conditions Grant, to be available alongside the mandatory schemes that are delivered under the housing adaptations delivered under the Housing Grants, Construction and Regeneration Act 1996.

These additional funding areas have not only increased client choice they have increased the scope for greater collaborative working with partners in health and social care and with registered providers, including working on projects for early intervention and prevention.

The progress made in the financial year 22-23 is demonstrable, and the service area will continue to build on these successes, will continue to look for new opportunities to increase

the number of partners, for example by partnering with colleague in the wider housing services and colleagues in social services to identify suitable homes, care packages, and adaptations as part of a wholistic solution to enabling people to stay well, safe and independent at home for longer. Representatives have begun attending BCF planning meetings to ensure alignment between the sources of care and support and that BCF (or ASCDF) funding can be used to cover any gaps in provision.

We will seek to build on the successes achieved (such as the interim accommodation in sheltered housing initiative – enabling people to be discharged whilst their home environment is better adapted to their needs) and identify where funding may be more effectively used.

The Homelessness and Rough Sleeping Strategy 2021-26 is preventative in nature and aims to help those who become homeless to find and keep suitable housing. The strategy is well embedded and socialised across health and care and the acutes have access to key leads who will support health colleagues as they identify a person who has no place to be discharged to.

Work is underway on a Care and Accommodation Strategy, which feeds into the Housing Strategy 2023-28. The Care and Accommodation Strategy will assess the priorities for care and accommodation in the future. The strategy covers older people and working age adults with care and support needs, drawing on current data to make estimates for future need and provision.

Collectively these actions are highly likely to contribute to achieving the objective of enabling people to stay well, safe and independent at home for longer.

6. **National Condition 2 continued**

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- **learning from 2022-23 such as**
    - **where number of referrals did and did not meet expectations**
    - **unmet demand, i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)**
    - **patterns of referrals and impact of work to reduce demand on bedded services – e.g., admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);**
- **approach to estimating demand, assumptions made and gaps in provision identified**
    - **where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?**
    - **how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.**

Demand and capacity modelling for 22/23 was challenging in many ways and it has been helpful to reflect back as this highlights even further areas of development that have been achieved.

The modelling requirements initiated conversations around East Berkshire and the Frimley ICS that were not previously had, and areas came together to share ideas and learning. One of the main challenges was that data was not collated in such a way as to inform the template.

Work was undertaken and shared across the ICS based on assumptions utilising the following model and data:

1. Using the 21/22 inpatient data as a proxy for splitting discharges by place for FHFT.
2. Applying the split seen in inpatients to the discharge total metric from the AE SITREP.
3. Further splitting the place total discharges along the lines of pathways,
    a. with 85% going to pathway 0,
    b. 8% for pathway 1,
    c. 5% for Pathway 2,
    d. and 1% Pathway 3.

When understanding demand and need - whilst we weren't sure of the context and pressures in the system as we were emerging from covid – we anticipated an intense winter period. Reflecting back on this now – we know we did experience a pressured winter system but alongside this we also saw ongoing pressures throughout the year.

In terms of unmet demand – all people had access to services where required. Thames Hospice service supported people to retain choice over where to die, additional support from the volunteer hub to support people with prescriptions and additional social care workforce from the BCF supported our admission avoidance approach.

The Bracknell Forest Integrated Intermediate Care Service is recognised for being flexible and responsive ensuring people receive the right care at the right time. The ongoing challenges of recruitment and retention are met with a flexible approach down to a granular level whereby staff will volunteer shift changes to meet system need and demand supporting an admission avoidance approach. We are striving to make better use of our responsive home care market and the ICS will support care workers to provide reablement as well as care and support. This has the effect of broadening our reablement offer.

The bedded intermediate care service Heathlands is a great resource and has played a key role in a step-up provision avoiding hospital admission. We are aiming to further enhance system flow by locating a trusted assessor / discharge coordinator in the bed-based unit to support effective discharge back into the community.

Planning for 23-25 capacity and demand modelling still presents its challenges. Good progress has been made to develop informative hospital dashboards and datasets. Therefore, this time next year we shall be able to evidence our assumptions and will be in a much better place to inform our modelling.

Please see examples of demand modelling for the ICS to support hospital discharge which informed the planning template:

- 1/3rd of the ICS services capacity is utilised to support people in the community
- Capacity calculations have been based on current filled positions only
- Number of hours a worker has available is 1318 per FTE (same methodology as TOM)
- This deducts hours for annual leave, bank holidays, sickness, supervision, team meetings and training
- To calculate no of people the ICS can provide a service to – the number of available contact hours divided by the average number of hours the person has in the service
- Demand levels were based on similar levels of activity as 22/23

The demand and capacity modelling has informed planning in the wider BCF for example anticipatory care and planning.

The Urgent Community Response and Virtual Ward provides excellent admission avoidance and an increase in referrals from PCNs, and care homes is on the increase.

In 22/23 the UCR was in development and therefore the capacity and demand was being evidenced on a month-to-month basis – 23-25 modelling has been based on the full capacity of the UCR now that it is well established.

In 23-25 as part of the assistive technology approach we need to consider our utilisation of our responder service ensuring that it is as effective as possible in preventing admissions. This will support the performance in monitoring emergency admissions due to falls..

23-25 will see a period of enhancing our home-first approach. Therefore, we will be looking to reduce bed-based discharge to assess, potentially leading to an increase on the demand of our Intermediate Care resources. In order to effectively deliver this service, we will need to ensure our intermediate care services are appropriately resources. Given that this work has not been undertaken to date – the modelling in the demand and capacity does not reflect an anticipated increase in resource under capacity.

7. National Condition 2 continued

(NC2: Enabling people to stay well, safe and independent at home for longer)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- **unplanned admissions to hospital for chronic ambulatory care sensitive conditions**
- **emergency hospital admissions following a fall for people over the age of 65**
- **the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

In Bracknell Forest we take a strengths-based approach to how we work with people – taking a personalised view of the person and focussing on their assets (including personal strengths and social and community networks) and not on their deficits or what they can't do. It means working with the individual (as the Fuller stocktake says: "what matters to me, not

what's the matter with me"), to work with people, promoting their overall wellbeing and resilience in a holistic way, demanding an integrated and multidisciplinary response.

Following an extensive review, with project management funding from the BCF, we will be introducing a co-produced structure and way of working – the "Target Operating Model" building on the findings of that review. In parallel with this we are working with SCIE (Social Care Institute of excellence) to enhance our practice and develop the way we use the 'three conversations' to ensure a more asset based and personalised approach. Many of the new roles will be funded from the BCF with the aim of ensuring everything is done to promote a Home First approach and wherever possible, avoid admissions to permanent care home placements. In particular two of the aims echo the aspirations for Primary Care in the Fuller Stocktake:

- streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions

When someone is due to be admitted to a Care Home from hospital, the home has to ensure they are capable of meeting that person's needs (at that time). This can cause delays of a few days whilst this is arranged and undertaken. At Frimley Park Hospital work is underway to explore a "Trusted Assessor" approach whereby the Trusted Assessor undertakes the assessment on behalf of the home, the home then reviews the information and decides whether they can admit the person.

The work to improve and maintain Bracknell Forest's record on delayed discharges has been successful over the last year with capacity in the local domiciliary care market supported by a recently introduced framework agreement. Where there can be some challenges has been around the Care Home market. Recent, previous investment in a new-build local Care Home that has just become fully operational, has introduced additional dementia nursing capacity (helping manage the market) as well as an integrated intermediate care unit.

Wherever possible, discharges are never be directly to a permanent placement and the use of Discharge 2 Assess beds or short-term placements is the normal route. However, with a small geographical footprint and several surrounding authorities also looking for placements, sometimes finding a D2A or interim bed can be a challenge. The approach planned for 23-25 is to provide even more support around Home First and use very intensive short-term packages, potentially including 24hr or intensive night-time care, overseen by a ASCDF funded "Home First Social Worker".

A critical part of our holistic approach is the involvement and leadership input of General Practice and other Primary Care services and GP/PCN representation is a key element of our BCF governance, which following a comprehensive BCF review, has been strengthened for 23-24 with a view to leveraging the full potential of working together.

Consistent with the principles of the Fuller Stocktake, we have already introduced, and through 23-25 will be building on, targeted local meetings focussing on more cases at risk of escalation or those that would benefits from more integrated planning and response.

The 'Locality Access Point' (LAP) is a daily, multidisciplinary meeting (typically a Senior OT, Senior SW, CPN, Community Matron) where complex cases (inc. Complex Discharges, Referrals from Community Matrons inc. from others e.g., Dietician, SW Duty Referrals, MH Referrals) are brought for discussion about the best approach. It works closely alongside other community support, especially Urgent Care Response (UCR) and helps coordinate a holistic, individual response including joint visits.

The Cluster Meetings are monthly meeting, including GPs, to examine the most complex cases and try to create an integrated holistic care plan and coordinated approach moving forward. Many referrals come from the Locality Access Point and the wider team engagement helps enable a more intensive, holistic, integrated approach.

