Frimley Health and Care

Bracknell Forest Council

Bracknell Forest Health and Care Plan for Adults 2023-25

2024 Refresh

Date: October 2024

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1. Introduction

Overview

The Bracknell Forest Health and Care Plan for Adults 2023-2025 describes the priorities for joint work between Frimley Health and Care Integrated Care System (ICS) and Bracknell Forest Council (the Council) for adults living in Bracknell Forest. It is not intended to include every area of activity that will be happening across the Bracknell Forest Place partnership, but rather to describe a number of key priorities that have been agreed between the partners, and reflect the achievements so far, and the work to be undertaken. It recognises that this is a time of unprecedented pressure on health, care, and support services, and it is more important than ever to take a joint approach to strategic planning at all organisational levels, if we are to deliver good health, care and wellbeing to adults in Bracknell Forest.

The Health and Care Plan for Adults is owned by the Bracknell Forest Place Committee. Accountability for the priorities in the plan sits within the governance of the Better Care Fund, and the schemes of delegation for the partner organisations.

A Bracknell Forest Place Strategy will be developed by Quarter 1 in 2024, which will include engagement and co-production with our residents and staff to describe our full ambitions for health, care, and support in Bracknell Forest Place.

Children and Young People

Whilst this plan is focused on health and care support for adults, it is recognised that adults are often part of family and support networks and have responsibility for the care for children and young people. In addition, local authorities have a responsibility with NHS partners for young people moving into adulthood in specific circumstances. Local authorities have a duty to support:

- any young person over the age of 16 who is, or has been, a looked after child until they are 21.
    - This increases to age 25 if the person is engaged in a programme of education or training [*The Children Act, 1989*]. Local authorities are also responsible for the effective preparation and support for:
- children and young people with Special Educational Needs and Disability (SEND) up to the age of 25
    - with a focus on when they and their families prepare for the transition to adulthood [*Children and Families Act, 2014; Care Act 2014*].

Therefore, this plan should be viewed in the context of links to system and Place-based approaches to the health and care of children and young people and the associated Children and Young People Plan.

Working on the effective preparation for adulthood for young people with health, care and/or educational needs is a priority for Bracknell Forest Place during the period covered by this plan. This involves supporting young people to identify and achieve their aspirations and ensuring that the right health support is also engaged to allow timely multidisciplinary support in this process.

Bracknell Forest

Bracknell Forest lies 28 miles west of London within the Thames Valley and the county of Berkshire. This is a thriving part of the country with strong economic performance marked by the location of a number of business headquarters. This is balanced with rich local green spaces and the nearby Thames Basin Heaths Special Protection Area.

There are around 125,000 people who live in Bracknell Forest, an increase of 10% between 2011 and 2021. Bracknell Forest's population profile is similar to England's, although the proportion of working-aged adults in Bracknell Forest is slightly higher than England with notably higher proportions of 35- to 54-year-olds. People aged 65 and over make-up 15% of Bracknell Forest's population, compared to 18% nationally, and life expectancy is significantly higher than national rates at 82 years for men and 85 for women.

As of 2021, nearly 78% of Bracknell Forest's population were from a white British background. 14% of residents were from ethnic minority groups (excluding white minorities), compared to 19% across England. The diversity in the population continues to increase with the proportion of non-white-British residents increasing by 47% between 2011 and 2021, to 22% of residents.

In September 2022, 77% of Bracknell Forest's working age population were in employment. The proportion of people in employment decreased during the pandemic and this drop was to a greater extent than the national average. The current level of employment is higher than the average for England and similar to the South-East.

Bracknell Forest's overall deprivation ranking sits within the 10% least deprived local authorities in England. More than a third of the Borough's neighbourhoods are also in the 10% least deprived nationally. While none of Bracknell Forest's Output Areas are in the 20% most deprived areas in England, there are areas of higher deprivation within Wildridings & Central, Crowthorne and Great Hollands North wards.

The Council has a history of genuine ambition for the Borough. This has enabled the Council to deliver its ambitious agenda including significant developments such as the regeneration of the town centre which has completely redefined the town over the last eight years.

Mapping the borough highlights where there is distinct variation across the population. For example, more older people live in the north and east of the borough. Broadly there is higher deprivation and lower attainment in Bracknell town. This information informs strategies and planning to efficiently target resources.

2. The Context for Health, Care and Support

This is a time of continued unprecedented pressure on the health, care, and support system. This is being felt across all parts of the UK. In summary, these pressures include:

- **Uncertainty about future funding for social care** – whether this will be sufficient to meet needs under the Care Act 2014 going forward. Whilst additional money will be going to the NHS and local authorities who commission social care through the Health and Care levy on National Insurance contributions, the NHS is being prioritised over adult social care for this funding during the first three years. NHS and social care partners will need to work in close partnership to take a holistic view of the health and care system to avoid the risk of adult social care being unable to support the NHS in managing pressures.
- **Pressure on NHS finances and capacity** – there is significant demand pressure on the NHS. This is due to the ongoing impact of Covid, the backlog of demand from the pandemic, particularly elective procedures, which has led to long waiting times, and growing demand in a number of areas, such as mental health.
- **Social Care providers are struggling financially** – in many cases, and there is uncertainty as to whether the market will be able to continue to respond to the increase in support required and the complexity of people's needs. Higher than expected inflation is likely to exacerbate pressures on the provider market and on social care.
- **Primary Care faces significant challenges** – these include increased demand, General Practice workforce and premise pressures. In addition, clinical capacity is stretched across routine, urgent, long term condition management and preventative services.
- **Health inequalities** – people in more deprived parts of Bracknell Forest experience poorer health outcomes than those living in the least deprived areas.
- **Acute hospital activity** – since the end of the pandemic, demand for acute hospital care has remained consistently high, with levels of activity normally seen only in winter now seen throughout the year.
- **Workforce** – there are national shortages of workforce across the sector, including care workers, occupational therapists, physiotherapists, allied health professionals, social workers, nurses and medical practitioners.

This plan explains how an integrated approach will be taken through the new Place-level partnership in Bracknell Forest to help address these pressures. The priorities in the plan are a sub-set of strategies and plans that already cover health, care, and wellbeing in Bracknell Forest. This can be summarised in the following diagram:

3. An integrated health and care system

In July 2022, The NHS Clinical Commissioning Groups (CCGs) ceased to exist, and Frimley Integrated Care Board (ICB) took over the planning functions of the former CCG as well as some from NHS England. Frimley ICB has a wider footprint than just Bracknell Forest, encompassing Bracknell Forest, The Royal Borough of Windsor and Maidenhead, Slough, North-East Hampshire, Farnham and Surrey Heath. The ICB contracts with providers to deliver NHS services and is able to delegate some funding to Place level to support joint planning of some NHS and council-led services.

The ICB has their own leadership teams, including members from NHS trusts/foundation trusts, local authorities and general practice. In consultation with local partners, the ICB produces a five-year plan (updated annually) for how NHS services will be delivered to meet local needs. In developing this plan and carrying out their work, the ICB has worked with partners and involved the public, to create an integrated care strategy, informed by the Bracknell Forest Joint Health and Wellbeing Strategy.

Integrated Care Systems

The creation of ICBs was parallel to the creation of Integrated care systems (ICSs). ICSs are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They represent a fundamental shift in the way the health and care system is organised – away from competition and organisational autonomy and towards collaboration, with health and care organisations working together to integrate services and improve population health.

Integrated Care Partnerships

Integrated Care Partnerships (ICPs) operate as a statutory committee, bringing together the NHS and local authorities as equal partners, to focus more widely on health, public health, and social care. The ICP includes representatives from the ICB, the local authorities within the area and other partners such as NHS providers, public health, social care, housing services, and voluntary, community and faith sector (VCFS) organisations. They are responsible for developing an integrated care strategy, which sets out how the wider health needs of the local population will be met. This should be informed by any relevant joint strategic needs assessments and involve local Healthwatch, the VCFS, and the people and communities in their area.

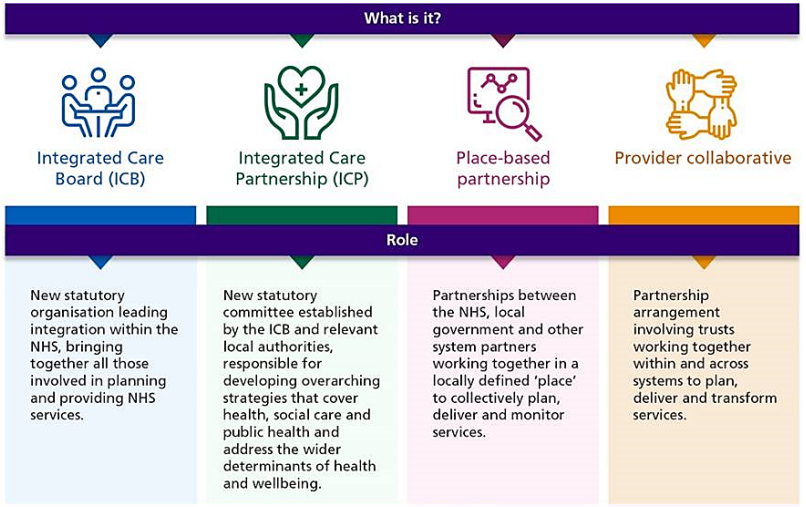
A number of partnership and delivery structures operate within the ICS at system, Place, and neighbourhood level. NHS providers work together at scale through provider collaboratives - new partnerships operating across ICSs to improve services.

Partnership and delivery structures

Several partnership and delivery structures will operate within an ICS at system, Place, and neighbourhood level. NHS providers will work together at scale through provider collaboratives, new partnerships operating across ICSs to improve services. These Provider Collaboratives, which may involve voluntary and independent sector providers where appropriate, are expected to be operating across England by July 2022 and will agree delivery objectives with partner ICSs.

Health and Wellbeing Board

The Bracknell Forest Health and Wellbeing Board (HWB) is a formal committee that brings together a range of local health and care partners to promote integration and joint working. The board is responsible for producing a joint strategic needs assessment and the Bracknell Forest Joint Health and Wellbeing Strategy.



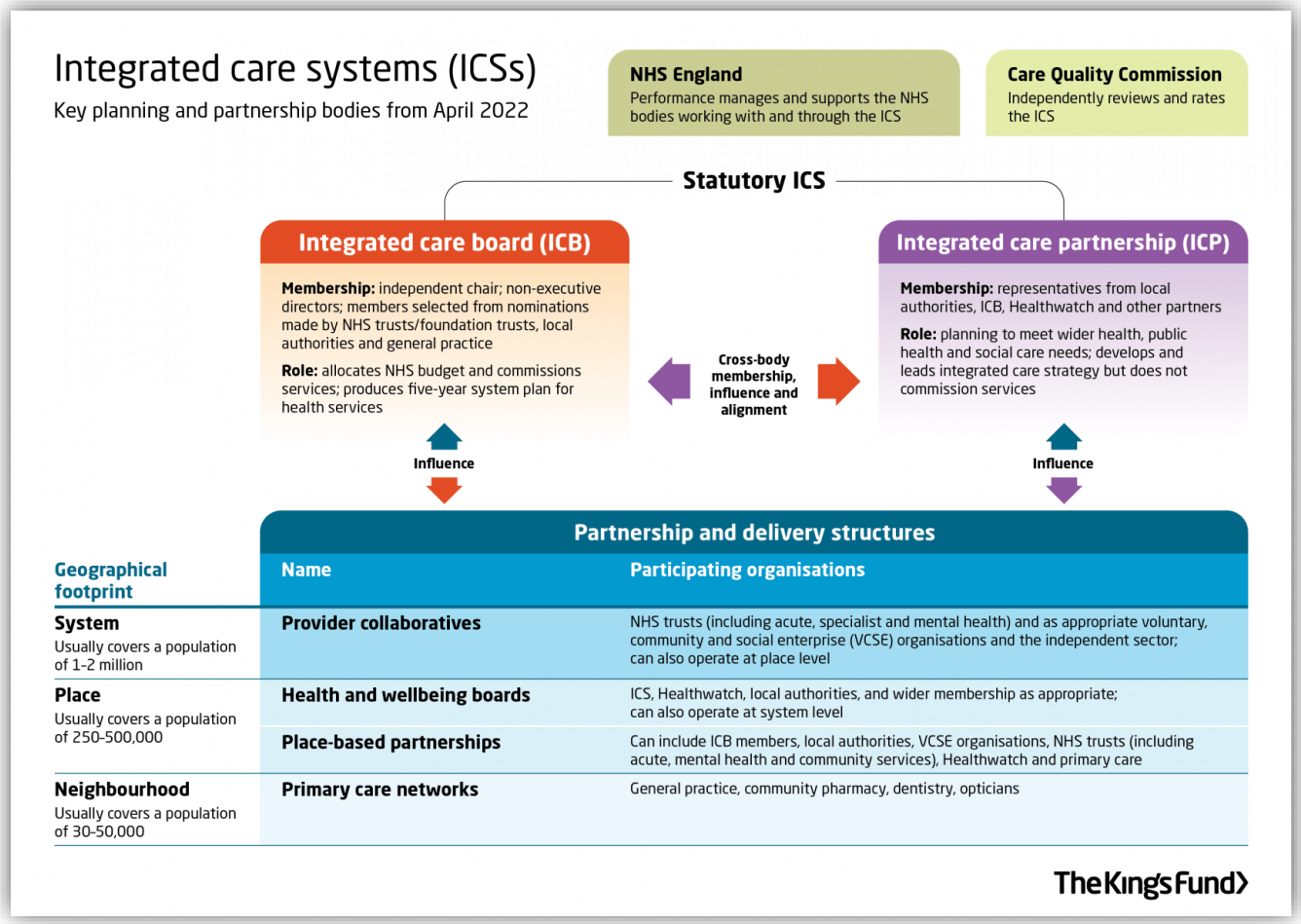
Place-based partnerships

Place-based partnerships operate on a smaller footprint within an ICS, often that of a local authority. They are where much of the work of integration will take place through multi-agency partnerships involving the NHS, local authorities, the VCFS and local communities themselves. In this case, the area covered by Bracknell Forest Council is the footprint for the Place-based partnership, led by the Place Committee.

Primary Care Networks

Primary Care Networks (PCNs) bring together general practice and other primary care services such as community pharmacy, to work at scale and provide a wider range of services at neighbourhood level.

The diagram below describes how the different parts of the system work together:



Integrated care systems: how will they work under the Health and Care Bill? | The King's Fund (kingsfund.org.uk)

4. Frimley Health and Care ICS

Frimley Health and Care ICS brings together local authorities and NHS organisations with a clear shared ambition to work in partnership with local people, communities, and staff to improve the health and wellbeing of individuals, and to use their collective resources more effectively.

The system has a diverse population of around 800,000 people in Bracknell Forest, The Royal Borough of Windsor and Maidenhead, Slough, North-east Hampshire, Farnham and Surrey Heath (shown in diagram).

The Integrated Care Board and Integrated Partnership Board will have responsibility for developing and co-ordinating health and care across the system.

Frimley ICS's refreshed ICS strategy followed the pandemic. The strategy maintains the six strategic ambitions originally established in 2019, "with new areas of focus and energy against a refreshed set of priorities which better reflect the challenges of 2023 and beyond". It sets out the following six, strategic ambitions:

1. Starting Well;
2. Living Well;
3. People, Places & Communities;
4. Our People;
5. Leadership and Culture;
6. Outstanding Use of Resources

5. Working at Place-based Partnership level

Working in Place-based partnerships will be key to driving forward integration. Bracknell Forest is one of the Places within the Frimley Health and Care ICS.

Health and wellbeing in Bracknell Forest

Health indicators for Bracknell Forest generally compare well with the rest of England and the South-East region. There are inequalities in health – there is a clear link between deprivation and decreased healthy life expectancy. There are also links between BAME groups and poorer health outcomes.

