

Bracknell Forest Health and Care Plan for Adults 2026-27



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1. Introduction

Overview

The Bracknell Forest Health and Care Plan for Adults 2026-2027 (Health and Care Plan) describes the priorities for joint work between Thames Valley Integrated Care Board (ICB) and Bracknell Forest Council (the Council) for adults living in Bracknell Forest.

It outlines a number of key priorities that have been agreed between the partners, and reflects 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.

There is no Adult Social Care strategy in Bracknell Forest; the Health and Care Plan acts as a key strategic partnership document that not only covers all priorities that would be included in an Adult Social Care strategy, but reflects the truly integrated nature of services in Bracknell Forest.

The Health and Care Plan 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. Section 5 outlines our approach to governance.

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 training¹. 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^{2 3}.

Additionally, the Neighbourhood Health Framework, which will be referenced within this plan, relates to both adults and children. 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 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.

¹ [Children Act 1989](#)

² [Children and Families Act 2014](#)

³ [Care Act 2014](#)

Bracknell Forest

- ❖ Bracknell Forest is a small unitary authority in the South East of England, specifically within the Thames Valley and the county of Berkshire, with a population of approximately 131,000 people.
- ❖ The median age is 39 years, which is lower than the UK average and the employment rate is 80.3%, above the Great Britain average.
- ❖ Life expectancy at birth is above the UK average at 85 for women and 81 for men whilst healthy life expectancy is 67 for women and 65 for men, which is above the UK average.
- ❖ For those aged 16 and above, the average happiness rating is 7.7 out of 10, and the average life satisfaction rating is 7.6 out of 10.
- ❖ 86.1% of residents are White; 7.1% are Asian, Asian British or Asian Welsh; 2.4% are Black, Black British, Black Welsh, Caribbean or African; 3.1% are Mixed or Multiple Ethnic Groups; and 1.3% are from other ethnic groups.
- ❖ Bracknell Forest is ranked 271 most income-deprived out of 316 local authorities in England. No area within Bracknell Forest is among the 20 percent most income-deprived in England. 32 of the 75 neighbourhoods within Bracknell Forest is among the 20 percent least income-deprived in England. Overall, 6.8% of residents in Bracknell Forest are estimated to be income-deprived, but in the most deprived neighbourhood in Bracknell Forest, it is estimated that 14.7% of people are income-deprived.⁴

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.

Key health and social care drivers include:

Demographic and population drivers

- **Ageing population**
 - More people living longer with **multiple long-term conditions**
 - Increased demand for social care, community services and end-of-life care
- **Rising prevalence of long-term conditions**
 - e.g. dementia, diabetes, frailty, mental ill health
- **Health inequalities**
 - Significant gaps in life expectancy and outcomes by deprivation, ethnicity and geography

Impact: Drives prevention, early intervention, community-based care and integration.

NHS policy and strategy drivers

National NHS priorities set expectations for the whole system and inform local plans.

⁴ All statistics in this section are from the Office of National statistics: [Bracknell Forest \(E06000036\) - ONS](#)

- [NHS 10-Year Health Plan](#)
 - Shift from hospital-based care to **prevention and community care**
 - Focus on integration, personalised care and population health
- [Operational Planning Guidance \(annual\)](#)
 - Sets national priorities for access, quality, recovery and productivity
- **Recovery and resilience agendas**
 - Elective recovery, urgent and emergency care performance, mental health access

Impact: Pressures systems to redesign pathways and invest in out-of-hospital care.

Integration and system reform drivers

These directly affect joint working between NHS and social care.

- [Health and Care Act 2022](#)
 - Statutory **Integrated Care Systems (ICSs)**
 - Stronger duty to collaborate across NHS, local government and partners
- **Place-based and** [neighbourhood working](#)
 - Emphasis on local partnerships and shared accountability
- **Integrated Care Strategies**
 - Joint NHS–local authority strategies focused on population needs
- [Better Care Fund](#)
 - Mandated pooled budget between local authorities and ICBs with national policy objectives and priorities set annually

Impact: Drives pooled budgets, shared outcomes and integrated commissioning.

Social Care policy and legislative drivers

National frameworks strongly influence local social care delivery.

- [Care Act 2014](#)
 - Wellbeing principle
 - Duties around prevention, information and advice, safeguarding
- **Market sustainability and workforce pressures**
 - National funding reforms and workforce strategies
- **Reforms and funding announcements**
 - Adult social care charging, fair cost of care, provider sustainability
- **Local Authority devolution**
 - the transfer of powers, funding, and decision-making from the UK central government to local areas

Impact: Focus on prevention, strength-based approaches and market shaping.

Financial and productivity drivers

National funding constraints shape service models.

- **Public sector financial pressure**
 - Need to deliver more care with limited resources

- **Efficiency and productivity expectations**
 - Reducing duplication, delayed discharges and avoidable admissions
- **Value for money and outcomes-based commissioning**
 - Emphasis on evidence-based interventions

Impact: Drives prevention, integration and service redesign.

Workforce drivers

National workforce challenges affect every part of the system.

- **Recruitment and retention issues**
 - Particularly in social care and community services
- **Skills mix and new roles**
 - Advanced practitioners, care coordinators, social prescribers
- **Wellbeing and burnout**
 - National focus on staff wellbeing and retention

Impact: Encourages multidisciplinary working and new models of care.

Local plans informed by the drivers include:

- [Thames Valley Commissioning Intentions 2026-2030](#)
- **Health and Wellbeing Strategy**
- **Joint Strategic Needs Assessment**
- [Bracknell Forest Council Plan 2023-2027](#)

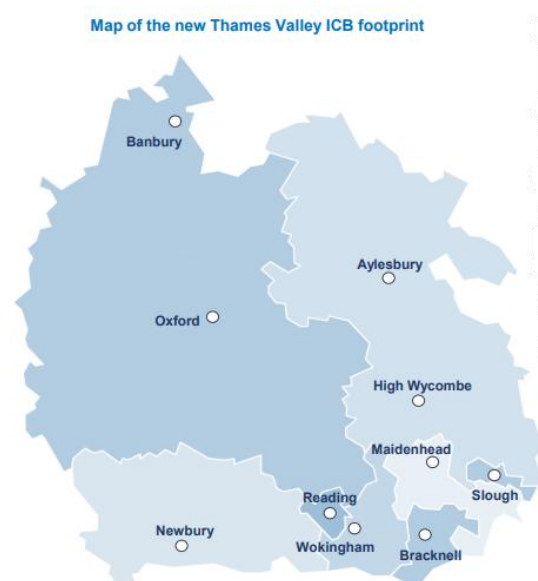
3. An integrated health and care system

The Bracknell Forest Partnership is comprised of a number of different organisations working together in an integrated way.

NHS Integrated Care Boards and Integrated Care Systems

Prior to April 2026, Bracknell Forest was located within the geography of Frimley Integrated Care Board (ICB) and Frimley Integrated Care System (ICS). As of 1st April 2026, the East Berkshire Places (including Bracknell Forest) within Frimley ICB joined with Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICB to become the newly formed Thames Valley ICB. 2026-2027 will be a year of transition, and there will be instances within this plan where Frimley ICB is still referenced, in appropriate circumstances.

The newly formed Thames Valley ICB and Thames Valley ICS encompasses Bracknell Forest, The Royal Borough of Windsor and Maidenhead, Slough, Wokingham, Reading, West Berkshire, Oxfordshire



and Buckinghamshire, covering a total population of 2.5 million people⁵.

An ICS is a geographically based local partnership that brings together NHS organisations, local councils, and other partners to improve health and care services, reduce inequalities, and manage resources efficiently.

An ICB is statutory organisation responsible for planning, commissioning, and overseeing NHS services for a local population. Thames Valley ICB has developed a five-year strategic commissioning intentions document to set out how NHS services will be delivered to meet local needs.

NHS provider trusts

An NHS provider trust is an organisation, such as a hospital, mental health, or ambulance service, responsible for providing NHS-funded healthcare directly to patients. There are two primary NHS provider trusts that form part of the Bracknell Forest partnership – Frimley Healthcare Foundation Trust (FHFT) for the acute and Berkshire Healthcare Foundation Trust (BHFT) for the community.

FHFT is the provider for Frimley Park Hospital, the acute hospital that is most utilised by Bracknell Forest residents, owing to its geographical location. FHFT is also the provider for other local Hospitals, including Wexham Park and Heatherwood. FHFT is also the service provider for the Intermediate Care Unit at Heathlands, a step down and step up provision to support discharge & flow as well as admission avoidance for local residents.

BHFT provides a wide range of physical and mental health community services to people of all ages living in Berkshire, operating from hospitals, health clinics and GP practices, as well as other community settings and in people's homes. These services are essential to support discharge & flow and admission avoidance.

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.

Voluntary Sector

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. The VCSE sector is integral to integrated working and the provision of effective support for residents in the Bracknell Forest partnership.

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.

⁵ [NHS Thames Valley - About us](#)

Neighbourhood Health

Neighbourhood health is a joint endeavour between the NHS and local authorities, alongside wider partners. It is a truly collaborative effort between all partners, combining the NHS's responsibility for health services with the local authority's responsibility for adult and children's social care services and public health. This fosters a true partnership for the benefit of all citizens to ensure we achieve the left shift from hospital to community, and sickness to prevention.

4. Working as a partnership

In Bracknell Forest, we place value on our partnership approach. We work together to understand joint priorities and measurables that are meaningful and evidence the great work that is taking place in Bracknell Forest.

Partners have jointly established a shared approach to partnership working and agreed the following priority focus areas:

- Strengthening early intervention, prevention, and community-based pathways to reduce escalation of need, increase healthy life expectancy, and support safe, timely discharge.
- This includes improving quality decision-making, ensuring clear senior oversight on complex cases, enhancing multi-agency and voluntary-sector coordination, and embedding neighbourhood models of integrated working.
- Supporting evidence-led practice, workforce resilience, voluntary sector sustainability, and increased intermediate care capacity underpin the delivery of consistent, person-centred outcomes across the system.
- Work together to respond to demand and determine what needs to be done differently, getting the best value from the Bracknell Forest pound.

Partners have jointly developed our vision for residents as:

- People experience easy access to primary care and timely health and social care support that prevents deterioration, promotes independence, and reduces health inequalities.
- This includes improving system flow, strengthening prevention and community participation, ensuring safety and wellbeing, and delivering person-centred outcomes with the right resources to increase healthy life expectancy.

Collectively we want to ensure that we hear the voice of the resident; effectively capture impact; and ensure we have oversight of shared risks.

5. Governance

The Health and Care Plan is owned by the Bracknell Forest Place Committee. Accountability for the priorities in the plan sits within the governance of the Better Care Fund (BCF), 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, the voice of the resident, outcomes and impact, as well as risks and issues. This quantitative data and qualitative narrative is incorporated into the Health and Care dashboard. The Health and Care dashboard includes:

- Performance against BCF metrics

- BCF scheme performance
- Health and Care Plan priority performance and development
- Hospital Discharge activity and performance
- Risks and Issues

The Health and Care dashboard, reviewed quarterly at the Bracknell Forest Place Committee provides both quantitative and qualitative insight which informs future planning.

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 Thames Valley 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 Thames Valley 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 Thames Valley 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), BHFT representative, FHFT representative, Primary Care Network Clinical Directors and a representative from the voluntary sector.

Quantitative measures listed in the action plan in appendix 1 are reported in the Health and Care dashboard.

Additionally, within the action plan, there will be a standalone section which sits outside of the priorities, relating to planned improvements to the Better Care Fund, as recommended by NHS England.

6. Risk

Whilst risks relating to individual schemes and priorities are reported by leads on a quarterly basis and escalated via the Health and Care Dashboard, as a partnership we have identified a need to be better sighted on our shared risk in a wider sense. This includes strategic partnership risks as well as operational risks. We need to develop a risk sharing pathway – a formal process for managing risk at a local level.