The Cluster meetings and LAP are both designed to provide care that enhances both the support provided and an individual's self-management, helping keep them as well as possible and helping avoid unnecessary admissions.

Supporting this proactive planning, the BCF funds a Falls Tier 3 service around a Falls Assessment and Rehabilitation Centre, and the ASCDF has been used to fund a Physiotherapist and Multi-Therapy assistant to support Care Homes. Both initiatives are working to reduce unnecessary admission for falls or falls-related occurrences.

For 23-24 we have examined the demand against predicted capacity (and cost) for schemes, especially those funded through the ASCDF. This identified some scheme, notably an A&E discharge facilitator and additional weekend homecare capacity, where demand proved far lower than predicted so this funding will be moved to where meeting BCF and SCDF objectives suggests higher prioritisation, e.g. to fund an Enhanced Home First Social Worker, who will specialise in people leaving hospital who would normally have placement and oversee very intensive packages of care (including night-times & telecare if needed), for specific periods of time as part of enabling people to go Home First at the very least for a fuller assessment of their needs.

This has been informed by a review of our Home First approach and any challenges or gaps that practitioners have identified, as well as a case review of admissions to Care Homes, including via Discharge 2 Assess beds, and whether they might have been prevented.

Our Intermediate Care service (ICS, Reablement workers), working alongside our Enhanced Intermediate Care Service (EICS, Therapists and Nursing) provide a seamless pathway for people needing reablement/rehabilitation. The service supports people requiring support from hospital and people living at home including people at the end of their life. For those people being discharged from hospital, ICS provides a responsive service to enable people to recover and regain their independence through a combination of reablement care and therapies.

With the reablement and therapies services working so closely together they can continue the journey from reablement care to rehabilitation seamlessly. This joined up approach has

resulted in positive outcomes with 80% of people receiving ICS from hospital exiting the service with no ongoing services.

In addition to facilitating discharges, about a third of the ICS service capacity is focussed on providing preventative interventions to people in the community particularly those over 65. People are referred to the service through the front door to ASC (Gateway), through Locality Access Points and via UCR and early intervention in people's homes, with associated home visits and risk assessments can enable adaptations, equipment, and therapy input to promote people's abilities and avoid decline. This reduces the likelihood of falls and exacerbation of other ambulatory care conditions that would lead to hospital admissions.

Engaging with people earlier and encouraging independence has improved wellbeing and resilience and has reduced the demand for council services and more costly interventions. Of those people from the community who received ICS 83% of them did not require ongoing services.

From previous demand vs capacity analysis, we have identified there are periods where ICS demand exceeds capacity, and we have to use the domiciliary framework providers. Whilst EICS ensure therapy input is still available, and the care workers try to work in a reablement focussed way, examining whether more can be done to provide additional spot-purchase care, operating in a fully reablement focussed way (like ICS) is planned for 23-24.

ICS and EICS get referrals from other practitioners, or families, or even self-referrals, that someone needs support at home due to a sudden health crisis or illness (including a fall), it is triaged at their gateway and then allocated for a prompt visit. Commonly referrals are for someone medically optimised in an acute hospital. If appropriate it is then passed to ICS or EICS for their input and any therapist input required, identifying where equipment may prove effective. As EICS has Nurses within the team, they are also able to provide support around medical issues such a Tissue Viability, Diabetes management. Some referrals also come via the Urgent Care Response team.

The Urgent Care Response (UCR) operates in partnership with the Frailty Virtual Ward Team, operating 08.00-20.00hrs, 7 days a week, 365 days. The team consists of Advanced Nurse/ Advanced Clinical Practitioners, Pharmacist, Senior Nurses, Physiotherapists and Multi-Therapy Assistants. The UCR team is a community-based service that delivers a 2-hour response time to assess people in their usual place of residence. This service is suitable for those approaching or following a crisis with the aim to develop a plan of care and deliver treatment to avoid an unnecessary hospital admission. Since commencement in 2022, the team have adopted an approach based on continual improvement and will continue to develop further over the next year. Their focus is on preventative work with their referrals all being potential imminent admissions. They have currently achieved a 98% record of preventing those admissions, working with partners such as ICS and EICS and the Frailty Virtual Ward.

If there is a requirement for the individual to receive treatment over several days, they would be transferred to the Frailty Virtual Ward. Whilst on this virtual ward, the person is under the care of a Consultant Geriatrician, upon discharge their care transfers back to their GP.

The rapid response and ability to provide holistic care and therapy, from a multi-disciplinary team, is effective at prevent avoidable admissions. Anticipatory Care in Bracknell Forest sits

within primary care as part of the NHS Long Term Plan (Ageing Well). Each of the three Primary Care Networks has a slightly differing approach to how they manage this, tailored to their locality.

Alongside this we also have an Anticipatory care approach. This is proactive, personalised, and coordinated health and care planning for people who may have multiple long-term conditions, moderate/ severe frailty. It aims to improve outcomes by focusing on what matters to the individual and offering earlier intervention, helping keep people at home and avoid unnecessary admissions. It is part of "Population Health Management" – a strategic aim across the Integrated Care System to improve wellbeing and reduce health inequalities across an entire population, with a specific focus on the wider determinants of health (things like housing, employment, education), helping predict current and future needs across Bracknell Forest

It does this by looking at the data held across the system (typically in 'Connected Care' – the Shared Care Record in use in Bracknell Forest) and identifying specific cohorts of people with multiple long-term conditions, moderate/severe frailty, to predict those at particular risk of deteriorating or needing a hospital admission. AS a key tool in building and enabling an integrated response, BCF funding will continue for this for 23-24.

In Bracknell Forest, Care Coordinators then conduct a holistic overview with the person (called "What Matters to Me") and develop pro-active approaches to improve the person's health and/or help them become better able to manage their conditions. This may be supplemented with remote monitoring approaches that help improve the accuracy and understanding of a person's current condition and take action accordingly, with resources targeted where they are most needed and have the most impact.

Connected Care is in daily use, providing access to a thorough Shared Care Record via seamless integration into a practitioner's normal line-of-business system (e.g., LAS for Social Care). This is underpinned by some of the most comprehensive Information Sharing Agreements in the country, across all partners. Our use of Connected Care for both the provision of Direct Care and as a data source for Population Health Management and Proactive Care will be further developed over the next two years.

As key additional support is 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 (e.g., automated reminders) – reporting into centralised control centre or directly to relatives or carers. This monitoring with a 'safety net' provides reassurance to family/carers, helps avoid hospital admissions and helps people them stay in their own home. And when something does happen, it can provide clarity that can safely help inform a decision as to whether a 999 response or emergency admission is really needed. The service can include a 'pick-up' service for people who have fallen and can then provide personal care, preserving the person's dignity. By working alongside other community responses, this can help prevent ambulance callouts or admissions.

To identify the most appropriate Assistive Technology, the BCF funded an assessment suite and Assessment Suite Expert so that people can see the technology in situ and identify what they feel may work best for them, in a domestic setting. BCF funding in 23-24 will be used to invest in 'Monica' – a digital personal assistant that can monitor the environment, record

SATS and other personal health readings, provide reminders for tasks and appointments even warning about the weather (e.g., if it is likely to be icy or raining) when someone has to go to an external appointment. The aim is to bridge the gap between requiring a constant presence of a carer and someone having independence, and early case studies have validated this assumption and proven the approach can work and maintain independence – providing a future reduction in the need for care home admission.

8. **National Condition 3**

Use this section to describe how your area will meet BCF objective 2: Provide the right care in the right place at the right time.

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- **ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.**
- **How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.**
- **Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow**.

Bracknell Forest Council and Frimley ICS are committed to person-centred, integrated care, with health, social care, housing, provider markets and the voluntary sector working together to provide better outcomes for the people of Bracknell Forest.

We have developed strong and effective integrated and joint working across health and social care with key partners across the ICB, adult social care and commissioning meeting weekly to identify barriers to progress, share key information and recognise areas of achievement. These meetings also plan for anticipated times of increased demand throughout the year. This will continue over the 2023 – 25 period.

The voice and inclusion of Bracknell Forest residents is an integral part of our approach. Involving patients and their families in decision making is key to ensuring people progress and regain their independence. Our Health and Wellbeing Strategy[1] looks to support joint working to enable older and vulnerable people to live independently in good health in their own homes for longer.

We have a locally agreed commitment to prevention, supported by our collaborative commissioning and including targeting of some BCF funding, An individual's own home (when they can be safely managed there), is our priority for providing the right care in the right place at the right time.

Should an individual be admitted into hospital, all discharges are automatically viewed as Home First unless assessed needs evidence otherwise. (Pathway 3 health-led needs are out of scope) Adult Social Care teams ensure that robust reviews are in place once a person has returned home.