There have been good gains in health over recent years, but the increase in life-expectancy has slowed, and there needs to be more progress in years of healthy life expectancy.

Improvement through Partnership – Learning from Inspection and Regulation

The Council and ICB are committed to working together to improve the quality of care and support for the people of Bracknell Forest. Both operate under regulatory frameworks overseen by the Care Quality Commission (CQC), and actively seek to use inspections, feedback and incidents to improve.

The ICB quality report is a standing item at the quarterly Place Committee and progress against any improvement plans is discussed – evidenced by the recent improvements at Heathlands.

CQC have introduced a new inspection regime for Local Authorities that looks at a number of statements against which the quality of their actions, and as a result the service they provide, can be measured. The ICB are active partners in supporting Bracknell Forest Council in working to improve further against these domains. Bracknell Forest Council's CQC inspection outcome was published on 16th August 2024 and the Council received a rating of Good. An action plan is being developed to address areas identified for further improvement.

Developing the Priorities for Bracknell Forest Place

The section describes how the priorities for the Bracknell Forest Health and Care Plan for Adults have been developed. It starts with a brief overview of the plans and strategies that already exist, then moves to articulating how a set of strategic drivers have been developed from these, which then inform Place-level ambitions and Place-level priorities.

Step 1: Strategy, planning and policy context for the Place-based priorities:

The diagram earlier in this document referred to three key strategies that underpin the approach to creating an integrated health, care and well-being system that will support the delivery of improvements to health outcomes, for people living and working in Bracknell Forest. These are briefly summarised in the table below:

Strategy/Plan	Strategic Themes	Outcomes
Frimley ICS Strategy March 2023 "Creating Healthier Communities"	• Starting Well • Living Well • People, Places and Communities • Our People • Leadership and Cultures • Outstanding use of resources	• Healthy life expectancy at birth to improve by two years. • The gap in healthy life expectancy between the least and most deprived communities will be reduced by three years.
Bracknell Forest Council Plan 2023-2027	• Engaged and healthy communities • Thriving and connected economy • Green and sustainable environment	• Residents can access appropriate care and have a safe and affordable place to live. • Children have quality education and opportunities. • Bracknell town centre continues to thrive and be a destination of choice. • Town, village and neighbourhood centres are thriving hubs for community activity. • There is a collective action to address and adapt to the climate and biodiversity emergency.
Bracknell Forest Health and Wellbeing Strategy 2022- 2026	• Give all children the best start in life. • Promote Mental Health and Improve the lives and health of people with mental ill-health.	• Reduce health inequalities. • Creating healthy environments. • Enhancing experience of seamless care.

Strategy/Plan	Strategic Themes	Outcomes
	• Creating Opportunities for individual and community connections. • Keep residents safe from Covid and other infectious diseases. • Improve years lived with good health and happiness. • Collaborate, plan and secure funds for local and national emerging new health and wellbeing priorities.	• Community development for wellness.

In addition, there also national policies that help to shape the ambitions for the Bracknell Forest Place Partnership and the priorities for the Bracknell Forest Place Health and Care Plan for Adults. These are explicit or implicit in the strategies and plans described above. These are explicitly referenced in Step 2 below where it helps to better illustrate the strategic drivers for the Place-level priorities. These are not intended to cover the entirety of the policy context for the health, care and wellbeing system:

- **The NHS Long Term Plan, 2019** – a ten-year delivery plan for the NHS.
- **Putting People at the Heart of Social Care, 2021 –** a White Paper that describes a ten-year vision for the development of social care for adults.
- **NHS England – 2022/23 Priorities and Operational Planning guidance** – this mandates the priorities that need to be included in planning at ICS and Place level, with a particular emphasis on recovery from the continued pressures of the Covid pandemic, including the effective management of the backlog of demand that was unmet during the pandemic, such as elective procedures.
- **The Health and Care Bill, discharge policy paper, 2022 –** this provides guidance to NHS and local authority partners about the ongoing arrangements for effective discharge from hospital following changes mandated during the Covid pandemic.
- **NHS National Collaborating Centre for Mental Health – Improving Access to Psychological Therapies Manual 2021** – revised guidance for further developing rapid access to talking therapies and further increasing successful rates of recovery.
- **Core20PLUS5** - NHS England's approach to inform action to reduce healthcare inequalities at both national and local system level.

A full description of the legislative context for health and social care is included in Appendix 1 for reference.

Step 2: Strategic Drivers, Place-level objectives, and high-level outcomes

This step describes how the strategy, planning and policy context summarised in Step 1 translates into the priorities for the Bracknell Forest Health and Care Plan for Adults. Some of the initiatives were programme based and whilst the national programme may be drawing to a close, the drivers behind the work, and the work itself continue to be part of delivering better outcomes for the people of Bracknell Forest:

Strategic Driver(s)	Place-level objective	Priorities	High-level Outcome(s)
• Frimley Health and Care ICS Five Year Strategy 2020-2025 • Bracknell Forest Council Plan 2023-2027 • Bracknell Forest Health and Wellbeing Plan 2022-2026 • Core20PLUS5	• Preventing ill health and delaying prevention of ill-health by addressing the wider determinants of health, and focusing on initiatives that support our whole community to enjoy better health and wellbeing.	1) Better Health and Wellbeing through Prevention	• Reduction in health inequalities • Increase in years of healthy life expectancy
• Frimley Health and Care ICS Five Year Strategy 2020-2025 • Bracknell Forest Council Plan 2023-2027 • Bracknell Forest Health and Wellbeing Plan 2022-2026 • Core20PLUS5	• Working with the wider determinants of good health and social connectivity, including employment.	2) Thriving Communities	• Reduction in health inequalities
• People at the Heart of Care – Social Care White Paper, 2021 • Bracknell Forest Council Plan 2023-2027 • Bracknell Forest Health and Wellbeing Plan 2022-2026 • Core20PLUS5	• Strengthening people's own family and other support systems to increase resilience at both individual and community level.	3) Strength and asset-based approaches	• Reduction in health inequalities and reduced/delayed demand for services.

Strategic Driver(s)	Place-level objective	Priorities	High-level Outcome(s)
• People at the Heart of Care – Social Care White Paper, 2021 • NHS Long Term Plan, 2019 • Core20PLUS5 • Bracknell Forest All Age Integrated Carers Strategy 2024 to 2029	• More unpaid carers are enabled to continue in their caring role should they choose to and have a better quality of life.	4) Unpaid Carers	• Reduced financial hardship and stress for unpaid carers and increased satisfaction among unpaid carers with services. • Reduction in health inequalities
• NHS England – 2022/23 Priorities and Operational Planning guidance • Frimley Health and Care ICS Five Year Strategy 2020-2025 • Bracknell Forest Health and Wellbeing Plan 2022-2026	• Improve timely access to primary care – expanding capacity and increasing the number of appointments available. • Continue to develop our approach to population health management, prevent ill-health and address health inequalities. • Exploit the potential of digital technologies to transform the delivery of care and patient outcomes.	5) Primary Care Transformation	• People with one or more long-term conditions (LTCs) are better able to self-manage their conditions with the appropriate level of support for their needs/ situation. • Reduction in health inequalities • Reduction in demand for secondary and tertiary care through prevention.
• NHS England – 2022/23 Priorities and Operational Planning guidance • NHS Long Term Plan, 2019 (Ageing Well)	• Identifying older people who are at most risk of deterioration without proactive support and ensuring timely intervention	6) Anticipatory and Personalised Care	• People with multiple LTCs and complex health and care needs will benefit from an integrated , multi-disciplinary approach to anticipatory care planning. • Reduction in hospital admissions and outpatient appointments. • Increase in the number of years lived in better health.

Strategic Driver(s)	Place-level objective	Priorities	High-level Outcome(s)
• NHS Long Term Plan, 2019 (Ageing Well) • NHS England – 2022/23 Priorities and Operational Planning guidance	• Improving timely access to integrated care for care home residents with complex health and care needs. • Access to the 2hr Urgent Community and Frailty response service. • Increasing the number of residents with personalised care plans.	7) Enhanced Health in Care Homes	• Reducing conveyances to hospital • Healthy communities • Tackling health and care inequalities • Number of years lived in better health
• People at the Heart of Care – Social Care White Paper, 2021 • Frimley Health and Care ICS Five Year Strategy, 2020-25	• Increased use of Technology Enabled Care (TEC). • Building on existing telehealth pilots in care homes. • Making best use of the existing digital platform available within Bracknell Forest Council's own telecare system for both telecare and telehealth.	8) Technology Enabled Care (TEC)	• Less intrusive ways of supporting people. • Enabler for anticipatory care • Reduction is social isolation Reduce/delay the need for traditional care support. • Better use of resources
• NHS England – 2022/23 Priorities and Operational Planning guidance • NHS Long Term Plan, 2019 (Ageing well)	• 2-hour Urgent community and frailty response for adults. • Urgent Community Response to continue care following an initial 2 hour response.	9) Urgent Care	• Ensuring a rapid community response for older people who might be at risk of hospital admission. • Fewer unnecessary admissions to hospital. • Responsive community rehabilitation and reablement.

Strategic Driver(s)	Place-level objective	Priorities	High-level Outcome(s)
• NHS England – 2022/23 Priorities and Operational Planning guidance • Health and Care Bill – Discharge Policy Paper, 2022	• People should not stay in hospital longer than they need to • Everyone should have the opportunity to recover and rehabilitate at home (wherever possible) before their long-term health and care needs and options are assessed and agreed.	10) Discharge to Assess and Home First	• Reduction in exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital. • Hospital flow is supported, maximising the availability of hospital beds for people requiring inpatient care and elective surgery, such as hip replacements.
• Frimley Health and Care ICS Five Year Strategy, 2020-2025 • Putting People at the Heart of Care – Social Care White Paper 2021	• People regain independent living skills in a timely way following an event such as a stay in hospital. • Prevention of admission to hospital or exacerbation of people's health and social needs.	11) Intermediate Care	• Increase in quality of life. • Decrease/delay in demand for services. Increase in the number of years of healthy life expectancy.
• NHS Long Term Plan 2019	• People are diagnosed with dementia in a timely way. • There is a comprehensive network of support for people with dementia and their unpaid carers.	12) Dementia	• Comprehensive support for people living with dementia and their families and carers. • Diagnosis rates reach or exceed the national target of 66.6%.

Strategic Driver(s)	Place-level objective	Priorities	High-level Outcome(s)
• Frimley Health and Care ICS Five Year Strategy, 2020-2025 • Bracknell Forest Health and Wellbeing Strategy 2022-2026 • NHS National Collaborating Centre for Mental Health – Improving Access to Psychological Therapies Manual 2021	• Increasing mental health wellbeing and transformation of services to provide timely and co-ordinated support for people with mental ill-health. • Reduction in physical ill health and mortality gap for people with mental ill-health.	13) Mental Health Transformation	• More people with significant mental health needs are supported through primary care. • Reduction in health inequalities. • Improved recovery rates for people experiencing mental ill-health.
• NHS Long-Term Plan, 2019 • Putting People at the Heart of Care – Social Care White Paper 2021 • Bracknell Forest Council Plan 2023-2027 • Core20PLUS5	• Further integration of health and social care support for people with learning disabilities and autism. • Reduction in physical ill health and mortality gap for people with learning disabilities.	14) Learning Disabilities and Autism	• People with learning disabilities and autistic people are enabled to live more independently. • Reduction in health inequalities.

Underlying all the above is the ambition to reduce health inequalities both at ICS and Bracknell Forest Place level.

Step 3: The Priorities for the Bracknell Forest Place Health and Care Plan for Adults 2023-2025

The priorities for this plan are to create an integrated health and care offer which encompasses the following:

Prevention

1. **Better Health and Wellbeing through prevention** – wider health and care approaches to address the wider underlying causes of poor health and wellbeing.
2. **Thriving Communities** – people are empowered to stay well and feel connected to their community.
3. **Strength and Asset-based approaches** – people are equal partners in building on their own strengths and those of their own social and support systems.

4. **Unpaid carers** are supported with achieving their own aspirations as well as being helped in their caring role.

Proactive Care

5. **Primary Care Transformation** – increasing timely access to primary care and using population health management tools to proactively support people who might otherwise be at risk of deterioration and/or the need for Urgent Care**.**
6. **Anticipatory and Personalised Care** – proactively identifying and meeting the needs of a defined population will improve their health and quality of life and reduce the use of health and social care resources.
7. **Enhanced Health in Care Homes (EHCH)** – extended multi-disciplinary support to care home in addition to the primary care Directly Enhanced Service (DES).
8. **Technology Enabled Care (TEC)** – the best use of the latest technology to provide less intrusive ways of supporting people, and to more quickly identify when they need more urgent help.

Reactive Care

9. **Urgent Community Response & Frailty Virtual Ward** – urgent care is available in a crisis to provide immediate support and prevent admission to hospital.
10. **Home First and Discharge to Assess** – people are supported with a smooth and co-ordinated discharge when they leave hospital and are helped to return home wherever possible.
11. **Intermediate Care** – people are helped to retain and regain independent living skills.

Transformation for population groups to improve health

12. **Dementia** – people living with dementia and their unpaid carers receive timely, comprehensive and ongoing support.
13. **Mental Health Transformation** – more people living with significant mental illness are supported in the community through primary care and experience better physical health.
14. **Learning Disabilities and Autism** – people with learning disabilities and autistic people are enabled to live independently with support, and experience better physical health.

These priorities, and what they mean for the Bracknell Forest Place Health and Care Plan for Adults, are explained in the following section.

