Frimley Health and Care

Bracknell Forest Council

Bracknell Forest Health and Care Plan for Adults 2025-26

Date: June 2025

1. Introduction

Overview

The Bracknell Forest Health and Care Plan for Adults 2025-2026 describes the priorities for joint work between Frimley Health and Care Integrated Care Board (ICB) 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 Plan will be developed for 2025 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, according to Census data. 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 the 2021 Census, 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.

According to the Office for National Statistics, in December 2023, 80.3% of Bracknell Forest's working age population were in employment. This was an increase of over 2% from the year before. 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 higher than 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 real pockets of deprivation in some wards of Bracknell Forest where up to 21% of children in a neighbourhood are affected by income deprivation. These neighbourhoods can be found in the Town Centre & Parks, Easthampstead & Wildridings, Priestwood and Garth and Great Hollands wards, according to the Income Deprivation Affecting Children Index (IDACI). Around 7.3% of under 16s in Bracknell Forest were living in absolute low-income families in 22/23, which is lower than the South East and England averages.

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

Policy drivers steer change and shape decisions within health and social care. They influence how services run, which priorities take centre stage and how public funding is spent. Policy drivers often come in response to new research, public expectations, political goals or changing health patterns in the population.

Health and social care national drivers; key influences include:

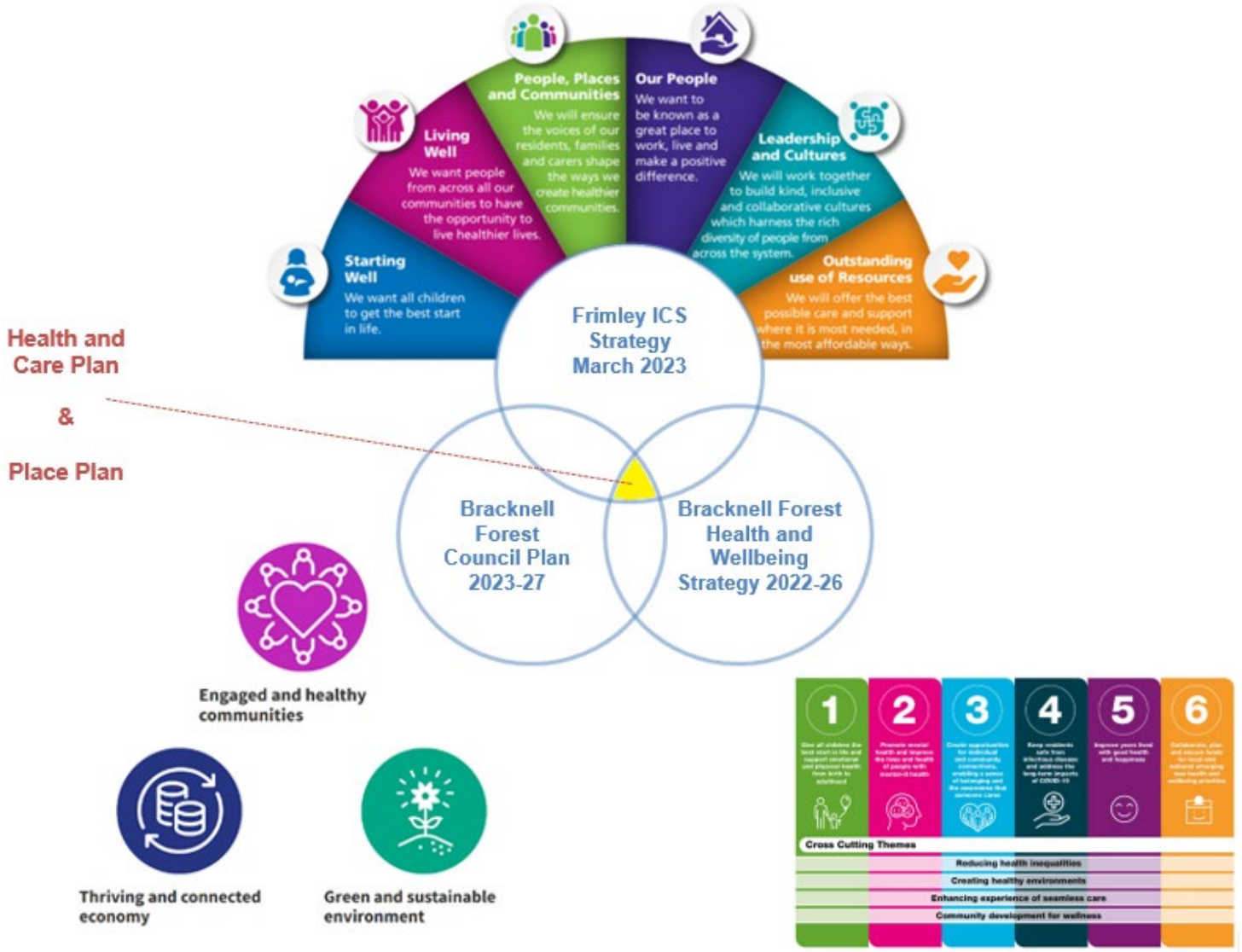
- Legislation and regulation (as referenced in Appendix 1)
- Economic factors and funding provisions
- Health and Social Care Integration
- Personalisation and choice
- Workforce policies

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:

- **Ongoing funding pressures for social care** – Local Authorities continue to feel the pressure to meet needs under the Care Act 2014 going forward. NHS and social care partners will need to continue 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 and acute hospital activity** – there is significant demand pressure on the NHS due to the increase in the number of people presenting with complex and acute conditions. Demand for acute hospital care is consistently high, with levels of activity previously seen only in winter now seen throughout the year.
- **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. High rates of inflation have exacerbated pressures on the provider market and on social care. The increase in employer National Insurance contributions as well as the increase in National Minimum Wage and National Living Wage from April 2025 will increase the financial pressure on providers.

- **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.
- **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 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:


People, Places and Communities
We will ensure the voices of our residents, families and carers shape the ways we create healthier communities.
Our People
We want to be known as a great place to work, live and make a positive difference.
Living Well
We want people from across all our communities to have the opportunity to live healthier lives.
Leadership and Cultures
We will work together to build kind, inclusive and collaborative cultures which harness the rich diversity of people from across the system.
Starting Well
We want all children to get the best start in life.
Outstanding use of Resources
We will offer the best possible care and support where it is most needed, in the most affordable ways.
Frimley ICS Strategy March 2023
Health and Care Plan
&
Place Plan
Bracknell Forest Council Plan 2023-27
Bracknell Forest Health and Wellbeing Strategy 2022-26
Engaged and healthy communities
Thriving and connected economy
Green and sustainable environment
1
2
3
4
5
6
Cross Cutting Themes
Reducing health inequalities
Creating healthy environments
Enhancing experience of seamless care
Community development for wellness

3. An integrated health and care system

Frimley Integrated Care Board (ICB) and Frimley Integrated Care System (ICS) have been in place since 2022, 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. In addition, Frimley ICB concluded a restructure in 2024 that means it is now a smaller organisation. Since the government's announcement in March 2025, additional organisational changes are expected during 2025/26.

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

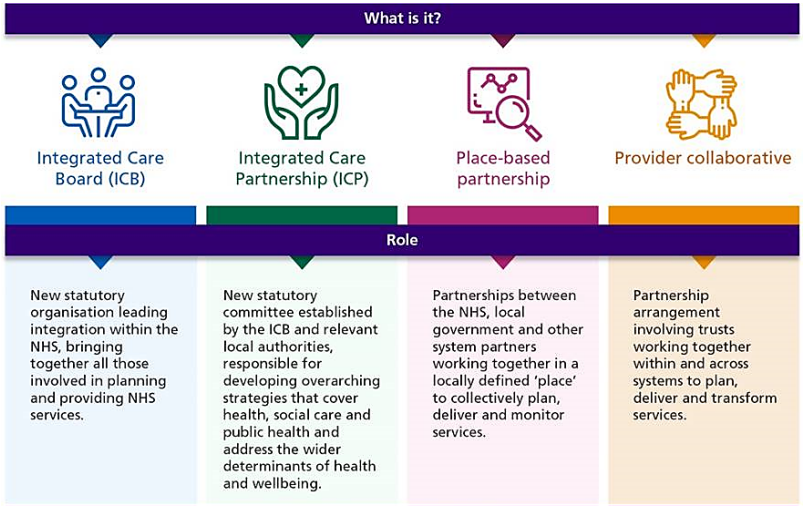
Integrated Care Partnerships (ICPs) operate as a statutory committee, bringing together the NHS and Local Authorities as equal partners, to focus more widely on health, public health, and social care. The ICP includes representatives from the ICB, the Local Authorities within the area and other partners such as NHS providers, public health, social care, housing services, and Voluntary, Community and Social Enterprise sector (VCSE) 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 VCSE sector, and the people and communities in their area.

Partnership and delivery structures

Several partnership and delivery structures operate within an ICS at System, Place, and Neighbourhood level. NHS providers work together at scale through provider collaboratives and partnerships operating across ICSs to improve services. The provider collaboratives are committed to working across a range of programmes and represent a new way that providers of health and care services collaborate to plan, deliver and develop services.

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. The current Health and Wellbeing Strategy comes to an end in 2026 and a new strategy is currently in development.