Key elements of our Home First approach include:

[1] Bracknell Forest Health and Wellbeing Strategy (bracknell-forest.gov.uk)

- Home First always considered for all patients
- Taking a Strengths Based approach with a focus on reablement
- Statutory partners working together: Health, Social Care, Education, Housing
- Support for and inclusion of unpaid Carers with Co-Production at the heart of our work
- Working in partnership with the Voluntary and Community Sector.
- Adopting a Technology First' approach
- Strong Integrated Teams - Adult Community Team, Mental Health, Intermediate Care
- Robust integrated Governance – Place Committee, Health & Well-Being Board
- 0Shared Care Record – Connected Care.
- Integrated Cluster MDTs and Daily Locality Access Point MDTs focussing on co-ordinating support for maximum impact

We have a broad range of services available to support a Home First approach. New, innovative or additional resources developed to improve our approach and support hospital discharge are trialled through the Better Care Fund which oversees the implementation of the Adult Social Care Discharge Fund. This approach has the advantage of providing a joint, integrated evaluation of proposals (and advice on improvement) through to ensuring they are socialised and work seamlessly alongside other services.

Good relationship with our Home Care provider market through regular forums and meetings. The Home Care market has managed to successfully recruit and retain their workforce. This enables people returning home to be supported with intense short-term packages of care to support recovery from a hospital stay.

A trusted assessor model is utilised whereby in-hospital assessments and observations by OT's, Physiotherapists, nursing staff and consultants make recommendations for a patient following discharge. For example, a consultant on the ward may advise that a residential placement is best suited to the patients' needs. The hospital discharge team based in the council will then review this recommendation within the context of the person's previous place of residence and family input. This can sometimes lead to a change in recommendation which can be contentious but can preserve an individual's right to choose and supports them to be more independent. In order to address this area, a support coordinator will support effective communication between the acute and social care, to facilitate an even more joined up approach.

Additional focus will be provided to pathway 3 residential placements, ensuring they are only placed in a care home if required. Overnight needs within the acutes are often observed as in place due to the culture and set up within the acutes – for example, commodes are placed next to the beds for ease, therefore the patient does not need to attempt to reach the bathroom themselves, evidencing additional levels of independence. In additional – short term placements in residential care for discharge to assess should be a last resort and only if the Home First pathway with robust monitoring is not feasible. Bracknell Forest Place are proposing to recruit a Home First social worker from the Adult Social Care Discharge Fund 23-25 to develop and enhance this approach.

Adult social care could strive to be more proactive when an Iris comes in – to seek out information as opposed to being passive recipients. A sharpened focus around hospital

discharge and discharge to assess will be facilitated by the proposed change in the jointly developed Adult Social Care Operating Model.

We have used the Adult Social Care Discharge Fund to explore new initiatives aimed at bridging gaps in available support that have been identified by operational teams, particularly where these deliver investment in social care or community capacity and can support discharge and free up beds

Examples of this include:

- making “Forestcare Grab-Bags” available for those being discharged from acute hospitals
- the introduction of a temporary accommodation scheme, in partnership with a local Housing Provider,
- Having a trusted assessor and discharge support worker at our Intermediate Care Unit
- Utilising a dedicated pathway 3 social worker
- Volunteer support coordinated to facilitate discharge
- A physio & multi therapy assistant supporting Care Homes, especially discharge 2 assess beds and to prevent readmissions

Forestcare Grab Bags are bags containing a pendant alarm and details of other assistive technology options. The alarm is of a type that becomes fully active almost immediately on being plugged in, providing those being discharged, and their carers and relatives, with reassurance around triggering a response should it be needed in the first, few, critical days following a discharge.

The temporary housing scheme offers temporary accommodation with a registered social provider. It provides a discharge destination for those whose home environment could be made more appropriate to their needs (e.g., by a deep clean, making space for equipment or installing adaptations), but helping them return to a less institutionalised environment (promoting their independence) and avoiding admission to a care home – especially given the local market capacity challenges. This scheme has been recently introduced and is already reporting a number of successes and has been extended for 23-24 with the anticipation of higher uptake. One service user who accessed this accommodation before being able to safely return home said, “I have missed my house, my 2 pet dogs and my cat, so I am looking forward to return home to see them”, “I have been very happy in the guest flat, I feel settled, and I have also has made a few friends. The staff in the sheltered accommodation all have been very helpful”.

Integrated workshops and forums have been held to trouble short areas of blockage in effective hospital discharge. These are reflected in the High Impact Change Model and in the enhancement of the Home First Approach. The ASC DF 23/24 will be utilised in the schemes described above to facilitate effective discharge and achieve home first. The capacity and demand section of the Planning Template reflects ‘gentle’ peaks and troughs of anticipated demand over the seasonal periods. This is because we are seeing consistent pressures on the acutes and hospital discharge – unlike the pre-covid winter pressure period. The acutes will remain on high alert periods for long periods.

Bracknell have been using the ‘three conversations’ approach for some time and are now engaging with the Social Care Institute for Excellence (SCIE) to improve their strengths-based practice. Alongside this is a thorough review and overhaul of the operating model, with a new “Target Operating Model” around how provide access to services, how teams are configured to work together and how the system best supports people through the care management process, from first contact through to support provision and then review.

From hospital we have numerous opportunities in Bracknell Forest to assess outside of the hospital, including in interim placements, rehabilitation units or other locations. Being able to conduct an assessment outside of hospital enables a more accurate focus on an individual’s strengths and helps avoid making permanent placements from an acute, institutional setting like a hospital.

In both the main acute hospitals (Frimley Park and Wexham) the Integrated Referral and Information Services (IRIS) hub is at the very centre of patients’ discharge from hospital. As the central link between community and the hospital and planning around discharges they receive referrals for patients about to be discharged, triage them and then refer on as appropriate e.g., to either social care of Intermediate Care. They do not ‘prescribe’ any outcomes, leaving this to the relevant team, but work to ensure referrals are manged as smoothly as possible – having a single point of contact for health and social care in Bracknell Forest makes this easier than in other areas, but ever trying to become more efficient, the IRIS teams are currently undergoing a review of how they work and how they can improve.

When someone is due to be admitted to a Care Home from hospital, the home has to ensure they are capable of meeting that person’s needs (at that time). These delays of a few days whilst this is arranged and undertaken. At Frimley Park Hospital work is underway to explore a “Trusted Assessor” approach whereby the Trusted Assessor undertakes the assessment on behalf of the home, the home then reviews the information and decides whether they can admit the person.

The work to improve and maintain Bracknell Forest’s record on delayed discharges has been successful over the last year with capacity in the local domiciliary care market supported by a recently introduced framework agreement. Where there can be some challenges has been around the Care Home market. Recent, previous investment in a new-build local Care Home that has just become fully operational, has introduced additional dementia nursing capacity (helping manage the market) as well as an integrated intermediate care unit.

Wherever possible, discharges are never be directly to a permanent placement and the use of Discharge 2 Assess beds or short-term placements is the normal route. However, with a small geographical footprint and several surrounding authorities also looking for placements, sometimes finding a D2A or interim bed can be a challenge. The approach planned for 23-24 is to provide even more support around Home First and use very intensive short-term packages, potentially including 24hr or intensive night-time care, overseen by a ASCDF funded “Home First Social Worker”.

23-25 will see a period of enhancing our home-first approach. Therefore, we will be looking to reduce bed-based discharge to assess, potentially leading to an increase on the demand

of our Intermediate Care resources. In order to effectively deliver this service, we will need to ensure our intermediate care services are appropriately resources. Given that this work has not been undertaken to date – the modelling in the demand and capacity does not reflect an anticipated increase in resource under capacity.

We ensure a joined-up approach across health care and housing with a preventative nature across both areas. The Homelessness and Rough Sleeping Strategy 2021-26 has the ambition of preventing homelessness in Bracknell Forest and helping homeless people who are vulnerable and need support.

Work is underway on a Care and Accommodation Strategy, which feeds into the Housing Strategy 2023-28. The Care and Accommodation Strategy will assess the priorities for care and accommodation in the future. The strategy covers older people and working age adults with care and support needs, drawing on current data to make estimates for future need and provision.

9. National Condition 3 (cont.)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- **learning from 2022-23 such as**
    - **where number of referrals did and did not meet expectations**
    - **unmet demand, i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)**
    - **patterns of referrals and impact of work to reduce demand on bedded services – e.g., improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);**
- **approach to estimating demand, assumptions made and gaps in provision identified**
- **planned changes to your BCF plan as a result of this work.**
    - **where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?**
    - **how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.**

Demand and capacity modelling for 22/23 was challenging in many ways and it has been helpful to reflect back as this highlights even further areas of development that have been achieved.

The modelling requirements initiated conversations around East Berkshire and the Frimley ICS that were not previously had, and areas came together to share ideas and learning. One of the main challenges was that data was not collated in such a way as to inform the template.

Work was undertaken and shared across the ICS based on assumptions utilising the following model and data:

4. Using the 21/22 inpatient data as a proxy for splitting discharges by place for FHFT.
5. Applying the split seen in inpatients to the discharge total metric from the AE SITREP.
6. Further splitting the place total discharges along the lines of pathways,
    a. with 85% going to pathway 0,
    b. 8% for pathway 1,
    c. 5% for Pathway 2,
    d. and 1% Pathway 3.