7. Celebrating what we've achieved in 2025-2026

Partners continue to work together to deliver joint priorities identified. It is important to recognise achievements as part of our ongoing approach to ensuring we collectively deliver effective health and care services for Bracknell Forest residents.

A snapshot of the achievements from 2025-2026 are captured below.

Neighbourhood Health and Thriving Communities

- Building on requests from local residents for a local mental health café, the programme connected a local community support group with the Happiness Hub (adult mental health services) and supported with setting up a new monthly Happiness Hub.
- The programme supported the creation of Third Spaces: a group for young adults run by young adults to address social isolation and support good mental health and wellbeing.
- The programme has worked in partnership with Bracknell Health PCN and Everyone Active on a pilot peer to peer weight management support group for a focus group of patients on their weight management waiting list. In total, 5 participants engaged over the 12-week programme period. Participants reported having better sleep due to lifestyle changes such as stopping late night snacking, reducing screen time before bed, and regulating meal timings. Participants also described feeling more motivated to eat healthily. This included replacing chips with salads while eating out and including more fruits and vegetables in their diet. For instance, "Since coming to this group I have started eating fruits without thinking it's boring". After completing chair-based exercises, participants reported that they incorporated the exercises in their daily lives and felt confident in moving more, which included putting their washing out, using the stairs instead of the lift, and gardening. A participant shared, "When I'm knitting or watching the tele, I just sit and do marches and do the arm exercises". The participants also valued the social connections and peer support, sharing "it's nice to spend time with them and talk to each other...it's safe here". Overall, participants lost some weight, ranging from 1-5kg, over the course of the programme and reported increased knowledge and perception of control over healthy lifestyle behaviours.

Strength-based practice

- Data across 25-26 shows that of the people who received reablement from our Intermediate Care Service, on average 56% had reduced support needs as a result. An additional 39% continued to need the same level of support as they had previously.
- On average, more than 50% of people who contacted the Adult Social Care 'front door' in 25-26 had their needs resolved without further action.
- A professional's feedback to the Adult Community Team: "V's approach is firmly person-centred and strength-based, with a clear focus on achieving meaningful outcomes for the individuals she supports. She applied the eligibility criteria with confidence and professionalism, ensuring robust and lawful decision-making. V's analysis was clear, thoughtful, and insightful, highlighting the depth of her understanding and the exceptional quality of her practice."
- A family member's feedback to the Adult Community Team: "E is an exceptionally competent and compassionate member of the Bracknell Forest care team who was sensitively responsive and understanding during a crisis situation with regard to my brother, and his need for priority support. E was very reassuring, informative, and fully cognizant of what measures were required to keep my brother safe. I wholeheartedly commend her as an outstanding and hardworking Senior Social Worker who, from my perspective, is an absolute credit to the Bracknell Forest

organisation. She is obviously someone who 'has a heart' and is fully aware of the sensitive needs of vulnerable people."

A digitally enabled health and care system

- When an individual was ready to be discharged from hospital, an assessment was done by one of our practitioners to enable him to be discharged home safely. It had been identified that the individual had good insight into his needs but also was keen to maintain his independence at home without having carers, as he found this too restrictive. Therefore, the practitioner placed memory prompts around the home in the identified areas where risk had been identified and arranged for sensors, provided by Forestcare, to be placed in his home. This meant that it was possible to reduce his package of care and increase his independence.
- There has been increased use of the assessment suite, ongoing work with the Adult Social Care Hub to ensure the assessment suite is the default offer for those able to access the suite when requesting more simple pieces of equipment. Sessions are being held for the Hub team by ACSM EIP, refreshing strength-based conversations.

Urgent Community Response (UCR) and Frailty Virtual Ward

- Around 145 people are seen each quarter by the UCR. These individuals would likely have otherwise attended A&E.

Home First

- The percentage of Bracknell Forest residents aged 65+ who have been discharged from hospital home to their usual place of residence is consistently higher than the England and South East average.
- A Bracknell Forest resident was initially assessed in hospital as needing 24-hour care, but his wish was to return home and be as independent as possible. Our therapists were able to assess his home environment and, using a strength-based approach, ensure that with the aid of assistive technology and regular district nurse reviews, he was able to live at home without a care package. A referral was also made to the DFG for a bathroom adaptation.

Intermediate Care

- After receiving reablement services, 50-60% of people have their support needs reduced; and 84% of individuals either require no ongoing care or do not experience an increase in their care package.
- One service user fed back "My care was superb, the ICS was great helping me become considerably more able at home. My manager, S, was extremely helpful and her regular assessments helped a great deal."

Unpaid carers

- Carer feedback to Dementia Advisor "I really was at my wit's end having been caring for my dad for over 18 months, subsequent to caring for both my mum and dad for over 2 years previous to that. I had had very few breaks in that time. Anyway, I called rather speculatively for a bit of advice regarding care for my dad. I was expecting a very brief chat but L went above and beyond to help. I felt genuine support for the

first time in a long time. We called Careseekers together and I subsequently found live in care agencies who could offer some temporary care for my dad. However, it was the real concern for my own wellbeing that made such a huge difference to me. It really was a huge weight off my shoulders to feel this genuine concern and support. L has continued to keep in touch regularly and offer support."

- The first annual progress report has been published to ensure residents are kept updated on the progress we have made since the publication of the All-Age Integrated Carers' Strategy.
- In the 2025-26 Survey of Adult Carers in England (SACE), the proportion of carers in Bracknell Forest reporting enough social contact exceeds comparator areas. Around 69–70% find it easy to access information, a percentage which is higher than England and improving over time.
- The 2025-26 SACE also demonstrated that social care-related quality of life scores are consistently strong (~7.5–7.6) and in line with or above regional/national benchmarks.
- Around 81%+ of carers reported feeling involved or consulted. This has improved significantly from previous years (mid-60s). Overall carer satisfaction has increased significantly to 45.1% from 36.6% previously. This is higher than England and South East comparators in the same period.

Mental Health Services

- The Mental Health Recovery Network (MHRN) follows up with people three and six months after they finish receiving one to one support from the service. On a quarterly basis throughout 25-26, of the people who had been contacted six months after their one to one support concluded, on average 81% of people were not accessing any primary or secondary mental health services.
- The MHRN typically supports around 100 individuals one to one every month and offers a wide range of group meetings, such as social groups and wellbeing sessions, with over 300 attendances each month. The Happiness Hubs typically have around 200 drop ins per month.
- Feedback from someone who has accessed the service: "I feel as though I found my happy self when working with MHRN. Having the support groups really helped me, seeing the same faces and making new friends within that. It helped me get out and about in the community both on my own and in group settings."
- BHFT's "OneTeam" approach has brought CMHT and MHICS teams together to create a single team that provides intervention for low, medium and high complexity patients.

Dementia

- A dementia needs assessment has been completed.
- The Dementia Forum is well received, in quarter three there were over 115 attendees including health, social care and voluntary sector as well as people with dementia and their family members.
- Service user feedback to our Community Mental Health Team for Older Adults (CMHTOA) includes: "Thank you for all your support with Mum and keeping her best

interests at heart. I'm really pleased the care calls are now in place, as this will help Mum continue living at home as she wishes."

- "I wanted to start by thanking you for the time you gave and the care you showed the other day. We all felt incredibly comfortable and heard by you."
- "A gentle kind compassionate but professional approach. Team member listened. Since my assessment I have explored various options (my husband has signed up for a tour of ASCOT SHED he is lonely and rarely goes out) also I have attended another dementia training course, investigated counselling for myself but find the "how we feel" app recommended by N suits me well at the moment. I feel more positive on some days now."

Learning Disabilities and Autism

- A five year forecast of housing needs has been completed to help us better plan for what style of accommodation is required.
- Bridgewell opened in October 2025 and consists of 4 x 5-bedroom apartments, enabling people to stay living within the community in Bracknell Forest with the support they need to remain independent, safe and well.
- Service user feedback to CTPLD includes "Thank you for valuing your staff and valuing the people that you care about, you are truly platinum standard. Thank you for finding the correct people to help me function. You are truly a lifesaver, and the people that you find to help me function. You are one in a 1 million people that gets it right and know their job very well and they know how to speak to me in a way that I can understand. I'm able to be myself now and I've been noticing more things about me that I never knew existed. I couldn't do it without your help and the people that you choose to help me. I am truly grateful. Thank you for knowing about the human conditions and helping me to remain positive, yours everlastingly grateful."

Frailty

- Case Co-Ordinators have been identified at each Primary Care Network (PCN) to lead the Frailty process.
- The Case Co-Ordinators have identified suitable Frailty patients for the 1.1 and 1.2 cohorts and ensured Multi-Disciplinary Team discussions have taken place regarding these patients and onward referrals have been made where appropriate.
- A Frailty webinar (clinically led) was attended by a number of stakeholders, to support the Care Co-ordinators.

8. Health and Care Plan priorities for 2026-2027

Section 2 referenced a number of key drivers that underpin our 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.

As a partnership, we have identified eighteen priority areas, which have been organised into four broad categories. However, it is important to note that some of these priorities sit across more than one of the four categories, and opportunities for preventative initiatives are sought in every area of the work that we do.

Prevention	Proactive approaches to care
1. Better health and wellbeing through prevention – wider health and care approaches to address the underlying causes of poor health and wellbeing. 2. Neighbourhood Health and Thriving Communities – people are empowered to stay safe and well and feel connected to their community. 3. Strength-based practice – people feel safe and are equal partners in building on their own strengths and those of their own social and support systems. 4. Extra Care – scoping an effective independent living facility supporting people to maintain their independence.	5. Primary Care Transformation – increasing timely access to primary care and using population health management tools to proactively support people who might otherwise be at risk of deterioration and/or the need for urgent care. 6. Proactive care – proactively identifying and meeting the needs of a defined population will improve their health and quality of life and reduce the use of health and social care resources. 7. Enhanced Health in Care Homes (EHCH) – developing a sharper and more consistent Quality Assurance (QA) approach for care homes. 8. A digitally enabled health and care system – 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
9. Urgent Community Response (UCR) & Frailty Virtual Ward – urgent care is available in a crisis to provide immediate support and prevent admission to hospital. 10. 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. 11. Intermediate Care and reablement – people are helped to retain and regain independent living skills. 12. Market Sufficiency, Care Home Framework and Market Position Statement for Adults – supporting market stability and ensuring consistent care for residents.	13. Unpaid carers are supported with achieving their own aspirations as well as being helped in their caring role. 14. Mental Health Services – more people living with significant mental illness are supported in the community through primary care and experience better physical health. 15. Dementia - people living with dementia and their unpaid carers receive timely, comprehensive and ongoing support. 16. Learning Disabilities and Autism – people with learning disabilities and autistic people are enabled to live independently with support, and experience better physical health. 17. Transitions for young people with Special Educational Needs and Disabilities (SEND) – a partnership approach supporting the successful transition into adulthood. 18. 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.

Prevention

1. Better health and wellbeing through prevention

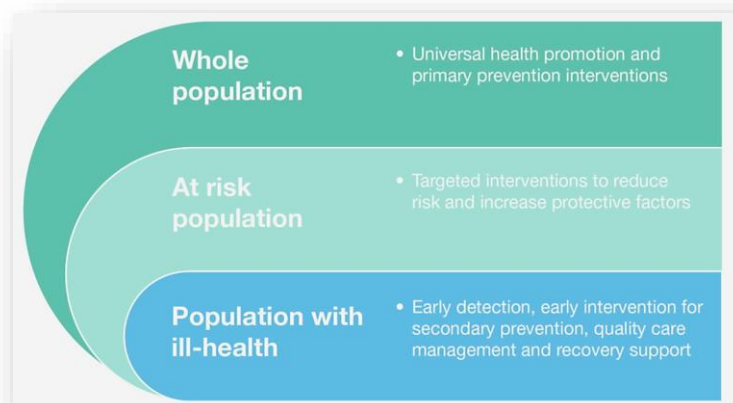
A detailed description of the strategic approach to prevention is described in the Joint Health and Wellbeing Strategy. However, it is important to describe key elements of this approach in this plan, as prevention is fundamental to improving the health and wellbeing of the whole population in Bracknell Forest. The approach to prevention also underpins all of the elements of the Health and Care Plan.