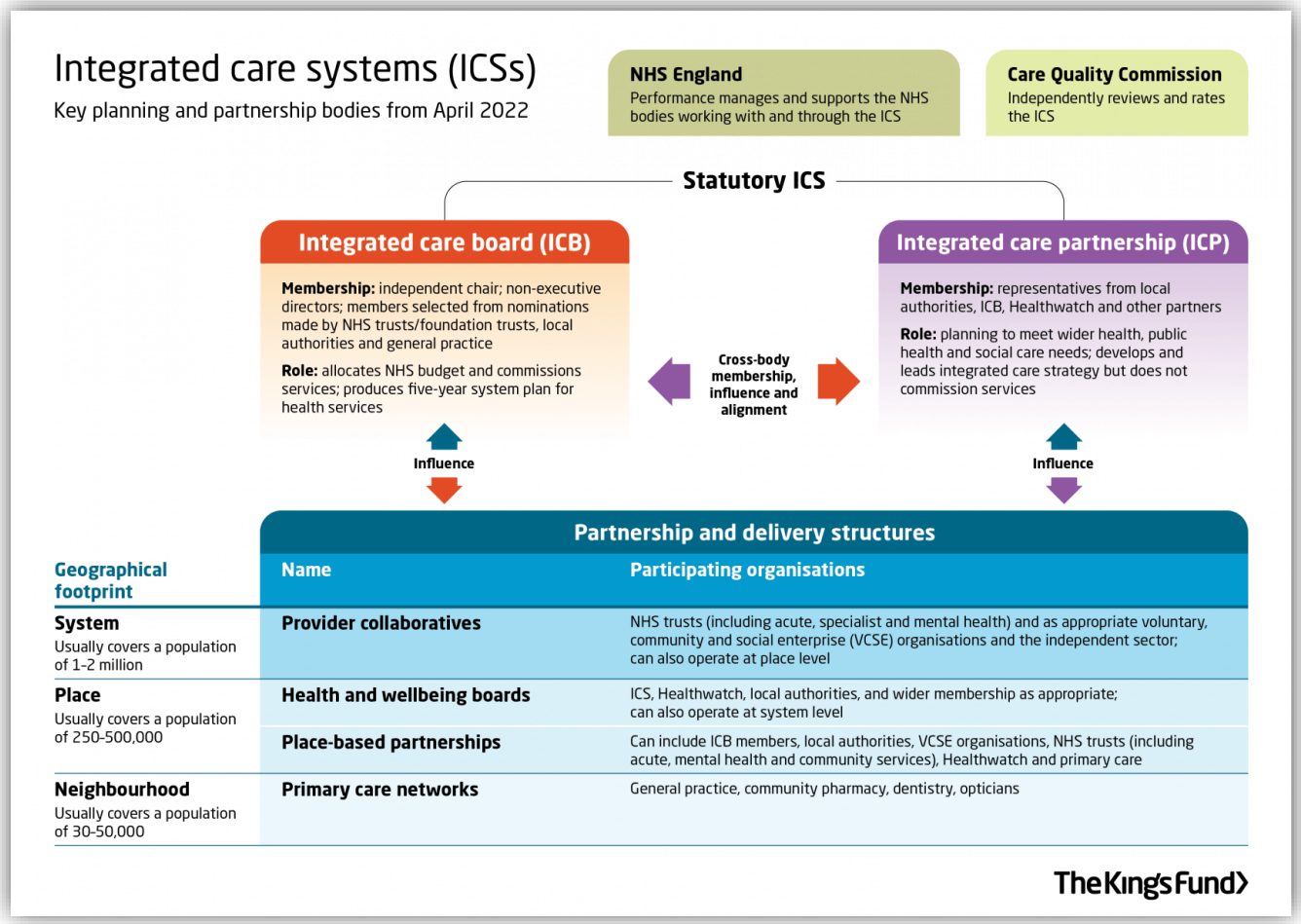
Place-based partnerships

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 VCSE sector 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.

GP Federations and Primary Care Networks

GP Federations and 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 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 Black, Asian and Minority Ethnic (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 wellbeing 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	• Reducing health inequalities for all our residents who experience unwarranted variation in their outcomes of experience. • Increasing healthy life expectancy for our whole population, ensuring an improvement not just in length of life but in the quality of those years as well.
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. • Creating Opportunities for individual and community connections.	• Reduce health inequalities. • Creating healthy environments. • Enhancing experience of seamless care. • Community development for wellness.

Strategy/Plan	Strategic Themes	Outcomes
	• Keep residents safe from Covid and other infectious diseases. • Improve year lived with good health and happiness. • Collaborate, plan and secure funds for local and national emerging new health and wellbeing priorities.	

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 and NHS 10 Year Health Plan for England 2025 –** 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 – 2025/26 Priorities and Operational Planning guidance –** this mandates the priorities that need to be included in planning at ICS and Place level. The number of national priorities has reduced from last year's **guidance**, instead focusing on a small set of headline ambitions and key enablers:
    - Reducing elective care wait times
    - Improving A&E and ambulance response times
    - Enhancing access to general practice and urgent dental care
    - Improving mental health and learning disability services
    - Living within the budget allocated, reducing waste and improving productivity
    - Maintaining collective focus on the overall quality and safety of services
    - Addressing inequalities and shift towards prevention.

Parallel to the planning guidance, NHSE has also released additional guidance documents to address the new objectives set forth in their plan such as the new Neighbourhood Health Guidelines.

- **NHS England Neighbourhood health guidelines 2025/26 –** this emphasises the need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. The ICB's Frailty Delivery Plan and Bracknell Forest's Joint Thriving Communities Programme will be delivered in line with this model.
- **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. For the purpose of this plan, the Core 20 Plus5 approach to Adults will be followed. (See page 20 for further information on adults and CYP).
- **Health and social care integration: joining up care for people, places and populations –** a White Paper that aims to bring together the NHS and local government to jointly deliver for local communities.
- **Bracknell Forest Place Plan –** a strategic document that will describe our full ambitions for health, care and support in Bracknell Forest Place.
- **Model Integrated Care Board – Blueprint v1.0** – this outlines the shared vision of the future for the role and functions of ICBs. There are three strategic shifts which form the foundation of the model ICB's approach to transformation and redesign:
    - Treatment to prevention
    - Hospital to community
    - Analogue to digital

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

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

Step 2: The Priorities for the Bracknell Forest Place Health and Care Plan for Adults 2025-2026

The strategy, planning and policy context summarised in Step 1 translates into the priorities for the Bracknell Forest Health and Care Plan for Adults, as listed below. 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. For full details of how these priorities link to the key strategic drivers, please see Appendix 3.

Underlying all the identified priorities is the ambition to reduce health inequalities both at ICS and Bracknell Forest Place level. These priorities, and what they mean for the Bracknell Forest Place Health and Care Plan for Adults, are explained in the following section.

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

Prevention	Proactive Care
1. **Better health and wellbeing through prevention** – wider health and care approaches to address the wider underlying causes of poor health and wellbeing. 2. **Neighbourhood Health and 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. **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**.** 5. **Proactive 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. 6. **Enhanced Health in Care Homes (EHCH)** – extended multi-disciplinary support to care home in addition to the primary care Directly Enhanced Service (DES). 7. **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	**Transformation for population groups to improve health**
8. **Urgent Community Response (UCR) & Frailty Virtual Ward** – urgent care is available in a crisis to provide immediate support and prevent admission to hospital. 9. **Home First** – people are supported with a smooth and co-ordinated discharge when they leave hospital and are helped to return home wherever possible across both health and care. 10. **Intermediate Care** – people are helped to retain and regain independent living skills.	11. **Unpaid carers** are supported with achieving their own aspirations as well as being helped in their caring role. 12. **Mental Health Services** – more people living with significant mental illness are supported in the community through primary care and experience better physical health. 13. **Dementia** - people living with dementia and their unpaid carers receive timely, comprehensive and ongoing support. 14. **Learning Disabilities and Autism** – people with learning disabilities and autistic people are enabled to live independently with support, and experience better physical health. 15. **Those who are frail or at risk of frailty** – improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care for adults with moderate or severe frailty via the neighbourhood health approach. 16. **Transition** – a partnership approach supporting the successful transition into adulthood.

6. Priorities for The Bracknell Forest Place Health and Care Plan for Adults 2025-2026

Prevention

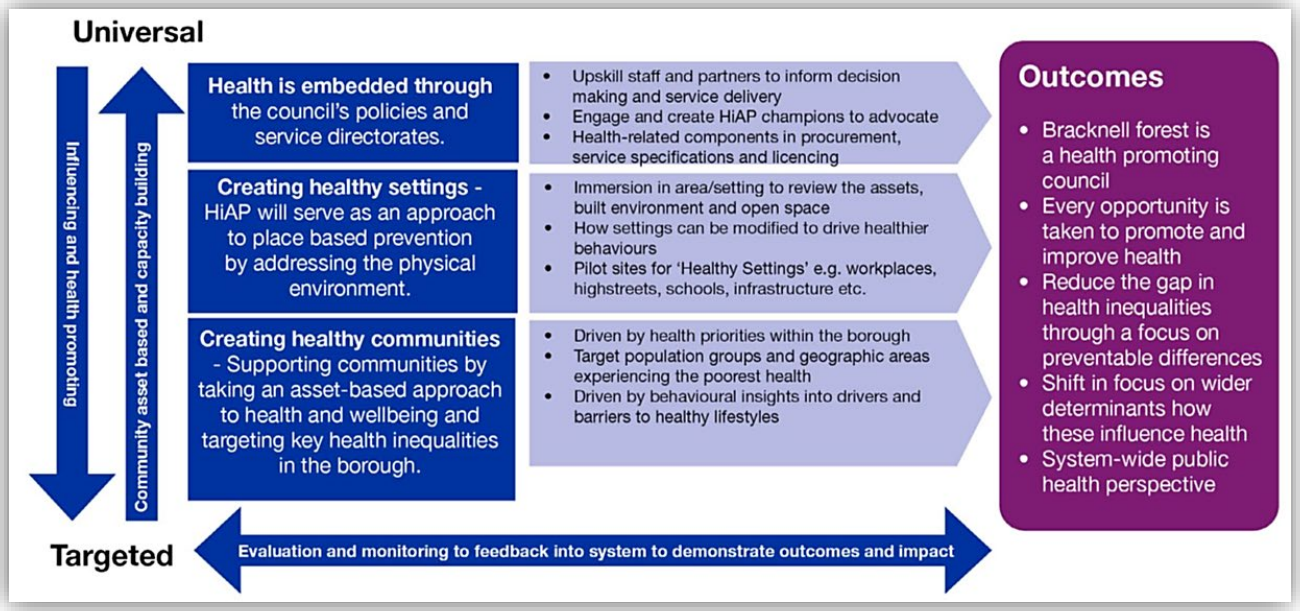
Better Health and Wellbeing through prevention

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 for Adults 2025-2026. 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.