When understanding demand and need - whilst we weren't sure of the context and pressures in the system as we were emerging from covid – we anticipated an intense winter period. Reflecting back on this now – we know we did experience a pressured winter system but alongside this we also saw ongoing pressures throughout the year.

The introduction of the ASC DF 22/23 did help alleviate some of that pressure albeit a really quick turnaround time to plan, agree implement and mobilise all of the schemes.

In terms of unmet demand – all people had access to services where required. However, learning from last year is that we need to robustly enhance our home first approach and improve communication in the acutes and towards families ensuring no assumptions about permanent residential care is required.

The Bracknell Forest Integrated Intermediate Care Service is recognised for being flexible and responsive ensuring people receive the right care at the right time. The ongoing challenges of recruitment and retention are met with a flexible approach down to a granular level whereby staff will volunteer shift changes to meet system need and demand. We are striving to make better use of our generous home care market and the ICS will support care workers to provide reablement as well as care and support. This has the effect of broadening our reablement offer.

The bedded intermediate care service Heathlands is a great resource and has played a key role in facilitating swift hospital discharge. We are aiming to further enhance system flow by locating a trusted assessor / discharge coordinator in the bed-based unit to support effective discharge back into the community.

Planning for 23-25 capacity and demand modelling still presents its challenges. Good progress has been made to develop informative hospital dashboards and datasets. Therefore, this time next year we shall be able to evidence our assumptions and will be in a much better place to inform our modelling.

Please see examples of demand modelling for the ICS to support hospital discharge which informed the planning template:

- 2/3rds of the ICS services capacity is utilised to support people from hospital discharge
- Capacity calculations have been based on current filled positions only
- Number of hours a worker has available is 1318 per FTE (same methodology as TOM)
- This deducts hours for annual leave, bank holidays, sickness, supervision, team meetings and training
- To calculate no of people the ICS can provide a service to – the number of available contact hours divided by the average number of hours the person has in the service
- Demand levels were based on similar levels of activity as 22/23

The demand and capacity modelling has informed planning in the wider BCF particularly within the discharge funding allocation.

We are seeing an increase in complexity (and an increase in LOS. Therefore, more resource has been given to the complex pathway 3 assessments to free up time for the hospital discharge team to focus on discharges.

We know that the larger number of pathway 0 discharges do not need additional support however in order to facilitate discharge and prevent re-admission, better use of assistive technology is drive through the discharge fund.

We are reviewing our approach to home first and providing additional support in the form of dedicated social care capacity centred around ensuring people can return home.

A previous area of demand we were not able to meet was a place for people to temporarily stay whilst their home was being made fit and safe to live in. People would end up in a short-term placement to a care home and often this would lead to a long-term placement. Through the BCF and Discharge fund we have set up temporary accommodation utilising the accessible guest suites in sheltered accommodation. This initiative was trialled during the 22/23 winter period and has been very successful, whilst numbers are low the impact is effective, especially on bed days saved in the acutes. We will continue this initiative and seek to increase the utilisation of this concept.

An area whereby we anticipated more demand that experienced was in A&E. It was originally estimated that a hospital discharge social worker based in A&E supporting people presenting with predominantly social care needs would facilitate swift discharge from A&E. Upon reviewing the admissions, most people were frail or sick and required admittance. Therefore, it has been decided to utilise this resource to provide additional capacity for D2A / Pathway 3 in Adult Community Team

23-25 will see a period of enhancing our home-first approach. Therefore, we will be looking to reduce bed-based discharge to assess, potentially leading to an increase on the demand of our Intermediate Care resources. In order to effectively deliver this service, we will need to ensure our intermediate care services are appropriately resources. Given that this work has not been undertaken to date – the modelling in the demand and capacity does not reflect an anticipated increase in resource under capacity.

10. National Condition 3 (cont.)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- **Discharge to usual place of residence**

Bracknell Forest Place are currently reviewing the home first approach in order to enhance the focus on people being discharged home. There have previously been high numbers of placements into care homes, above the national average, so this is a key focus moving forward to ensure people get the right support at the right time.

During the ASC DF over winter 22-23, two schemes were developed, one for home preparation and the other for temporary accommodation. Both of these schemes had positive feedback and are therefore being continued, with funding being increased provisionally. For 23-24, these schemes are being merged with the aim being to provide temporary accommodation for a person who is medically fit for discharge, whilst their home is prepared for safe habitation. There has been an increase in occurrences of hoarding, which can prevent people from being safely discharge to their home. This scheme will help to clear the home to ensure it is safe for the person to be living there on discharge from hospital. These schemes support performance against this metric by preventing people from being temporarily placed in care homes. One service user that utilised the temporary accommodation told the Social Worker “I have missed my house, my 2 pet dogs and my cat, so I am looking forward to return home to see them”, “I have been very happy in the guest flat, I feel settled, and I have also has made a few friends. The staff in the sheltered accommodation all have been very helpful”.

A care home physiotherapy pilot is a scheme that will be set up for 23/24 following the positive impact over the winter period funded through the ASC DF. This scheme is used to provide physiotherapy and reablement to people returning to a care home placement following hospital discharge. It provides support for falls prevention, preventative therapy, and rehabilitation. The aim is to support people back to care homes in a timely way with rapid access to physiotherapy, this helps to prevent the need for a nursing home or even staying in hospital. This scheme also enables care homes to feel confident to accept the residents back after hospitalisation. This service has a positive impact on the discharge to usual place of residence metric as it enables people to be discharged back to their care home.

There is now a fully functioning assessment suite set up and live, funded via the BCF. This assessment suite is dedicated to assistive technology solutions and equipment and is used to assess people’s needs to enhance their independence and enable them to remain in their own home. Practitioners are able to get full demonstrations of how to use equipment at the suite to support a tech first approach. There was underspend for this project in 22-23, due to a delay with the building works, which is provisionally going to be spent on even more equipment for the suite.

Bracknell Forest are beginning to work on a new Assistive Technology strategy, which is due to be developed in 2023-24 and will assist with this tech first approach. Discharge funding

was provided for Assistive Technology Grab Bags, this provides people with monitoring equipment at the point of discharge from hospital. The aim of this, is for someone to be discharged back home with the necessary equipment and support to enable them to be safe at home. This funding will be provisionally increased slightly for 23-24 to provide even more equipment to those requiring it upon hospital discharge.

The homecare framework that is in place operates in a robust market. Recently there have been successful recruitment strategies from the provider to ensure they have the capacity required. Some complex packages of homecare have been set up for example 2x12hr. This helps to support hospital discharge and ensure people are receiving the right level of care at the right time and are not having to wait for a residential or nursing home assessment. These complex packages aid with a person-centred approach as they help to determine what level of care the person needs. It might be determined that less care is actually required so the hours can reduce, or it might show that the person does need 24-hour care in which case a placement can be arranged.

There is a plan for a new Home First Social Worker via the discharge fund for 23-24. This post will provide dedicated social care in order to support people to achieve independence on discharge from hospital. The aim will be to provide people being discharged with appropriate support to enable them to be discharged to their usual place of residence, which will ideally be back home. This post will also look into why someone is not able to go home to see if there are areas to be improved on with the home first approach.

There are additional schemes funded through the BCF which are ongoing and provide support to Bracknell Forest residents on discharge from hospital. included in these schemes is the Home from Hospital service. This service supports residents, who have been discharged home from hospital, for up to six weeks. The aim of this is help improve people's independence, prevent hospital readmission, and enable them to stay at home.

The increase in our LOS for 14+ and 21+ days underpins the narrative described by our operational colleagues that we are seeing an increase in complexity of health needs. People are staying in hospital for longer. In addition to this we know we place a high number of our older age cohort into permanent residential care. We want to ensure that everyone receives care in the right place at the right time and therefore ongoing resource to support our home first approach will be implemented as described above.