Prevention for Bracknell Forest 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.

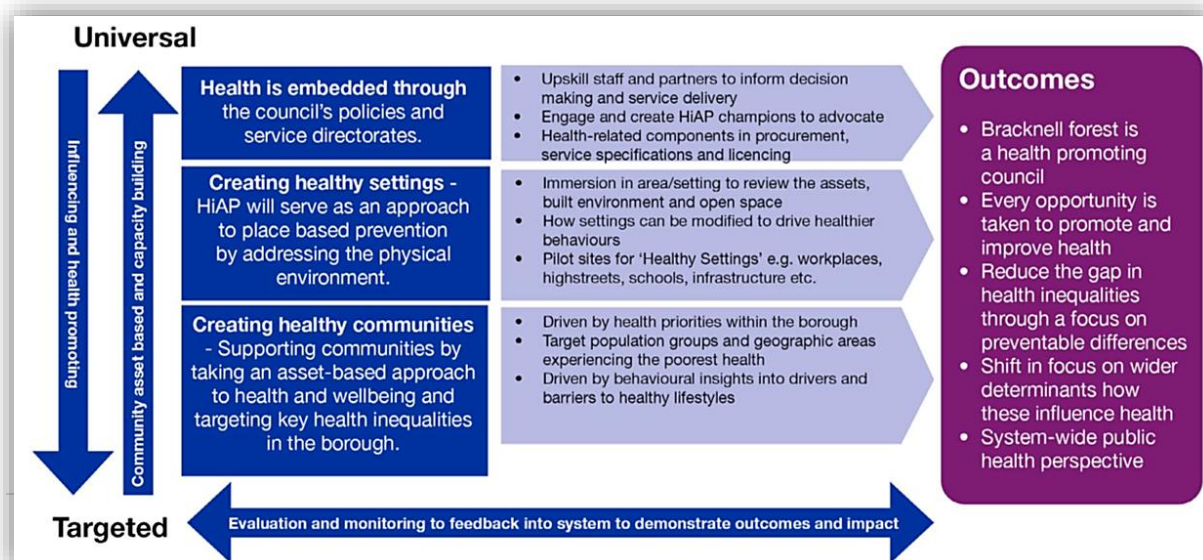
For example, a nurse may provide an individualised care plan for a person with diabetes, but population health provides a strategy to both prevent diabetes by identifying key risks and protective factors in the whole population and improve the care and management of the diabetic population (a sub-population 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 Bracknell Forest partnership is described in the following diagram:

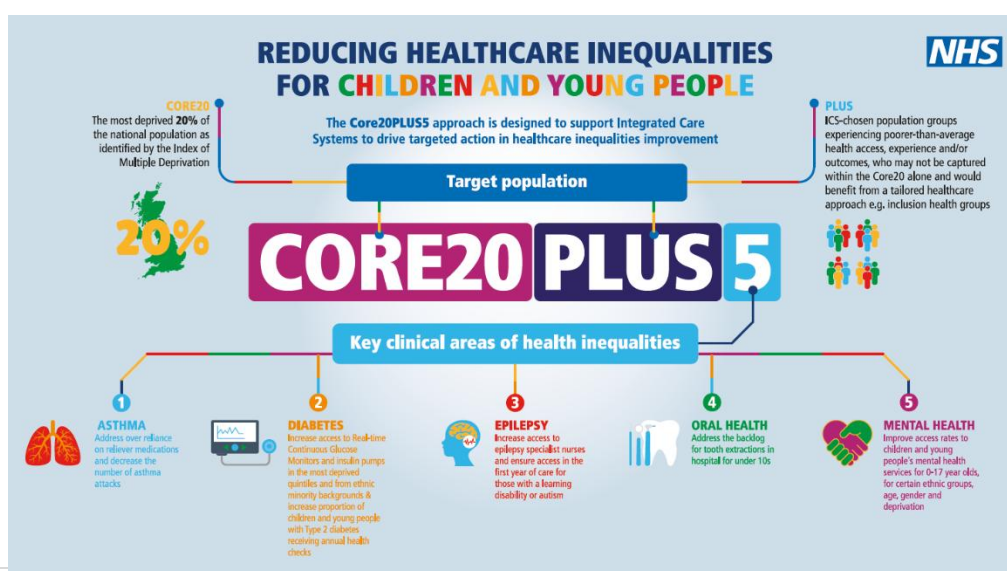
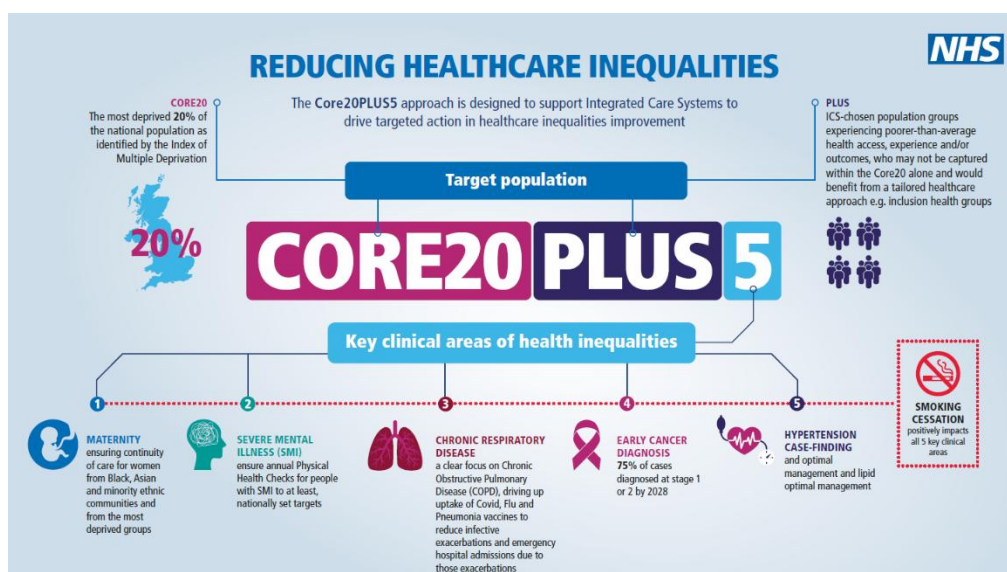


Core20PLUS5

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, due to very low numbers in the most deprived 20%, this is extended to the most deprived 40% of the population.
- PLUS population groups identified at a local level. In Bracknell Forest, these groups for adults are people with learning disabilities and carers. There is ongoing work to reduce health inequalities for these cohorts of individuals, including linking into system work for wider insights and sharing of practice and approaches. For children and young people, the focus is on school readiness for those eligible for free school meals, children who are obese, and those 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 Care⁶ as of the end of March 2026, there are 9,298 adults in Bracknell Forest in deprivation deciles 1-4 and/or PLUS groups.

Type	% Prevalence	# Prevalence
☐ Core20+5		9,298
☐ Core20		5,535
Deprivation Decile 1	0.0%	12
Deprivation Decile 2	0.0%	24
Deprivation Decile 3	3.6%	3,331
Deprivation Decile 4	2.4%	2,168
☐ Plus		3,956
Carers	3.9%	3,552
Learning disability	0.5%	415
Total		9,298

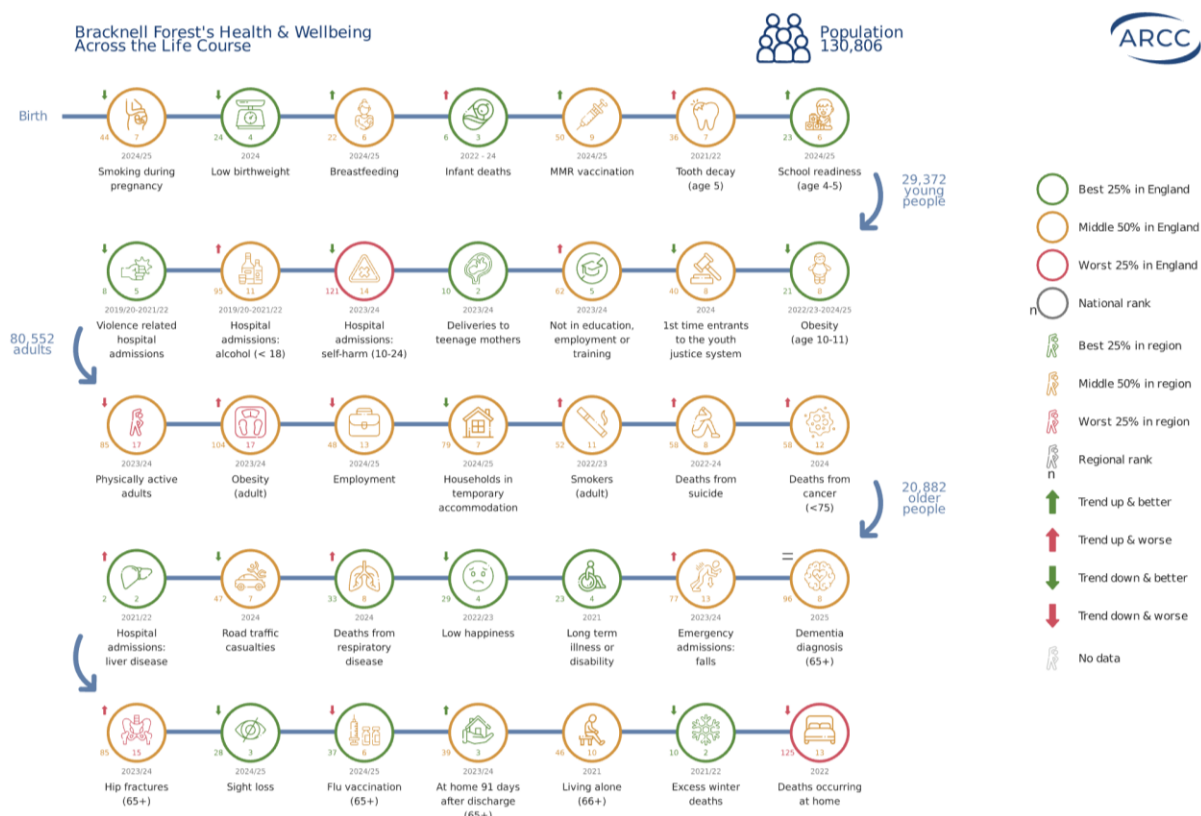
PLUS groups can be identified across the 5 key clinical areas and smoking.

RegisterType	Carers	Learning disability	Total
☐ 5	1,455	109	1,560
Cancer	324	11	335
COPD	128	0	131
Hypertension	1,206	70	1,273
Mental health	46	31	76
Pregnant (last 12m)	28	0	30
Total	1,455	109	1,560

Where are we?

The production of the Joint Strategic Needs Assessment (JSNA) has provided population health insight and informed priority areas for focus and action. The JSNA provides a comprehensive oversight of the Bracknell Forest population, current and emerging needs and health inequalities. The diagram below shows the overarching need in Bracknell Forest across the life course from birth and the early years through to older aging adults and death.

⁶ Connected Care data includes individuals registered with a Bracknell Forest GP. It excludes individuals who have opted out, or who are not registered with a GP.



The emerging JSNA has helped us identify five key areas of focus for Bracknell Forest where there is a clear opportunity for joint action to improve health and wellbeing outcomes and reduce inequalities.