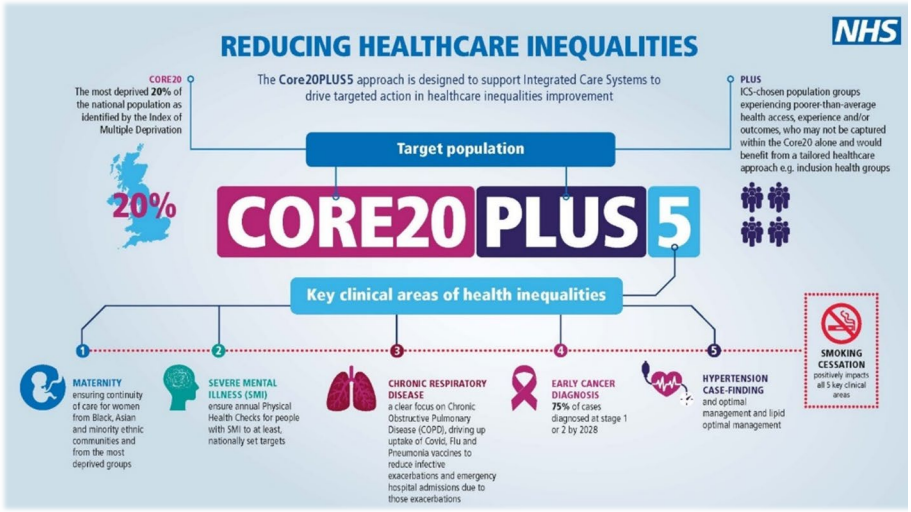
The HiAP approach across the Frimley Health and Care Integrated Care System, and at Bracknell Forest Place partnership level is described in the following diagram:

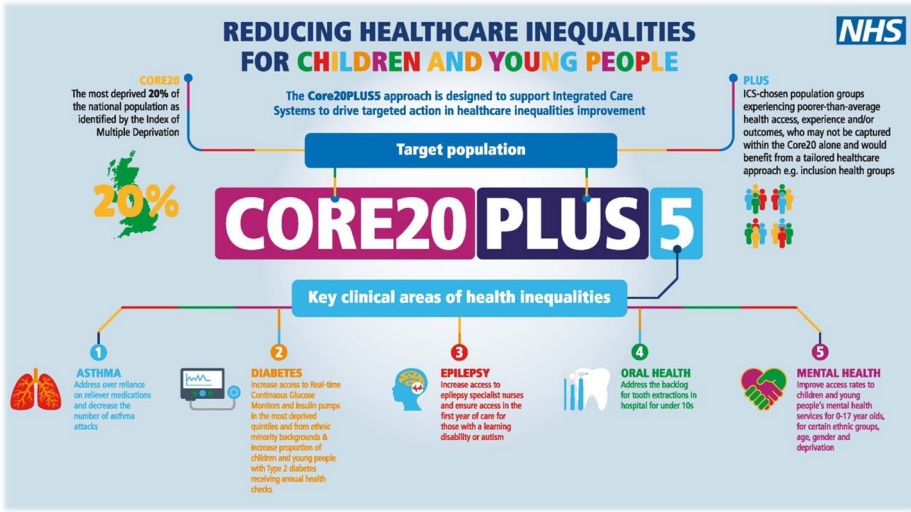


Core20PLUS5 - Core20PLUS5 is the national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. As such it focuses efforts on priority areas, whilst complementing other initiatives such as HiAP and Population Health Management.

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 60 adults and CYP).
- PLUS population groups identified at a local level. In Bracknell Forest, these groups for adults are people with 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 Forest 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.





According to Connected Care[1] as of February 2025, there are 8,551 adults in Bracknell Forest in deprivation deciles 1-4 and/or PLUS groups. This figure has increased by 12% in two years.[2]

Type	% Prevalence	# Prevalence
Core20+5		**8,551**
Core20		**4,959**
Deprivation Decile 1	0.0%	30
Deprivation Decile 2	0.0%	28
Deprivation Decile 3	3.3%	3,035
Deprivation Decile 4	2.0%	1,866
Plus		**3,753**
Carers	3.7%	3,348
Learning Disability	0.5%	415
Total		**8,551**

PLUS groups can be identified across the 5 key clinical areas and smoking. This figure has increased by 8.5% in two years.

RegisterType	Carers	Learning Disability	**Total**
5	**1,626**	**128**	**1,747**
Cancer	292	11	**303**
Copd	105	5	**109**
Current Smoker	415	38	**450**
Hypertension	1,118	67	**1,182**
Mental Health	47	26	**72**
Pregnant (last 12m)	29	0	**31**
Total	**1,626**	**128**	**1,747**

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.

[1] Connected Care data includes individuals registered with a Bracknell Forest GP. It excludes individuals who have opted out, or who re not registered with a GP.
[2] The number of carers registered on Connected Care relates only to those who have registered with their GP as a carer. The actual number of unpaid carers in Bracknell Forest is believed to be much higher.

The Drug and Alcohol Action Team (DAAT): The DAAT initiatives align with the broader health and wellbeing prevention goals, focusing on reducing harm from substance misuse. There is an emphasis on support for individuals to stay well and feel connected to their community, such as working with the Stepping Stones recovery college to create a peer support programme to help develop a community-driven recovery model in Bracknell Forest via the DAAT. The DAAT contributes to addressing health inequalities, particularly within the Core20 most deprived groups, by identifying and supporting vulnerable people in recovery from substance misuse.

Where are we?

Population health management data has been analysed in order to ensure a comprehensive oversight of the Bracknell Forest population and highlight any population groups experiencing health inequalities. Some key findings from the Council Plan and Connected Care, as of April 2025, are listed here:

- People aged 65 and over make-up 15% of Bracknell Forest's population, compared to 18% nationally, and the average age of a Bracknell Forest resident is 39.5.
- 15.3% of the Bracknell Forest population are from Black, Asian and Minority Ethnic groups. 9.1% are Asian or Asian British, 2.9% are Black or Black British. It is known that there is a large Nepali community within Bracknell Forest.
- 65% of adults are overweight or obese and 7.4% have a BMI over 35.
- 13% of residents aged 16+ have a common mental health disorder such as depression or anxiety.
- 10.3% of residents currently smoke.
- 6.1% of residents are recorded as having a medium or high level of alcohol consumption.
- Connected Care data indicates that unpaid carers are at an increased risk of cancer, COPD, hypertension and mental health conditions compared to the prevalence of these conditions amongst the total Bracknell Forest adult population.
- Connected Care data also indicates that mental health conditions and neurodivergence are significantly more prevalent among young carers compared to the total population of children and young people in Bracknell Forest.
- Bracknell Forest has a significantly higher than average male premature mortality rate for cancer.
- 0.7% of people in Bracknell Forest are recorded as having a serious mental health disorder. On average, people with severe mental illness die 15 to 20 years earlier than the general population.

The Joint Strategic Needs Assessment (JSNA) reports that life expectancy and healthy life expectancy indicators in Bracknell Forest are better than national rates. However, boys born in Bracknell Forest today can expect to spend 15 years of their life in poor health, and girls can expect to spend 18 years of their life in poor health. There is a 6.1 year difference in life expectancy between boys born in the least deprived areas

and most deprived areas of Bracknell Forest. The gap in healthy life expectancy is greater at 10 years. There is a 2.3 year difference in life expectancy between girls born in the least deprived and most deprived areas of Bracknell Forest. The gap in healthy life expectancy is greater at 7.8 years.

Where do we want to get to?

The vision is for Bracknell Forest to be one of the healthiest places to live, work, study, and play, providing residents with opportunities to be healthy, happy, and productive. This will be supported 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 the Bracknell Forest 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.

The Frimley ICS Creating Healthier Communities Strategy has a focus on prevention of Cardio Vascular Disease, as well as encouraging positive behaviours such as smoking reduction and healthy weight management.

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.

Actions relating to Health and Wellbeing through prevention are captured in the Health and Wellbeing Strategy so are not duplicated in the action plan for the Health and Care Plan for Adults 2025-2026.

Neighbourhood Health and Thriving Communities

There is a need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. More people are living with multiple and more complex problems and the proportion of our lives spent in ill-health has increased.

Neighbourhood health reinforces a new way of working for the NHS, local government, social care and their partners, where integrated working is the norm and not the exception. Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care.

The focus in 2025/26, as the initial scoping year of the move to the neighbourhood health model, should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs, according to NHS England analysis from adapted Bridges to Health data. In Bracknell Forest, the target cohort for 2025/26 is adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia).

Following the previous work by Bracknell Forest Council and Frimley ICB to develop an approach to implementing the ICB "Community Deal" ambition through partnership working at Place, the Thriving Communities programme has launched. Since June 2024, work has been underway to build relationships with pilot communities and system staff members to strengthen health and wellbeing outcomes.

The 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 the focus for expanding the range and scale of joint working will be in understanding the priority needs of the Bracknell Forest community. This shared understanding will guide how the next steps are delivered and embody the principles of joint working that have been agreed.

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.

Where are we?

The Thriving Communities programme is operating through a partnership governance group and two operational project teams, one focusing on embedding co-production initiatives directly in the community, and one focusing on organisational development. An independent evaluator has also been appointed to lead the evaluation across the three-year programme.

Over the past year a focus has been on two areas of the programme: community development and co-production and organisational development. The Centre of Bracknell area, including a focus on specific flats and housing blocks there have led to strong relationships and community groups forming. Several initiatives have been developed such as the Community chest and Organisational workshops have been held and are planned to support organisations to engage with local people and co-produce offers with residents.

Initial engagement has taken place with eight pilot communities and the conversations are continuing to develop community led initiatives. Planning will commence in spring 2025 to transition to year two of the programme, scaling the work to another community in Bracknell Forest.

Workshop and engagement sessions are scheduled to identify the focus for the organisational development action plan. This will span the three years of the programme.

Where do we want to get to?