6. Priorities for The Bracknell Forest Place Health and Care Plan for Adults 2023-2025

Prevention

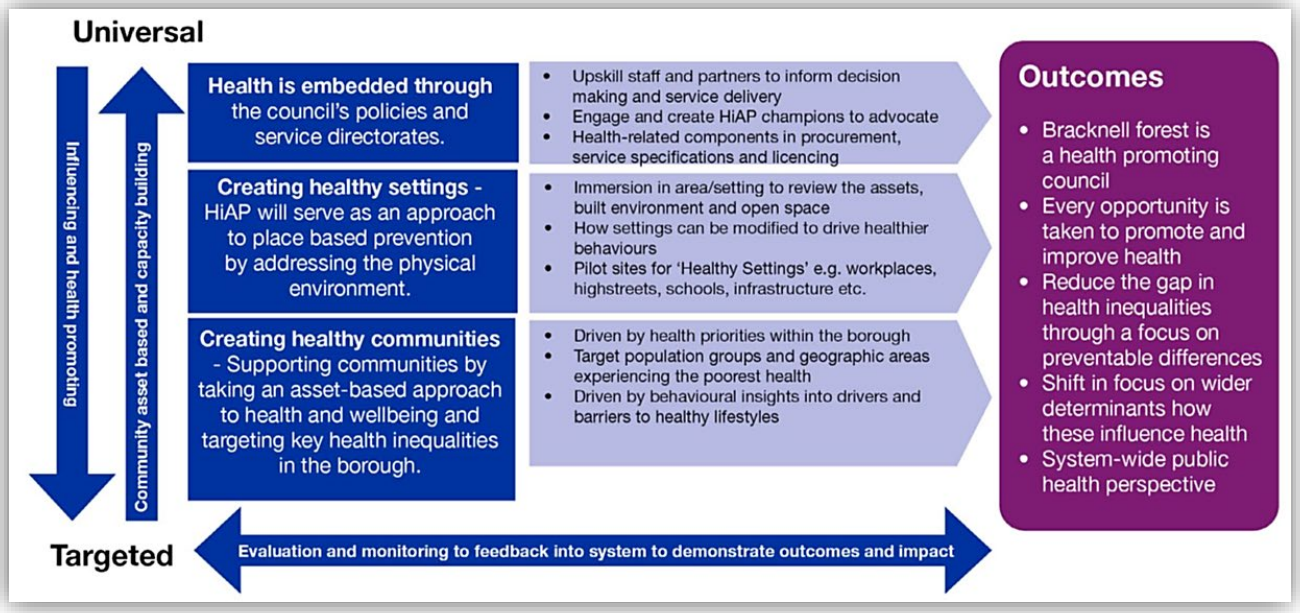
Better Health and Wellbeing through prevention

A detailed description of the strategic approach to prevention is described in the Bracknell Forest Health and Wellbeing Strategy 2022-2026. However, it is important to describe key elements of this approach in this plan, as prevention is fundamental to improving the health and wellbeing of the whole population in Bracknell Forest Place. The approach to prevention also underpins all of the elements of the Bracknell Forest Health and Care Plan 2023-2025. Prevention for Bracknell Forest Place includes the following approaches:

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

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

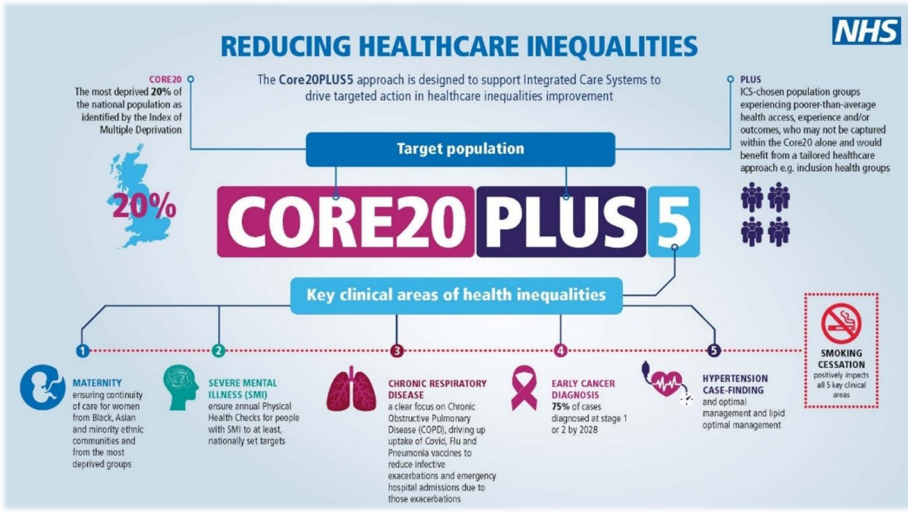
The HiAP approach across the Frimley Health and Care Integrated Care System, and at Bracknell Forest Place partnership level is described in the following diagram:

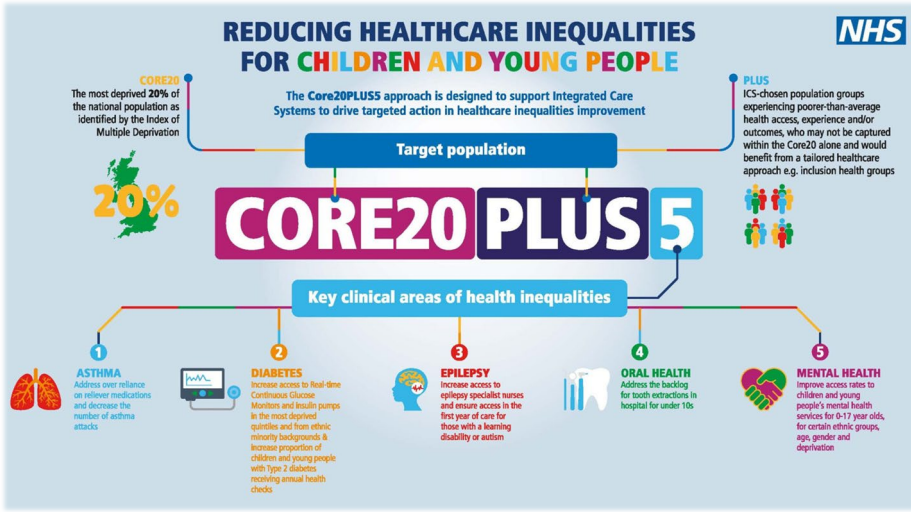


Core20PLUS5 - Core20PLUS5 is the national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. As such it focuses efforts on priority areas, whilst complementing other initiatives such as HiAP and Population Health Management.

The approach defines a target population and comprises of three elements:

- The Core20, the most deprived 20% of the national population as identified by the national index of multiple deprivation. In Bracknell Forest, this is a low number (approximately 50 adults and CYP).
- PLUS population groups identified at a local level. In Bracknell Forest, these groups for adults are learning disabilities and carers. For Children and Young People, the focus is on school readiness for those eligible for free school meals, childhood obesity and living in households with smoking.
- '5' is a focus on clinical areas requiring accelerated improvement. The 5 clinical areas are different for Adults and Children & Young People, but in Bracknell there are key cross-cutting themes, especially with the local PLUS focus on young carers, children in care and care leavers, households with obesity, households with smoking and school readiness for those eligible for free school meals.





There are 7,627 people in Bracknell Forest, in deprivation deciles 1-4 and/or PLUS groups:

Type	% Prevalence	# Prevalence
Core20+5		**7,627**
Core20		**4,259**
Deprivation Decile 1	0.0%	27
Deprivation Decile 2	0.0%	25
Deprivation Decile 3	3.0%	2,675
Deprivation Decile 4	1.7%	1,532
Plus		**3,507**
Carers	3.5%	3,142
Learning Disability	0.4%	374
Total		**7,627**

PLUS groups can be identified across the 5 key clinical areas and smoking:

RegisterType	Plus		
RegisterType	Carers	Learning Disability	**Total**
5	**1,510**	**105**	**1,610**
Cancer	254	7	**261**
Copd	95	4	**98**
Current Smoker	434	36	**469**
Hypertension	985	49	**1,031**
Mental Health	47	26	**72**
Pregnant (last 12m)	25		**25**
Total	**1,510**	**105**	**1,610**

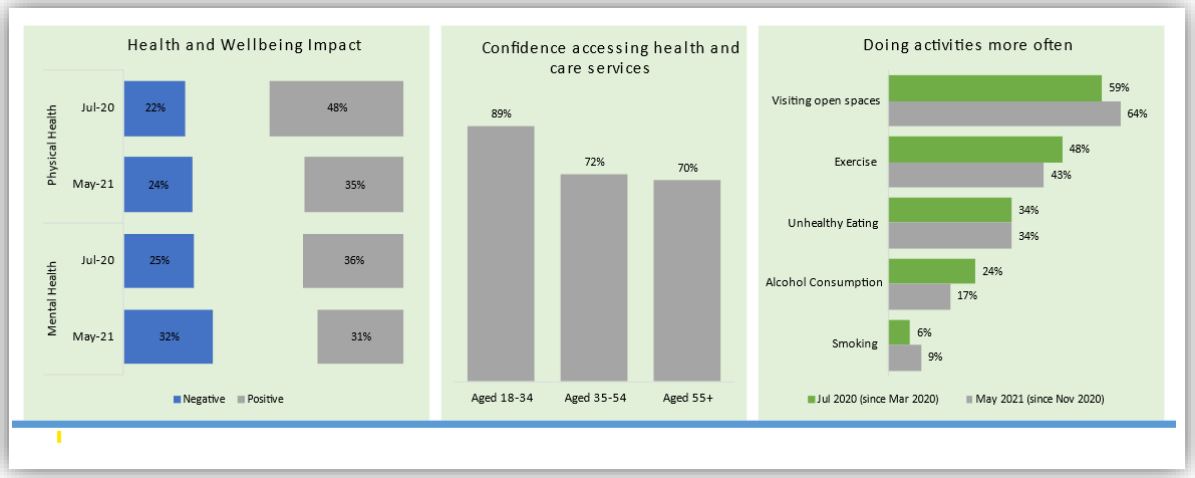
Core20PLUS5 Work in Bracknell Forest: There was a Deep Dive exercise into patients in Deciles 1 and 2. PLUS groups were discussed at System-wide meetings with Place input. At this stage Place views had been informed through a GP Council workshop. System priorities for PLUS Groups (carers and adults with learning disabilities) were aligned with the Place assessment. Work is now taking place to identify ways of reducing health inequalities for carers and patients with learning disabilities, including linking into system work for wider insights and sharing of practice and approaches.

Where are we?

As with every part of the UK, Covid had an impact on Bracknell Forest. Bracknell Forest Council considered the context of demographics during the pandemic through reports such as the Community Impact Assessment, and this has allowed more tailored decision making and a focus of resources. The ongoing impact of Covid on the NHS and social care system cannot be underestimated.

The most recent Community Impact Assessment was undertaken by Bracknell Forest Council in July 2021 and showed the impacts outlined below on health and health-related behaviour. There is still a legacy from the pandemic and whilst the impact has reduced, they still persist to a significant degree.

- The decrease in demand for health services has now broadly returned to pre-pandemic levels.
- Mental health is worsening and there is less of a positive impact on physical health. Suggests longer term impacts emerging.
- There remains lower confidence from older adults to access community sites, shops and services.
- There has been a sustained increase in people visiting open spaces more often, but fewer people are maintaining new exercise habits.



The diagram left summarises the impact of Covid (July 2021) on the population in Bracknell Forest

Health Inequalities: Data from all surveys and studies highlight that existing inequalities widened during the pandemic. This meant that proportionally, the highest burden of the pandemic was seen in communities that were already struggling or had the poorest health outcomes. A key report from Public Health England (PHE) presents findings based on surveillance data available to PHE at the time of its publication, including through linkage to broader health data sets. It confirmed that the impact of Covid replicated existing health inequalities and, in some cases, has increased them. The largest disparity found was by age. Among those diagnosed with Covid, people who were 80 or older were 70 times more likely to die than those under 40. Risk of dying was also higher in males, those living in more deprived areas, and for people from Black, Asian, and Minority Ethnic (BAME) groups. These inequalities largely replicate existing inequalities for mortality rates from previous years, except for BAME groups as mortality was previously higher in white ethnic groups.

Where do we want to get to?

The vision is for Bracknell Forest is one of the healthiest places to live, work, study, and play, providing our residents with opportunities to be healthy, happy, and productive. We will support this by taking a Health in All Policy (HiAP) approach with a focus on promotion of health, prevention of ill-health and reduction in disparities in health outcomes between our communities.

Six key priorities have been identified in the Bracknell Forest Health and Wellbeing Strategy 2022-2026. These are:

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

Underpinning these health and wellbeing priorities are four cross-cutting themes:

1. Reducing health inequalities.
2. Creating healthy environments.
3. Enhancing the experience of seamless care.
4. Community development for wellness.

What objectives will we deliver going forward?

Creating healthy communities: This approach will focus on working with communities and residents who have the poorest health and, therefore, form the basis of the audience which link to the strategy objectives (e.g. children, young people and their families, adults with mental ill-health). This will look into the key wider determinants of health that impact on specific population groups or communities including:

- Housing
- Employment including meaningful employment and workplace health
- Local infrastructure and physical access to services
- Access to open space
- Social connections

This helps to inform our approach to “Thriving Communities”, which is described in more detail in the next priority section.

Making Every Contact Count (MECC): This involves training for everyone in the partner organisations at Bracknell Forest Place level who has some level of contact with members of our community in their day-to-day work. This also encompasses the voluntary and community sector. MECC training includes appropriate material for emotional and mental health promotion, detection, and early intervention.

Better Mental Health: The Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public’s mental health has been shown to make a valuable contribution to achieving a fairer and more equitable society. The concordat is intended to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across:

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

The Prevention Concordat for Better Mental Health acknowledges the active role played by people with lived experience of mental health problems, individually and through user-led organisations.

The key aims in the Bracknell Forest Health and Wellbeing Strategy 2022-2026 to improve mental wellbeing are:

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

Create opportunities for individual and community connections: Good social connections and a sense of belonging are important protective factors for physical and mental health. Studies have shown that people with good quality social connections have, on average, longer life expectancy compared with those who lacked social connections. Covid has had an impact across all ages on social isolation and loneliness. Key deliverables include:

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

Keeping Residents Safe from Covid and other infectious diseases: The Local Outbreak Management Plan has been reviewed in the autumn of 2021, and aims to deliver:

- Engagement and communication.
- Data integration and surveillance.
- Testing, contact tracing, self-isolation, and outbreak management.
- Legislation, compliance, and enforcement.
- Vaccination programmes for infectious diseases other than Covid.
- Scoping the local health protection response so as to align with national public health system reforms.
- Plan and deliver Covid vaccinations to eligible populations, working with partners to ensure high uptake across all ages and communities.
- Feedback from local communities on how best to engage and communicate the ongoing pandemic response in Bracknell Forest.
- Updating the joint winter plan based on national guidance and local modelling.

Thriving Communities

Throughout 2022-2023 Bracknell Forest Council and Frimley ICB worked on developing our approach (Thriving Communities) to implementing the ICB “Community Deal” ambition through partnership working at Place. Considering how we build a different relationship with communities,

residents and staff to design and deliver solutions together and working together to realise wider public health opportunities presented by Covid-19 as part of Community Deal conversations.

Our joint ambition is to support the community to be as healthy, independent and resilient as possible whilst delivering cost effective and sustainable services. This means that our focus for expanding the range and scale of joint working will be in understanding the priority needs of our community. This shared understanding will guide how the next steps are delivered and embody the principles of joint working that we have agreed to.

The Bracknell Forest Place partnership wants to focus on harnessing individuals' and communities' strengths, together with services, to find solutions. Working jointly between Bracknell Forest Council, the ICB and Involve / the voluntary, community and faith sector (VCFS), the Thriving Communities Programme aims to enhance the impact and reach of positive outcomes. Some of these benefits will be directly experienced by the community; other benefits will be indirect through reinvestment in the community.

Funding was secured for the 3-year Thriving Communities programme in 2022-23. A working group is leading the approach and are engaging a wide range of partners including across the VCFS including through a well-attended engagement event to co-design the delivery of the programme.

Shared Principles - It is important to have some principles that will guide the development of Thriving Communities in Bracknell Forest. The overarching principles are:

1. Everyone has a part to play in building and creating healthier communities.
2. Using community-based approaches to enable children to have the best start in life and to focus on wellbeing will have the most impact on improving health and wellbeing across all communities.
3. Building strong neighbourhoods and places will impact positively on overall health and wellbeing outcomes.
4. Individuals and communities must have the freedom to innovate.
5. Councillors will play a key role as community connectors and champions.
6. We will achieve more by collaborating and sharing resources across the voluntary, community, faith, public and business sectors.

Innovation Fund

The joint working between NHS Frimley ICB and Bracknell Forest Council has been successful in delivering the Bracknell Forest Innovation Fund. £130,000 was awarded to 10 local projects in July 2023 to enhance community led action related to the health and wellbeing of vulnerable residents. This funding was specifically aimed at those experiencing long term challenges following the pandemic such as isolation. A launch event was held in October 2023 to support the development of local connections and partnership building across the

projects. A project development session was then jointly facilitated by the Council, ICB and Involve in March 2024 to support the projects in developing their evaluation approach and sustainability of projects.

In the recent months, a number of these projects have been completed, with closure reports to be collected over the winter of 2024. A final showcase event for the outcomes of the work will be held through the Older People's Consortium in January 2025.

Where are we?

The programme will be focused initially on a pilot. A data and insights evidence base has identified the pilot community to work with. Asset mapping for the pilot community area, Bracknell Town Centre, has been completed. Recruitment to programme posts has now been completed and further engagement with partners will take place in Q3 2024/25 focused on the pilot area. Work is underway to improve the understanding and skill sets of staff for effective co-production in partnership with communities. Resources have been identified through the Better Care Fund to fund the programme.

Where do we want to get to?