These are:

- **healthy weight**
- **children and young people's mental health**
- **social isolation and loneliness**
- **frailty**
- **people living with multiple disadvantage.**

Together, these themes provide a strong evidence base for action across the life course and have directly informed the priorities and delivery approach set out in the emerging Joint Health and Wellbeing Strategy. They highlight where the Board and system partners can make the greatest difference through prevention-first, neighbourhood-based, and person-centred action.

Where do we want to get to?

Our inclusive vision set out in the Health and Wellbeing Strategy is to work in partnership to ensure our residents fulfil their full potential, live in healthy and thriving communities while fostering connectedness and inclusivity.

The emerging Joint Health and Wellbeing Strategy sets out our ambition to move to a more prevention-first, neighbourhood-based system that tackles health inequalities earlier and more consistently across the life course. This means focusing collective effort on the conditions that shape health, strengthening community resilience, and ensuring that people can access joined-up, person-centred support before needs escalate. Over time, we want to see healthier starts in life, healthier and more connected adult lives, and more people ageing

well and independently, with the greatest improvements seen in those communities experiencing the poorest outcomes.

Going forward, the objectives set out in the Health and Wellbeing Strategy are to embed a health inequalities lens across prevention activity, use neighbourhood-level insight to target support where it will have the greatest impact, and strengthen partnership action on the wider determinants of health such as housing, employment, social connection and access to community assets. We will support earlier intervention through community-based and primary care pathways, continue to promote good mental wellbeing and reduce loneliness and isolation, and work with residents, community organisations and system partners to co-design practical solutions that help people stay well for longer. This will ensure that prevention is not a standalone programme, but a shared way of working across health, care and the wider system.

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.

Taking a life course approach to prevention: The Joint Health and Wellbeing Strategy has identified the following areas for action across the life course:

 Start Well Give every child in Bracknell Forest the best start in life through integrated, prevention-first support from pregnancy through to adolescence.	Healthy Pregnancy and Early Years Integrated antenatal and early years pathways; joined-up support across midwifery, health visiting, family hubs and early help; targeting families experiencing inequalities. How we will measure success: <i>Continued reduction in smoking rates in pregnancy and people living with the child, improved experience and uptake of healthy start vouchers in deprived areas, narrowing inequalities school-readiness</i>
	Healthy Weight in Children and Young People Whole system approach coordinating schools, local authority and health, neighbourhood-level environments; planning levers to address food environments near schools. How we will measure success: <i>Reduction in % children overweight/obese in Year 6 with inequalities by ward narrowing, increase in children meeting physical activity guidelines</i>
	Children and Young People's Mental Health Whole-school approaches; needs-based pathways aligned to THRIVE framework; trauma-informed practice; strengthened early help for those with SEND and suspected neurodiversity. How we will measure success: <i>Reduction in self-harm hospital admissions (10-24 year olds), reduction in crisis presentations, increase in early help services and uptake</i>



Live Well

Work systematically to ensure all adults in Bracknell Forest live in healthy, thriving neighbourhoods with access to integrated, person-centred health and social care.

Social isolation, loneliness and community resilience

Coherent community infrastructure; sustainable VCS; neighbourhood coordination in areas of highest need

How we will measure success:

Reduction in self-reported loneliness/isolation, ensure services are inclusive and accessible by improving reach among people experiencing multiple disadvantage

Preventing long-term conditions through healthier environments

Embedding prevention by addressing wider determinants; planning and licensing levers for healthier environments; coherent neighbourhood health systems

How we will measure success:

Reduction in HFSS outlet density near schools, increase in % adults physically active in deprived areas, improve uptake of NHS HC and management of conditions, ward-level tracking of access to green space and food



Age Well

Create the conditions for older people in Bracknell Forest to live independently, stay connected and age well

Mid-life prevention

Promote healthy ageing from mid-life using key touchpoints such as NHS Health check programme; joined up pathways into lifestyle, mental health and social wellbeing support

How we will measure success:

Increase in MECC, increase uptake of preventive programmes/pathways e.g NHS HC, Diabetes Prevention Programme

Age-friendly environments

Housing, planning and transport considers healthy ageing impact e.g. age-friendly design in new developments

How we will measure success:

Age friendly assessments integrated in planning decisions, reduction in transport-related access barriers captured via resident surveys

Stronger Together Communities Strategy 2026-36: This is a 10-year strategy, co-produced by over 20 organisations, including the Berkshire Health Foundation Trust (BHFT), Frimley ICB, Healthwatch, Involve Community Services, Bracknell Forest Council, and other public sector and VCSE sector organisations, working closely with residents. The vision of the strategy is “Together we will further strengthen our community to ensure everyone belongs, is listened to, well informed and connected; people can join in, help each other and take pride in where they live and work.”

The aims and objectives of the strategy are grouped into two main themes: community actions and community cohesion, with a focus on aligning plans, implementing enabling actions and promoting inspiring actions so residents and people learning or working in the

borough can come together to address common challenges and common aspirations towards better health and wellbeing outcomes. The aims of this strategy are:

1. We are connected and support each other to live well
2. We can join in and contribute to community life
3. We feel safe and get on well together
4. We have fair access to opportunities, and everyone belongs
5. We take pride in and care for our community

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.

2. Neighbourhood Health and Thriving Communities

Neighbourhood Health

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 2026-27, as the initial year following the publication of the neighbourhood health framework, should be to start developing and embedding our approach to Neighbourhood Health services in Bracknell Forest. Rather than operating in silo, Neighbourhood Health is an approach which will be threaded through multiple priority areas within this plan.

Thriving Communities

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, the Thriving Communities programme was launched. Since June 2024, work has been underway to build relationships with three 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 is on understanding the priority needs of the Bracknell Forest community. This shared understanding guides how the next steps are delivered and embody the principles of joint working that have been agreed.

Shared Principles: The principles that guide the development of Thriving Communities in Bracknell Forest 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?

Neighbourhood Health: The Bracknell Forest population includes individuals with increasing complexity, leading to additional demand across health and social care. The following areas have been identified as priorities for Bracknell Forest:

- Children and Young People's Mental Health – with a focus on prevention and support in schools.
- Frailty and older adults – including people with dementia, falls, people at the end of their life, and individuals with multiple long-term conditions.

There are a number of existing areas that can be built upon as part of the neighbourhood health approach:

- Integrated neighbourhood teams including:
 - Fully integrated community teams.
 - Intermediate care (step-up/step-down) services.
 - Locality Access Point multi-disciplinary team (MDT) model.
 - Integration across physical health, mental health and social care.
- Community hubs and co-located services such as:
 - Brants Bridge.
 - Skimped Hill.
 - Binfield Community Hub.
 - Happiness Hub.
- Community-led support and peer networks including:
 - Foxes Den CIC.
 - Happiness Hub.
 - Peer support for anxiety, confidence and loneliness.
 - Community groups supporting wellbeing.
- Digital-enabled care such as:
 - My Frimley App.
 - Remote monitoring.
 - Digital assistive technology.
 - Ambulatory blood pressure monitoring.

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

Over the first half of the three-year programme there has been a focus on two areas: community development taking a strengths-based approach and organisational development. Community development work in the Centre of Bracknell area, including a

focus on specific flats and housing blocks there, Easthampstead & Wildridings and Priestwood & Garth, have led to strong relationships and community groups forming. Several initiatives have been developed such as the Community Chest and Third Spaces, a group for young adults run by young adults to address social isolation and support mental health and wellbeing. An Organisational Development Action Plan has been co-developed with council, health and community partners to support organisations to engage with local people and co-produce solutions with residents.

Happiness Hub: The Happiness Hub is a core component of Bracknell Forest's preventative, community-based mental health offer, aligning with the system's focus on early intervention, reducing inequalities, and supporting residents to remain well and independent within their communities.

The model operates as a visible, open-access gateway to support, enabling residents to seek help at the earliest possible stage, without the need for referral. Through neighbourhood-based drop-ins and outreach, the Hub reduces barriers to accessing services, supports self-management, and promotes social connection—recognised protective factors for long-term mental and physical wellbeing.

The Happiness Hub contributes to prevention across all levels of the population health model:

- **Primary prevention (whole population):** Promotes awareness of services, self-help, and wellbeing, encouraging residents to seek support before needs escalate.
- **Secondary prevention (at-risk groups):** Provides early access to multi-agency support for individuals experiencing emerging mental health concerns, reducing escalation to statutory or clinical services.
- **Tertiary prevention (those with ill-health):** Supports recovery and ongoing wellbeing through connection to appropriate services, helping prevent relapse and reduce re-admissions.

The Hub operates as part of a wider preventative system alongside the Mental Health Recovery Network and Community Access Panel, collectively ensuring a joined-up, strength-based pathway that keeps people well and reduces demand on acute and secondary care services.

Impact as a Preventative Model:

- Enables early identification and intervention through informal, non-clinical access points.
- Reduces barriers to engagement, particularly for those less likely to access traditional services.
- Strengthens community resilience and social connections.
- Supports self-management and informed decision-making.
- Contributes to reduced reliance on statutory and acute services.

This aligns directly with the partnership vision to prevent deterioration, promote independence and improve health outcomes through community-based approaches.

Where do we want to get to?

Neighbourhood Health: We want to more effectively support our communities to be able to manage increasing complexity and be more resilient. We want to support community actions so Bracknell Forest residents can come together to address common challenges and common aspirations towards better health and wellbeing outcomes.

An initial neighbourhood health plan for 2026-27 needs to be developed. This needs to include a plan to:

- Reduce non-elective admissions and bed days
- Tackle unwarranted variation and improving access to general practice
- Agree neighbourhood footprints around natural communities
- Establish Integrated Neighbourhood Teams (INTs) focused on high priority cohorts
- Establish a new neighbourhood approach for elective pathways
- Meet 18-week community waits and eliminate 52-week waits
- Use pooled funding under the Better Care Fund
- Continue to improve the primary and secondary care interface in line with the red tape challenge
- Confirm organisational ownership of planned deliverables
- Have the appropriate data-sharing arrangements in place.

There are opportunities to:

- Extend proactive identification and earlier intervention before people reach service thresholds.
- Replicate successful hub models in other neighbourhoods.
- Scale community-led approaches and strengthen links with formal services.
- Use technology more systematically for prevention, self-management and earlier intervention.

Thriving Communities: A detailed evaluation framework has been developed to articulate the success measures of the Thriving Communities programme. Broadly this focuses on outcomes that strengthen communities and shift to empowering communities to lead sustainable 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. 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 & Garth and Easthampstead & Wildridings.

Happiness Hub: Building on an established monthly drop-in model, the Happiness Hub has moved beyond business-as-usual delivery and is actively being expanded to improve access, reach and impact via:

- Ongoing growth in attendance and engagement by increasing footfall and sustained community utilisation across hubs. This demonstrates increased early engagement, supporting demand reduction in statutory services.
- Introduction of sensory friendly sessions to improve accessibility and support early engagement. This reduces barriers to access for vulnerable groups, enabling earlier intervention and preventing crisis escalation.
- An enhanced digital access offer with improved online presence to enable early, easy virtual access to information and services. This supports early self-help and navigation, reducing reliance on formal services.
- A strengthened partner engagement model enabling broadened engagement with health and well-being partners, supported by a timetabled offer to improve access to

service information across Bracknell Forest. This improves visibility and coordination of support, enabling residents to access help earlier and preventing unmet need.

- Strengthening partnership delivery via continued expansion of multi-agency participation at drop-ins and events. This supports a whole-system prevention approach, reducing duplication and improving navigation across services.
- Integration into wider system pathways via alignment with the Mental Health Community Access Panel, enabling earlier and more appropriate signposting into community support. Strong links with Mental Health Recovery Network pathways, supporting continuity of care and long-term recovery. This demonstrates movement beyond standalone activity to embedded system infrastructure.
- Increasing visibility and alternative engagement routes via ongoing delivery of community events and outreach activity to raise awareness and promote early help. Expansion of digital and community-based engagement approaches (e.g. social media, community messaging, event-based support). This supports earlier access and wider population reach, particularly for underserved groups.