2025/26 is the first year of the shift to the neighbourhood health approach, with a focus on the NHS and social care working together to prevent people spending unnecessary time in hospital or care homes.

A detailed evaluation framework is being developed to articulate the success measures of the Thriving Communities programme. Broadly this will focus on outcomes that strengthen communities and shift to empowering communities to lead initiatives that improve health and wellbeing. This enhanced community resilience offers further prevention opportunities for services.

Priestwood, Central Bracknell and Wildridings and Bullbrook are in the top 12% affected by income deprivation. The health status of residents in these areas is worse than Bracknell, the South East and England national average. Depression, obesity and hypertension are the highest recorded health conditions in these areas. The focus in the last year has been on Central Bracknell and, therefore, over the next year the aim is to continue the development work in the town centre and extend community development work in the areas of Priestwood and Bullbrook.

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.
- Reduction in the number of unnecessary admissions to hospital or care homes.
- To co-produce with communities and partners solutions to improve the health status of those in the most deprived areas.

Strengths-Based Practice (Asset-Based Practice)

In Bracknell Forest a strengths-based approach to working with people is followed – 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 Social Care Institute of Excellence (SCIE) were involved in 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 Better Care Fund.

Where do we want to get to?

- For strengths-based practice to become the way that Bracknell Forest works, in partnership, with everyone who needs either social care or integrated health and care support.

- By implementing strengths-based approaches the aim is 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.

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 2019 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. Bracknell Practices are also members of their local successful GP Federation which provides services at a wider scale and on behalf of the PCNs to enable consistency and efficiencies.

GP Federations and PCNs form a key building block of the NHS Long Term Plan 2019 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.

GP Federations and 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. The 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 Bracknell Forest 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 the 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.

To inform prevention, a population health management approach has been used, with a new focus on the national NHS model, CORE20PLUS5. PCNs and Practices have been working with ICB colleagues to identify local population groups who would benefit from a renewed focus on their health needs.

Additionally:

- All Practices are utilising digital telephony (voice of internet protocol telephony) and provide an online consultation solution to provide different ways to engage the Practice.
- There has been a positive uptake of Frimley Healthier Together (both the website and app) to support expectant as well as new parents and young people.
- All PCNs are maximising their Additional Roles Reimbursement Scheme roles.

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.

In Bracknell Forest the aim is to continue 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.
- 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.
- Continue to support the uptake of digital tools such as Frimley Healthier Together, as well as the NHS app.
- Continued engagement with all health partners including PCNs and Practices for the development of Integrated Neighbourhood Teams.

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 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 continue to 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.
- Digitally enabled practices to support service delivery and engage patients in a variety of ways suitable to their needs and abilities.
- Building on the Additional Roles Reimbursement Scheme (ARRS) roles within PCNs, funding has now increased to enable the recruitment of newly qualified GPs.
- Work with PCNs to develop a Proactive Care approach to management of Long Term Conditions.
- 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. It is known 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. In Bracknell Forest the aim is 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: this is called 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 development of this approach to tackling inequalities will continue, ensuring that all of the relevant cohorts of individuals within the Bracknell Forest population are being covered.

The Drug and Alcohol Action Team (DAAT) supports Proactive Care by helping to manage long-term conditions related to substance misuse. Proactive strategies such as outreach, early intervention, and long-term recovery support aim to reduce hospital admissions and improve life quality for individuals with substance misuse problems via a number of the DAAT functions, such as working with the rough sleepers' team and the hospital liaison post.

Where are we?

- Bracknell Forest's Primary Care Networks are leading on delivering Proactive Care. They have implemented ways of working based on the nationally published 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.
- The use of a population health management approach has been adopted to identify people with moderate to severe health needs. The aim is to align this with public health knowledge of health needs and areas of deprivation across Place.
- Regular risk stratification of the 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 a Proactive Care tool has been developed - "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, more consistent ways of capturing activity and outcomes through the GP patient record systems and Connected Care have been developed.
- 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 the 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 the Bracknell Forest population who are frail, socially isolated and at higher risk of deterioration and hospital admission without Proactive Care and support. Work is taking place with 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 the Primary Care Networks around Proactive Care supporting people with "what matters to me" conversations. The learning has been captured from this pilot with recommendations from Age UK that can be taken forward as development continues on the local model.
- Healthwatch Bracknell Forest has helped to find out what residents thought about Proactive Care and what would be important to them as patients, service users and carers. Healthwatch Bracknell Forest has outlined some recommendations that can be taken forward as development continues on the local model.
- The learning from Age UK and Healthwatch Bracknell Forest is used 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 Bracknell Forest communities.

Where do we want to get to?

- Understand how people can be best supported 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 Bracknell Forest 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 Bracknell Forest 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.

Enhanced Health in Care Homes (EHCH)

There is an ambition for Bracknell Forest Place to go further on the 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. More detail on frailty work can be found on page 58.

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 the 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 the Bracknell Forest community health services now take direct referrals from care homes.
- Care Homes have access to the Urgent Community Response and Frailty Virtual Ward pathway, 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 the 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 Bracknell Forest 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 the 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 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.
- 7 out of 15 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 Bracknell Forest 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 a difference is being made and areas where more focus is needed.
- 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. Work is currently being undertaken to ensure the most vulnerable Bracknell Forest residents are transitioned to a digital platform.

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 doing this, as an alternative to a scheduled care visit. New technology, such as smart watches, can monitor 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 2025/26 Priorities and Operational Planning guidance and the NHS 10 Year Health Plan for England 2025 stress 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 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 CQC registered response service for the borough, and also has expertise in finding digital solutions for care and support provision. A new Assessment Suite, 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 the wider objectives for Bracknell Forest and are fully aligned, work has begun on a new Assistive Technology Strategy, the findings of which will underpin and inform the Bracknell Forest approach going forwards.

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 7 of 15 care homes in Bracknell Forest are 'live'
- 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 December 2024, 1,070 patients were being monitored in this way, which is an increase of 8% from the previous year.

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 the Bracknell Forest approach to using Assistive Technology.
- Exploration of options to expand into additional proactive and preventative services.
- 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.
- Develop an understanding of what technology is currently being utilised by carers, using a survey to inform this.
- 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.
- Develop an options appraisal for the introduction of preventative services, in line with the ADASS and TSA blueprint, such as:
    - technology that can be used proactively to build a more complete understanding of the known and hidden care needs of a person prior to their Care Act Assessment/Reassessment, in order to right size their care package.
    - Using technology to maintain existing care packages and delay the need for residential care, supporting people to stay in their own homes for longer.
    - Monitoring individuals via passive falls sensors to detect falls more quickly and understand when behavioural change may indicate an imminent fall is more likely.

Reactive Care

Urgent Community Response & Frailty Virtual Ward

Urgent Community Response (UCR) 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 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, Pharmacists, Senior Nurses, Physiotherapists and Multi-Therapy Assistants. The service is provided by Berkshire Healthcare Foundation Trust (BHFT) across East Berkshire.

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 (FVW).

The Frailty Virtual Wards help prevent hospital stays by supporting people in their own home or care home if they suddenly become unwell. A 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 / contacted 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 the Bracknell Forest Locality Access Point (LAP), 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 3 x Bracknell Forest Primary Care Networks with referrals seeing a steady increase 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 services.

The service has worked with relevant partners to maximise ambulance and 111 referrals to UCR, 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 local Bracknell Forest Care Homes to raise awareness of the service to reduce the number of people being admitted to Hospital from Care Homes.

Where do we want to get to?

To continue to improve community capacity, resilience, and sustainability 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 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 UCR standards).
- Ensure a robust Bracknell Forest Falls Management Framework is in place, supporting a UCR response.

Home First

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 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 in a familiar place, they better reflect what the person is able to do.

In Bracknell Forest a **strengths-based approach** is taken when working 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. Social care staff are in-reaching to the acute hospital, working together with therapists and ward staff, having meaningful and strength-based conversations, resulting in better transition to care and support in the community.

Most commonly Home First has been associated with providing short-term care, e.g. 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 delivered in an individual's own home or at another temporary location (such as interim care home or temporary housing) as part of that journey. This enables staff to focus on each individual and personalise their support, to get them Home First.

The Disabled Facilities Grant (DFG) service plays a crucial role in supporting the Home First approach by enabling essential adaptations in the home environment. By funding modifications such as accessible bathrooms, stairlifts, widened doorways and ramps, DFGs help individuals regain independence and remain safely at home, reducing the likelihood of hospital readmission and the need for long-term residential care. These interventions not only support timely hospital discharge but also align with the broader goal of promoting reablement and independent living in the community. Adaptations can prevent falls, support mobility, and reduce the risk of avoidable admissions. When the home environment is not immediately suitable for discharge, discretionary grants can also support deep cleaning, decluttering, or one off repairs to make the property safe and accessible.

Frimley ICB has a strategic ambition to reduce reliance on bed-based care, shifting focus towards community-based and preventative care. This involves increasing capacity for intermediate care, strengthening community support, and improving patient flow through various pathways, including Mental Health and Urgent & Emergency Care. The goal is to enable more people to receive care in their homes and communities, promoting independence and improving health outcomes.

The areas of focus include:

- **Shifting focus to Community-Based Care:**
  - Working with partners to increase capacity and improve the quality of community-based services, such as intermediate care, rehabilitation, and reablement.
  - Strengthening home-based care and support systems, reducing the need for hospital admissions and facilitating earlier discharges.
  - Empowering individuals to maintain their independence and manage their health in their own homes, reducing reliance on bed-based care.
- **Integrated Care and Prevention:**
  - Integrated Care across different settings, ensuring seamless transitions between hospital and the community (and Primary Care).
  - A focus on preventative care and early intervention to address health needs before they escalate, reducing the demand for more intensive and costly interventions like hospital admissions.
  - By investing in community-based services and preventative measures, the aim is to improve population health and reduce the overall burden on the Health & Social Care system.

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 temporary 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 where it is safe to do so and the support, including assistive technology, is available.