There will be engagement with the community in the Bracknell Town Centre area of the Town Centre and The Parks ward to co-create the approach, with a timetable for further roll-out to other parts of Bracknell Forest to be determined following evaluation of the pilot.

What objectives will we deliver going forward?

- Increasing people's independence.
- Increased community resilience.
- Creating an empowering and enabling culture – developing listening and co-production skills.
- Making the most of strengths and assets.
- Better use of existing resources for people, such as libraries as community hubs.
- Better managing demand for health and care resources.

Strengths-Based practice (Asset-Based practice)

In Bracknell Forest we take a strengths-based approach to how we work with people – taking a personalised view of the person and focusing 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”) promoting their overall wellbeing and resilience in a holistic way, demanding an integrated and multidisciplinary response.

This way of working is also more rewarding for staff, as it correlates directly with their professional value base and makes full use of their professional skills. It represents a move away from the deficit-model that typified many previous care management approaches.

Where are we?

Bracknell Forest introduced strengths-based practice in 2019. The rollout of this model was paused due to the impact of Covid on staff capacity. We have worked with Social Care Institute of Excellence (SCIE) on the roll-out of strengths-based practice. Strengths-based approaches have been embedded as ‘business as usual’ since August 2023. Many of the new roles as well as the project management of this work are funded from the BCF.

Where do we want to get to?

- For strengths-based practice to become the way that we work, in partnership, with everyone who needs either social care or integrated health and care support.
- By implementing strengths-based approaches we aim to prevent, delay and reduce needs, and reduce the number of people needing more intensive support or services. Key enablers will be the use of assistive technology, reablement and rehabilitation.

What objectives will we deliver going forward?

- For people, their unpaid carers and support network to feel like equal partners in planning how best to meet their needs and to feel more connected to their community.
- Develop co-production as part of a programme of work with SCIE.
- Better use of resources.
- An increase in the number of people whose needs are resolved at the social care ‘front-door’.
- A reduction in the number of people moving on to more intensive support.
- A reduction in the number of people moving to permanent residential/nursing placements.
- This approach better enables social care to support the Place-based partnership, and the NHS, by freeing up resources whilst providing an opportunity for more people to remain independent in the community for longer.

Unpaid Carers

The number of unpaid carers in Bracknell Forest was recorded in the Census 2021, totalling 8,770 people or 7% of the population, of which 4.2% (aged 5 years and over) provided up to 19 hours of unpaid care a week, 1.3% (aged 5 and over) provided 20-49 hours of unpaid care a week, and 2.2% provided more than 50 hours of unpaid care per week. It is important to note that almost 3% of carers in Bracknell Forest are aged between 5-17 years old and many provide unpaid care for an adult.

Unpaid carers are estimated to save the UK economy over £119bn a year. They are a major asset within the health and social care system and are vital partners in the provision of care as well as being experts in the delivery of care.

Whilst caring is rewarding and can bring life affirming experiences to people's lives, without the right support it can also have a significant effect on a person's health, wellbeing, relationships, employment, and finances. Carers experience negative impacts on their physical and mental health and wellbeing, educational and employment potential and social contacts and relationships. The latest published Personal Social Services Survey of Adult Carers in England is for 2023/24. It shows that for Bracknell Forest:

- Of carers who had received services, 45.1% were extremely or very satisfied (an increase of 8.5% from the 2021/22 survey), whilst 7.4% were extremely or very dissatisfied (an increase of 3.4% from the 2021/22 survey). This compares favourably with the England average of 36.7% for extremely or very satisfied, and 8% for extremely or very dissatisfied.
- The percentage of Bracknell Forest carers who responded to the survey who felt they could look after themselves was higher than the England average (51.8% against 46.7%) and the percentage that reported that caring had a financial impact on them was 48.9% (an increase of 3.7% from the 2021/22 survey) as opposed to the England average of 46.6%. This is within the context of the overall picture for England declining in terms of outcomes for carers reported in the survey, which is undertaken every two years.
- In addition, the ONS states that the Covid-19 pandemic had a disproportionately negative impact on the lives on unpaid carers compared with non-carers (63% compared with 56%).

Where are we?

Frimley ICB and Bracknell Forest Council jointly commission services for carers through the Better Care Fund. In 2021 the Ark was commissioned to provide a comprehensive new carers' service: SIGNAL4Carers. They provide an Information, Advice and Guidance service, and they also facilitate social events, such as group lunches and other opportunities for people to connect. The Ark also provided significant additional support during Covid by identifying those carers with priority needs and increasing their contact with them.

Where do we want to get to?

- A New All Age Integrated Carers Strategy 2024-2029 has been developed which gives a more comprehensive view of the pressures unpaid carers are facing. This will have a delivery plan which will guide our support for carers.
- We have introduced a Carers' Strategy Partnership group to support oversight of the delivery of our new strategy and co-production of health and social care services.

What objectives will we deliver going forward?

- To ensure delivery of the action plan which supports the All Age Integrated Carers Strategy.
- We want to continue to ensure that primary care practices have the information they need to refer unpaid carers to Signal For Carers.
- Ensure that unpaid carers in the wider community are recognised and supported.
- Provide services and support that work for carers.
- Work collaboratively with carers and VCFS partners to support unpaid carers to remain in employment.

Proactive approaches to Care

Primary Care Transformation

Bringing general practices together to work at scale has been a policy priority for some years for a range of reasons, including improving the ability of practices to recruit and retain staff, manage financial and estates pressures, provide a wider range of services to patients and to integrate with the wider health and care system more easily. While GP practices have been finding different ways of working together over many years – for example in super-partnerships, federations, clusters and networks – the NHS Long-Term Plan and the new Five-Year Framework for the GP contract, published in January 2019, put a more formal structure around this way of working, but without creating new statutory bodies. The creation of Primary Care Networks (PCNs) in 2018 was a key component of the new integrated health and care system. There are currently eight GP practices in the Bracknell Forest Place, forming three PCNs.

PCNs form a key building block of the NHS Long-Term Plan and the Frimley Health and Care ICS. PCNs have responsibility for the health of the populations that they cover. They are therefore key leaders and partners in the heath and care system for Bracknell Forest Place.

PCNs will continue to play a pivotal role in maintaining and improving the health of the local population through partnerships working, building on what we have learned during the pandemic to transform delivery of services, continuation with recovery and restoration work and reducing health inequalities within our communities.

Where are we?

During 2022/23, PCN development was shaped by the emergence from the pandemic, with a focus on recovering access to GP surgeries and a refocus on some of the core elements of the network contract, including early cancer diagnosis, personalised care, proactive care and enhanced access. Our PCNs are adopting a population health management approach to address health needs and inequalities working closely with local partners, including communities, the voluntary sector, and local councils.

PCNs have continued to play a pivotal role in addressing backlogs in care and deterioration in health and wellbeing including through long term conditions checks, childhood immunisations, health checks for people with a learning disability and those with significant mental illness, and cancer screening. Through partnership working, PCNs continue to transform delivery of services with partners, continue with recovery and restoration work, and focus on reducing health inequalities within our communities. In addition, there is a renewed focus on the outcomes of the Fuller Stocktake, which promotes the role of Primary Care and PCNs in streamlining access to services, providing more proactive care and helping people stay well for longer. As an example of this focus, all our PCNs have taken up opportunities to work on a project that support patients with remote monitoring equipment, allowing the care providers to be more responsive to the patients' needs whilst supporting

improved access by freeing up capacity. Projects that are enabled through enhanced digital capability will become available through the course of the year as innovative digital solutions move from pilot phase into the mainstream.

Primary Care has continued to play a central role in the delivery of the Covid vaccination programme, supporting booster programmes for priority cohorts in Spring and Autumn. PCNs have been working in partnership to run clinics from a mix of existing NHS sites and commercial premises.

To inform prevention we have been using population health management, with a new focus on the national NHS model, CORE20PLUS5. PCNs and practices have been working with ICB colleagues over the last year to identify local population groups who would benefit from a renewed focus on their health needs.

Where do we want to get to?

There is a very clear focus over the next couple of years on improving access to general practice for patients, with the release of the Primary Care Access Recovery Plan from NHS England. This focuses on the use of digitally enabled access models for practices, with use of at-scale models delivered through PCNs for same day access and use of new digital innovations that allow a more targeted approach to access for patients. Alongside this, the Population Health Management programmes across the Place will continue to facilitate a more efficient delivery of preventative care to the most vulnerable and high need patients.

We aim to utilise a population health management-based approach using a patient segmentation tool to support the delivery of general practice at scale, with the aim to deliver the following benefits:

- Streaming appropriate patients to pathways outside general practice, educating patients in the process to self-care and access to the right pathways in future.
- Improve access and reduce “failure demand” by streaming patients into the most appropriate services to meet their needs.
- Better patient experience by using the enhanced features of digital telephony, such as patient call back functions.
- Make best use of resources, including non-clinical care navigation and best use of the PCN Additional Roles Reimbursement Scheme (ARRS) workforce to support minor illness and routine care for the generally well population, as well as developing at scale. Personalisation and Proactive Care Team workforce to support clinical staff with patients with long-term conditions (LTCs) and complex needs, supported by the patient segmentation data.
- Maintain continuity of care for the patients who need it most – not a “one size fits all” approach.

What objectives will we deliver going forward?

- Patients will have a better experience accessing PCN and general practice services, as primary care delivers on the new access requirements included in the PCN Network Contract DES and the Primary Care Access Recovery Plan.
- Maturing organisational development of PCNs so they can play a full role in delivery of local plans/visions, including development of Integrated Network Teams as described in the Fuller Stocktake.
- PCNs will engage with projects developed through the CORE20PLUS5 Model to identify and reduce health inequalities within their patient populations.
- PCNs will make full use of population health management tools to support streaming of patients into the most appropriate services to meet their needs, as well as informing the most efficient use of resources to facilitate proactive care of patients.
- PCNs will play a key role in supporting the Place implementation of the Frimley system plan for patient access to Same Day Urgent Care.
- PCNs will develop and deliver a PCN Estates Toolkit, as part of coherent strategy to provide fit for purpose estate that delivers the population health management model of care for general practice.
- Digitally enabled practices to support service delivery and engage patients in a variety of ways suitable to their needs and abilities.
- Additional primary care workforce recruited and deployed using all available resources – Additional Roles Reimbursement Scheme (ARRS) roles within PCNs.
- Work with PCNs to develop a proactive care approach to management of Long Term Conditions.
- Ongoing delivery of the Covid vaccination programme in PCN-led sites, utilising sustainable workforce models.
- Through links with the ICB workforce team, Training Hub and other partners, deliver opportunities to practice and PCN staff for workforce development and to improve retention.
- Complete a programme of practice visits to support engagement and resilience across general practice in Bracknell Forest Place.

Proactive Care - *formerly "Anticipatory Care"*

Being able to stay healthy in later life is a crucial issue for all of us. We know that sometimes, people do not feel supported to look after their own health, particularly people with multiple long-term conditions, including frailty. This has a detrimental impact on quality of life and health outcomes. We aim to provide extra support to people who are at risk of increasing frailty offering them much earlier support and help to stay in the place they call home longer. This works by working with people, their carers, and partner organisations to proactively plan for their future needs: We call this Proactive Care. It is about understanding what matters to the person and working together to make a plan that fits any

needs they may have now or in the future. Proactive Care operates at different levels depending on the level of need and what is important to individuals.

A Proactive Care approach is already in place across Bracknell Forest Place, and we will continue to develop this approach to tackling inequalities and ensuring that we are covering all of the relevant cohorts of individuals within our population.

Where are we?

- Bracknell Forest's Primary Care Networks are leading on delivering proactive care. They are currently testing out ways of working based on the nationally published draft pathway and come together regularly to share learning and best practice.
- Care Co-ordinators and clinicians in the Primary Care Networks support the delivery of Proactive Care.
- We have adopted the use of a population health management approach to identify people with moderate to severe health needs. We are aiming to align this with public health knowledge of health needs and areas of deprivation across Place.
- Regular risk stratification of our population's needs is conducted, and appropriate residents identified who would benefit from a proactive care approach.
- In partnership with other Places across Frimley ICS we have developed a proactive care tool "What Matters To Me?" to support holistic assessment and conversations around proactive care planning. This tool is now being used by primary care staff.
- Across Frimley ICS, we have developed more consistent ways of capturing activity and outcomes through the GP patient record systems and Connected Care.
- Some people with very complex health and social situations require coordination of activities across multiple disciplines and partners to plan proactive care. This is conducted through our local Integrated Cluster Teams who work closely with individuals, carers, and families to ensure all eventualities are anticipated, coordinated through joint planning, and reflect what is important to the individual. These are currently small numbers.
- There are cohorts in our population who are frail, socially isolated and at higher risk of deterioration and hospital admission without proactive care and support. We are working closely with our social prescribers and voluntary sector partners on a personalised approach to Proactive Care by working with this group to improve their social resilience within their local communities.
- Age UK in 2022 delivered a pilot in partnership with one of our Primary Care Networks around proactive care supporting people with "what matters to me" conversations. We have captured the learning from this pilot with recommendations from Age UK that we can take forward as we continue to develop the local model.

- Healthwatch Bracknell Forest have helped to find out what our residents thought about proactive care and what would be important to them as patients, service users and carers. Healthwatch Bracknell Forest have outlined some recommendations that we can take forward as we continue to develop the local model.
- We continue to take the learning from Age UK and Healthwatch Bracknell Forest to ensure a local Proactive Care pathway that meets the needs of individuals to improve health and care outcomes, wellbeing and to reduce health inequalities across our communities.

Where do we want to get to?

- Understand how we can best support people to recognise when they might need extra help and support as they grow older, or their circumstances change.
- Increase in years gained living in better health.
- Better quality of life outcomes for our residents.
- Provide person-centred services that enable people to age well.
- Aim to ensure that most care is provided in the local community close to people's home providing the right expertise and support in a timely way.
- Target cohorts where proactive and coordinated management of their conditions will improve health outcomes.
- Improve identification of at-risk individuals living in deprivation.
- Ensure all stakeholders including health, social care, voluntary sector and housing are actively engaged in the proactive care planning pathways so that our residents are offered holistic assessment and proactive care planning.
- Effectively capture carers who may be at risk and support them to better care for themselves.
- Align Proactive Care planning with public health and agree cohorts to target including addressing inequalities and deprivation.

What objectives will we deliver going forward?

- Deliver integrated and collaborative working with all partners, which is vital to a successful model of Proactive Care.
- Increase the number of people identified who will benefit from Proactive Care, identified in primary care using a population health management approach.
- Increase the overall number of people with Proactive Care Plans.
- Increase the number of complex individuals who would benefit from better coordination of care, across partners, through Integrated Cluster Multi-Disciplinary Teams (MDTs).

- Reduce the incidence of hospital admission/attendance associated with long term conditions and frailty.
- Develop a consistent personalised care planning and support tool for use across Bracknell Forest.

Enhanced Health in Care Homes (EHCH)

We have an ambition for Bracknell Forest Place to go further on our care homes programme and strengthen local support for residents and care home staff.

The NHS Long Term Plan (2019) contained a commitment as part of the Ageing Well Programme to roll out EHCH across England by 2024, commencing in 2020. This reflected an ambition for the NHS to strengthen its support for the people who live and work in and around care homes. Requirements for the delivery of Enhanced Health in Care Homes by Primary Care Networks (PCNs) were included in the Network Contract Directed Enhanced Service (DES) for 2020/21. Complementary EHCH requirements for relevant providers of community physical and mental health services have been included in the NHS Standard Contract to support the NHS Long Term Plan goal of "dissolving the historic divide" between primary care and community healthcare services and helped to set a minimum standard for NHS support to people living in care homes.

The Ageing Well programme, set up to deliver the implementation of EHCH, Urgent Community Response and Proactive Care, across Frimley ICS came to an end in July 2023 with the key elements of the DES and the NHS Standard Contract having been implemented. Work on improving access to health, care, and support for care home residents across Frimley ICS continues and is overseen by the new Frailty Advisory Board.