What objectives will we deliver going forward?

- Increase people's independence.
- Increased community resilience.
- Creating an empowering and enabling culture – developing listening, strength-based development 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.

3. Strength-Based Practice

In Bracknell Forest a strength-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 strength-based practice in 2019. The Social Care Institute of Excellence (SCIE) were involved in the roll-out of strength-based practice. Strength-based approaches have been embedded as 'business as usual' since August 2023. This is not a standalone priority, but a way of working that is threaded through all the work that we do. Embedding this approach has meant a better use of community assets and resources.

Strength-based ambassadors, who are specially trained adult social care and health practitioners, are embedded within local care teams. They act as champions for a strength-based model of practice, helping staff shift focus from traditional service-led assessments to supporting individuals based on their personal strengths, skills, and community resources.

Where do we want to get to?

- For strength-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 strength-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.
- 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 Bracknell Forest partnership, and the NHS, by freeing up resources whilst providing an opportunity for more people to remain independent in the community for longer.

4. Extra Care

Extra Care accommodation (also known as housing with care) is a model of supported housing that enables older people or those with care needs to live independently in self-contained homes while having access to flexible, on-site care and support services available 24/7. It combines the privacy and security of independent living with communal facilities and tailored care, helping individuals maintain autonomy, wellbeing and social connection, and reducing reliance on traditional residential or nursing care settings by providing a preventative and more adaptable form of support.

Where are we?

While still in the early stages of developing its Extra Care provision, Bracknell Forest has identified Extra Care as a strategic priority and is embedding it within its medium-term financial and service planning. The Council has identified a significant unmet need for Extra Care provision and is progressing work to address this gap and establish a cost efficient route to market.

Where do we want to get to?

The Council's ambition is to establish a sustainable Extra Care offer within the borough that provides a viable alternative to residential and nursing care, delivering better outcomes for residents while reducing long-term costs. This includes developing schemes that enable people to remain independent for longer, delay or prevent admission to care homes, and support integrated care delivery. In doing so, the Council aims to realise significant financial efficiencies—through lower care costs, reduced NHS utilisation and housing benefit-funded

accommodation—while improving quality of life and creating a more preventative, community-based model of care.

What objectives will we deliver going forward?

- Establish dedicated programme capacity to lead delivery.
- Complete a detailed options appraisal and financial modelling to determine the preferred delivery model for Extra Care in Bracknell Forest.
- Agree a strategic delivery plan and funding approach, aligned to the Council's medium-term financial strategy.
- Develop a pipeline for initial schemes, working with developers and partners to move towards delivery within the three-year timeframe.

Proactive approaches to care

5. 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 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. Moving forward, the NHS 10-Year health plan and the neighbourhood health guidance will frame this work.

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 Bracknell Forest, 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 10-Year Health Plan and the Thames Valley ICS. PCNs have responsibility for the health of the populations that they cover. They are therefore key leaders and partners in the health and care system for Bracknell Forest.
- 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 learnings post-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 continues to be a very clear focus 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 Bracknell Forest 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 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 Neighbourhood 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 continue to play a key role in supporting 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.

6. Proactive 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, 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 (PCNs) 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 PCNs 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 Bracknell Forest.
- 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 part of the proactive care approach.
- 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.

7. Enhanced health in care homes (EHCH)

There is an ambition for Bracknell Forest to strengthen its care homes programme through a sharper and more consistent Quality Assurance (QA) approach, ensuring that local support for residents and care home staff is not only well coordinated but demonstrably safe, effective, and continuously improving.

While the NHS Long Term Plan (2019) and the Ageing Well Programme have successfully embedded the Enhanced Health in Care Homes (EHCH) model, the next phase of delivery requires a stronger focus on system-wide quality oversight, assurance, and continuous improvement.

As system transformation has matured, the challenge is no longer solely implementation, but ensuring consistency of delivery, evidencing impact, identifying variation, and responding proactively to emerging risks. This requires dedicated QA capacity to oversee standards across partners, ensure compliance with agreed pathways, and provide assurance to the system.

Although the Ageing Well Programme formally concluded in July 2023, delivery continues under the Frailty Advisory Board. However, QA arrangements remain distributed, and there is an increasing need for dedicated resource to coordinate, analyse, and drive quality improvement across the system, particularly as expectations on care homes continue to grow.

Where are we?

There is a strong foundation of integrated working across Bracknell Forest; however, current QA activity is fragmented, and oversight is not consistently applied across all elements of the pathway.

All care homes are aligned to Primary Care Networks (PCNs) with named clinical leads, and regular “home rounds” are in place. However, there is limited systematic QA to assess consistency, outcomes, and adherence to expected standards across PCNs. There is no overarching QA framework to monitor responsiveness, equity of access, or resident outcomes with data on timeliness, appropriateness, and outcomes not consistently triangulated due to limited QA capacity to systematically evaluate impact, learning, and opportunities for optimisation.

A collaborative approach to care home support exists, with links into governance pathways. However, current QA processes are largely reactive and rely on existing contract monitoring rather than proactive, system-wide assurance. Training offers and initiatives such as falls prevention and physiotherapy support are well received, but evaluation is not consistently standardised or systematically reported.

Overall, while there is strong delivery and partnership working, QA is not yet sufficiently resourced or coordinated to provide robust assurance, drive continuous improvement, or fully evidence impact.

Where do we want to get to?

- Establish a robust, system-wide Quality Assurance framework for care homes, with clear standards, metrics, and reporting mechanisms.
- To ensure consistent oversight of quality, safety, and outcomes across all care homes and supporting services.
- For care home residents to receive equitable, high-quality care, underpinned by transparent QA processes.
- To move from reactive monitoring to proactive identification of risk, variation, and improvement opportunities.
- To embed data-driven QA, enabling better understanding of impact, trends, and areas requiring intervention.
- To ensure all pathways are not only in place but consistently delivered in line with agreed standards.
- To strengthen training assurance, ensuring staff capability aligns with expected standards and that learning translates into improved outcomes.
- To ensure the system can evidence improvement in quality of care, experience, and outcomes, supported by robust QA infrastructure.

Central to achieving this is the establishment of dedicated QA resource to coordinate, oversee, and drive this agenda.

What objectives do we want to deliver going forward?

- Secure Quality Assurance resource to lead on the development and implementation of a comprehensive Quality Assurance framework for care homes, including clear KPIs, reporting cycles, and escalation processes.
- Introduce regular routine QA reviews of identified key quality components and KPIs (e.g., evidence of personalised care plans, effectiveness of Audits and Reviews, continuous improvement, etc.).

- Establish consistent monitoring and evaluation cycles, including resident experience, health outcomes, and service responsiveness.
- Secure dedicated QA capacity to coordinate data collection, analysis, and insight across partners.
- Develop a systematic approach to auditing and reviewing pathways, ensuring consistency and identifying variation across providers.
- Enhance quality and impact evaluation of training and workforce development within care homes.
- Reduce hospital admissions and ambulance conveyances through QA-led identification of avoidable variation and improvement interventions.
- Support care homes through Adult Social Care Reform with clear QA oversight of new requirements and expectations.

8. 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 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 on 31st January 2027, 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 if their alarm is commissioned via the local authority provision of Forestcare.

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 England Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 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.

A survey was undertaken to explore what technology is currently being utilised by carers, findings from the survey have been used in the carers' strategy annual progress report.

The 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 5 of 16 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. As of October 2025, 1,124 patients were being monitored in this way, which is an increase of 5% from the previous December.

Evaluation across the former Frimley ICS compared a group of care home residents enrolled onto remote monitoring with a comparator group that did not, which revealed a 33.2% reduction in A&E attendance and a 43% reduction in admissions.

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.
- 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?

- Continue to increase use of the Forestcare Assessment Suite.
- Increased use of remote monitoring of patients.

Reactive Care

9. Urgent Community Response (UCR) and Frailty Virtual Ward (FVW)

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 helping 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 three Bracknell Forest PCNs with referrals seeing a steady increase since the launch of the service (including referrals from Care Homes).

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:

What objectives do we want to deliver going forward?

- Avoid Unnecessary Hospital Admissions - treat patients in their own homes or care homes, avoiding the deconditioning and risks associated with hospital stays.
- Rapid Response Standards - provide urgent clinical care within two hours for crisis situations (e.g., falls, acute infection, or sudden deterioration in chronic conditions).

- Facilitate Rapid Discharge – to provide immediate support to help patients settle back home after a hospital stay and maintain their independence.
- Enhance Independence (Reablement) – provide tailored care that helps individuals regain their skills, confidence, and ability to live independently.
- Integrated Care Pathways - collaborate with ambulance services, GPs, and social care providers, often acting as a single point of access for patients in crisis.
- Provide Short-Term Interventions – provide up to 48 hours of care to stabilize patients during an acute crisis.

10. 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 **strength-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 in Bracknell Forest 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.

Thames Valley 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 strength-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.

11. Intermediate Care and Reablement

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 Thames Valley 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, and 9am-5pm on weekends and bank holidays. 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. Eligibility criteria has recently been reviewed, which has led to an increased number of referrals into the service.

A weekly review takes place to compare planned visit durations with actual visit times so that plans can be amended to accurately reflect individuals' needs and maximise the amount of time that staff can spend supporting people.

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 (FHFT) with additional specialist therapies provided by Berkshire Healthcare NHS Foundation Trust (BHFT).

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 use the intermediate care offer for groups that have previously been less well-supported by this approach.
- To introduce scheduling changes to maximise efficiency by allocating staff differently so that their direct client-facing contact time is increased.
- 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 continue 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.
- Implement a new rostering and scheduling system which will have the functionality for real-time updates, planned-versus-actual reporting, and peak demand analysis. Additional reporting capabilities will enable accurate tracking of individuals' journeys back to independence.

12. Market Sufficiency, Care Home Framework and Market Position Statement for Adults

Bracknell Forest Council is committed to delivering a sustainable and resilient care market that can meet current and future demand. Working collaboratively with providers, the Council seeks to ensure sufficient market capacity, long-term sustainability, value for money, and high-quality outcomes for residents. This strategic approach is reflected in the development of the Council's new *Market Position Statement*, which will set out its commissioning intentions over the next five years.

The *Market Position Statement* will play a key role in shaping the future of Adult Social Care provision across the borough by providing a clear picture of current and anticipated demand. It will support informed decisions, encourage innovation, and provide greater transparency for existing and prospective providers regarding the Council's commissioning intentions. Bracknell Forest aims to foster a diverse and sustainable market, capable of responding flexibly to changing levels of need, including increasing demand for complex care. In parallel, the Council is strengthening its market-shaping role by developing closer partnerships with providers and stakeholders. This includes promoting early engagement, improving intelligence, and identifying opportunities for collaborative solutions that enhance service quality.

Bracknell Forest Council is also undertaking a strategic review of its commissioning arrangements for older people's residential and nursing care provision. In collaboration with neighbouring local authorities, the Council is exploring alternative contracting models designed to strengthen market sustainability, improve purchasing leverage, and secure high-

quality, cost-effective services for residents. The approach seeks to establish a strategically managed network of providers that meet agreed standards for quality, safeguarding, and value for money, ensuring residents can access appropriate care settings in a timely manner. The approach aims to ensure a diverse and flexible supply of residential and nursing care placements, including specialist provision for people living with dementia and those with complex nursing needs, enabling the Council to respond effectively to changing patterns of demand.

Where are we?

The Council currently relies largely on external market provision and spot purchasing arrangements. Within this market the Council recognises the increasing demand for placements and the associated pressures on affordability, capacity, and market sustainability. The Council is focused on moving towards a more proactive and planned approach that balances quality, value for money, and sufficiency of provision, supported by a stronger understanding of current and future market capacity and identified gaps in provision. This includes exploring the potential benefits of more formal commissioning mechanisms, such as framework arrangements and collaborative approaches with neighbouring authorities, to strengthen market influence, enhance provider relationships, and secure sustainable, high-quality care provision.