11. National Condition 3 (cont.)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Impact Change	Progress	Areas of Improvement
Change 1: Early discharge planning	Staff from ACT going into hospital daily to help with discharge planning Improved communication across the system to support with discharge	BF explored whether the discharge process would start in A&E - numbers were lower than anticipated and A&E admissions were for assessed needs and not predominantly social care needs as anticipated.
Change 2: Monitoring and responding to system demand and capacity	Good integrated working and planning through seasonal capacity and responding to gold calls - proposed new ASC target operational model	Time-limited D2A assessments
Change 3: Multi-disciplinary working	Stepping up the temporary accommodation scheme was a positive development for joint working with social care, health, and housing.	Ensuring a joined-up narrative on post discharge placements when liaising with families.
Change 4: Home first discharge to assess	Assistive Technology scheme encouraging the use of alarms/pendants on discharge from hospital to improve patient and family confidence for the patient to be discharged home. Complex packages of homecare put in, such as 2x12hr. Enables level of care to be determined while person is at home instead of waiting in hospital. Helps to speed up discharge as there is no need to wait for a residential or nursing home assessment.	Home First Social Worker post to come in to boost the home first approach Home first approach currently being reviewed and developed Case reviews being carried out where the person has not been discharged home, with an aim of determining why they did not go home. Assistive Technology strategy being developed for Bracknell Forest Council, which will help improve the use of Assistive Technology
Change 5: Flexible working patterns	Flexibility within the ICS where recruitment has been difficult, but the team have managed to continue to run as normal and cope with the referrals. Weekends manage in post	This needs to be more consistent across the system and provider markets to effectively support 7 days working
Change 6: Trusted assessment	Heathlands ICS trusted assessor facilitating discharges more effectively	Sometimes challenge required on acute based assessment which is completed without the home context

Change 7: Engagement and choice	Support coordinate to triangulate communication between acute, families and social care	Improved comms within wards and social care
Change 8: Improved discharge to care homes	Care home physiotherapy scheme underway supporting people to be discharged back to their care home.	Currently not managed through block contracts therefore no standard service levels
Change 9: Housing and related services	Temporary accommodation scheme stepped up via ASC DF to enable prevent admission to care home where it was not needed.	Extra care facilities minimal in BFC

12. National Condition 3 (cont.)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Local authorities have a range of general responsibilities under the Care Act 2014, which may be summarised as follows:

- Provision of comprehensive information and advice
- Entitlement to care and support eligibility
- Personalised care and support planning
- Charging and financial assessments
- Safeguarding
- Responsibilities to carers
- Continuity when people move between areas
- Market oversight and provider failure
- Transition to adult services
- Integration, co-operation and partnership working

Under these obligations Bracknell Forest's Better Care Fund Plan 23/25 provides a range of schemes which contribute to improving wellbeing, and meeting personal outcomes, including

- Supporting informal carers via the carers support services funded out of the BCF which provides information, advice, and guidance as well as short term support to unpaid carers. Additional support is provided by health, social care, and community sector partners work through, for example, the dementia café, and the Integrated All Age Carer Strategy which is being developed which seeks to protecting older people
- Advocacy support – supporting people to ensure their voice is heard and supporting them to understand their rights and express their views when planning/receiving healthcare
- Stroke support service - provides vital support for people post-stroke, to assist with regaining skills including communication, managing social isolation, etc.
- The Community Equipment Service provides an extensive range of equipment to residents which will enable them to be discharged from hospital, remain safely in their homes, helping them manage their conditions and needs, improving their independence, and preventing or delaying any escalation in their needs.
- The Disabled Facilities Grant scheme supplementary fund is available to cover costs which exceed DFG funding, allowing people to remain in their own homes for longer, retaining their independence, and enjoying a better quality of life. Early discharge from hospital may be achievable.

Under the Care Act, people should experience equality of opportunity; no-one should be disadvantaged by their circumstances, or by any special characteristics. In 2022 Bracknell Forest Council launched the All of Us Equality Scheme. The scheme has 5 objectives:

- Objective 1 Inclusive – aiming for all services to be more inclusive and culturally
- Objective 2 Accessible – aiming to ensure all information, engagement and communications are easy to understand for all

- Objective 3 Accountable and Fair – all people will be treated fairly without favouritism or discrimination while recognising some people will need additional support
- Objective 4 Diverse and inclusive workforce - the workforce will have the right skills, behaviours and mindsets supported by high quality people managers and inspiring leaders
- Objective 5 Recovering from the COVID-19 pandemic - addressing the increased inequalities and disproportionate impact of the pandemic on people and communities

Bracknell Forest's Better Care Fund 2023-2025 supports it's All of Us Equality Scheme through:

- The Carers Support Services, providing information and advice, and valuing carers for the support they provide.
- Home Start - supporting families with young children that need extra support
- Social Isolation through health needs is supported by the Stroke Support Service and the Social Activities service for people with blindness and visual impairment.
- Thriving Communities is a collaborative scheme across health and social care, seeking to empower communities to develop individual and community assets, to be more active and collaborative in managing their own health.
- Ageing Well seeks to avoid admission wherever possible, encourages a Home First approach to discharge, with improved reablement, assistive technology, and which provides financial support when family members act as informal carers.
- All commissioned services have an Equality Impact Assessment completed as part of the commissioning process.

- Family safeguarding model – working with people with addiction and mental health concerns to overcome challenges and barriers in order to keep their families safe.

Responding to sustained system pressure across the acutes in terms of bed capacity, by utilising the ASC Discharge Funding, Bracknell Forest's Better Care Fund Plan 23-24 strives to work with acute settings to facilitate early discharge home from hospital on a Home First basis wherever possible, fulfilling Care Act requirements to work with people's outcomes and to promote wellbeing, through

- The Home First Social Worker, providing early assessments with the aim of supporting each individual towards regaining their previous level of independence
- The provision of Assistive Technology via IT Grab Bags which are available in acute settings, include basic technology (lifeline and/or pendant), with additional assistive tech equipment supporting a range of prompts for ADLs, providing reassurance also available
- The ICS Discharge to Assess scheme to a step-down bed when a period of bed-based reablement or rehabilitation would be beneficial
- The Adult Community Team provides a Discharge to Assess social worker to support Pathway 3 and Discharge to Assess cases; these may be discharges home or to a short- or long-term placement
- Where a person is returning to a care home they know as home, support is available via the Care Home Physiotherapy Pilot, so they are physically able to remain there safely rather than move to a higher level of residential or nursing care
- Pathway 3 Discharge Social Workers for older adults supported by the Community Mental Health Team, work with a multidisciplinary/multi agency approach, to holistically support discharges back to a person's home

- Early support on discharge on Pathway 1 may require a short period of Complex Home Care, to support a person's recovery towards increasing independence
- The provision of short-term alternative accommodation allows discharge of people who are able to return home but whose home environment is currently unsuitable, requiring adaptations, decluttering, or deep cleaning. Our DFG lead included in these conversations to link up the adaptations offer. Alternative accommodation also allows for the provision of home-based reablement or rehabilitation.

The Care Act requires an integrated approach to working between local authorities, health, local services, and the voluntary and community sector, allowing for the joined-up provision of holistic, multidisciplinary support that is person-centred, tailored to the needs and preferences of those needing care and support, carers, and their families. Bracknell Forest achieves this through

- Working collaboratively with health, including the co-location of discharge social workers at local acute settings
- Integrated work with other social care teams within the Council, including housing, children's social care, community mental health teams, etc.
- Working with health colleagues to provide multidisciplinary support in care homes and people's homes
- Jointly commissioning services, including the stroke support service, equipment service.
- Commissioning carers support from a local charitable organisation

BFC's Adult Social Care Senior Management operate a system-wide escalation model, working with the AD for Adult Social Care to identify how additional resources may be deployed to help manage pressures in acute settings. This includes the provision of support to prevent admission, in addition to facilitation of rapid discharge. Daily (or bi-daily, as needed) teleconferences with Discharge Teams and therapists are held to maintain patient discharge flow in a safe and timely manner, also allowing identification and resolution of any pinch points or areas for escalation.

Health, social care, and community partners work in a collaborative whole system approach to ensure available funding streams and resources are used as efficiently and system intelligence is shared widely. Leads of NHS Charities, Public Health and the community sector are working collaboratively to ensure an integrated approach to tackling health inequalities.

13. **Supporting unpaid carers**

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The number of people who identified as an unpaid carer in the Census of 2021 was 8,770 or 7% of the population. This is a decrease from those that identified as an unpaid carer in the Census of 2011.

According to the Office of National Statistics there could be a number of reasons for this decrease:

• Coronavirus guidance on reducing travel and limiting visits to people from other households

• Unpaid carers who previously shared caring responsibilities may have taken on all aspects of unpaid care because of rules on household mixing during the coronavirus pandemic

• There were a higher number of deaths than expected in the older population at the beginning of 2021 due to coronavirus (COVID-19) and other causes; this could have led to a reduction in the need for unpaid care

• Changes in the question wording between 2011 and 2021 may have had an impact on the number of people who self-reported as unpaid carers

Therefore, it is advised when planning services to ensure that local knowledge is also captured from providers and professionals currently supporting carers.

Carers make a unique difference to the quality of life of many of our most vulnerable people in our community including older people, people with a disability or those with a long-term illness. It is this recognition that has led key stakeholders in the BCF to provide additional support over and above the 22/23 plan in order to improve outcomes for carers.

The Care Act 2014 and the Carers Action Plan 2018-2020 place significant importance on local authorities to ensure that those people who provide unpaid care for others are able to have a quality of life outside of caring, they can meet with friends or family, be in employment and take part in recreational activities and interests

The government white paper People at the Heart of Care (2021) shone a spotlight on unpaid carers, the value they add to our communities and the difference they make to people's lives. The government has pledged £25 million to work with the sector to kick start a change in the services provided to support unpaid carers.

Unpaid carers play a pivotal role in delaying or reducing the need for statutory services. According to ADASS for every £1.00 spent on carers services £4.00 is saved on Adult Social Care budgets. (ADASS (2018) Economic Case for Local Carer Investment).

It is widely recognised that the Covid-19 pandemic had a disproportionately negative impact on the lives of unpaid carers. Some young carers say they feel invisible and often in distress

with the NHS Long Term Plan highlighting that up to 40% report mental health problems arising from their experience of caring.