Where are we?

- All care homes in Bracknell Forest are aligned to a Primary Care Network and have a named clinical lead. Weekly “home rounds” are being delivered by primary care.
- Care co-ordinators in each of Primary Care Networks support with the weekly "home rounds" and act as a single point of access for care homes to GP practices, simplifying access to health care.
- The Care Home Multi-Disciplinary Meeting (MDT) has been aligned to the Primary Care Networks and has common referral pathways with our integrated care teams. This has aimed to further strengthen relationships between community and primary care and simplified access to health and care services.
- Most of our community health services now take direct referrals from care homes.

- Care Homes have access to the Urgent Community Response and Community Virtual Ward, 8am to 8pm, 7 days per week which has reduced the number of conveyances to hospital.
- A "learning review" of a 2022 pilot testing out an enhanced MDT was carried out with recommendations to strengthen integrated community support and simplify pathways for care home residents to access health and social care.
- Mapping of all services supporting care homes has supported better integrated working between those teams supporting care homes and reduced duplication and gaps in the provision of health and care.
- With a focus on prevention and early intervention, the multidisciplinary Care Homes Support Team provide care home staff with the right skills, training and advice to support residents. This has been welcomed by our care homes and has made a big difference to the quality of life of care home residents and is helping care homes to manage health challenges to avoid unnecessary hospital admissions. The team works closely with Bracknell Forest health and social care colleagues and are a vital component of our Care Home MDT.
- There is a collaborative approach to supporting our care homes to deliver safe, high-quality services. A range of care home support services meet regularly to identify where clinical and other support may be required and offer this to our care homes in a co-ordinated way. This is linked in with the formal care governance pathways. This is in addition to contract monitoring and quality assurance activity.
- There is an excellent local training offer to care homes to support good clinical practice. Feedback from our care homes is that they value this.
- A Post Falls Protocol for Care Homes developed and programme of training around falls prevention has been delivered.
- Dedicated physiotherapy into care homes has been introduced, initially as a pilot, to ensure early access to rehabilitation and preventative therapy with a strong focus on falls management and prevention.
- 6 out of 13 Bracknell Forest Care Homes now use a “remote monitoring” system in conjunction with primary care. This supports early identification of residents who are unwell and need intervention, faster response from primary care/Urgent Community Response and minimises the need for conveyance to hospital. Early evaluation is showing good outcomes.
- Diadem (Diagnosing Advanced Dementia Mandate), a tool to support GPs in diagnosing dementia for people living with advanced dementia in a care home setting, has been piloted in Bracknell Forest Care Homes, since January 2023.
- Care Homes are supported by networking and information sharing forums led by the local authority and the Integrated Care Board.
- Development of an Activities Co-ordinator Champions Forum which shares ideas and promotes good practice supports access to meaningful activity for residents. This is important to support people to maintain a good quality of life.

Where do we want to get to?

- To have a clear local model for delivering Enhanced Health in Care Homes, building on the existing integrated pathways.
- For care home residents to receive the same level of care and support as anybody else who is part of the community in Bracknell Forest Place.
- To ensure that care home residents have timely access to all health (physical and mental) and care services required to support better health.
- Earlier proactive identification of care home residents who would benefit from multidisciplinary discussion and care planning.
- To have clearer, integrated and simplified pathways for care home residents to access health and care support when they need it.
- For care homes and those clinical and ancillary staff supporting care homes to have access to information and guidance on services in one place.
- All our care homes to be taking advantage of the benefits of digital solutions such as EMIS proxy for medication management, remote monitoring for early identification of deteriorating residents and using NHS mail and Connected Care for better and secure sharing of information.
- To have a better understanding of where we are making a difference and areas where we need to focus.
- Optimise training of care home staff.

What objectives to we want to deliver going forward?

- For personalised health and care plans to be in place within 7 days of admission/readmission to a care home.
- For all care home residents who need a Structured Medication Review to have access to this when they need it.
- For all residents to have access to rehabilitation and preventative therapy when they need it.
- More care home residents supported at the End of Life in care homes where this is their choice.
- To ensure our collaborative community workforce model is sustainable and resilient to deliver all aspects of Enhanced Healthcare in Care Homes.
- Improve the number of years lived in better health for all care home residents.
- Improved experience of care home residents of community health and care services.
- Reduction in hospital admissions and ambulance conveyances from care homes.
- To work with and support care homes through Adult Social Care Reform.

A Digitally Enabled Health and Care System

The innovations in the technology sector have changed the way we live our lives over the past few years, from voice activated home management systems, to video calling from mobile devices. Whilst these have had an enormous impact on the daily lives of millions, the full capacity of Technology Enabled Care (TEC) to enable more effective delivery of health and social care has still not been fully realised. As we near the switch-off of analogue telephone services in the UK in 2025, telecare response services are working hard to ensure that they have a complete transition to a digital platform well in advance. The move to a digital interface opens more opportunities for devices that do not have to rely on a landline telephone connection.

Whilst basic personal alarm systems are widely in use, technology is not always the first consideration when working in partnership with people to set up their health and care support. For example, video systems such as Amazon View could support people in prompting to take medication and enable them to be observed them doing this, as an alternative to a scheduled care visit. New technology, such as smart watches, can track all of a person's key biometrics and activity levels, and warn of any change in these. The watches also provide emergency alarm buttons, and automatically set off an alarm if somebody falls, with voice-activation to a carer or professional response service. Most of all, new telecare and telehealth devices look far less like special medical devices than their predecessors, and more like familiar everyday devices.

The NHS 2022/23 Priorities and Operational Planning guidance stresses the importance of digitisation across all areas of the NHS at an ICS footprint level. The pandemic accelerated the use of digitisation within healthcare, including the NHS app and the Covid app, and this increasing use continues across the system, including extending access to GP systems to care homes and extending the use of data and analytics.

Where are we?

Bracknell Forest runs Forestcare, which provides a full telecare and response service for the borough, and also has expertise in finding digital solutions for care and support provision. A new assessment centre, to demonstrate new technology and help people to find the right solutions for them, opened in September 2023 and it provides a focus for encouraging the use of technology to help people remain as independent as possible.

To ensure efforts in this area meet our wider objectives and are fully aligned, work has begun on a new Assistive Technology Strategy, the findings of which will underpin and inform our approach from 2024 onwards.

Frimley ICB is delivering the rapid deployment of remote monitoring to support complex and highest risk patients. Utilising a centralised clinical led remote monitoring team to support virtual care, this enables more patients to be managed within their primary residence and releases

capacity in primary and urgent care by monitoring key clinical indicators, symptoms and social indicators to spot intervention early. Currently two groups are managed within Bracknell Forest:

- Care Home Residents: Currently 6 of 13 care homes in Bracknell Forest are 'live' with a further 5 homes working to achieve this status.
- High Risk Patients: Remote monitoring of high-risk patients is available to patients of all Bracknell Forest GP Practices (the first Place within the Frimley ICS to achieve 100% practice sign up). As of the end of December 2023, 993 patients were being monitored in this way.

Where do we want to get to?

- A "technology first" approach, to use less intrusive and more cost-effective ways of providing integrated support across health and care, whilst recognising the continued importance of person-to-person interaction in decreasing social isolation.
- A unifying strategy summarising our approach to using Assistive Technology
- Further utilisation of remote monitoring through:
    - Extending remote monitoring to all care homes in Bracknell Forest.
    - Increasing the remote monitoring of high-risk patients by onboarding more patients.
    - Increasing the remote monitoring offer by building upon successful remote monitoring pilots that have been operationalised in other areas (such as diabetes patients in Slough).

What objectives do we want to deliver going forward?

- Increase use of the Forestcare Assessment Suite.
- A joint strategy between Frimley ICS and Bracknell Forest Council to align the increased use of TEC with the wider ambitions of the ICS system as part of the digitisation plan at ICS level.
- Increased use of remote monitoring of patients.

Reactive Care

Urgent Community Response & Frailty Virtual Ward

Urgent community response teams provide face to face urgent care to people in their homes (including care homes) which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. This includes access to physiotherapy and occupational therapy, medication prescribing and reviews, and help vulnerable people with staying well-fed and hydrated.

Where are we?

The Urgent Community Response (UCR) team is a community-based service that delivers a 2-hour response time to assess people in their usual place of residence. The team consists of Advanced Nurse/ Advanced Clinical Practitioners, Pharmacist, Senior Nurses, Physiotherapists and Multi-Therapy Assistants.

The 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 conveyance. It operates 8am to 8pm 7 days a week, 365 days a year. Primary Care Networks (PCNs) and the Locality Access Point also form an integral part of the Urgent Community Response. While on the UCR pathway, the patient remains under the care of their GP. The UCR team also supports the Frailty Virtual Ward.

The Frailty Virtual Wards help prevent hospital stays by supporting people in their own home or care home if they suddenly become unwell. Our Virtual Ward gives the same level of high-quality patient care, with access to all the same investigations and treatment as a person would receive in hospital, without needing to be admitted. Those admitted on to the Virtual Ward will be under the care of a consultant geriatrician and can expect to be seen by a healthcare professional at home every day. The hub is supported by community geriatricians and nurses responsible for assessing referrals and triggering an appropriate level of response. A crisis is responded to within 2 hours of liaising with Place, where an integrated health and care response is required to alleviate crisis.

The UCR service was launched in April 2022 and is now fully embedded and delivering high quality health care to people in their own homes. The service has excellent working relationships with our Locality Access Point, Intermediate Care Teams, Adult Social Care Teams and Community Responder Service and is an essential part of the local multidisciplinary response to admission avoidance.

Data shows the service is being consistently used by GP practices across the Primary Care Networks with referrals having gone up month on month since the launch of the service.

Response rates are consistently well above the national standard of 75% of people having an urgent response within 2 hours.

Frailty Virtual Ward length of stay remains low at just on average 3 days, supporting better capacity across the services.

The service has worked with relevant partners to maximise ambulance and 111 referrals to UCR, testing out a “call to convey” pilot, giving ambulance crews the option to refer to UCR services rather than convey to hospital, where a hospital admission is not necessary.

The UCR service has also worked closely with our local care homes to raise awareness of the service to reduce the number of people being admitted to hospital from care homes.

The UCR (& FVW) pathway now has excellent working relationships and integration with the Locality Access Point, Intermediate Care Teams, Adult Social Care Teams, Community Responder Service and Primary Care, and is an essential part of the local multidisciplinary response to admission avoidance.

Where do we want to get to?

We aim to continue to improve our community capacity, resilience, and sustainability at Place to ensure a consistent timely level of response, improve patient outcomes and meet national UCR standards, contributing to the overall performance of the ICS. Objectives include:

- Ensure Place rehabilitation / reablement capacity continues to be in place to meet the UCR demand of frailty-related conditions.
- Improve and sustain working arrangements with voluntary and community sector partners.
- Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development.
- Improve health outcomes for the population of Bracknell Forest.
- Contribute to the improvement of an increase in years lived in better health.
- Provide the right care for people in the right place, which is usually their own homes.

What objectives do we want to deliver going forward?

- Reduce ambulance conveyances.
- Reduce hospital admissions.
- Development of a self-referral pathway (as set out in the national standards).
- Ensure a robust falls management framework is in place supporting a UCR response.

Home First (and Discharge to Assess)

Home First *- People are supported to remain at home wherever possible, and where a hospital visit is required, they are enabled to leave hospital with a focus on reablement, independent living, and returning to their normal place of residence.*

Home First is the name given to an approach to helping people who find themselves in hospital return back to their 'home' as soon as possible and helping them get to "the best they can be" before committing to any longer-term plans for supporting them. This means people do not have to wait unnecessarily for assessments in hospital, and when those assessments are done, they better reflect what the person is able to do.

In Bracknell Forest we take a **strengths-based approach** to how we work with people – taking a holistic view of the person and focusing on their strengths (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 to promote their wellbeing and working across all services in an integrated and multidisciplinary way.

Most commonly Home First has been associated with providing short-term care reablement in people's homes or using 'step-down' beds to bridge the gap between hospital, but at Bracknell we have an extensive range of other types of support, including "Discharge to Assess" enabling us to focus on each individual and personalise their support, to get them Home First.

Part of the NHS's "High Impact Change Model" includes "discharge to assess", where a person is discharged home as soon as they are considered well enough to leave hospital by the consultant responsible for their care and receives immediate support pending a full health and care assessment of their support needs. It is an integral part of a Home-First approach and can either be to an individual's own home, or to another temporary location (such as an interim care home or temporary housing) as part of that journey.

Where are we?

The integrated Intermediate Care Service provides support for all people returning home from hospital. Where somebody is not ready to return home, interim residential or nursing home placements or discharge to assess flats can be considered, provided by the local authority, ICB or both e.g. using the Better Care Fund. In some cases, people will need long term nursing home or residential care, but as far as possible people are supported to return home from interim placements.

We now have 7-day working to support people to be discharged and recover in more suitable locations, primarily home, as soon as they no longer need to be in hospital.

The virtual ward for Bracknell Forest Place is provided by Berkshire Healthcare NHS Foundation Trust (BHFT). It enables people to receive medically supervised care at home as an alternative to needing to be admitted to an acute hospital bed. 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. There is a direct link with the Urgent Community Response, as described above.

Implementation of our home care framework has increased the capacity and sustainability of local home care providers. We work in partnership with providers to support innovative and high-quality approaches to supporting hospital discharge and prevention of admissions and this has reduced the delays in care packages commencing.

Where do we want to get to?

- To maintain and enhance the Discharge to Assess and Home First model for people leaving hospital.
- To avoid the need for people to be admitted to hospital if they can be supported with their medical needs in the community.
- Increasing the use of assistive technology, including the assessment suite, will enable greater safety and independence for residents, enabling them to stay in their own home longer.

What objectives do we want to deliver going forward?

- Through improving our strengths-based practice, Home First and Discharge to Assess processes, we will reduce the number of people needing a care home.
- Increasing system oversight will enhance responsiveness and flexibility, with improved information and communication across the system, and will support a reduction in admissions, reduce delays in discharges and enable more appropriate timely care to facilitate a home first approach.
- Using multi-disciplinary approaches we will optimise the impact of reablement and support to ensure that not only are people enabled to go ‘Home-First’ but also have the best possible outcomes to enable them to stay there.
- The new social care ‘front-door’ will leverage the potential of neighbourhood and voluntary sector support to enable people to receive appropriate and timely support.

Intermediate Care

People often lose a degree of functioning following, for example, a stay in hospital. Older people are at the greatest risk of losing independent living skills. In many cases, it is possible to help people regain some of these skills, which will give them greater confidence and allow them to

live more independently. People will need different types of rehabilitation and reablement depending on their needs. It is therefore important to have a range of services on offer that can provide the most appropriate and timely support at a time that is so influential in maintaining and promoting people's independence.

Where are we?

Bracknell Forest Council and Frimley ICB jointly fund a community Intermediate Care Service, which consists of reablement, and an enhanced intermediate care service that includes nurses, physiotherapists, and other allied health professionals. The two parts of the service work together to both provide support for people leaving hospital, and to support people identified as having urgent needs within the community where hospital admission could be avoided by having a period of more intense therapy and reablement support. The reablement service currently runs from 8am-10pm 7 days a week, with the enhanced service running from 8am-8pm Monday to Friday. Any new referrals for support for older people go through this route to ensure that every opportunity is explored to help people to live as independently as possible, as well as setting up longer term support plans once therapeutic goals have been met.

Heathlands Intermediate Care Service continues to provide 20 beds for people who need rehabilitation and are not yet ready to return home following a stay in hospital. This is run by Frimley Health NHS Trust with additional specialist therapies provided by Berkshire Healthcare NHS Foundation Trust.

Where do we want to get to?