Where do we want to get to?

The ambition is to establish a strategically managed network of approved providers that meet agreed standards for quality, safeguarding, and value for money, ensuring timely access to residential, nursing, dementia, and other specialist care placements while supporting greater consistency in pricing, service quality, and contract oversight. Through the introduction of a more structured and consistent commissioning approach, the Council aims to strengthen market management, reduce reliance on high-cost spot purchasing, enhance oversight of provider quality and performance, and develop stronger partnerships with the care market. This approach will support improved resident outcomes by ensuring timely access to appropriate care placements while delivering greater financial sustainability, control, and predictability across the Adult Social Care system.

What objectives will we deliver going forward?

- Undertake a comprehensive market analysis to understand current provision, gaps (e.g. nursing, dementia), and future demand.
- Strengthen provider relationships and market engagement, supporting sustainability and quality improvement.
- On review of the market analysis, market engagement and needs analysis we intend to develop and implement alternative Commissioning approaches to current Spot Purchasing arrangements with the aim to:
 - i. Revise service specifications, pricing models and contractual terms.
 - ii. Establish quality and performance standards, including clear monitoring and assurance processes for providers.
 - iii. Introduce a more consistent placement and brokerage process, reducing reliance on spot purchasing.
 - iv. Ensure alignment with the Council's medium-term financial strategy, delivering improved cost control and value for money.
 - v. Work with pre-approved providers to create sufficient local residential and nursing capacity to meet future demand.

Transformation for population groups to improve health

13. Unpaid carers

The Census 2021 recorded 8,770 unpaid carers in Bracknell Forest, representing approximately 7% of the population. Of these, 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.

Where are we?

Thames Valley 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' support service: SIGNAL4Carers. They provide an Information, Advice and Guidance service, and they also facilitate social events and other opportunities for people to connect.

The [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. A Carers' Strategy Partnership Board meets quarterly, to oversee the delivery of the strategy, through the five workstreams. A quarterly dashboard tracks progress against the priorities.

The [Carers' Strategy: Annual Progress Report 2025](#) was presented to the Health and Wellbeing Board to outline key achievements and any risks to milestones to date. This progress report was informed by engagement with carers through focus groups, surveys and workshops. There was also a comprehensive review of all data available through the quarterly dashboard and Connected Care.

Key achievements noted in the progress report include:

- New carers' assessment – covering a range of topics including respite, contingency planning and assistive technology needs. Since it launched in May 2025, 252 carers' assessments have been completed.
- Co-produced carers' self-assessment – set up to determine whether carers may need additional support in their caring role, enabling them to be signposted to relevant information and pre-populating some of the full carers' assessment if one is required.
- Improved communication – refreshed BFC webpage to make it more accessible.
- Increased number of people registered as a carer on GP records.
- New young carers' assessment developed as part of the new BFC offer for young carers.

Where do we want to get to?

The strategy has a five-year working plan so will continue to be reviewed annually with carers, ensuring the action plan is updated as necessary. There will continue to be regular

workstream meetings and quarterly partnership board meetings to review progress and monitor the ongoing work.

Some of the next key areas of focus are:

- Analysis of the Survey of Adult Carers in England returns once the full data set is released.
- Develop links to the local Connect to Work programme to ensure carers are identified as a group that need support to find or remain in employment.
- Implement training webinars for social workers, early help professionals, school staff, Health colleagues and the VCS, to help with the identification of young carers.

What objectives will we deliver going forward?

- Deliver the refreshed action plan supporting the All-Age Integrated Carers' Strategy.
- Publish a carers' handbook to support new carers to navigate available services and support.
- Implement the 'No Wrong Doors' Memorandum of Understanding, tracking progress to ensure young carers are identified, assessed and supported regardless of which service or agency has contact with them in the first instance.
- 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.

14. 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 Berkshire Healthcare Foundation Trust (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.

Thames Valley 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.

Bracknell Forest has established a strong preventative community mental health offer that supports people to maintain good mental health, access help early and reduce the escalation of needs. The Mental Health Recovery Network (MHRN), the Happiness Hub and the Mental Health Community Access Panel together provide accessible, non-clinical and community-based support focused on early intervention and long-term wellbeing, alongside the Mental Health Integrated Community Service, Stepping Stones, and the Safe-Haven.

The MHRN is a core preventative service supporting adults experiencing mental ill-health to remain well and independent within their communities. Using a recovery-oriented and strength-based approach, individuals are supported to better understand and manage their mental health, build resilience, prevent relapse and access flexible one-to-one and group-based support that reflects what matters to them. This early and preventative support reduces reliance on statutory and acute services and promotes sustained wellbeing.

The Happiness Hub provides a visible and accessible preventative offer that enables residents to access information, advice and support without the need for a referral. Through neighbourhood-based drop-ins and outreach activity, people can seek help at an early stage, reducing barriers to support and preventing needs from escalating. The Hub promotes self-help, community connection and informed decision-making, supporting residents to take an active role in maintaining their own wellbeing.

The Mental Health Community Access Panel ensures that non-urgent mental health referrals are considered early using a strength-based lens and directed to the most appropriate community support. By providing a structured, multi-agency forum hosted by the Mental Health Recovery Network, the Panel supports timely access to preventative services and reduces unnecessary escalation to secondary care.

Together, these services form a preventative, person-centred mental health system that focuses on keeping people well, intervening early, reducing demand on acute services and improving long-term outcomes for residents.

Where are we?

BHFT's "OneTeam" approach has brought CMHT and MHICS teams together to create a single team that provides intervention for low, medium and high complexity patients.

Working towards more integrated care, the Community Mental Health Service (CMHS) now brings together the former Mental Health Integrated Community Service (MHICS) and Community Mental Health Team (CMHT) into a single integrated service. This One Team approach represents a partnership between Berkshire Healthcare NHS Foundation Trust (BHFT), the Primary Care Networks (PCNs) and key voluntary sector stakeholders, with the aim of providing joined-up mental health support in the community. The CMHS team includes mental health professionals from BHFT, Community Connectors from Buckinghamshire Mind, administrators from Primary Care, and wider community mental health staff working as one service to support people with significant mental health needs in the community as an alternative to more traditional secondary care pathways. The benefits of the new CMHS model include improved access to support closer to home, reduced fragmentation between primary and secondary care, a more holistic and person-centred response, earlier intervention to help prevent escalation and crisis, and stronger partnership working to ensure people receive the right support at the right time.

To support people with more significant mental illness who are unable to access mainstream Citizens Advice Bureau services, there is an 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.

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.

The Mental Health Recovery Network (MHRN) uses 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 is in operation – 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 Additional Roles Reimbursement Scheme (ARRS) roles are now fully embedded 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 work within the OneTeam Approach, ensuring people have quick access to services, with assessment taking place within two weeks of referral.
- Continue to work with people in a strength-based way to enable them to step down from hospital or supported living and live independently in the community. This includes working with Glenfield House.
- Continue to assess people within two weeks of referral.

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.
- 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.

15. Dementia

In Bracknell Forest, dementia is recognised as a long-term, progressive condition that requires coordinated, whole-system support. Wherever possible, people are supported to continue living at home, with the help of unpaid carers. There is a strong emphasis on promoting independence, dignity and quality of life through prevention, early intervention and person-centred care.

The Community Mental Health Team for Older Adults (CMHTOA) is a well-established integrated service, working collaboratively across primary care, specialist mental health services, adult social care and the voluntary sector. The team plays a vital role in supporting people with more complex psychological, behavioural or co-existing mental health needs, working alongside partner services to ensure continuity and coordination of care.

Community engagement is an increasing strength locally. Community organisations and local assets contribute to reducing isolation, improving access to support and promoting inclusion. Co-production is becoming more embedded, with people living with dementia and their carers valued as experts by experience whose insights help shape service design, development and improvement.

The older population (over 65) in Bracknell Forest is increasing year on year. The population aged 65 and over in Bracknell Forest was 21,280 in 2025 and is predicted to rise to 28,589 by 2040. Older age is a key risk factor for dementia; this demographic change is therefore expected to increase the number of people living with dementia and the number of carers supporting them. Services and support need to meet both current need and future demand.

Young-onset dementia refers to dementia diagnosed before the age of 65. In April 2026, the CMHTOA identified 58 people living with young-onset dementia. The number of people affected is expected to increase to 162 by 2040. This figure does not include people with a learning disability and dementia, so it is likely to underestimate the true number of people living with young-onset dementia in Bracknell Forest. People with a learning disability, particularly those with Down's syndrome, are significantly more likely to develop dementia than the general population and are also more likely to develop young-onset dementia.

As of February 2026, 839 people in Bracknell Forest have a recorded dementia diagnosis aged over 65. However, dementia prevalence is estimated at 1,368 people, suggesting a gap of 529 people who may be undiagnosed and therefore not receiving appropriate support. The number of people living with late-onset dementia in Bracknell Forest is projected to rise to 2,165 by 2040.

Comparing estimated prevalence with recorded diagnoses indicates the likely level of under-diagnosis locally. Bracknell Forest is currently recorded at 61.3%. Earlier national policy frameworks included a target that approximately two-thirds (66.7%) of people with dementia should receive a diagnosis, which functioned as a key performance indicator for service

delivery. However, more recently NHS England operational guidance has removed this target and the NHS now states the focus is increasingly on improving post-diagnostic support, care planning, and quality of life for people living with dementia and their carers. Despite this shift, continued monitoring of diagnosis rates remains a valid metric to understand potential levels of underdiagnosis locally.

Where are we?

A dementia needs assessment was completed in 2025, highlighting Bracknell Forest's ageing population, a projected increase in the number of people living with dementia, and growing demand for carer support.

A Dementia Strategy Steering Group (DSSG) has been established to oversee development of an Integrated Dementia Strategy. Membership spans health, social care and the voluntary sector. Monthly meetings are in place and the terms of reference have been agreed. The DSSG has agreed the scope, governance arrangements and structure of the strategy.

A Dementia Lived Experience Group (DLEG) has been established and is running in parallel to the DSSG, meeting monthly. The group brings a wide range of experience, including caring for people with early onset dementia, balancing caring responsibilities alongside work and young children, end of life care, and complex needs (co-existing conditions alongside dementia).

The first major dementia strategy themed engagement event at the Dementia Forum bi-annual meeting has taken place, co-produced with membership from health, social care, voluntary sector and carers of people with dementia. Over 80 people attended, and feedback was gathered through round-table discussions. Six questions were used to explore experiences and priorities across the dementia pathway. Feedback is being analysed to identify themes that will inform the development of the integrated dementia strategy.

Thames Valley ICB is also developing its dementia strategy. Commissioning team members are attending quarterly BOB/TV Dementia Partnership Oversight Group meetings to share learning and align approaches where appropriate.

Where do we want to get to?

Partners have agreed the dementia strategy will be all-age and cover a five-year period, supported by a delivery action plan to be developed by March 2027. The strategy will be structured around five pillars: preventing well, diagnosing well, supporting well, living well and dying well (end of life).

Further upcoming engagement is planned to continue shaping the strategy. This includes attending coffee mornings and local meetings (including the Memory and Wellbeing Festival in Bracknell Town Centre in May) and the Community Nurses' Forum and Care Home Forum.

Next steps are to co-produce and launch a public survey to broaden engagement and inform priorities. Work will also identify synergies with other Bracknell Forest strategies (including housing, carers and the local environment) to support aligned delivery where appropriate. In addition, an Equality Impact Assessment will be completed to ensure actions address inequalities and improve access and outcomes for all communities.

What objectives do we want to deliver going forward?

- Undertake a public and stakeholder survey to broaden engagement and inform priorities for the Dementia Strategy.
- Develop an Integrated Dementia Strategy, co-created with people with dementia and their families and key partners, with a comprehensive implementation plan outlining a collective system approach to addressing identified areas of service development.