7-day working continues 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 the Bracknell Forest home care framework has increased the capacity and sustainability of local home care providers. Partnership working with providers supports 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 Home First model for people leaving hospital and in-reach to meet the person and start the assessment on the ward if it is needed.
- 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 the strengths-based practice and Home First processes, there will be a reduction in the number of people needing a permanent 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 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 focus on early intervention and prevention starting at the ‘front-door’ will leverage the potential of neighbourhood and voluntary sector support to enable people to receive appropriate and timely support.
- To further embed the Disabled Facilities Grant (DFG) service and discretionary housing grants within integrated discharge and community reablement pathways, ensuring that both physical adaptations and environmental risks such as hoarding or unsafe conditions are addressed early to prevent delays and promote sustainable independence at home.

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 individuals over 18 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 Foundation 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.
- To continue to recruit support workers to the service to increase capacity within the Intermediate Care Service.
- To continue to embed the close working relationship with Urgent Community Response (UCR) and Locality Access Point (LAP).

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 20) has highlighted new priorities for the system, linking to both national priorities and encompassing locally identified priorities.

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.

Where are we?

Frimley ICB and Bracknell Forest Council jointly commission services for carers through the Better Care Fund. In 2024 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 and other opportunities for people to connect. The Ark provided significant additional support during Covid by identifying those carers with priority needs and increasing their contact with them.

A new All-Age Integrated Carers Strategy 2024-2029 was published in 2024 which gives a more comprehensive view of the pressures unpaid carers are facing. An action plan supports how priorities for carers will be delivered. An annual progress report will be presented to the Health and Wellbeing Board to outline key achievements and any risks to milestones to date. In order to inform this progress report, annual engagement through focus groups, surveys and workshops will be held with carers. The Carers Partnership Board meets quarterly to review progress against the five workstreams.

Where do we want to get to?

- A Carers' Strategy Partnership group has been introduced to support oversight of the delivery of the new strategy.
- A dashboard will be developed to track progress against the priorities.
- The strategy will be reviewed annually with carers and updated as necessary.

What objectives will we deliver going forward?

- To ensure delivery of the action plan which supports the All-Age Integrated Carers Strategy.
- To embed the new carers' assessment and self-assessment.
- To gain a clearer understanding of carers data with reference to respite and assessments.
- To continue to ensure that Primary Care Practices have the information they need to refer unpaid carers to SIGNAL4Carers.
- 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 VCSE sector partners to support unpaid carers to remain in employment.

Mental Health Services

The Community Mental Health Transformation Programme formed part of a national programme set out in the NHS Long Term Plan 2019 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. With the One Team approach that BHFT has adopted, residents are able to access services more quickly and have interventions or services provided without having to wait for a long period of time. Locally in Bracknell Forest, assessments are being undertaken twice a week which has helped to reduce waiting times for people accessing services and ensure they get the support they need sooner.

This approach 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.

Frimley ICB has a strategic ambition to shift its focus towards community-based and preventative care. One area of focus is addressing Mental Health needs by:

- Improving access to and the quality of Mental Health services, including crisis care and community-based support.
- Developing transformation plans to reduce reliance on subcontracted beds and out-of-area placements.
- Ensuring individuals experiencing Mental Health difficulties can access the right care and support in the community, minimizing the need for inpatient admissions.

There are a number of services available to support people in Bracknell Forest with mental health conditions, such as the Bracknell Forest Community Network, the Happiness Hub, Mental Health Integrated Community Service, Stepping Stones, and the Safe-Haven.

Bracknell Forest Community Network (BFCN) was set up back in 2017 by the Council in partnership with Berkshire Healthcare Foundation Trust (BHFT). Collaborating with partners in the mental health and wider health and care systems, it aims to support individuals living with a range of mental health conditions to remain socially included by better understanding their mental health and supporting them in preventing relapses. Recovery Facilitators empower individuals to develop their confidence, life skills and resilience by extending the pathways of mental health and wellbeing support and remove barriers to access so they can live as independently as possible. The service has a client base of over 1000 people, many of whom are engaged in activities offered by the service.

BFCN takes a strength-based approach to support and through genuine conversation, establishes a holistic picture of the person's life. There is a focus on the individuals' strengths, ambitions and what's important to them. Work is carried out with the individuals' support networks; their needs and risks; and the available community and voluntary groups and resources. This initial conversation aids the individual to produce a personalised recovery plan to work on, with the support of the Recovery Facilitator.

The primary aim is to enhance the quality of life for individuals with mental health conditions through:

- Collaboration: Working with clinical and non-clinical services to provide comprehensive support.
- Prevention: Helping individuals understand their mental health and prevent relapses.
- Empowerment: Developing confidence, life skills, and resilience for clients.
- Accessibility: Removing barriers to accessing mental health and wellbeing support.

Where are we?

Working towards more integrated care, 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. The Happiness Hub continues to aim to improve access to these services and provide support for people who want to make positive changes to their lives.

There is now coverage of MHICS teams across all Bracknell Forest PCNs and work is underway to co-design 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 the MHICS teams.

To support people with more significant mental illness who are unable to access mainstream Citizens Advice Bureau services, since 2022/23 there has been the offer of 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 Bracknell Forest's 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.

BFCN use existing community assets to support their clients with engagement and social interaction. Many of the clients start their recovery journey with little to no access to any activities/groups available to them. This can be due to feelings of anxiety and low mood which prevent them from engaging, and for some having no confidence or self-belief and motivation in themselves that they can do it and that they will okay. The service uses graded exposure techniques and motivational interviewing methods to encourage and support clients access the huge variety of activities that are available in Bracknell Forest. Many clients build their confidence over time and start to attend sessions/activities by themselves.

The East Berkshire Safe-Haven offers free, walk-in mental health support, as well as support via telephone and video call, in a welcoming, comfortable, non-judgmental, and non-clinical environment. They provide emotional support and information to people who are in crisis or heading toward a crisis situation.

A Mental Health Community Access Panel has recently been introduced – this provides a coordinated and collaborative approach to addressing the mental health needs of individuals within the Bracknell Forest community. The panel brings together mental health service providers from local government, health, and voluntary sectors to discuss referrals and determine the most suitable services to support individuals with their mental health journeys. This has meant 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.

The new Additional Roles Reimbursement Scheme (ARRS) roles have been fully recruited into and this is working well, the PCNs have been appreciative of this service. On average, each ARRS Mental Health Practitioner is seeing between 50-60 residents per week.

Substance misuse is often linked with mental health issues. The DAAT takes an integrated approach in supporting individuals with dual diagnoses and has a key role in improving mental health outcomes for this cohort, via the joint DAAT/ Community Mental Health Team dual diagnosis worker role. Individuals who are referred to the DAAT with substance misuse problems are supported to access mental health support where needed.

Where do we want to get to?

- Continue to embed 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, by December 2025.
- A focus on inequalities will look to understand and better meet the needs of seldom heard communities and further build innovative new workforces such as the Lived Experience Practitioners, by January 2026.
- Improve transition pathway for people of any age, by February 2026.

What objectives do we want to deliver going forward?

- Work will continue to sustain the link between the Additional Roles Reimbursement Scheme (ARRS) roles and the PCNs.
- 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.

Dementia

Data taken from the most recent diagnosis rates for Bracknell Forest Primary Care Dementia Data, February 2025 - NHS Digital suggest that there are 849 people aged 65+ with a dementia diagnosis, with an estimated number of 1334 aged 65+ who have dementia, giving a 63.6% diagnosis rate. Early diagnosis of dementia is important to ensure people have the right support and care in a timely way.

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

Where are we?

The 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.

New Additional Roles Reimbursement Scheme (ARRS) roles were introduced 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 by March 2026.
- To work with Primary Care to identify the support needed to work effectively with people with dementia and their carers by March 2026.
- To continue to build on 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 colleagues within the wider ICB by March 2026.

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.
- Scope out a dementia strategy.

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 was an extensive period of development in supported living for people with learning disabilities and this work continues into 2025-2026. Work is currently being undertaken to ensure people are brought 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 included 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 the 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 has established 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 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 and autism in preparing for adulthood. Individuals with a single diagnosis of autism have their care and support provided for by the Council through in-house and commissioned services. The Learning Disability and Autism Manager role (which was funded by the ICB but hosted by BFC) was put in place to tackle health inequalities and complete a reasonable adjustments project. This has enabled autistic adults to make their GP aware of any reasonable adjustments needed to support their GP/health appointments.

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 March 2025, the building works continue, and the team are working with individuals who may wish to move there as well as their families/carers and are ensuring they receive advocacy support. This will 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 Forest 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, work is being undertaken to increase uptake of cancer screening offers among the learning disabilities population through engagement and support.

Where do we want to get to?

- Increase the uptake of annual health checks for people with learning disabilities in line with NHS England's targets of 75% of patients aged 14 years and over on the Learning Disability register, by identifying patients who have not had their annual health check and working with these patients and their carers to understand the barriers and aim to address these.
- Collaborate with GPs to ensure that annual health checks are of high quality and that patients or they and their carers receive an accessible copy of their health action plan so they can follow up on actions before their next health check.
- Building on the process of monitoring annual health checks, introduce a similar approach to engage with patients overdue for cancer screenings, identifying barriers and working to emphasise the importance of attending these screenings.

- Collaborate with Frimley ICB to develop easy-read resources (e.g., leaflets, posters, videos and social media campaigns) to address concerns and/or key barriers for patients and their carers.
- Continue the Reasonable Adjustments Project by ensuring partners collaborate to identify patients with learning disabilities or autism during new GP registrations and recommending improved communication strategies through leaflets and TV screens in GP waiting areas.
- Continuation of the programme to learn from lives and deaths of people with a learning disability and autistic people (LeDeR), including through Frimley ICB's Learning Into Action group.
- 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.
- In order to understand the population and empirically inform service development, address gaps in capacity and inform Bracknell Forest's strategic approach, a fully comprehensive all-age Disability Needs Assessment needs to be developed.

What objectives do we want to deliver going forward?