- To continue to develop and expand the integrated intermediate care system, including a seamless join-up with the intermediate care service at Heathlands.
- To expand the current integrated Intermediate Care Service to provide full cover on weekends as well as weekdays.
- To use the intermediate care offer for groups that have previously been less well-supported by this approach.

What objectives do we want to deliver going forward?

- The Better Care Fund continues to resource a weekend manager who provides additional management and oversight activity.
- To extend provision of intermediate care to people with learning disabilities and mental health needs.
- For the Intermediate Care Service to work with Heathlands to provide in-reach to support people to return home.

Transformation for Population Groups to Improve Health

In addition to the below, the introduction of Core20PLUS5 (see page 23) has highlighted new priorities for the system, linking to both national priorities and encompassing locally identified priorities.

Dementia

Data taken from the most recent diagnosis rates for Bracknell Forest Primary Care Dementia Data, June 2024 - NHS Digital suggest that there are 836 people aged 65+ with a dementia diagnosis, with an estimated number of 1307 aged 65+ who have dementia, giving a 64% diagnosis rate. Early diagnosis of dementia is important to ensure people have the right support and care in a timely way.

Bracknell Forest have won a national award for one aspect of our dementia support and have a carer document as an example of good practice in a portfolio within Memory Services National Accreditation Programme (MSNAP).

Where are we?

A Community Mental Health Team for Older Adults supports people with complex needs in relation to dementia and is provided in partnership between the council and Berkshire Healthcare NHS Foundation Trust (BHFT) in Bracknell Forest.

A dementia advisory service, joint funded by Bracknell Forest Council and BHFT, provides comprehensive information, advice, and support to people with dementia and their carers. This network of support ensures that everybody with dementia in Bracknell Forest has a named service within the Community Mental Health Team for Older Adults (CMHTOA) whom they can turn to for advice, support, and care.

A memory clinic in Bracknell Forest is run by BHFT and assesses people who might be experiencing memory difficulties. They may diagnose people with dementia and if appropriate commence them on memory enhancing medication. They also offer advice and prior to discharge signpost them to ongoing support.

We introduced new Additional Roles Reimbursement Scheme (ARRS) roles from April 2022 to embed specialist mental health care in primary care.

The Dementia Partnership Board has membership including health, social care and the voluntary sector, as well as patient/carer representation. Positive collaboration between members assists with information sharing, updates and joint working, helping promote a community/holistic approach to service development. This in turn reduces duplication and focuses resources on the needs of both the people with dementia and their families.

Bracknell Forest Dementia Forum is funded by Public Health and hosted by Bracknell Forest CMHTOA. It is a biannual event bringing together services and people with dementia and their family members. The aim is as an awareness raising event as well as an opportunity to gather feedback on what is working well, as well as identifying any key issues. The information and feedback from the forum is then disseminated to various stakeholders for follow up.

The Dementia Voice Group is a co-production group, predominantly guided by carers of people with dementia, and is jointly facilitated by Bracknell CMHTOA and Alzheimer's Society. This group actively engages in various co-production projects as well as sharing their views on various aspects of service delivery.

Bracknell CMHTOA provides outreach work to help raise community awareness of dementia and dementia prevention. This includes attending public events, presenting to other key services including GPs, and distributing information on dementia prevention within the wider community. As of October 2024, Bracknell Forest had over 7500 Dementia Friends (an Alzheimer's Society initiative to help raise awareness of dementia), an increase of 78% over eighteen months.

For people with young onset dementia, there is a specialist service - Young Onset Dementia. This includes a specialist Dementia Adviser, an Admiral Nurse and a local charity offering workshops/outings, education and peer support for both people with young onset dementia and their carers.

In Bracknell Forest there is a good network of community groups. This includes social outings, physical activities, day centres and peer support. People with dementia and their families are kept updated with information on groups through a Bracknell Forest Council webpage on dementia, a monthly e-newsletter, and a hard copy Dementia Directory that is updated annually and distributed within the community. There is also a focus on improving dementia diagnosis in the community and in care homes. This helps people get the right information/advice and support in a timely manner.

Where do we want to get to?

- Bracknell Forest is dementia-friendly - collectively identifying as a system, in co-production with people with dementia and their families, areas of service development and improvement. Utilising a strengths-based approach, build on the areas that are working well in order to ensure all identified improvements are collectively addressed as a collaborative, system approach.
- To work with primary care to identify the support needed to work effectively with people with dementia and their carers.
- We want to continue to build on our successes in delivering good support for people with dementia and their carers. This includes working with people with dementia and their carers to ensure services are effective and also sharing/learning about good practice with our colleagues within the wider ICB.

What objectives do we want to deliver going forward?

- Develop an Integrated Dementia Strategy, co-created with people with dementia and their families and key partners at Place, with a comprehensive implementation plan outlining a collective system approach to addressing identified areas of service development.
- Increase dementia diagnosis rates to reach or exceed the national target.
- To increase the capacity and skill set within primary care to work effectively with people with dementia and their carers.
- Structured systems for sharing/learning about good practice, with local ICS partners.

Mental Health Transformation

The Community Mental Health Transformation Programme forms part of a national programme set out in the NHS Long Term Plan to enable adults with significant mental illness to access care and support in a new, more joined up and effective way, regardless of their diagnosis or level of complexity.

This is about offering flexible and personalised care and support that responds to an individual's mental health needs and preferences close to home; while also increasing support for the wider factors that can impact wellbeing, such as employment, housing and physical health. To do this, health and care providers are working more closely together, based within Primary Care Networks (PCNs), alongside local authorities and voluntary and community organisations.

Where are we?

Working towards more integrated care as part of the Community Mental Health Transformation Programme, the Mental Health Integrated Community Service (MHICS) represents a partnership approach between Berkshire Healthcare NHS Foundation Trust (BHFT) and the Frimley PCNs, supported by key stakeholders in the voluntary sector. The MHICS team are trained and experienced in helping people with their mental health and emotional wellbeing. The MHICS team includes mental health professionals from BHFT, Community Connectors from Buckinghamshire Mind, and administrators from primary care. The MHICS team works with primary care networks in Bracknell Forest to help support people with more significant mental health needs to be supported in the community through primary care, as an alternative to secondary care provision.

Similarly, a number of mental health services offered in the community have collaborated to offer an integrated approach to improve access to support services for people who want to make positive changes to their lives. Under the banner of the Happiness Hub, residents are offered an opportunity to find out first-hand about the array of services available to them, empowering them to make an informed choice about the type of support they need, ensuring partners are working as one team to offer individuals the best possible solution.

Through this partnership a panel is being set up to discuss inappropriate referrals and offer providers a place to share concerns and good practice, this is currently an identified gap between the mental health services across the council, NHS and voluntary sector. We are working closely with the community transformation team in Frimley, this service is designed to complement and enhance the National and Frimley Transformation programme to manage inter-dependences and work in synergy.

We now have coverage of MHICS teams across all our PCNs and are now co-designing the shared vision to deliver the final stage of this programme, the One Team approach. This will redesign and reorganise core community mental health teams aligned to our MHICS teams.

To support people with more significant mental illness who are unable to access mainstream Citizens Advice Bureau services, in 2022/23 we started and continue to offer a specialised service from Citizens Advice East Berkshire (CAEB). The service has supported people with complex requirements to avoid homelessness and manage debt, in line with our commitment to address the social determinants underpinning serious mental illness.

A recovery college in Bracknell Forest, Stepping Stones, supports people in their recovery from a range of mental health difficulties, and offers a comprehensive range of courses to help people regain their confidence, identity, and independent living skills.

Where do we want to get to?

- Through the One Team Approach, build collaborative trust and shift cultures to move towards a new Place-based, multidisciplinary offer across health and social care aligned with Primary Care Networks.
- A focus on inequalities will look to understand and better meet the needs of our seldom heard communities and further build innovative new workforces such as our Lived Experience Practitioners.
- A more integrated way of working between organisations which enables residents of Bracknell to have timely access to the service that best meets their need.

What objectives do we want to deliver going forward?

- Create a sustainable model of specialist Mental Health workers in primary care by adding of two new Additional Roles Reimbursement Scheme (ARRS) roles, employed by BHFT, and working with GPs by April 2024.

- Use a population health management approach to improve services within Bracknell Forest and make them more accessible to residents.
- Increase Bracknell Forest residents' access to out of hour crisis service, the Safe-Haven.
- Avoid re-admissions by keeping people well and engaged in a community drop-in within a social setting, offering an opportunity to build self-confidence and the ability to interact, creating communities and support mechanisms where individuals are less reliant on secondary care services.

Learning Disabilities and Autism

The national policy direction is to reduce provision of care and support in inpatient settings, address premature mortality and health inequality and ensure that action is taken to address serious quality/safety concerns. The priorities of Frimley Health and Care ICS reflect these themes along with work that is specifically relevant to the Bracknell Forest Place Partnership.

2023-2025 is 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 is being developed through joint engagement with health partners including CHC funded circumstances.

This work also includes 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 framework commenced on 1st July 2024 for an initial period of 3 years.

Bracknell Forest has an ageing population of people with learning disabilities and extensive consideration will continue to ensure adequate housing is provided which can accommodate ageing needs.

Where are we?

Berkshire Healthcare NHS Foundation Trust (BHFT) is a partner in the Berkshire-wide Transforming Care Programme, working with commissioners, local authority and third sector partners to improve service quality and outcomes, informed by the views of people using our services and carers. In support of this programme, inpatient services have been rationalised, enabling assessment and treatment beds to be focused at the Prospect Park Hospital site. This service has gained national accreditation, providing assurance to people using the service and their families about the quality of services provided. BHFT is also establishing an intensive community support team working with people who may require admission into hospital, to avert the need for admission where appropriate, and when admission is the correct approach, to minimise the time spent in hospital.

There is an integrated learning disabilities and autism service in Bracknell Forest Place, which is a partnership between BHFT and Bracknell Forest Council. This provides support to adults in Bracknell Forest with learning disabilities and autism, as well as working with children's services to support younger people with a learning disability or autism in preparing for adulthood. Individuals with a single diagnosis of autism have their care and support provided for by the Council.

There is a significant amount of supported living accommodation, however, the majority is within a standard housing format and in some instances, accessibility is limited for people as they age. The Bridgewell project, which is in development, will accommodate people with a range of needs, including those with learning disabilities, enabling people to remain safe and independent in their home. As of October 2024, the build has now started and we are working with the identified individuals to ensure a smooth transition into Bridgewell takes place in Summer 2025. Due to the development of Bridgewell this will free up additional supported living provision within the Bracknell area.

Learning Disabilities is one of the PLUS Groups identified as a priority by Frimley ICB and Bracknell Forest Place as part of the Systems Core20PLUS5 work. Within Bracknell Forest, a pilot project has been initiated with one PCN to increase uptake of cancer screening offers among the learning disabilities population through engagement and support.

Where do we want to get to?

- Increase health checks for people with learning disabilities – a new post has been introduced in Bracknell Forest to support the connection between primary care and the learning disabilities and autism service.
- Continuation of the programme to learn from lives and deaths of people with a learning disability and autistic people (LeDeR).
- Fully integrated support for people with a learning disability or autism. This includes a consideration of further integration of the existing team so that they can take a fully joined-up approach to enabling people with complex needs to live as independently as possible. It also includes making sure that young people and their families are partners in planning at the right time for the move to adulthood and ensuring that the right level of support is in place to enable them to live as independently as possible, as well as realising their goals in life, including further education.
- Recruitment of a Learning Disability & Autism Support Manager to address local need within the primary care setting and reduce health inequalities for individuals with a learning disability and autism. Their role is to plan, deliver and innovate programmes of work relating to learning disabilities and autism alongside Primary Care Networks and the integrated Community Team for People with a Learning Disability. As of October 2024, the current project is focusing on creating a reasonable adjustments flag on the GP database to ensure people with a learning disability and autism are being supported with any required reasonable adjustments to ensure access and appointments with the GP can meet their required needs.

- In order to understand our population and empirically inform service development, address gaps in capacity and inform our strategic approach a fully comprehensive all-age Disability Needs Assessment needs to be developed.

What objectives do we want to deliver going forward?

- The development of an Autism Strategy by March 2025.
- Delivery of the NHS Long Term Plan ambition that by April 2024, at least 75% of people aged 14 or over with a learning disability will have had an annual health check.
- Review of the integrated learning disabilities and autism service in Bracknell Forest, with the aim of further integrating the health and social care functions of the service, with appropriate governance (such as a pooled provider arrangement under S75 flexibilities of the 2006 NHS Act) by April 2025. This will increase joined-up care and support for people with learning disabilities.
- Review our approach to supported living for people with a learning disability and develop accommodation and support that helps people to be independent and achieve positive outcomes.
- Develop a clear strategy for employment and day activities for adults with a learning disability and autism to provide supported opportunities for people to achieve their potential.
- Develop an All-Age Disability Needs Assessment for the population of Bracknell Forest by March 2025.

7. Enablers

There are a number of underpinning areas that are integral to enabling the successful delivery of the ambitions of the Bracknell Forest Place Health and Care Plan for Adults 2023-2025.

Resources

The Integration White Paper 2022 encourages greater integration and alignment of resources, both at Integrated Care System and at Place level. Bracknell Forest already has jointly commissioned services and integrated working across community services, as well as jointly developed strategies and approaches to funding (like the Better Care Fund) via the Place Committee. For Bracknell Forest this includes building on the success of the Better Care Fund (BCF) and Additional Discharge Fund and ensuring that the BCF 2023-2025 plan supports the Health and Care Strategy. The BCF was reviewed in early 2023 to evaluate effectiveness in delivering intended outcomes.

Workforce

There is a national and local shortage of experienced therapists, social workers, and the healthcare workforce, including nurses and medical practitioners. This needs to be addressed through joint workforce planning at a Place level to ensure that the right capacity is available to drive further integration, particularly for experienced professionals who can make decisions with a degree of autonomy to support the expansion of urgent and intermediate care responses.

Staff wellbeing across the NHS and social care must be integral to workforce planning. Staff in all parts of the health and care system are working harder than ever through the challenges of increased demand. Looking after the wellbeing of our existing staff, including their development and retention, is a key priority for Bracknell Forest Place.

The care workforce is also challenged although the domiciliary care framework for Bracknell Forest is working well and currently there is capacity in the system. There is awareness that this can change quickly, especially if that capacity is not leveraged, and there continues to be a challenge over care home capacity in the borough. Any shortage of care resources is a risk to delivering effective and timely care, and to supporting the NHS in ensuring the timely discharge of patients from hospital.

There are no ready solutions for this, but developing a career pathway for care workers, particularly looking towards a more integrated care workforce, will support recruitment and retention of staff, and give care work the recognition and status that it deserves.

Joint workforce planning between Bracknell Forest Council and Frimley Integrated Care System at Place level through a joint workforce board or planning group, in partnership with providers of health and care, will be critical to making the Bracknell Forest Place-level partnership the place of choice for people to work as part of a growing integrated workforce. Emphasising new ways of working, such as strength-based practice, and multi-disciplinary working, will help in attracting staff, as they encourage greater use of professional skill sets than more traditional health and care management approaches.

Integrated Care Records and Insights

The digitisation of care records, and the ability to share records across the integrated health and care system, is not only key to providing timelier and more joined up care for people but is also a national requirement, underpinning the legal duty to share care records.

Bracknell Forest is part of the Thames Valley shared care record – Connected Care. 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.

Partners across the Frimley system including social care teams have collaborated with the acute trust to design a shared discharge planning template in the acute electronic patient record (Epic) to record key discharge planning information and communication. This is improving the flow of information within the transfers of care hub and the ward to facilitate more timely discharges and reduce the length of stays. The outputs of this data are feeding into dashboards to monitor daily capacity and areas of pressure as well as providing trend information to establish areas for improvement strategically and operationally.