- Increase dementia diagnosis rates.

16. 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.

2023-2026 was an extensive period of development in supported living for people with learning disabilities and this work continues into 2026-2027. 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 Continuing Healthcare (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, 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. Work will continue to ensure this is embedded effectively.

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. A new, purpose-built development called Bridgewell opened in October 2025 and accommodates individuals with a range of needs. The opening of Bridgewell meant that several properties became available for young people across Bracknell. This has enabled a large number of young people to move out of their family homes into supported living properties, allowing them to remain in their local area and build on their independence skills.

Work has taken place to complete a five year forecast of housing needs to help us better plan for what style of accommodation is required. Further work is now required to embed this and to create a supported living strategy that supports better outcomes for the people we support. A strategy helps ensure supported living is:

- Person-centred, not service-led.
- Focused on independence, skills development and quality of life.
- Designed to support people to live in their own homes rather than institutional settings.

We have been working collaboratively with our BFC housing team which has seen us moving individuals out of supported living services into more independent accommodation once they have developed the necessary skills to do so. This approach ensures that people are placed in appropriate housing that fosters independence and community living. The housing team has established a Move On Protocol for the Community Team for People with Learning Disabilities (CTPLD), which facilitates this transition. By supporting individuals to move into general housing and more independent living arrangements, we are also able to make supported living homes available for those who need them most.

Learning Disabilities is one of the PLUS Groups identified as a priority by the ICB and Bracknell Forest as part of the System's 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.

Breakthrough

Breakthrough offers supported employment services in Bracknell Forest, helping people with learning disabilities and/or an autism diagnosis identify the types of jobs they enjoy, prepare for work, secure employment, and stay successful in their roles. We provide help with job searching, interview preparation and on-site interview support, travel training, and engaging with employers. We also run project groups for people who want to develop and use their skills in creative ways.

Our key priorities are to strengthen our commitment to the local community by expanding inclusive employment opportunities for individuals with learning disabilities, neurodivergent conditions, autism, and other barriers to employment. As a delivery partner for the government's Connect to Work programme, we aim to support more people in accessing and sustaining meaningful employment through this initiative. Connect to Work is a voluntary programme that helps people overcome barriers to employment and find meaningful work. Barriers to employment can include health issues, disabilities, or other challenges that make it hard to get a job.

The programme offers up to 12 months of support that is tailored to each person's needs. This support is:

- personalised to help you achieve your goals
- focused on you as an individual
- one-to-one, so you get the help you need.

The 6 local councils in Berkshire (Bracknell Forest, Reading, Royal Borough of Windsor and Maidenhead, Slough, West Berkshire and Wokingham) have been awarded grant funding by the Government to help about 2,300 people during the 5-year programme.

Breakthrough Supported Employment is the delivery partner of the programme for Bracknell Forest.

Autism

The Autism Team have recently collaborated with the Happiness Hub to improve the wellbeing of autistic adults and their carers by providing an autistic friendly drop in session on a monthly basis. The Happiness Hub brings together local community services to make it easier for Bracknell Forest residents to access mental health and wellbeing support. It offers a welcoming space where people can discover what support is available locally, make informed choices, and feel confident that services are working together to provide the best possible care. This provision is currently under review to ensure it remains safe, autistic friendly and the location is appropriate.

Work underpinning the Autism Strategy continues to be implemented through five workstreams, which meet regularly to monitor progress across education, health, community access, transition, and employment.

Preventative support provided by the Generic Support Worker has achieved positive outcomes, reducing the need for long-term formal care. *"I do want to thank you for letting me join these groups because there was a time where I was at a really low point in my life and this has helped me get out more and socialise. I really appreciate the support you have given me. Thank you"*

The Generic Support Worker role is currently under review to assess whether additional capacity would enhance the team's ability to support more individuals in building confidence with community access, developing peer relationships, and increasing independence skills.

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 the 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 the 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.

Breakthrough: We will continue to develop our employer engagement programme by building new relationships, including with Bracknell Forest Council's recruitment team, to raise awareness of our service and explore local employment opportunities. We will also support employers who recruit people we work with by providing onboarding support, advice on reasonable adjustments, and training where required.

In addition, we will continue to contribute to and support the various workstreams within the local autism strategy, helping to improve outcomes and opportunities for autistic people across the community.

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 26-27.
- Delivery of the ICB ambition that at least 80% 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. This will increase joined-up care and support for people with learning disabilities.
- Develop a supported living strategy to ensure that people are placed in appropriate housing that fosters independence and community living.
- 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.

17. 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 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?

Bracknell Forest has adopted the **Approaching Adulthood Operating Model** following a review of the Approaching Adulthood team for Adult Social Care. This operating mode provides a structured and joined-up approach to transition planning from age 14 onwards. This model is now shaping how children's services, Adult Social Care, education and health partners work together to prepare young people for adulthood.

Under the operating model are key components already in place:

Early Identification and Entry to the Pathway

- Young people are identified early (from Year 9 onwards) using a consistent multi-agency process.

- Schools, health partners and children's services can raise young people via the **Approaching Adulthood Referral Form**.
- The referral form ensures all relevant information is captured, including aspirations, health needs, education pathways and any potential Care Act considerations.

Approaching Adulthood Referral Portal. Referrals are submitted through the **AA Referral Portal**, providing:

- A single, standardised point of entry.
- Automatic workflow allocation.
- Visibility for children's and adults' teams.
- Improved timeliness and consistency of triage.
- The portal helps reduce duplication and ensures smoother coordination between SEND, Children's Social Care, Adult Social Care and health partners.

Approaching Adulthood (AA) Operating Panel. The **multi-disciplinary AA Panel** meets regularly to:

- Review submitted referrals.
- Identify young people likely to require Adult Social Care involvement.
- Recommend early assessments, joint visits or screening.
- Agree lead professionals and next steps.
- Ensure the "what matters to me" and Preparing for Adulthood (PfA) domains shape planning conversations.
- The panel provides governance, oversight and consistent decision-making across education, health and social care.

AA Dashboard and Reporting. The **Approaching Adulthood Dashboard** provides real-time oversight of the cohort, including:

- Number of young people on the pathway.
- Referral volumes, timeliness and outcomes.
- Age-based tracking (14–25).
- Anticipated Care Act demand at 18.
- Risk indicators (e.g., housing, mental health, behaviours that challenge, health deterioration).
- Dashboard data informs workforce planning, commissioning intentions and early intervention.
- Quarterly reports summarise trends, performance and system pressures across both health and social care.

Coordinated Preparation for Adulthood

- Preparation for Adulthood (PfA) is embedded as a shared responsibility across all agencies, not an isolated activity within SEND teams.
- Partners are using a common framework to consider needs across the four PfA domains: **Education & employment, Health, Independent living, and Friends, relationships and community inclusion.**

Strategic alignment

The operating model now underpins transition commitments within:

- Bracknell Forest SEND Strategy
- Bracknell Forest Children & Young People's Plan

- Autism strategy
- SEND Improvement Programme

Collectively, these frameworks support a more predictable, timely and coordinated transition into adulthood.

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 do we want to deliver going forward?

- **Scope and co-produce an Integrated Bracknell Forest Transitions Strategy**, using the operating model as the foundation and ensuring alignment with Thames Valley ICB priorities.
- Strengthen the use of early identification tools, transition panels, dashboards and joint case planning arrangements across the system.
- Ensure young people and families are active partners in planning, decision-making and reviewing outcomes.

18. Those who are frail or at risk of frailty

The NHS neighbourhood health framework 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. One of the high priority cohorts is adults with mid to 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. An initial cohort of 3,000 people in Bracknell Forest were identified for the proactive care approach (using Connected care data). Engagement has been taking place with 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 practice 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 the frail population when they present in crisis within secondary care.
- Develop and optimise digital opportunities to integrate care for frail patients across our interfaces in secondary, community and Primary Care.

9. Enablers

There are a number of underpinning areas that are integral to enabling the successful delivery of the ambitions of the Bracknell Forest Health and Care Plan. These support data-led decision making and evidence-based changes and priorities.

Resources

The Integration White Paper 2022 encourages greater integration and alignment of resources, both at Integrated Care System and at local level, and this remains a key enabler for delivery of the Health and Care Plan. 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.

Building on this strong foundation, partners will continue to ensure that funding is deployed in a way that best supports agreed priorities and improves outcomes for residents. For Bracknell Forest this includes building on the success of the Better Care Fund (BCF) in previous years and ensuring that the BCF 2026-2027 plan supports the Health and Care Plan. In future years, the BCF will be closely linked to the neighbourhood health approach, which will be a truly collaborative effort between all partners.

Ongoing monitoring mechanisms, including regular review and performance dashboards, will be used to demonstrate the impact of resource allocation and ensure value for money, while maintaining flexibility to respond to emerging pressures and opportunities.

Workforce

Health and social care services in Bracknell Forest continue to face significant workforce challenges, reflecting wider national pressures alongside local demand. Increasing complexity of need, particularly linked to an ageing population and the rise in long-term conditions, is placing sustained pressure on staff capacity across all sectors.

Recruitment and retention remain key issues, particularly within some specialist health roles, alongside the need to support staff wellbeing and resilience in a high-demand environment. This needs to be addressed through joint workforce planning at a local level to ensure that the right capacity is available to drive further integration.

At the same time, there is a growing requirement to further develop multidisciplinary working approaches, and more flexible models of care, through the neighbourhood health approach. Partners are therefore focused on strengthening the workforce through collaborative planning, supporting career development, and building innovative roles and skills that enable integrated, person-centred care and support delivery.

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.

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, which will hopefully be addressed by the introduction of the Care Home Framework. Any shortage of care resources is a risk to delivering effective and timely care, and to ensuring the timely discharge of patients from hospital.

BFC Adult Social Care has made significant progress in stabilising and strengthening its workforce through:

- A more targeted and values-led recruitment approach
- Increased workforce stability and reduced reliance on agency staff
- A strong learning culture and “grow your own” model
- Investment in inclusive practice and staff experience (SC-WRES)

This has resulted in a more stable, skilled and supported workforce, contributing directly to improved service delivery and outcomes for residents.

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 Adult Social Care teams have collaborated with the acute trust to design and implement a shared discharge planning template and live

dashboard in the acute electronic patient record (Epic). This solution captures key discharge planning information and communication.

This collaborative approach has delivered significant benefits, including:

- **Reduced manual processes and reporting**, saving time and minimising the risk of data misinterpretation.
- **Improved communication**, with information accessible electronically and remotely, reducing delays associated with contacting busy wards.
- **More focused daily multidisciplinary huddles**, contributing to a reduction in the number of patients with No Criteria to Reside (NCtR).
- **Improved information flow between wards and the Transfers of Care Hub**, supporting more timely discharges and a reduction in length of stay.

Data from the acute discharge planning system, alongside daily extracts from Community Hospitals, is consolidated into a system-wide Discharge and Flow dashboard used for both operational and strategic decision-making. The dashboard provides:

- Real-time visibility of **patients with NCtR**, segmented by place, site, pathway and reason for delay, including timescales, enabling targeted action to remove barriers to flow.
- **Historical discharge data**, supporting analysis of key pathways, recurring reasons for delay and identification of improvement opportunities.
- Monitoring against **system-agreed optimal pathway standards**, which have been instrumental in driving consistent improvement and measuring progress over time.

Within Adult Social Care, a suite of Power BI dashboards provides comprehensive insight into activity, finance and performance across all areas. These dashboards enable managers and practitioners to:

- Monitor demand, activity levels and allocations
- Identify emerging bottlenecks and pressures
- Reduce reliance on manual spreadsheets
- Improve transparency and visibility of organisational performance

The introduction of these dashboards has strengthened data quality and the robustness of performance information. While the shift towards a consistently evidence-based decision-making culture is ongoing, there is clear engagement and commitment across the organisation to embed this approach over time.