- Robust governance and oversight for the draft autism strategy leading to public consultation and publication of the strategy in 25-26.
- Delivery of the NHS Long Term Plan 2019 ambition that at least 75% of people aged 14 or over on the learning disability register will have had an annual health check.
- Review of the integrated learning disabilities service in Bracknell Forest, with the aim of further integrating the health and social care functions of the service, with appropriate governance by April 2025. This will increase joined-up care and support for people with learning disabilities.
- Review the 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.

Those who are frail or at risk of frailty

The NHS neighbourhood health guidelines for 2025-26 emphasise a focus on supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. In Frimley ICS, the cohort that will be focused on is adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia), or those who are at risk.

Where are we?

The Frailty Network is engaging with a broad group of stakeholders who are involved in frailty, to implement the approach to integrated neighbourhood health starting with frailty and extending to end of life/palliative care. An initial cohort of 3,000 people has been identified for the Proactive Care approach, to be followed by a further cohort. Engagement is taking place with Place and PCN teams to identify care plans for those that need a comprehensive frailty assessment with associated interventions to manage care proactively.

Where do we want to get to?

The aim for this cohort is to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, improving outcomes for individuals with frailty or who are at risk of frailty.

Increasing coordination, consistency and scale in delivering health and social care to this cohort should result in the following benefits over time:

- avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life.
- streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up.
- maximising the use of community services so that better care is provided close to or in people's own homes.
- reducing health inequalities, supporting equity of access and consistency of service provision.
- improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing.
- improving staff experience.
- connecting communities and making optimal use of wider public services, including those provided by the VCSE sector.

What objectives do we want to deliver going forward?

- Reduction of emergency department attendances and hospital admissions, and where a hospital stay is needed, reduction in the amount of time spent away from home and the likelihood of being readmitted to hospital.
- Reduction in avoidable long-term admissions to residential or nursing care homes.
- Build a training and leadership support pack to upskill PCN and practices staff to complete frailty assessments.
- Increase patients into remote monitoring to support ongoing care where appropriate.
- Implement advanced care planning and completion of RESPECT forms for frail EOL patients as identified in data.
- Ensure a comprehensive offer is embedded in the community for frail patients when in need of rapid response and are in crisis.
- Develop effective pathways and support for frail population when they present in crisis within secondary care.
- Develop and optimise digital opportunities to integrate care for frail patents across our interfaces in secondary, community and Primary Care.

Transitions for young people with Special Educational Needs and Disabilities (SEND)

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.

Where are we?

- It is recognised that children and young people with Special Educational Needs and Disabilities (SEND) do not always have the required support, advice or guidance to transition to their next stage or on to adulthood successfully. The Council and the ICB are working together to improve the joint strategic approach to transition planning to ensure children and young people receive the right help and support they need, including in preparation for adulthood.
- Transitions are being considered as part of phase two of the Target Operating Model and as part of the joint SEND Improvement work. Additionally, transitions are captured in the following strategies:
    - Bracknell Forest Health and Wellbeing Strategy 2022-2026
    - Bracknell Forest Children and Young People's Plan 2023-2026
    - Bracknell Forest Special Education Needs and Disabilities (SEND) Strategy 2023-2026

Where do we want to get to?

- An improved joint strategic approach to transition planning that ensures children and young people receive the right help and support they need, including in preparation for adulthood.

What objectives to we want to deliver going forward?

- Undertake a review of respective system partnership plans across health and social care and ensure alignment in regards to transition.
- Identify any gaps in the existing plans.
- Develop one clear centralised message regarding what work is happening and what work still needs to take place around transitions.
- Scope out an integrated Bracknell Forest Transitions Strategy.

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 2025-2026.

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 2025-2026 plan supports the Health and Care Strategy. The BCF was reviewed in early 2023 to evaluate effectiveness in delivering intended outcomes. In 2024, a quarterly dashboard was introduced to demonstrate impact of the BCF schemes as well as the outcomes as outlined in the action plan of the Health and Care Plan.

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 existing staff, including their development and retention, is a key priority for Bracknell Forest Place.

The care workforce is also challenged, although the home 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, is 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 strengths-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 continue to be further developed and used to further support improving patient health outcomes.

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.

2024 saw the introduction of a Discharge and Flow dashboard which displays real-time data which is fed through from the Epic system, recording details of the number of patients discharged from hospital via each pathway, and the percentage of discharges completed within the target timeframe, according to the optimum discharge standards. The dashboard also shows the number of patients currently in hospital, and the number of patients that are medically fit to be discharged. This has been instrumental in monitoring system performance and responding to emerging pressures.

Across Adult Social Care, work is progressing to develop Power BI dashboards to enable and assist the drive for self-service performance data and allow for more effective data analysis. Several dashboards are now live and available for use for relevant staff.

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's home care framework has been notably successful, 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 Dementia Nursing beds as well as 20 beds for intermediate care step-down and step-up services. These additional intermediate care beds provide in-borough support for people leaving hospital with complex intermediate care needs as well as helping 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 June-August 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 on estates planning is ongoing, with a particular emphasis on ensuring that primary care services can be provided from good quality and accessible sites. Primary Care has 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 Acute Trust continues to see a high level of demand and patients who are presenting with complex needs. This has led to both Acute sites in Frimley needing to escalate to an OPEL 4 status and on some occasions, declaring a Business Continuity Incident (BCI). In response to this, the Frimley ICS Discharge and Flow Steering Group renewed its focus on key priorities. System partners across Frimley ICS are supporting to deliver the scope of workstreams aimed at improving the Discharge & Flow process.

The following schemes were identified as key to delivering a robust integrated approach across Bracknell Forest and the broader Frimley System to improve Hospital Discharge and Flow:

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

As part of Frimley ICB's strategic ambition to shift focus towards community-based and preventative care, there is a focus on ehancing patient flow and discharge:

- Improving patient flow through various care pathways, including Urgent & Emergency and Elective Care, to reduce length of stay in hospitals.
- Addressing discharge delays and implementing models like discharge to assess (D2A), where appropriate, to streamline the transition from hospital to home.

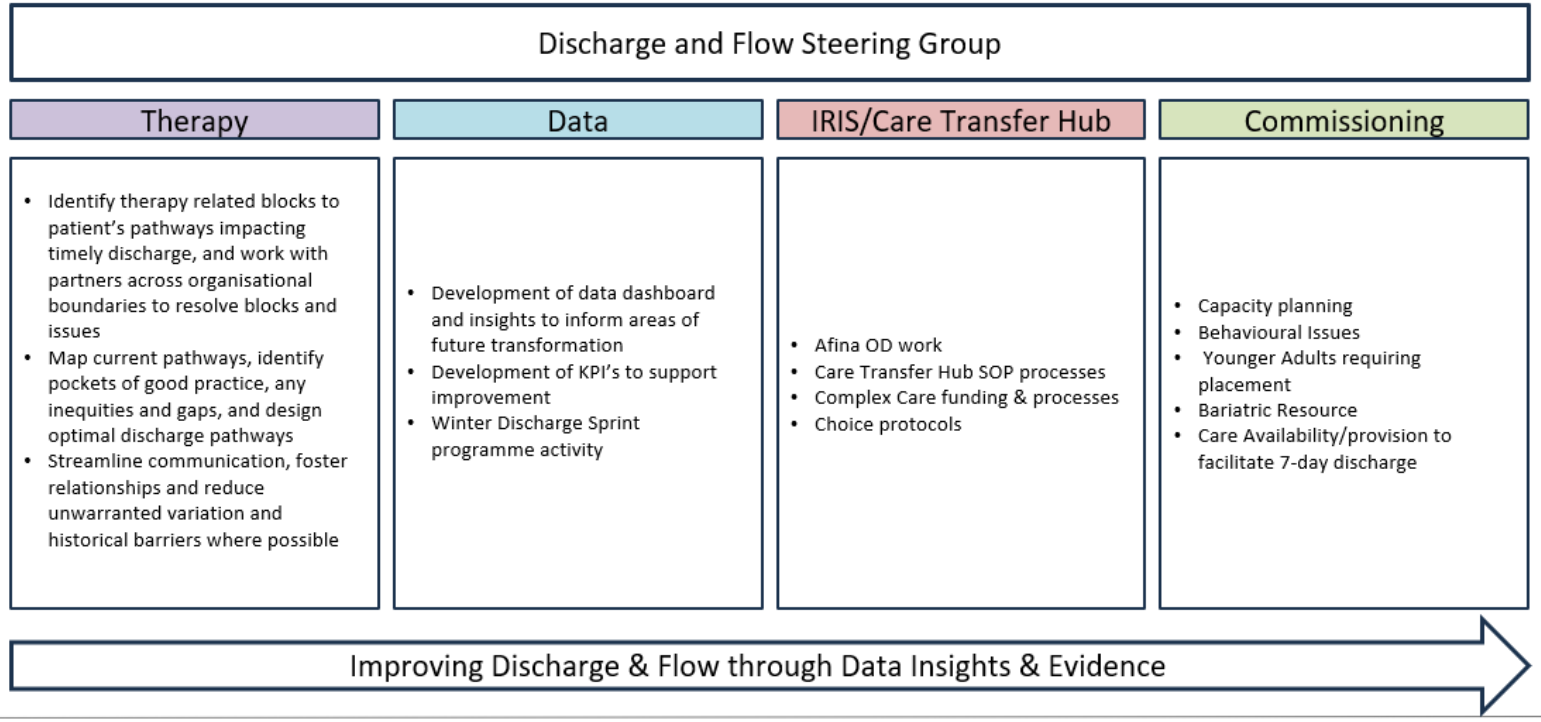
- Improving discharge planning and the co-ordination between Health and Social Care services is crucial to facilitate timely and effective discharges.
- Understand and address the factors contributing to increased demand for hospital beds and the impact of discharge delays.

Where are we?

Work continues 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 Forest.
- Manage choice and complexity on discharge - system discharge challenges, complex decision making, brokering of care provision and funding arrangements.