Carers Support Service

The BCF funds the Carers Support contract through our provider Signal4Carers. Signal4Carers provide a range of support including

- Information, Advice and Guidance
- Encouraging carers to enjoy activities outside of their caring responsibilities, providing carers with opportunities to engage with other carers over lunch, and small groups.
- A range of training opportunities
- Monitors and supports the well-being of carers, assessing the level of support they may require.

Health, social care, and community sector partners work jointly to support carers i.e., the Dementia Café.

Integrated, All-Age Carers Strategy

BCF 22/23 oversaw the development and co-production of an Integrated, All-Age Carers Strategy that has set out joint ambitions across health, social care and the voluntary sector for carers living in Bracknell Forest. The strategy is for unpaid carers, including young carers and parent carers.

The Integrated, All-Age Carers Strategy is aligned to the Council Plan Priorities: Ensuring help is available for our most vulnerable residents to keep them safe and to help them remain independent, whilst avoiding loneliness, isolation and maintaining value for money. The strategy will consider a carers experience and role in both acute, primary healthcare settings as well as in the community.

The strategy is aligned to and reflects:

- Berkshire Healthcare Strategy
- NHS Long Term Plan commitment to carers
- BFC Health and Care Plan 2022-2025
- Health and Wellbeing Strategy 2022-2026.

The strategy has been co-produced by an integrated steering group consisting of representatives from Frimley ICS, Berkshire Healthcare Foundation Trust, primary care networks the voluntary sector, parent-carer reps, carers, adult social care and children's services.

Work commences in 2023 to ensure that the outcomes of the strategy will ensure:

- There is a seamless transition between children and adult services for young carers who wish to remain in that role
- Carers will have access to information, advice and guidance, including how to maximise income

- Carers will be treated as experts by experience across health and care settings and their views included in care plans.
- All professions across health, social care, education and the community will become carer / young carer aware
- Working carers will have improved mental health as well as financial well-being.
- Carers feel safe, isolation and loneliness will be reduced, well-being and mental health improved.
- Young carers will be safe, healthy and able to enjoy life and achieve their aspirations.
- There will be a reduction and delay in the need for statutory services

The strategy aims to be published in September 2023 and will have a 3–5-year implementation plan. Key information gathered from the work completed in 22/23 has highlighted some areas of development in our young carers service, support for the working age carer, better access to straight forward information and respite.

In 23/24 a Carers Partnership Board will be developed that will monitor the progress and delivery of the carer's strategy implementation plan. The board will include representatives from Frimley ICS, Berkshire Healthcare Foundation Trust, the voluntary sector, parent-carer reps, carers, adult social care and children's services. They will report to the Bracknell Forest Place Committee and the Health and Wellbeing Board on the progress against the five priorities that have been determined:

1. Recognising and Supporting Carers in the Wider Community
2. Services and Support that work for Carers
3. Employment and Financial Wellbeing
4. Supporting Young Carers
5. Young Adult Carers

Additional payments to carers

Following a successful winter initiative whereby carers were given additional payments in order to support the care of family members coming out of hospital, the BCF 22/23 plan has continued to fund this arrangement for the duration of 22/23.

A fund has been set up to support family members who could take on a short-term caring role but are prevented due to loss of earnings. The fund offers incentive to suitable carers therefore enabling speedier discharge whilst alternative caring solutions are sought and implemented.

This fund has had some success to date. By June 2022, four carers received additional funding of £300 each. Due to the family support, earlier discharge was facilitated. One carer completed her mother's collar care due to lack of agency support to undertake this. Carers

have also received assistive technology support to facilitate hospital avoidance. Additional funding also allowed family members to pick up people discharged from hospital as opposed to relying on hospital transport.

Whilst the uptake of this initiative is on a small scale, it has made a difference to each family that the fund has supported. This is in line with BFC and Frimley ICS's commitment to a personalised approach and supporting a home-first approach.

14. **Disabled Facilities Grant (DFG) and wider services**

What is your strategic approach to using housing support, including DFG funding, which supports independence at home?

Bracknell Forest Council's Housing service is committed to supporting older and disabled people to remain living independently in their own homes for as long as safely possible. Health, Social Care and Housing work together to support disabled and older residents to remain in their own homes in the following ways:

Housing Assistance Policy 2021-2026

Bracknell Forest Council's Housing Assistance policy sets out a range of financial assistance that the Council can make available to improve living conditions for vulnerable residents in our community. The policy framework enables more flexible use of the Disabled Facilities Grant budget providing new forms of support including assisting people to move to a more suitable property and to support specific aims such as enabling faster hospital discharge, relieving pressures on accident and emergency services, and reducing the need for residential care.

The mandatory Disabled Facilities Grant (DFG) is seen as one of the main support packages that both older people and people with long-term health conditions are able to access to support this ambition, however, it is also acknowledged that the DFG is an 'old' grant based on legislation which is over 30 years old and which in modern society can be limiting in terms of the support it can offer. Therefore, the Council has decided to use the powers available to extend the support it offers using the DFG funding to ensure that all allocated funding is spent and ensure that support is available to as many people as possible.

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

The policy supports the practical delivery of the aims and ambitions of the Health and Wellbeing Strategy "Seamless Health" which looks to support joint working to enable older and vulnerable people to live independently in good health in their own homes for longer.

The enhanced grant provision outlined within this policy supports this priority and will enable older and disabled people to remain living independently in their own home for longer.

Strategy Development

A housing strategy is in development to bring together and consolidate in one document the evidence, policies and strategies available or in development across a number of housing related workstreams.

Included in this is the development of a strategy for Housing with Care and Support with the strategic aims of enabling people with care and support needs in Bracknell Forest to live as independently as possible in their own homes for as long as possible. To achieve this, the

right amount and type of accommodation to meet people's needs and the right range of care and support options to enable people's individual needs and aspirations to be met.

The Care & Support Strategy contributes to the overall Housing Strategy and considers the needs of older people and working age adults with care and support needs (including people with learning disabilities, people with mental health needs and people with physical and sensory needs) over the next 5 years.
The draft Strategy aims to set out the Council's vision for developing accommodation for people with care and support needs based on:

- Policy and good practice
- Current and future levels of need
- Current level and types of provision available
- What is working well and areas where new or additional provision may be needed

There is also work underway on a Care and Accommodation Strategy, which feeds into the Housing Strategy 2023-28. The Care and Accommodation Strategy will assess the priorities for care and accommodation in the future. The strategy covers older people and working age adults with care and support needs, drawing on current data to make estimates for future need and provision. One part of this strategy is looking at the level of need for different types of specialised housing and accommodation for older people.

Homelessness and Rough Sleeping Strategy 2021-2026

Bracknell Forest Council's Homelessness and Rough Sleeping Strategy 2021-2026 has five main priorities to prevent homelessness occurring and to assist those who do become homeless to find and keep suitable housing:

1. Universal Prevention – ensuring everyone knows about the housing options available in Bracknell Forest, can help themselves and know where to go for help
2. Targeted Prevention – reaching people earlier if they could be at high risk of becoming homeless in the future
3. Preventing and relieving homelessness at crisis point – help to keep a home or find another option
4. Recovery – helping homeless people who are vulnerable and need support to recover to they can manage a home in the future
5. Having a range of suitable Housing Options – housing for those in housing need and who are homeless to move in to with support if needed

Disabled Facilities Grant Strategy and Action Plan

Delivery of the DFG has been impacted by challenges brought about by the Covid-19 pandemic. The DFG team have developed an action plan to set out the strategic approach of reaching the highest level of professional practice in administrating the Disabled Facilities Grant and overcoming any delays experienced during the pandemic

The three priority areas of the service include:

1 Review and resolve outstanding cases ensuring customers are kept informed of progress:

- Allocate a small team of officers to work on all legacy cases per 2021/22 (circa 70 cases as at December 2021)

- This team will prioritise cases according to the length of time the customer has been waiting and the urgency of the work required.
- They will look to utilise and extend the existing framework agreement for stairlifts & through floor lifts which account for around 20% of the outstanding works, and will look for a similar arrangement for ramps & hard standings which account for around 20% of works
- As a large proportion of cases (40%) are for level access showers, we will need the expertise of a surveyor or an experienced technical officer
- Ensure all works are inspected upon completion and signed off by the customer, OT and case officer

2 Ensure current referrals are prioritised according to need with a clear, straightforward process and easily understood by customers and partners with achievable timescales made clear to all:

- Review current cases – non legacy cases from April 2021, prioritising those with the most urgent need.
- All customers will be contacted to ensure they are aware of the next steps in achieving the works identified with a clear process map to be devised and made available for customers to understand how the system works.
- A revised application form to be created.
- A new DFG panel with OT managers for adults' and children's services will be created to provide oversight of performance (including timescales and customer satisfaction); to consider options and authorise works for complex cases; to oversee expenditure including on the new discretionary forms of assistance
- Ensuring regular liaison with OT services
- Regular reporting on progress with service delivery review
- Customer Satisfaction form designed and implemented
- Implement the new Housing Assistance Policy - from April 2022 onwards

3. Improve the efficiency and effectiveness of the service, including easier to follow process, forms and use of technology to improve the customer journey. Reduction of waiting times an ensuring the customer need is central to process:

- Develop new software and database to improve record keeping, case management and performance reporting
- Develop a simple, easier to follow process for referrals from OTs with clear clinical rationale for works, detailed recommendations and revised forms/agreement for additional or new works.
- Consider use of existing and available IT tools/hardware/software to improve assessments and referrals from OT's
- Consider creation of framework agreements for the majority of DFG cases- over 60% relate to LAS's, Stairlifts and Ramps (a framework is already in please covering stairlifts)
- Improve/resolve staff structure- i.e., TO/case officers and/or surveyors/access to surveyors when required- retainer?
- Create new procedures and standard letters.
- Ensure residents are aware of the service- social media/website review?
- Review contractual relationship with Silva Homes for DFG's

Therefore, whilst the BCF funds the DFG, additional services such as the Berkshire Community Equipment Service, this aligns and supports broader strategic work across the council.