Care Market Sustainability

A sustainable social care market is essential to an effective health, care, and support system in Bracknell Forest. As with all other local authorities with social care commissioning responsibility, there is uncertainty as to whether the market will be able to continue to respond to increases in the demand for support and the rising complexity of the needs of people who require care. Although Bracknell Forest has been notably successful with their home care framework, there are challenges round the availability of care homes.

Higher than expected inflation is exacerbating pressures on the provider market and on social care. The mandatory cost of care exercise in October 2022 and market sustainability plan produced by Bracknell Forest Council in March 2023 demonstrated that local authorities will need

to pay more for the cost of care, and that local authorities will need to demonstrate how they will move towards paying the fair cost of care in their area.

Some additional government monies continue to be provided to support this. However, it's unclear whether this will be sufficient to sustain a market that offers choice and quality to those using services and is attractive to new entrants.

Innovative solutions, use of assistive technology, a robust approach to using the Better Care Fund, and developing the existing estate in Bracknell Forest will continue to help mitigate the risks in this area. Bracknell Forest has shown considerable excellence at partnership and collaborative approaches, working with the market to best find solutions that meet both providers' and commissioners' needs.

Estates

Joint planning on estates is essential to ensure that health, care and support can be provided from good quality bases closer to home. This includes bed-based intermediate care services, and residential and nursing home provision that can be provided in borough, so that people do not have to be far from their home and support network if they need care home support in the short term or as a new permanent home. There is a strong foundation of good estates working between the NHS and Bracknell Forest Council. This includes developments such as:

- **Heathlands** – (opened in March 2022). This consists of 46 beds for nursing care for people with dementia, plus 20 beds for intermediate care for step-down and step-up services to provide in-borough support for people leaving hospital with complex intermediate care needs, and to help prevent hospital admission.
- **Bridgewell** – The development of new supported living accommodation for up to 20 adults with care and support needs, to help ensure more people can stay living within the community in Bracknell Forest. This is due to open in May-July 2025.
- **The development of multi-disciplinary health and care hubs**, which will provide a range of health and care services, and a flexible base for staff to work from.
- **Binfield Health and Community Centre** – (opened in August 2024). This is the redevelopment of a former golf club to provide a multi-use health and care hub in Bracknell Forest.
- **Bracknell Forest Integrated Care Hub in the town centre** – a new multi-use health and care hub in the centre of Bracknell.

Further work will be undertaken on estates planning over the next year, with a particular emphasis on ensuring that primary care services can be provided from good quality and accessible sites. Primary Care have recently undertaken an extensive estates review to identify priorities for any investment that might become available. Estate and premises continue to present a significant risk to general practice resilience and the delivery of primary care transformation focused on the development of primary care networks. Even taking into account the rapid shift to

remote and digital services the primary care estate will require significant investment over the coming years to address the existing deficits and rapidly expanding PCN workforce along with significant housing growth across the ICS footprint.

Key Operational Enablers

Discharge and Flow

The last winter period saw an accumulation of demand in acutes through a combination of an early onset of flu and ongoing cases of covid. In addition, patients were presenting with complex needs that had not been addressed in a preventative way throughout the pandemic. This led the acutes to escalate above the ongoing black opal 4 level experienced over a period of a few months to declare a critical incident in early December. In response to this the Frimley ICS discharge and flow steering group renewed its focus on key priorities. Existing resources within Frimley ICS are supporting to deliver the scope of workstreams but due to competing demands this is impacting on delivery.

The following schemes have been identified as key to delivering a robust integrated approach across Bracknell and the broader Frimley system to improve hospital discharge and flow. An intensive period of accelerated activity is required to undertake this work and will require an injection of short- to medium-term resource to create the capacity required:

1. Consider the national specification for transfers of care from hospital and what would work for Bracknell and the Frimley system and interfaces.
2. Improve infrastructure aspects to improve discharge and flow to align with Frimley system and new operating model in Bracknell.
3. Managing choice and complexity on discharge - system discharge challenges, complex decision making, brokering of care provision and funding arrangements.
4. Development of integrated dashboards to monitor discharge and flow across Bracknell and wider Frimley ICS.

In July 2022 Section 91 of the Health and Care Act came into force, revoking the procedural requirements in Schedule 3 of the Care Act which required local authorities to carry out long-term health and care needs assessments before a patient is discharged from hospital. The new duty states that this assessment should be carried out as soon as possible after trusts begin planning the patient's discharge.

Systems should work together across health and social care to jointly plan, commission, and deliver discharge services that are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate.

Where are we?

Work is required in Bracknell Forest and across the wider Frimley ICS to:

- Consider the national specification for transfers of care from hospital and what would work for the Frimley system and interfaces.
- Improve infrastructure aspects to improve discharge and flow to align with the Frimley system and operating model in Bracknell.

- Managing choice and complexity on discharge - system discharge challenges, complex decision making, brokering of care provision and funding arrangements.

Work has already begun under 6 workstreams to progress the system approach, for example, integrated dashboards have now been developed to monitor discharge and flow, and support operational delivery and evidence base for system improvements and commissioning strategies.

D&F Steering Group Work Stream	WS 1: Therapy	WS 2: Data	WS 3: Places and Plans	WS 4: The 'Commissioners Space'	WS5: IRIS (ToC Hub)	(WS6: FHFT Everyday matters and LOS)
High Level Thinking	Working with AHP's within the system and the AHP T&F group to: *Support work local thinking around Place and e.g. MSK ***Review MDT discharge planning with Home First thinking** **Embedding describing; not prescribing nor recommending** *Unlocking therapy blocks within the system making the best use of resources now and in the future	Accurate data is needed to support demand and capacity planning and monitor performance: *CtA/CtR (EPIC) ***Performance dashboards** *MRD for Senior managers and churn ***Winter - discharge fund** *Current and future accurate D&C plans	Local System pressures and Planning meetings have given opportunity for focus. We need to: ***Pull the 'winter plans together', identify costs, agree metrics and impacts** *Consider the 'trends' and think around a system alongside localised approach where appropriate * Consider other areas of work e.g. Trusted Assessment, UCR, Virtual ward, Intensive / additional support to care homes) how they cross and the potential / actual impacts of these ***Ensure our community providers (beds and services) are linked into plans and supported to deliver their own**	Trends (challenges to discharge)include but are not limited to: ***Those with behavioural issues (delirium, confusion etc)** ***Bariatric individuals** ***Younger Adults (with or without MH / LD related issues) requiring placement** * Care availability / provision / workforce for facilitating seven day discharge Is there a system solution, what is the art of the possible, can commissioners think together and share ideas, consider joint funding / commissioning - we won't know until we ask?	IRIS is in place on both sites We need to: * **Review what we have in place and the SOP (prior to COVID)** ***Build on what we have considering the most effective use of space, time, huddles and the opportunity for real collaboration and timely communication** *Consider the national specification and what would work for the Frimley system and interfaces	This programme of work provides a single focus that brings all our actions to deliver our strategic ambitions together We need to: * **Understand this internal programme within FHFT** *Work with places and at system level to dovetail, increasing flow and reducing delays
Links to: *100 day initiative *High impact change *Frimley UEC Winter planning *Frimley UEC Strategic priority/ intervention	100 day: 1,2,5,6,7,8,10 HIC: 1,2,3,4,5,6,7 Frimley UEC winter: 5,6 Frimley UEC strategic priority: To be added	100 day: 1,5,6,7, 8,9,10 HIC: 1,2,4,5 Frimley UEC winter: 5,6 Frimley UEC strategic priority: To be added	100 day: 1,2,5,6,7,8,9,10 HIC: 1,2,3,4,5,6,8 Frimley UEC winter: 5,6 Frimley UEC strategic priority: To be added	100 day: 1,5,6,7,8,9,10 HIC: 1,2,4,5,6,8,9 Frimley UEC winter: 5,6 Frimley UEC strategic priority: To be added	100 day: 1,2,3,4,5,6,7 HIC: 1,3,4,5,6,7,8,9 Frimley UEC winter: 5,6 Frimley UEC strategic priority: To be added	100 day: 1,2,3,4,5,6,7 HIC: 1,2,3,4,5,6,7 Frimley UEC winter: 5,6 Frimley UEC strategic priority: To be added

Where do we want to get to?

- Enable a comprehensive understanding of transfer of care to address system challenges, improve flow and increase safe and timely discharges with joined up data.
- Develop a transfer of care hub which aligns with the national specification and NHS Long Term Plan.
- Streamline complex care discharge pathways including funding processes.
- Introduce standard operating procedures documentation for transfer of care hub and complex care pathways.

What objectives will we deliver going forward?

- Improved response, safety and management of patient discharge and flow around the system, informed by a real-time, integrated dashboard.
- Improved safety and quality of care from better coordination through a transfer of care hub.
- Faster, safer discharges of patients with complex needs.

New Social Care Operating Model

The pandemic drove change and increased integration across our community teams (both health and social care) and following an extensive review, we have introduced 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.

Where are we?

After extensive co-production with operational teams and development of new approaches, staff have been allocated into the new roles, and the line-of-business IT system (LAS) has been reconfigured to enable better reporting and improve consistency of practice. Additional resources have been allocated to significantly improve the discharge and patient flow from hospital, establish a new front door into Adult Social Care from the community and better coordinate the Early Intervention and Prevention service to improve people’s independence in the community. New ‘to be’ operational processes have been developed and this has enabled improved system processes and workflow to reduce duplication of effort and off-system ‘manual’ recording.

Where do we want to get to?

- For people to have a common point of access and consistent, quality experience throughout their interaction with services.
- For staff to have clarity about their role and for 'handoffs' to be seamless and simple, with no information lost, both for staff and for the people using services.
- Improved discharge and patient flow from hospital, including continued commitment to the home first approach.

What objectives will we deliver going forward?

- Improved reporting with a view to using management information more effectively, to understand capacity and demand, and inform resource allocation and future developments.
- This approach should enable improvements in patient flow in and out of acute hospitals, helping prevent avoidable admissions as well as improving timely discharge, on a home first basis.
- Additional technology improvements will also be implemented to provide self-service options through portals for online referrals into the services, including financial assessments and charging. A later phase will broaden the capability of self-service.

Technology First

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 (BCF) has supported the additional purchase of technology for demonstration purposes to social care colleagues and members of the community. As part of this work a new Assistive Technology Strategy will be developed.

Where are we?

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 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 the constant presence of a carer, and someone having independence, and early

case studies have validated this assumption and proven the approach can work and help a person maintain independence – providing a future reduction in the need for care home admission.

Where do we want to get to?

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.

The new Assistive Technology Strategy, on which work has already begun, will outline and clarify an approach to how we use technology as part of the wider system, over the next few years.

What objectives will we deliver going forward?

- Strengthen the prioritisation of a technology first approach in developing care and support plans.
- Encourage and increase use of the Assessment Suite as part of working with people to find the most appropriate solutions for maintaining their independence and/or ability to stay at home.
- Produce and finalise the Assistive Technology Strategy for Bracknell Forest.

Co-Production

It is vital that residents are equal partners in the co-production and co-creation of the health and care landscape in Bracknell Forest. There are areas of good practice already in evidence – for example, involving people with dementia and their carers in the development of nursing home care in the new Heathlands development. The Ark Trust has been commissioned to provide Voice and Inclusions sessions, which will have a number of strands on areas such as dementia and learning disabilities. Co-production was a key element of the All-Age Integrated Carers Strategy.

It is recognised that both the Council and Frimley ICS are on a journey in developing the co-creation of joined-up services so that people have greater ownership of the solutions to health and care challenges.

The council has been developing the consistency and expectations for using co-production through developing a framework and practitioner toolkit. Independent expertise from the Ideas Alliance was commissioned to develop these documents, which included workshops with residents, councillors, staff and partners. Whilst the framework commits the Council's approach it can form part of a blueprint for testing more

widely in the health and care system. A series of training sessions have also been held including with representation from NHS Frimley and the voluntary, community and faith sector (VCFS).

Continued work is required to establish how co-production activity can be delivered consistently and jointly across the system.

Partners across Health and Care want to build a different relationship with communities, residents and staff to design and deliver solutions together and work together to realise wider public health opportunities.

Our joint ambition is to work with people to enable them to be as healthy, independent and resilient as possible whilst delivering cost effective and sustainable services. This means that our focus is on expanding the range and scale of joint working to increase and improve the effectiveness of our co-production.

Where are we?

Through the Thriving Communities programme, we will be aiming to transform the relationship between organisations across the system and communities, with our approach 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 council has been developing the consistency and expectations for using co-production, through developing a framework and practitioner toolkit. Independent expertise from the Ideas Alliance was commissioned to develop these documents, this included workshops with residents, councillors, staff and partners. Whilst the framework commits the council's approach it can form part of a blueprint for testing more widely in the health and care system. A series of training sessions have also been held including with representation from NHS Frimley and the VCFS.

Where do we want to get to?

We will see an increased commitment to, skills in, and demonstrable evidence of, community engagement, co-design, and co-production across the system/organisations, aligned with personalised care development and social care transformation work that addresses inequalities across health and social care. Sharing learning from, and evaluating our co-production activities with residents, will ensure that we are increasing the effectiveness of co-production.

There will be a new culture across the system that is increasingly prevention- and person-centred, and flexible enough to enable innovative approaches to engaging and supporting people. In turn, this will enable residents to be more active and collaborative participants in managing their own health and wellbeing.

What objectives will we deliver going forward?

- To increase skills in co-production through training and development activities across the system with partners, communities and residents.
- To develop our approach to evaluating and sharing experience from co-production activities so that we are always learning.
- To work with partners including the VCFS to develop a borough wide framework and approach to co-production and resources to support it.
- Establish how co-production activity can be delivered consistently and jointly across the system.

Voluntary, Community & Faith Sector (VCFS)

The voluntary, community and faith sector proved the vital role it plays in an integrated health, care, and support system during the Covid pandemic. Involve is the VCFS network enabler for Bracknell Forest and supports organisations in activities such as bidding for contracts. Organisations such as Age UK have demonstrated nationally the role that they can play in areas such as increasing activity and reducing isolation for older people, as well as supporting discharge home from hospital. It is key that the VCFS sector is involved in the developing Integrated Care Partnership at ICS level, as well as being integral to the development of integrated working and provision of support in the Bracknell Forest Place-level partnership.

The VCFS plays a significant role in building the community connections that support and sustain people, families and communities to be independent and self-reliant, and enable increase in individuals' agency, community action, activities, and asset development. Working with the VCFS will be vital in both developing and successfully delivering the Thriving Communities work. This will deliver improved health and wellbeing outcomes and reductions in health inequalities, through building capacity to access quality care and support in the community.

Where are we?

Bracknell Forest has a number of good quality but small charitable and community groups who are able to offer regular and diverse services to Bracknell Forest residents and support in addressing health inequalities. Social return on investment suggests that for every £1 local authorities invest in community development, £15 of value is created (Nef, 2010).

The greatest challenges facing the sector, highlighted in Involve Community Services' recent "State of the Sector" report, are increasing financial pressures, sustainability of existing assets and increasing resource costs to maintain and develop support services into the future.

Funding routes are also narrowing and the levels of success in securing funding are lower than during the pandemic. The sector has been supported locally by dedicated VCFS grant funding schemes such the Covid Recovery Grant and Financial Hardship Grant.

Recent collaboration with the VCFS related to health and wellbeing has been to deliver the Bracknell Forest Innovation Fund. Involve participated in the decision-making panel for awarding the grant funding, alongside the council and the ICB. A number of projects were put forward from VCFS groups to support residents who were shielding during the pandemic, where they were continuing to face barriers to health and wellbeing. This is enabling the delivery of community-led solutions.