The workstreams below underpin the programme of work to progress the Frimley system approach for Discharge & Flow:



The Frimley Discharge Data Dashboard was established in July 2023 and is now used regularly by all System partners. The purpose of this was to improve communication between partner agencies and the Hospital Discharge Teams and to provide more granular detail about discharge information to enable partners as a System to improve Discharge and Flow. It also replaces a number of time-consuming manual processes relating to the recording and provision of discharge data. The Dashboard now enables key stakeholders across the system involved in Hospital discharge, to view and interrogate data more effectively.

Where do we want to get to?

- Continue 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.
- Continue development of a Transfer of Care hub which aligns with the national specification and NHS Long Term Plan 2019.
- Streamline complex care discharge pathways including funding processes.
- Continue to develop and implement Standard Operating Procedure documentation for Transfer of Care hub and complex care pathways.
- Build on the successful integrated working approach in Bracknell Forest, to continue to support Discharge & Flow at a Place and System level.

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 Discharge Data Dashboard.
- Improved safety and quality of care from better coordination through a Transfer of Care hub.
- Faster, safer discharges of patients with complex needs.

Social Care Operating Model

The pandemic drove change and increased integration across Bracknell Forest's community teams (both health and social care) and following an extensive review, a co-produced structure and way of working has been introduced – 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.

The new Operating Model went live as planned on 1st October 2023. Since then, there has been an improvement in the number of people being dealt with at the point of contact, and an increased number of people accessing Early Intervention and Prevention Services to help maintain their independence in the community. IT system improvements have resulted in improved recording practice and reporting capability which is now available through self-service dashboards available to all staff and managers. Self-service options are available with a portal to enable residents to self-refer into services alongside financial assessments and charging. Provider portals are in place for the purpose of improving communications with providers when commissioning care and reducing the time taken to get appropriate care in place with care providers.

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.
- Continued improvement to Discharge and patient Flow from hospital, including continued commitment to the Home First approach.

What objectives will we deliver going forward?

- Continued improvements to 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 continued 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 self-assessment and carers self-assessment. A later phase will broaden the capability of self-service further.

- Continued improvements to pathways particularly for young people moving into adulthood, learning disability, autism and mental health social care pathways for care needs assessment as part of the next phase of work.

Technology First

Going forwards there will be an increased focus in developing and enhancing the technology first approach across health and care. There is an aim to utilise a wider range of monitoring equipment at the point of discharge and a fund has been set aside 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.

The Accelerated Reform Fund has enabled Bracknell Forest to be part of an East Berkshire project which will explore how assistive technology can support people to live independently and how carers can utilise it as a method to support their wellbeing.

Where do we want to get to?

As part of the Assistive Technology approach it is necessary to consider utilisation of the 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. Our aim is to support people to remain safe at home, in control and independent.

What objectives will we deliver going forward?

- Strengthen the prioritisation of a technology first approach in developing care and support plans.
- Develop an understanding of what technology is currently being utilised by carers, using a survey to inform this.
- 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.
- Jointly develop the Assistive Technology approach across Bracknell Forest Place.

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 in alignment with the Bracknell Forest Co-Production Framework. 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 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 and the development of the All-Age Integrated Autism 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 previously sought to develop 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 Social Enterprise sector (VCSE).

Co-production is being further embedded and expanded through the Thriving Communities programme.

Where are we?

Through the Thriving Communities programme, there is an aim to transform the relationship between organisations across the system and communities, with an 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. Further discussions are underway with the Ideas Alliance to explore wider funding opportunities to enhance co-production locally.

Over the past year a focus has been on two areas of the programme: community development and co-production; and organisational development. The Centre of Bracknell area, including a focus on specific flats and housing blocks there have led to strong relationships and community groups forming. Several initiatives have been developed such as the community chest and organisational workshops have been held and are planned to support organisations to engage with local people and co-produce offers with residents.

Where do we want to get to?

There will be 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 co-production activities with residents, will ensure that the effectiveness of co-production is increased.

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 be identified in the Thriving Communities organisational development action plan such as:

- To increase skills in co-production through training and development activities across the system with partners, communities and residents.
- To develop the approach to evaluating and sharing experience from co-production activities so that Bracknell Forest is always learning.
- To work with partners including the VCSE sector 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.
- To co-produce with communities and partners solutions to improve the health status of those in the most deprived areas.

Voluntary, Community & Social Enterprise Sector (VCSE)

The Voluntary, Community and Social Enterprise (VCSE) sector plays a vital role in an integrated health, care and support system. Involve is the VCSE 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 VCSE 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 VCSE sector 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 VCSE sector 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 sector survey report, are increasing financial pressures including staff costs, venue hire costs, utility costs and reductions in charitable donations; and barriers to recruiting and retaining staff and volunteers. Funding routes are narrowing and the levels of success in securing funding have reduced, which means that for some organisations, the implications of this could well mean a reduction in service at a time when demand is increasing

Recent collaboration with the VCSE sector 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 VCSE sector groups to enable the delivery of community-led solutions.

Involve continues to offer quality low-cost training, governance support (including start-up advice and guidance), volunteer recruitment and funding advisory services to the charitable sector locally in the hope that this small but impactful sector can thrive into the future.

Where do we want to get to?

- Develop further the partnership working 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 the VCSE sector, develop a diverse pool of local volunteers.
- Support volunteers and groups to develop their volunteering skills through sector training courses.
- Ensure the VCSE sector 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 2025/26 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 NHS Long Term Plan 2019 and NHS 10 Year Health Plan for England 2025** – a ten-year delivery plan for the NHS.

G. **NHS England Neighbourhood health guidelines 2025/26** – this emphasises the need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. The ICB's Frailty Delivery Plan and Bracknell Forest's Joint Thriving Communities Programme will be delivered in line with this model.

9. APPENDIX 2 – Governance

The Health and Care Plan 2025-2026 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.

Health and Care Plan scheme leads, as well as BCF scheme leads, complete quarterly highlight reports which include data around the activity that has taken place, as well as accompanying narrative that highlights any key trends and themes, service user voice, as well as risks and issues. Reporting in 2024-25 has been further enhanced by the development of a Health and Care dashboard. The Health and Care dashboard includes:

- Performance against BCF metrics
- BCF scheme performance
- Health and Care Plan project performance and development
- Hospital Discharge activity and performance
- Risk and Issues concerns

The Health and Care dashboard, reviewed quarterly at the Bracknell Forest Place Committee provides both quantitative and qualitative insight which has informed future planning for 2025-26.

At each Place Committee meeting, presentations are given by Health and Care Plan scheme leads, providing a deep dive into the work that is taking place. Over the course of the year, all scheme leads give a presentation to ensure that partners are sighted on all priority areas of work.

An integrated Seasonal Capacity planning group meets on a weekly basis. The planning group consists of colleagues from Frimley ICB and BFC, including representatives from Access to Resources, Strategic Commissioning, Housing (DFG), and Team Managers and the Head of Service across Adult Social Care including the Hospital Discharge Team and Intermediate Care Service.

The Better Care Fund Strategic Group meets quarterly to consider performance, business cases and other developments. The membership consists of senior managers and assistant directors from Frimley ICB, Adult Social Care, Commissioning, Housing, and Public Health, as well as finance leads for BFC and the ICB, and a representative from the voluntary sector.

The Bracknell Forest Place Committee meets quarterly and supports the Health & Wellbeing Board, which is a Committee of the Council, and functions as a Place Board within the ICB and Integrated Care System. Membership consists of representatives from Frimley ICB and BFC, including the Executive Director: People (BFC), Associate Director of Places and Communities (ICB), Place Clinical Lead, Director of Public

Health, Health Watch representative, Head of Primary Care (East Berkshire), Berkshire Healthcare Foundation Trust representative, Frimley Healthcare Foundation Trust representative, Primary Care Network Clinical Directors and a representative from the voluntary sector.

All quantitative measures listed in the action plan in appendix 3 are reported in the Health and Care dashboard.

10. APPENDIX 3 – Delivery Action Plan

PREVENTION

NEIGHBOURHOOD HEALTH AND 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	Jointly develop and scope the neighbourhood health approach. To include the frailty programme and Thriving Communities priority neighbourhoods.	Associate Director Places and Communities, ICB	2025-2026	Approved Bracknell Forest Place neighbourhood approach
	Continue to support the Thriving Communities programme in Central Bracknell and expand to reach out to Priestwood and Bullbrook (12% affected by income deprivation). Work with residents and partners to co-produce improvements in depression, obesity and hypertension (the highest recorded health conditions in these areas and worse than England average).	Associate Director Places and Communities and the Thriving Communities Programme Team	2025-2026	Co-produced initiatives in place in priority neighbourhood areas
	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	An Evaluation Framework coproduced with residents and partners

NEIGHBOURHOOD HEALTH AND THRIVING COMMUNITIES				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
	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	An Evaluation Framework coproduced with residents and partners

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 reduction of needs using assistive technology, reablement and rehabilitation.	Complete phase 2 of the Change Programme.	Principal Social Worker	In progress	Phase 2 completed
	Continue to support people through the assessment and provision of assistive technology.	Principal Social Worker	Ongoing (BAU)	Not reportable at present

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)	Ongoing	TBD – suggested percentage of practices
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	Ongoing	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	Ongoing	Regular update of search for eligible patients

PROACTIVE AND PERSONALISED CARE				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
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	Ongoing	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	Ongoing	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**
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 ICB Integration Lead)	Ongoing	Data from ICB care home dashboard around care home use of emergency services and emerging themes

ENHANCED HEALTH IN CARE HOMES				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
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.	Care Home Support Team, ICB (supported by Bracknell Forest ICB Integration Lead)	Ongoing	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

A DIGITALLY ENABLED HEALTH AND CARE SYSTEM				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Assistive Technology Strategy	Following the development of an Assistive Technology Position Statement, next steps are to produce an Assistive Technology Strategy with a focus on supporting people to remain at home.	Commissioning, ICT and Forestcare	On hold - capacity	A Bracknell Forest Assistive Technology Strategy approved following public consultation
	Understanding residents' utilisation and perception of assistive technology	Senior Commissioner, Integration	Q2 2025-2026	Data analysis on survey response
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	Increase the number of care homes where remote monitoring is deployed.	TBC - ICB	Ongoing	Number of care homes where remote monitoring is deployed
	Increase the number of eligible patients who are onboarded.	TBC - ICB	Ongoing	Number of eligible patients who are onboarded
Explore proactive and preventative care services	Develop an options appraisal regarding possible proactive and preventative care services that could be implemented in Bracknell Forest.	Forestcare	2025-2026	Completed options appraisal