Respite breaks for the cared for person are set up via our brokerage team. In addition, whereby families or carers have sourced the support for the cared for person a direct payment has been awarded.

Significant progress in meeting the objectives for areas identified for improvement in 2022-23 is evidence by way of the increased number of adaptations completed and a reduction in the average timescale from referral to the Service to completion of works.

To further build on the successes of 2022-23, housing, health and social care partners have fostered a joined-up approach to improving access to services, and to identifying service user needs. Within this collaborative approach there is a clear emphasis on interventions that encourage and enable early discharge to the usual place of residence, reablement, and supporting residents to live more independently at home for longer.

Bracknell Forest Housing Strategy 2023-2028 has brought together and consolidated in one document the evidence, policies, and strategies available, or which may be in development across several housing related workstreams. The Housing Strategy 2023-2028 has a clear strategic aim of enabling people with care and support needs to live as independently as possible in their own homes for as long as possible. The Housing Strategy acknowledges that a co-ordinated response is required to ensure that the correct quantity and type of accommodation to meet needs, and a suitable range of care and support options, are available and accessible to enable individual needs and aspirations to be met. With this recognition at the forefront, a joined up and co-ordinated approach aims to deliver an enhanced support and adaptations service that supports the aims and ambitions of the Health and Wellbeing Strategy and the Better Care Fund Plan for households to remain living in their homes, where appropriate to do so.

We will be utilising the Adult Social Care Discharge Fund to support temporary accommodation, liaising with our housing colleagues. The temporary accommodation scheme enables people to be discharged from hospital into temporary accommodation while they wait for their home to be made fit for purpose. This could involve the installation of new equipment, decluttering or cleaning the house to make it safe for the person to return to. This helps to support hospital discharge as well as service users as it prevents them from being discharged into a care home on a short-term basis and enables them to regain their independence with the right support. This scheme was started during the winter period 22/23 and one service user who accessed this accommodation before being able to safely return home said, “I have missed my house, my 2 pet dogs and my cat, so I am looking forward to return home to see them”, “I have been very happy in the guest flat, I feel settled, and I have also has made a few friends. The staff in the sheltered accommodation all have been very helpful”.

In 2023-25 BCF spending will continue to support the approach set out in the 2022-23 plan, principally by enabling the Council to make available a range of financial assistance to improve living conditions for vulnerable residents. As such BCF spending is of paramount

importance in assisting the Council in meeting increasing demand for funding for aids and adaptations so that people can remain living independently in their homes for as long as possible.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Using the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) Bracknell Forest Council implemented a Housing Assistance Policy with six areas of discretionary funding. The Housing Assistance Policy 2021-2026 has widened the scope of available funding and increased opportunities for collaborative working with the objective of identifying and carrying out works with a focus on early intervention and prevention. The Hospital Prevention & Discharge Assistance and Relocation Grants are examples of such funding areas.

In addition, with the inclusion of a Contribution Assistance Grant, and Discretionary Disabled Facilities Assistance, the Housing Assistance Policy 2021-2026 affords greater financial support to the most vulnerable applicants for who adaptations may not have previously been undertaken due to personal financial constraints.

The availability of a Dementia, Cognitive and Behavioural Conditions Grant and a Safe and Secure Grant has increased the scope for person-centred approaches to service delivery by providing grants with the objective of meeting the client's needs by making homes, friendly and helping the person to live safely, manage their surroundings, and retain their independence for longer.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

The amount allocated collectively for all six areas of discretionary funding is 15 percent of the annual allocated budget. The available of discretionary funds is reviewed regularly to ensure it is sufficient and effective.

15. **Equality and health inequalities**

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- **Changes from previous BCF plan**
- **How equality impacts of the local BCF plan have been considered**
- **How these inequalities are being addressed through the BCF plan and BCF funded services**
- **Changes to local priorities related to health inequality and equality and how activities in the document will address these**

- **Any actions moving forward that can contribute to reducing these differences in outcomes**

How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Data emerging from the Census 2021 suggests:

- Bracknell Forest Council has a total population of 124,500 whereby 49% of the population are males compared to 51% females.
- There are approximately 50,200 households across Bracknell Forest
- Population by age band highlighting a 'younger' population compared to population dynamics across the Southeast and England.
    - 0-14 age - 19% of the population
    - 15-64 age - 66 % of the population
    - Age 65+ age - 15% of the population
- There is a similar profile of ethnicities in Bracknell Forest compared to the Southeast with approximately 5% of the population Asian / Asian British
- A further 1.9% of the population are Black/ African /Caribbean / Black British
- 85.7 % of the population are White with 14.3% of the population Ethnic Minorities

Compared to data from the Census in 2011, the proportion of population aged 65+ has increased by 32.5%, representing 14.9% of the population.

Data from the Census 2021 suggests that in Bracknell Forest 53.4% of people Religion in Bracknell Forest, more people have a faith (53.4%) while 46.6% have no religion or have decided not to identify a religion. The breakdown of religions indicates:

- Christians 47.5%
- Buddhist 0.8%
- Hindu 2.4%
- Jewish 0.2%
- Muslin 1.8%
- Sikh 0.8%

Bracknell Forest has relatively low levels of deprivation with just under half of the neighbourhoods in the least deprived 20% of the country. However, 16% of neighbourhoods are more deprived than the national average, with parts of Crown Wood, Wildridings, and Central being the most deprived in the borough.

Changes since 22/23
Bracknell Forest Council launched the All of Us Equality Scheme 2022 – 2025 which set out the commitment and equality objectives for progressing equality and inclusion within Bracknell Forest Council up to 2025.This is still an ongoing piece of work – 2023-2025 will see the ongoing implementation of the All of Us Equality Scheme

The Equality Scheme describes how equality, diversity and inclusion are essential to the way we operate as a community leader, a service provider, and an employer and integral to everything we do. It sets out clearly our priorities for our borough whether it is in how we

work with our residents; in the services we provide or through the recruitment of our workforce.

Whilst all individually commissioned schemes across health and care undertake an in-depth Equalities Impact Assessment to ensure we retain central focus on equality, diversity, cohesion and integration – improvement needs to be made on how the Better Care Fund and its schemes / programmes strategically focus on maintaining equality and reducing inequality.
This will happen over the next two years by:

- Drafting into the business case a specific focus point on how new schemes will reduce inequalities and maintain equality
- Strategic discussions across the delivery group and strategic group to ensure the BCF underpins, reflects and supports council and health priorities towards equalities and health inequalities.
- Consideration of the impact of the Discharge Funding schemes to understand how they have supported the reduction in health inequalities.
- This approach feeds into our ageing well and frailty support; quality oversight of provider markets and early intervention / prevention local priorities.
- Training opportunities for staff across health and care to be scoped to embed awareness and develop tools to ensure equality and reduce health inequalities.
- Building on health colleagues' approach to ensure universal support and the person-centred approach embedded in social care to all supporting staff across health and care to deliver services with an enhanced awareness of equalities and health inequalities forming a foundational approach to all support.

Adding to the above areas of development for 23-25 – we will aim to build on the data and intelligence we have available through connected care, population health management, ensuring these are key drivers of the work we take forward.

Our Thriving Communities approach will provide valuable insight informed by the community as to how behaviour and approach by health and social care can improve and better adapt to reduce inequalities and eliminate deep seated drivers of inequalities currently in place. Together, the lived experience of the communities, health and care data sets and population health management approach will drive forward changes required to ensure the right care in the right place at the right time.

The percentage of people identifying as having disabilities that limit their life has changed since the 2011 Census. The 2021 Census reports:

- People with disabilities that limit their life a little – 9.2% (increased from 8.7%)
- People with disabilities that limit their life a lot – 5.3% (decreased from 6.7%)

Key objectives of the Equality Scheme:

- Inclusive in all we do – continue to make our services more inclusive and culturally competent in a borough where everyone is made to feel include and valued.
- Accessible for all - ensure that we provide information, engage, and communicate in ways that are easy to understand for all
- Accountable and fair - we will treat all people fairly without favouritism or discrimination while recognising some people will need additional support
- Diverse and inclusive workforce – we will strive to have a workforce who have the right skills, behaviours and mindsets supported by high quality people managers and inspiring leaders

- Recovering from the Covid pandemic – address the increased inequalities and disproportionate impact of the pandemic on people and communities.