Additional financial support has been provided to Involve, by the Council, to maintain a grant writing service that submitted grant applications of £900k in the financial year 2022-23. Bracknell Forest has a local sector that remains committed to doing its best for residents. A key strength of the local sector was demonstrated during the pandemic, which saw a range of VCFS groups able to respond quickly and on an ongoing basis to needs of local communities and the more vulnerable residents through increased volunteering and neighbourly support. Post-pandemic there remains a healthy local interest around volunteering, however with interest slowing to pre-pandemic levels, the surge in volunteering has returned to the standard position. Bracknell Forest, however, benefits from a diverse pool of volunteers and available volunteering opportunities across the borough to meet the interest and expectations for anyone wishing to volunteer.

Where do we want to get to?

- Develop further the partnership working seen during the pandemic with increased co-design and co-production.
- Work with the sector and stakeholders to ensure the ongoing sustainability of the existing assets.
- Highlight and access sources of funding to keep the sector sustainable and support those groups who may be struggling financially.
- To nurture new ambitions, assets and a local volunteer pool that complement statutory support services.

What objectives will we deliver going forward?

- Create the right conditions to ensure that the sector remains able to thrive going forward.
- Working with Involve and VCFS, develop a diverse pool of local volunteers.
- Support volunteers and groups to develop their volunteering skills through sector training courses.
- Ensure the VCFS is a key delivery partner in the Thriving Communities programme.

8. APPENDIX 1 – The Legislative and Policy Context

A. **The Health and Care Act 2022** – As previously outlined, this established Integrated Care Systems and Integrated Care Boards on a statutory footing to co-ordinate health care. It also introduced a new assurance regime for adult social care provision by local authorities by the Care Quality Commission, as well as changing the legislation around hospital discharge, including when assessments occur.

B. **The Care Act 2014 (and subsequent amendments)** – The Care Act 2014 sets out local authorities' duties when assessing people's care and support needs. This resource, updated December 2022 (above), supports care practitioners and answers their questions about assessment and determination of eligibility under the Care Act.

C. **The Integration White Paper 2022** – this emphasises the need for co-ordination of care between health and social care, as well as other local authority functions such as housing. There is an emphasis on further integration of services to provide better joined-up care for people, as well as further pooling or aligning of resources between local authorities and the NHS. There is a requirement for a single named individual to have responsibility for the integration of the health, care and support offer at Place level (Place in this case meaning Bracknell Forest).

D. **NHS England 2022/23 Priorities and Operational Planning guidance** – this is to support the ongoing delivery of the NHS Long Term Plan. A number of the priorities relate to integration.

E. **Putting People at the Heart of Care** – a White Paper that presents a 10-year vision for adult social care. Some additional monies were announced in the paper. There is an emphasis on the greater involvement of housing and technology as part of care, and the White Paper re-emphasises the importance of personalised solutions to support that fully involve the person and their family/support network.

F. **The Health and Social Care Levy** – announced in September 2021. This effectively raises more money for the NHS and social care via increased taxation. An estimated £12bn will be raised per year. The government confirmed that £5.4bn will go to social care over the first three years of the levy (from April 2022). There is concern that the NHS is being prioritised at the expense of a sufficient settlement for social care, and that £5.4 billion will not be sufficient to ensure a sustainable adult social care system in many places.

9. APPENDIX 2 – Delivery Action Plan

PREVENTION

THRIVING COMMUNITIES				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Healthy, independent, and resilient communities/reduction in health inequalities	Engage with partners and the voluntary, community and faith sector organisations based in the pilot area to further co-design the approach.	Head of Community Engagement and Equalities, Bracknell Forest Council	Ongoing	To be defined when Evaluation Framework is developed
	Launch the pilot programme activity focusing on the Town Centre part of the Town Centre and The Parks ward.	Assistant Director Chief Executive's Office, Bracknell Forest Council	From January 2024 for 3 years	To be defined when Evaluation Framework is developed

STRENGTHS-BASED PRACTICE				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Strengths-based approaches lead to the prevention, delay, and	Scope out phase 2 of the Change Programme.	Principal Social Worker	In progress	Not reportable at present

reduction of needs using assistive technology, reablement and rehabilitation.	Continue to support people through the assessment and provision of assistive technology.	Principal Social Worker	Ongoing (BAU)	Not reportable at present
	Ensure access to meaningful metrics that are operationalised to deliver service improvement.	Principal Social Worker	December 2024	Not reportable at present
	Ensure feedback from people with lived experience is available to deliver service improvement.	Principal Social Worker	December 2024	Not reportable at present
	Ensure CQC recommendations are embedded within strength-based practice.	Principal Social Worker	December 2024	Not reportable at present

UNPAID CARERS				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Bracknell Forest is a community that supports unpaid carers of all ages in their caring role in a meaningful way	Develop and mobilise the action plan which will drive forward the ambitions of the Carers Strategy.	Senior Commissioner, Integration	October 24	Percentage complete
	To ensure delivery of the action plan which supports the All-Age Integrated Carers Strategy.	Senior Commissioner, Integration	2024-2029	Not applicable

PROACTIVE APPROACHES TO CARE

PRIMARY CARE TRANSFORMATION				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Improved access to general practice	All practices in Bracknell Forest to adopt the Modern General Practice Access Model (MGPAM)	Head of Primary Care – East Berkshire (with input from BF PCN Clinical Directors x3)	March 2025	TBD – suggested percentage of practices
Reduce health inequalities	PCNs to engage with and deliver against projects developed through the CORE20PLUS5 model to reduce health inequalities	Head of Primary Care – East Berkshire (with input from BF PCN Clinical Directors x3)	March 2025	TBD – suggested number of projects completed
Integrate services with local partners in line with the Fuller Stocktake priorities	Each PCN to engage with Place partners to deliver an integration project that delivers on the objectives of the Fuller Report	Head of Primary Care – East Berkshire (with input from BF PCN Clinical Directors x3) Senior Developmental Manager: Primary and Community Care	March 2025	TBD
Provide fit for purpose estate that delivers the population health management/ integration model of care for general practice.	PCNs will develop and deliver a PCN Estates Toolkit	Head of Primary Care – East Berkshire	March 2025	TBD

PROACTIVE AND PERSONALISED CARE				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
People with multiple LTCs and complex health and care needs will benefit from an integrated, multi-disciplinary approach to proactive care planning	Implement a model of proactive care across the Primary Care Networks based on a population health management approach, informed by: • Best practice locally and nationally • Recommendations by Healthwatch Bracknell Forest and Age UK Berkshire.	Bracknell Forest PCNs x3	March 2025	Regular update of search for eligible patients
Develop a way of capturing and recording conversations, decisions and agreed outcomes or goals in a way that makes sense to the person	Implement a personalised care and support planning tool that supports recording what matters to people which can be shared with the person and their network.	Bracknell Forest PCNs x3	March 2025	Number of proactive care consultations taking place with use of the tool
Increase the overall number of people accessing proactive care pathways	Develop local information for patients about the benefits of proactive care.	Bracknell Forest PCNs x3	March 2025	Number of proactive care consultations taking place

ENHANCED HEALTH IN CARE HOMES				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Tackling health and care inequalities and have a clear local model for delivering enhanced health in care homes	Care home residents to have timely access to health and care services by implementing a local EHCH model. Building on existing MDT working, weekly home rounds and integrated pathways.	Quality – Care Home Manager (supported by Bracknell Forest Integration Lead)	March 2025	TBD
Reduction in hospital admissions and ambulance conveyances from care homes	Identify care homes that have greater input from emergency services and have higher emergency admission rates and work in partnership with care homes, MDT and other stakeholders to support those care homes to reduce admissions and conveyances.	Quality – Care Home Manager (supported by Bracknell Forest Integration Lead)	March 2025	Data from ICB care home dashboard around care home use of emergency services and emerging themes
Ensure our collaborative community workforce model is sustainable and resilient to deliver all aspects of Enhanced Healthcare in Care Homes	Collaborative approach in place across stakeholders to identify local training need and deliver appropriate training and development. Care practitioners to be trained in competencies such as wound management, nutrition, and falls and all the care elements and sub elements of the EHCH framework.	Quality – Care Home Manager (supported by Bracknell Forest Integration Lead)	March 2025	TBD – percentage of care homes receiving training, percentage of care practitioners accessing training

A DIGITALLY ENABLED HEALTH AND CARE SYSTEM				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Assessment Suite fully operational	Promote and increase utilisation by staff and residents. Increase Assistive Technology use in support planning, including linking into the SATA role at Forestcare.	Technology Enabled Care Manager	Ongoing	Number of clients and staff using the service
Assistive Technology Strategy	To produce an Assistive Technology Strategy with a focus on supporting people to remain at home.	Commissioning, ICT and Forestcare	Working group completed position statement	Not applicable
Increase the use of Remote Monitoring to increase capacity, promote self-management and improve outcomes	Increase the number of care homes where remote monitoring is deployed.	ICS Connected Care Team	Ongoing	Number of care homes where remote monitoring is deployed
Increase the use of Remote Monitoring to increase capacity, promote self-management and improve outcomes	Increase the number of eligible patients who are onboarded.	ICS Connected Care Team	Ongoing	Number of eligible patients who are onboarded

REACTIVE CARE

URGENT COMMUNITY RESPONSE AND FRAILTY VIRTUAL WARD				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Ensure a robust falls management framework is in place, supporting a UCR response	Scope out and implement falls management framework (using Association of Ambulance Chief Executive's Falls Response Framework as a minimum standard).	Bracknell Forest Integration Lead	Ongoing	Percentage of framework implemented
Frailty Virtual Wards to increase capacity	Increase capacity for Frailty Virtual Ward "beds" supported by appropriate workforce plans.	BHFT / Bracknell Forest Integration Lead	Mar 2025	Number of available beds
Improve & sustain working arrangements with all stakeholders	Monthly Bracknell Forest UCR working groups and partner forums, to ensure collaborative working.	Bracknell Forest Integration Lead	Ongoing	Number of referrals (accepted and inappropriate), reasons for referrals

HOME FIRST AND INTERMEDIATE CARE				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
People are supported to remain at home where possible and return to their home environment following admission into hospital.	Increase number of people supported via Home first D2A.	Head of Adult Community Team, Strategic Commissioning Manager, Integration	Ongoing	Percentage of people going home following hospital stay, number of care home placements prevented/pathways changed, number of short-term bed-based placements
	Evaluate effectiveness of Home first D2A.	Head of Adult Community Team, Strategic Commissioning Manager, Integration	March 2025	

TRANSFORMATION FOR POPULATION GROUPS TO IMPROVE HEALTH

DEMENTIA				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Bracknell Forest residents have a diagnosis rate equal to or exceeding the national target of 67%	Hold Dementia Partnership Board to provide collaboration between members to assist with information sharing, updates and joint working helping promote a community/holistic approach to service development.	Dementia lead, ICS	Ongoing	Not applicable

	Outreach work to raise community awareness of dementia and dementia prevention. Work with primary care to support people with dementia and their carers in a meaningful way.	Community Mental Health Team for Older People Manager	Ongoing	Dementia diagnosis rates

MENTAL HEALTH TRANSFORMATION				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Improved recovery rates for people experiencing mental ill-health	Bracknell Forest Community Network will work with residents on their recovery to promote long term independence, admission avoidance and help with supported discharge.	Bracknell Forest Community Network Manager	2023-2025	Percentage of people who were not accessing primary or secondary mental health services, three and six months after the end of their 1 to 1 support from the Bracknell Forest Community Network
Address health inequalities and improve community and primary care mental health	To create a mental health local access panel that will co-ordinate referrals across a variety of community organisations. This will help people reach the right service in the shortest time possible.	Bracknell Forest Community Network Manager	2023-2025	TBD once panel is set up
Residents of Bracknell Forest are aware of mental health services	Once the Safe-Haven operates over 7 days will be allocated to maintain and/or increase referrals from Bracknell by establishing local links in the community and local organisations.	Head of Mental Health, ICB	2023-2025	TBD

LEARNING DISABILITIES AND AUTISM				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Autistic people are involved in the development of services and support provided by Bracknell Forest	Development and co-production of all-age integrated autism strategy.	AD Commissioning	March 25	TBD
Reduction in Health Inequalities	Learning Disability & Autism Support Manager to plan, deliver and innovate programmes of work for learning disabilities and autism alongside Primary Care Networks and the Integrated Community Team for People with a Learning Disability.	Head of Service, Learning Disabilities	2023-2025	TBD
	People with learning disabilities are supported to have health checks in primary care. This includes education sessions for people (Health Sub-group) and working in conjunction with staff at PCNs should issues arise.	ICB	2023-2025	Percentage of people with learning disabilities having health checks
	Develop an All-Age Disability Needs Assessment.	Public Health	2025	TBD

Actions completed 2023-2024:

PREVENTION

PRIORITY OUTCOME	ACTION	WHO LED THE WORK	COMPLETION STATUS
Healthy, independent, and resilient communities/reduction in health inequalities	Complete programme initiation including recruitment and governance.	Assistant Director Chief Executive's Office, Bracknell Forest Council	Complete

STRENGTHS-BASED PRACTICE			
PRIORITY OUTCOME	**ACTION**	**WHO LED THE WORK**	**COMPLETION STATUS**
Strength-based approaches lead to the prevention, delay, and reduction of needs using assistive technology, reablement and rehabilitation	To continue to work with SCIE on the roll out of strength-based practice.	Principal Social Worker	Complete
	Strength based ambassadors embedded in each team – each service areas will develop an action plan.	Principal Social Worker	Complete

UNPAID CARERS			
PRIORITY OUTCOME	**ACTION**	**WHO LED THE WORK**	**COMPLETION STATUS**

Bracknell Forest is a community that supports unpaid carers of all ages in their caring role in a meaningful way	Publish the Carers Strategy for public consultation.	Senior Commissioner, Integration	Complete
	Set up a Carers Partnership Board to oversee the progress of the action plan.	Senior Commissioner, Integration	Complete

PROACTIVE APPROACHES TO CARE

A DIGITALLY ENABLED HEALTH AND CARE SYSTEM			
PRIORITY OUTCOME	**ACTION**	**WHO LED THE WORK**	**COMPLETION STATUS**
Increase the use of Remote Monitoring to increase capacity, promote self-management and improve outcomes. Increase the use of Remote Monitoring to increase capacity, promote self-management and improve outcomes	Make remote monitoring available to patients registered with all Bracknell Forest GP Practices.	ICS Connected Care Team ICB Bracknell Forest Place Team	Complete
	Deliver additional remote monitoring initiatives by expanding eligibility criteria to make it available to more patients.	ICS Connected Care Team ICB Bracknell Forest Place Team	Complete

REACTIVE CARE

HOME FIRST AND INTERMEDIATE CARE			
PRIORITY OUTCOME	**ACTION**	**WHO LED THE WORK**	**COMPLETION STATUS**
People are supported to remain at home where possible and return to their home environment following admission into hospital	Review discharge to assess data to determine effectiveness of D2A.	Strategic Commissioning Manager, Integration	Complete

TRANSFORMATION FOR POPULATION GROUPS TO IMPROVE HEALTH

MENTAL HEALTH TRANSFORMATION			
PRIORITY OUTCOME	**ACTION**	**WHO LED THE WORK**	**COMPLETION STATUS**
More people with significant health needs are supported through primary care	Berkshire Healthcare Foundation Trust in conjunction with the local PCNs will recruit and employ two more mental health ARRS workers for primary care.	Transformation Manager – Mental Health, Learning Disabilities and Autism, ICB	Complete

LEARNING DISABILITIES AND AUTISM			
PRIORITY OUTCOME	**ACTION**	**WHO LED THE WORK**	**COMPLETION STATUS**
Reduction in Health Inequalities	Recruitment of Learning Disability & Autism Support Manager to address local need within the primary care setting.	Transformation Manager – Mental Health, Learning Disabilities and Autism, ICB Head of Service Learning Disabilities, BFC	Complete