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 ICB Integration Lead	Ongoing	Percentage of framework implemented
Improve & sustain working arrangements with all stakeholders	Monthly Bracknell Forest UCR working groups and partner forums, to ensure collaborative working.	Bracknell Forest ICB 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	Increase number of people supported via Home First.	Head of Service: Adult Social Care, Strategic Commissioning Manager, Integration	Ongoing	Percentage of people going home following hospital stay, number of care home placements prevented/pathways

HOME FIRST AND INTERMEDIATE CARE				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
home environment following admission into hospital.	Continue to evaluate effectiveness of Home First and formerly ringfenced discharge fund resources.	Head of Service: Adult Social Care, Strategic Commissioning Manager, Integration	Ongoing	changed, number of short-term bed-based placements. Number of people supported by Intermediate Care Service, percentage of people who go on not to have long-term care, or who have a reduced package of care

TRANSFORMATION FOR POPULATION GROUPS TO IMPROVE HEALTH

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	To ensure delivery of the action plan which supports the All-Age Integrated Carers Strategy.	Senior Commissioner, Integration	2024-2029	Progress and impact of workstream milestones and projects Additional data: number of carers registered with Connected Care, number of carers assessments completed, number of carer respite services, number of carers receiving DPs

MENTAL HEALTH SERVICES				
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	Ongoing	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 (BFCN). Data on BFCN usage (e.g. referrals, number of people supported 1 to 1, number of group activities attended).
Reduced waiting times for people experiencing mental ill-health	Residents to have an assessment, and at least one intervention within 28 days of being referred into the service.	Community Mental Health Services	Ongoing	Data on length of time between referral and intervention

DEMENTIA				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Bracknell Forest residents have a diagnosis rate	Hold Dementia Partnership Board to provide collaboration between members to assist with information	Dementia lead, ICS	Ongoing	Not applicable

DEMENTIA				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
equal to or exceeding the national target of 67%	sharing, updates and joint working helping promote a community/holistic approach to service development.			
	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
	Scope out a timeline for the development of the dementia strategy now that the needs analysis has been completed.	Commissioning	2025-2026	Completed timeline

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	Sign off and publication of All-Age Integrated Autism Strategy.	AD Commissioning	2025-2026	Publication of an Integrated All-Age Autism Strategy following public consultation
	Development of an action plan which supports the All-Age Integrated Autism Strategy.	Senior Commissioner, Integration	2025-2026	Approved action plan

LEARNING DISABILITIES AND AUTISM				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Reduction in Health Inequalities	Deliver and innovate programmes of work for people with learning disabilities and autism alongside Primary Care Networks and the Integrated Community Team for People with a Learning Disability.	Learning Disability and Autism Transformation Manager, ICB	Ongoing	Progress against programmes of work
	People with learning disabilities (on the learning disability register) 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.	Learning Disability and Autism Transformation Manager, ICB	Ongoing	Percentage of people with learning disabilities on the learning disability register having health checks – NHSE target 75%

THOSE WHO ARE FRAIL AND THOSE AT RISK OF FRALITY				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
Improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, improving outcomes for	Define cohort for proactive approach 1.1 (3000 people).	Associate Director of Out of Hospital Care	2025-2026	TBD – suggest number of cohort identified
	Re-establish case for change and engage with Place and PCN teams to identify care plans for those that need comprehensive frailty assessment.	Associate Director of Out of Hospital Care	2025-2026	TBD – suggest number of care plans identified

THOSE WHO ARE FRAIL AND THOSE AT RISK OF FRALITY				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
individuals with frailty or who are at risk of frailty.	Address variability of care planning within PCNs and access resource for those with larger cohorts, e.g. Bracknell.	Associate Director of Out of Hospital Care	2025-2026	TBD
	Build a training and leadership support pack to upskill PCN and practice staff to complete frailty assessment.	Associate Director of Out of Hospital Care	2025-2026	TBD – suggest number of assessments completed using pack

TRANSITION				
PRIORITY OUTCOME	**ACTION**	**WHO WILL LEAD THE WORK**	**WHEN WILL IT BE DELIVERED**	**QUANTIFIABLE MEASURES**
An improved joint strategic approach to transition planning that ensures children and young people receive the right help and support they need, including in preparation for adulthood.	Undertake a review of respective system partnership plans across health and social care and ensure alignment in regards to transition.		2025-2026	

Actions completed 2023-2025:

PREVENTION		
Scheme	**Priority outcome**	**Action**
THRIVING COMMUNITIES	Healthy, independent, and resilient communities/reduction in health inequalities	Complete programme initiation including recruitment and governance.
STRENGTHS-BASED PRACTICE	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.
		Strength based ambassadors embedded in each team – each service areas will develop an action plan.
		Scope out phase 2 of the Change Programme.
		Ensure access to meaningful metrics that are operationalised to deliver service improvement.
		Ensure feedback from people with lived experience is available to deliver service improvement.
		Ensure CQC recommendations are embedded within strength-based practice.
UNPAID CARERS	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.
		Set up a Carers Partnership Board to oversee the progress of the action plan.
		Develop and mobilise the action plan which will drive forward the ambitions of the Carers Strategy.
PROACTIVE APPROACHES TO CARE		

Scheme	Priority outcome	Action
PRIMARY CARE TRANSFORMATION	Reduce health inequalities	PCNs to engage with and deliver against projects developed through the CORE20PLUS5 model to reduce health inequalities
	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
ENHANCED HEALTH IN CARE HOMES	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.
A DIGITALLY ENABLED HEALTH AND CARE SYSTEM	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.
	Increase the use of Remote Monitoring to increase capacity, promote self-management and improve outcomes	Deliver additional remote monitoring initiatives by expanding eligibility criteria to make it available to more patients.
REACTIVE CARE		
Scheme	**Priority outcome**	**Action**
URGENT COMMUNITY RESPONSE AND FRAILTY VIRTUAL WARD	Frailty Virtual Wards to increase capacity	Increase capacity for Frailty Virtual Ward “beds” supported by appropriate workforce plans.
HOME FIRST AND INTERMEDIATE CARE	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.

TRANSFORMATION FOR POPULATION GROUPS TO IMPROVE HEALTH		
Scheme	**Priority outcome**	**Action**
MENTAL HEALTH TRANSFORMATION	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.
	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.
	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.
DEMENTIA	Bracknell Forest residents have a diagnosis rate equal to or exceeding the national target of 67%	Develop a Dementia Needs Analysis
LEARNING DISABILITIES AND AUTISM	Reduction in Health Inequalities	Recruitment of Learning Disability & Autism Support Manager to address local need within the primary care setting.
	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.

11. APPENDIX 4 – Strategic Drivers, Place-level objectives, and high-level outcomes

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 • NHS 10 Year Health Plan for England 2025	• 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 • NHS England Neighbourhood Health Guidelines 2025/26 • NHS 10 Year Health Plan for England 2025	• Working with the wider determinants of good health and social connectivity, including employment.	2) Neighbourhood Health and 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	• 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)
• Core20PLUS5			
• NHS England – 2025/26 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.	4) 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 – 2025/26 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	5) Proactive and Personalised Care	• People with multiple LTCs and complex health and care needs will benefit from an integrated , multi-disciplinary approach to proactive care planning. • Reduction in hospital admissions and outpatient appointments. • Increase in the number of years lived in better health.
• NHS Long Term Plan 2019 (Ageing Well) • NHS England – 2025/26 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.	6) Enhanced Health in Care Homes	• Reducing conveyances to hospital • Healthy communities • Tackling health and care inequalities • Number of years lived in better health

Strategic Driver(s)	Place-level objective	Priorities	High-level Outcome(s)
	• Increasing the number of residents with personalised care plans.		
• People at the Heart of Care – Social Care White Paper 2021 • Frimley Health and Care ICS Five Year Strategy 2020-25 • NHS 10 Year Health Plan for England 2025	• 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.	7) Technology Enabled Care (TEC)	• Less intrusive ways of supporting people. • Enabler for proactive care • Reduction is social isolation Reduce/delay the need for traditional care support. • Better use of resources
• NHS England – 2025/26 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.	8) Urgent Community Response (UCR) and Frailty Virtual Ward	• 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.
• NHS England – 2025/26 Priorities and Operational Planning guidance • Health and Care Bill – Discharge Policy Paper, 2022 • NHS 10 Year Health Plan for England 2025	• 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.	9) 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.

Strategic Driver(s)	Place-level objective	Priorities	High-level Outcome(s)
• 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.	10) Intermediate Care	• Increase in quality of life. • Decrease/delay in demand for services. Increase in the number of years of healthy life expectancy.
• 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.	11) Unpaid Carers	• Reduced financial hardship and stress for unpaid carers and increased satisfaction among unpaid carers with services. • Reduction in health inequalities
• 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 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.	12) Mental Health Services	• 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	• People are diagnosed with dementia in a timely way. • There is a comprehensive network of support for people with dementia and their unpaid carers.	13) 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)
• 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.
• NHS England – 2025/26 Priorities and Operational Planning guidance • NHS England Neighbourhood Health Guidelines 2025/26	• More coordinated interventions and support for people who are frail. • Optimisation of acute frailty services to reduce length of stay for frailty patients.	15) Those who are frail or at risk of frailty	• Reduction in health inequalities.
• Bracknell Forest Health and Wellbeing Strategy 2022-2026 • Bracknell Forest Children and Young People's Plan 2023-2026 • Bracknell Forest Special Educational Needs and Disabilities (SEND) Strategy 2023-2026	• Develop an improved joint strategic approach to transition planning.	16) Transitions for young people with Special Educational Needs and Disabilities (SEND)	• Children and young people receive the right help and support they need, including in preparation for adulthood.