The Council's Equality Group monitors and reports progress in delivery of the equality scheme. The scheme is reviewed annually, and reports are published annually on the Council's website.

In addition, work is being undertaken to support and report on performance measures across all service plans that support the equality objectives. The objectives relating to public health are:

- Improve the mental health and emotional wellbeing of all citizens
- Address stigma and discrimination of poor mental health
- Work to narrow the gaps in life chances and outcomes for vulnerable people and support them through prevention, early intervention, and self-care
- Develop inclusive relationships between different communities and celebrate their diversity

The NHS Charities Community Partnership Grant has achieved the following impact and outcomes:

- Established good working relationship with key BAME and faith communities in Bracknell Forest
- Led a number of communities' listening exercises, joint working with the communication team. Key covid and key winter messages were able to reach out to the BAME communities via different platforms. e.g., Nepalese shop, Chinese chat group for new arrivals, Polish and Romanian Facebook platforms etc.
- Also developed harm reduction approach messaging e.g., focus on ventilation messaging with vaccination information to address vaccination hesitancy and gained further insights in the Community health belief systems.
- Diverse and Faith workshop from communities made direct contribution in the Community Wellness work strand for the Bracknell Forest Health and Wellbeing Board
- Introduced the Making Every Contact Count to the community and recruited 7 Champions for the initial pilot

Bracknell Forest Financial Hardship Needs analysis:
BFC are taking a proactive approach to financial hardship and undertook a needs analysis to identify the causes, impact, and extent of financial hardship in the borough.
Several characteristics can increase the risk of poverty:

- Having a disabled individual in the household
- Having a carer in the household
- Individuals from ethnic minority groups, particularly Bangladeshi and Pakistani ethnic groups
- Individuals with poor health

It has recently been announced that as a new labour council under the request of Sir Keir Starmer, labour councils will review and accelerate their focus on the cost-of-living crisis within the first 100 days ahead of Winter 2023.

Although Bracknell ranks as 35th least deprived local authority, there are wards that rank highly for specific domains such as children's education and housing barriers.
Priority risks:

- Distance to services

- Housing barriers
- Child education
- Income deprivation affecting older people

The percentage of unpaid carers in Bracknell Forest has changed since the 2011 Census. Unpaid carers aged 5+ years recorded in the 2021 Census are:

- Providing 20-49 hours of unpaid care per week – 1.3% (increased from 1.1%)
- Providing 50+ hours of unpaid care per week – 2.2% (increased from 2%)

In developing an All-Age Carers Strategy which has been co-produced with carers across the borough in 22-23, a range of inequalities were identified:

- A lot of carers do not access support from BFC or VCS
- Number of carers from ethnic groups does not reflect those who identify as carers within the community
- More cares are female, can have an impact on work and income
- More carers 5-29 than 75+ but they receive the least of the support/services
- Financial poverty is an issue
- Health inequalities, carers have physical and mental health and wellbeing issues to a greater extent than their peers who are non-carers
- Some carers cannot access advice/information as they do not have Internet access
- Carers with disabilities/ or if the people they care for have disabilities are excluded from face-to-face groups due to lack of transport
- No services for 18-24 year olds
- Young carers prohibited from activities due to cost or location
- Young carers miss school/have lower educational attainment because of caring responsibilities than other children

Information gathered during the development of the strategy will be used to inform Bracknell Forest's carers support service as the current contract comes to an end December 2024.

A comprehensive implementation / delivery plan in development following the completion of the strategy in 22/23 will oversee the development of our support for unpaid carers over the lifetime of the strategy (5 years) Therefore the period 23-25 will oversee the sign off of the strategy, development and implementation of the delivery plan.

In addition to this, the Carers lead in Bracknell Forest Council is a key partner in the Frimley ICB Carers Strategic Group. In 2023 – 2024 the group will drive forward the development of a best practice model to encourage people from ethnic minorities to 'Think Carer' and feel confident to access carers support services.

Frimley Health and Care: Approach to Reducing Health Inequalities:
Reducing inequalities is at the heart of the approach - Core 20plus5

Ambitions:
Increase overall healthy life expectancy and reduce the differences in healthy lives of our residents:
This will be addressed by:

- Starting well – all children to get the best possible start in life
- Focus on Wellbeing – all people to have the opportunity to live healthier lives, no matter where in our system they live
- Community Deals – we will agree with our residents, families, and carers how we work together to create healthier communities
- Our People be known as a great place to work, live and make a positive difference

- Leadership and Culture – work together to encourage, co-design, collaboration , inspiration, and a chance to contribute
- Outstanding use of resources: offer the best possible care and support where it is most needed in the most affordable ways.

Bracknell Forest Better Care Fund Plan 23/25 aims to reduce inequalities through:

- Anticipatory Care Planning for older people. – together our PCN's and Healthwatch are working with adult social care to identify older peoples who have health needs that may escalate into requiring additional services. Bracknell Forest have a high rate of placing people into residential and care homes as outlined in our EoY report 22/23 and planning template 23-25/ Work is being undertaken to enhance our home first approach through the ASC DF 23-25 and reduce permanent placements to residential care.
- In addition, older people are supported to access assistive technology to anticipate and support their health needs through monitoring changes in their health. The Assessment suite is available for demonstrations and how a person can best be supported to live independently through assistive technology – in a person-centred approach according to their specific needs.
- Additional resource through a developmental manager and two additional recovery facilitators has been provided through BCF to support the integrated Community Health Network. People with mental health needs are supported to navigate the system in a seamless way and reduce escalation of need.
- The Better Care Fund Planning Template 23-25 outlines how we are seeing an increase in complex need. Our length of stay has increased saw an increase over 22-23 from 14+ days moving up from 10.6% to 14.7%. 21 + days increased from 5.4% in 21/22 to 8.7% in 22/23. The Discharge Fund 23-25 has been developed to support people with complex needs return to their original place of residence where possible.
- A comprehensive equalities impact assessment was undertaken for the development of the Carers Strategy and Implementation Plan. All protected characteristics were considered. The Carers strategy outlined the under representation of ethnic minority groups accessing our services and part of the implementation plan will be to ensure all residents are actively engaged with and supported to access sour services.
- Thriving Communities: establishing and embedding a joint three-year programme to improve health and wellbeing outcomes and reductions in health inequalities within the borough through building capacity to access quality care and support in the community targeting specific communities with the most need and with low-income families
- Home start – supporting families with young children that need extra support for a variety of reasons, including parents struggling with their own mental or physical wellbeing needs, or those which relate directly to their child/ren.
- Advocacy support – supporting children and young people and adults with learning disabilities, or cognitive impairment, and/or difficulty making life decisions on their own to ensure their voice is heard and supporting them to understand their rights and express their views when planning / receiving healthcare, including cases were protected characteristics affect access, or rights are denied.
- Our Stroke support services are providing vital support for people to maintain or returning to employment and/or access to benefits following a stroke and therefore change in quality of life.

People with special characteristics are supported to maintain or increase their independence through several schemes. These include

- The DFG supports by facilitating adaptations to people's homes, providing a safe environment, which accommodates disabilities, etc. so that any inequalities relating to health conditions and disability are supported.
- The Temporary Accommodation provision provides a safe place for people to live while their own home is adapted or made safe for their return. This can also facilitate with a rapid discharge from hospital and prevents the need for placement in a care home for older people or people with new or existing disabilities.
- The Home Preparation service will work with a person who may otherwise be unable to return to their own home following hospital discharge. This may include cleaning or clutter removal, etc. supporting older people or those with a disability to return to an environment safely, providing a more easily manageable and maintainable living environment.
- The Community Equipment Services provides equipment for people to remain safely in their homes, giving them confidence and supporting needs of disability, etc.
- The Assessment Suite allows people with specific needs (frailty or disability) to try out a variety of Tech equipment to support them as independently as possible, ensuring that the right equipment is identified prior to provision.
- IT Grab bags are provided to acute settings, which typically include a falls pendant and/or lifeline, ensuring that older people or those living with a disability, feel confident at home once they have been discharged from hospital. A responder service backs up the fall's pendants/lifelines.

Health, Social Care and Community partners work in a collaborative whole system approach to ensure available funding streams and resources are used efficiently and system intelligence is shared widely. Leads of NHS Charities, Public Health and the community sector are working collaboratively to ensure an integrated approach to tackling health inequalities.

- The Thriving Communities scheme support via a deep dive into a number of patient cases in the CORE20 group to help understand particular needs, to identify any patterns, etc. allowing for the development of support systems, including for older people, those with disabilities, or any other special characteristics which may lead to isolation.
- People living with Dementia (those in the older age group but also younger people living with dementia), and their carers, are support via a range of services, including the provision of advocacy, via carers support services, and primary care.