Care market sustainability

A sustainable and diverse social care market is essential to delivering an effective health, care, and support system in Bracknell Forest. As with all other Local Authorities with social care commissioning responsibility, there is ongoing uncertainty as to how the market will be 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 around the availability of care homes, which will hopefully be addressed by the introduction of the Care Home Framework.

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.

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** – Provides supported living accommodation for up to 20 adults with care and support needs. Bridgewell opened in October 2025 and consists of 4 x 5-bedroom apartments, enabling people to stay living within the community in Bracknell Forest with the support they need to remain independent, safe and well.
- **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.

Discharge and Flow

The newly formed Thames Valley ICB continues to focus on improving patient flow and reducing hospital discharge delays. Priorities include reducing health inequalities, enhancing productivity via system-wide collaboration, and ensuring prompt patient discharge to appropriate care settings to improve capacity.

The key aspects of discharge and flow include:

- **Capacity & Flow** – utilising models like the Discharge Pathways Model to 'right-size' home-based and bed-based services for rehabilitation and recovery.

- Partnership Working – close collaboration with local authorities to manage the Better Care Fund, focusing on reducing delays and providing care packages, supported by national funding.
- Patient Experience – a focus on "home first" principles.
- Strategic Goals – Thames Valley ICB aims to improve efficiency and align health boundaries for better performance management.

To support this, the Frimley Discharge Data Dashboard (established in July 2023) is 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.

The Completion of the Adult 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 was developed and introduced in October 2023 – the "Target Operating Model", building on the findings of that review. It took into account data covering capacity and demand for all services, including intermediate care, hospital discharge and community referrals.

After extensive co-production with operational teams and development of new approaches, staff were allocated into the new roles, and the line-of-business IT system (LAS) was reconfigured to enable better reporting and improve consistency of practice. Additional resources were 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 were developed and this has enabled improved system processes and workflow to reduce duplication of effort and off-system 'manual' recording.

The model has now been embedded as business as usual. This has led to:

- An improvement in the number of people being dealt with at the point of contact.
- 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.

People now have a common point of access and consistent, quality experience throughout their interaction with services. Staff have clarity about their role and 'handoffs' are seamless and simple, with no information lost, both for staff and for the people using services.

There is continued improvement to Discharge and patient Flow from hospital, including continued commitment to the Home First approach; and 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 enables 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 have also been implemented to provide self-service options through portals for online self-assessment and carers' self-assessment.

This ensures continued improvements to pathways, particularly for young people moving into adulthood, learning disability, autism and mental health social care pathways for care needs assessments.

Technology First

A technology first approach is a key enabler in supporting people across health and care to live more independently, safely, and for longer at home, while reducing avoidable admissions and reliance on formal care. By embedding assistive technology into care planning, technology empowers individuals to manage their health, environment and daily routines, while providing reassurance to carers and professionals. Investment through the Better Care Fund, including the use of the Assessment Suite, and participation in wider East Berkshire initiatives demonstrates how technology bridges the gap between constant carer presence and independence, supports prevention (including falls and emergency admissions), enhances carer wellbeing, and underpins a more sustainable, proactive model of care delivered collaboratively across Bracknell Forest.

Co-Production

It is vital that residents are equal partners in the co-production and co-creation of the health and care landscape in Bracknell Forest 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.

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 the 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 the ICB and the Voluntary, Community and Social Enterprise sector (VCSE).

Co-production is being further embedded and expanded through the Thriving Communities programme. Through the 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. An action plan has been developed and is being implemented

to deliver opportunities to enhance strength-based approaches, including Co-Production locally.

Our aim is to achieve 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.

Voluntary, Community and 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 partnership at ICS level, as well as being integral to the development of integrated working and provision of support in the Bracknell Forest 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 both the Thriving Communities work and the Communities Strategy. 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.

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' most 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.

In the future we hope 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.
- 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.
- Involve will adopt and encourage other VCSE organisations to adopt the Communities Strategy, and work to inspire and create the right conditions for communities to take positive actions for themselves.

10. Appendix 1 – Action Plan 2026-2027

Prevention

Neighbourhood Health and Thriving Communities		
Priority outcomes: Healthy, independent, and resilient communities/reduction in health inequalities		
Action	Lead	Quantifiable measures
Jointly develop and scope the neighbourhood health approach. To include the frailty programme and Thriving Communities priority neighbourhoods.	Associate Director Places and Communities, ICB	Approved Bracknell Forest neighbourhood health approach
Continue to support the Thriving Communities programme in Central Bracknell and expand engagement in Priestwood & Garth and Easthampstead & Wildridings. 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, ICB and the Thriving Communities Programme Team	Co-produced initiatives in place in priority neighbourhood areas
Continue engagement with partners and the voluntary, community and faith sector organisations based in the pilot area to further co-design the approach.	Thriving Communities Programme Team	Activities included in the Evaluation Framework (coproduced with residents and partners) are capturing evidence about the strengths and recommendations for improvements for the programme and further organisational development. Number of workforce participants engaged in activities to increase commitment, skills and confidence in community engagement and co-design in the system/organisations.
Continue to work in pilot area of Town Centre and expand reach of programme to Easthampstead & Wildridings and Garth & Priestwood.	Assistant Director Communities and Policy, BFC	Co-produced initiatives in place in 3 areas. Residents linked to assets in local community. Evaluation reports qualitative and quantitative evidence about the impact on outcomes for residents. Number of residents engaged. Number and type of new community activities, initiatives or assets developed.

Strength-based practice

Priority outcomes: Strength-based approaches lead to the prevention, delay, and reduction of needs using assistive technology, reablement and rehabilitation

Action	Lead	Quantifiable measures
Continue to support people through the assessment and provision of assistive technology.	Principal Social Worker	TBD
Increase in the number of people whose needs are resolved at the social care 'front-door'.	Principal Social Worker	Number of people whose needs are resolved at the social care 'front-door'
Reduction in the number of people moving on to more intensive support.	Principal Social Worker	Number of people who required no further support following reablement services, and the number of people whose support needs reduced following reablement services
Reduction in the number of people moving to permanent residential/nursing placements.	Principal Social Worker	Number of people moving to permanent residential/nursing placements

Extra Care

Priority outcomes: Establishment of a sustainable Extra Care offer that provides a viable alternative to residential and nursing care

Action	Lead	Quantifiable measures
Complete a detailed options appraisal and financial modelling to determine the preferred delivery model for Extra Care in Bracknell Forest.	Strategic Commissioning Manager – Adults	Options appraisal completed
Agree a strategic delivery plan and funding approach, aligned to the Council's medium-term financial strategy.	Strategic Commissioning Manager – Adults	Strategic delivery plan agreed

Proactive approaches to care

Primary Care Transformation

Priority outcomes: Improved access to General Practice; Integrate services with local partners in line with the Fuller Stocktake priorities

Action	Lead	Quantifiable measures
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)	TBD – suggested percentage of practices
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	TBD

Proactive Care

Priority outcomes: People with multiple long term conditions and complex health and care needs will benefit from an integrated, multi-disciplinary approach to proactive care planning; develop a way of capturing and recording conversations, decisions and agreed outcomes or goals in a way that makes sense to the person; increase the overall number of people accessing proactive care pathways

Action	Lead	Quantifiable measures
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	Regular update of search for eligible patients
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	Number of proactive care consultations taking place with use of the tool
Develop local information for patients about the benefits of proactive care.	Bracknell Forest PCNs x3	Number of proactive care consultations taking place

Enhanced health in care homes

Priority outcomes: Bracknell Forest has an effective Quality Assurance process in place

Action	Lead	Quantifiable measures
Undertake a programme of Quality Assurance visits to Adult Social Care providers.	Strategic Commissioning Manager – Adults	Total number of QA visits/meetings undertaken
Develop Action Plans with providers where needed and step up or close these as appropriate.	Strategic Commissioning Manager – Adults	Number of active Action Plans, stepped up Action Plans and closed Action Plans
Work with Adult Social Care providers to support improvements in line with CQC recommendations.	Strategic Commissioning Manager – Adults	% of total Home Care Service with Good / Outstanding Providers % of 65+ "In Area" Care Home Service with Good / Outstanding Providers % of Working Age Adult Supported Living Service with Good / Outstanding Providers

A digitally enabled health and care system

Priority outcomes: Assessment Suite fully operational; Assistive Technology Strategy; 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

Action	Lead	Quantifiable measures
Promote and increase Assessment Suite utilisation by staff and residents. Increase Assistive Technology use in support planning, including linking into the SATA role at Forestcare.	Technology Enabled Care Manager	Number of people using the service
Increase the number of care homes where remote monitoring is deployed.	TBC - ICB	Number of care homes where remote monitoring is deployed
Increase the number of eligible patients who are onboarded.	TBC - ICB	Number of eligible patients who are onboarded

Reactive Care

Urgent Community Response and Frailty Virtual Ward

Priority outcomes: Improve community capacity, resilience, and sustainability to ensure a consistent timely level of response, improve patient outcomes and meet national UCR standards

Action	Lead	Quantifiable measures
Monthly Bracknell Forest UCR working groups and partner forums, to ensure collaborative working.	Bracknell Forest ICB Integration Lead	Number of UCR referrals (accepted and inappropriate), Number of people using the Frailty Virtual Ward
UCR team to regularly attend partner team meetings to support links with other services (including Care Homes).	Bracknell Forest ICB Integration Lead	N/A

Home First and Intermediate Care and Reablement

Priority outcomes: People are supported to remain at home where possible and return to their home environment following admission into hospital

Action	Lead	Quantifiable measures
Increase number of people supported via Home First. Continue to evaluate effectiveness of Home First and formerly ringfenced discharge fund resources.	Head of Service: Adult Social Care, Strategic Commissioning Manager, Integration	Percentage of people going home following hospital stay, number of care home placements prevented/pathways 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

Market Sufficiency, Care Home Framework and Market Position Statement for Adults

Priority outcomes: Bracknell Forest has an effective 65+ Care Home Framework

Action	Lead	Quantifiable measures
Undertake a comprehensive market assessment to understand current provision, gaps and future demand.	Strategic Commissioning Manager – Adults	Completed market assessment
Develop and implement a 65+ Care Home Framework	Strategic Commissioning Manager – Adults	Implementation of Care Home Framework

Transformation for population groups to improve health

Unpaid carers

Priority outcomes: Bracknell Forest is a community that supports unpaid carers of all ages in their caring role in a meaningful way

Action	Lead	Quantifiable measures
To ensure delivery of the action plan which supports the All-Age Integrated Carers Strategy.	Senior Commissioner, Integration	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 outcomes: Improved recovery rates for people experiencing mental ill-health; reduced waiting times for people experiencing mental ill-health		
Action	Lead	Quantifiable measures
The Mental Health Recovery Network will work with residents on their recovery to promote long term independence, admission avoidance and help with supported discharge.	The Mental Health Recovery Network Manager	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 Mental Health Recovery Network (MHRN). Data on MHRN usage (e.g. referrals, number of people supported 1 to 1, number of group activities attended).
Residents to have an assessment, and at least one intervention within 28 days of being referred into the service.	Community Mental Health Services	Data on length of time between referral and intervention

Dementia Priority outcomes: Bracknell Forest residents with dementia receive a timely diagnosis and are supported to live well through joined-up health, care, and community services.		
Action	Lead	Quantifiable measures
Hold Dementia Partnership Board to provide collaboration between members to assist with information sharing, updates and joint working helping promote a community/holistic approach to service development.	Dementia lead, ICS	Not applicable
Outreach work to raise community awareness of dementia and dementia prevention. Work with primary care to support people with dementia and their carers in a meaningful way.	Community Mental Health Team for Older Adults Manager	Dementia diagnosis rates
Sign off and publication of the co-produced All-Age Integrated Dementia Strategy.	Senior Commissioner, Integration	Publication of an Integrated All-Age Dementia Strategy following public consultation
Development of an action plan which supports the All-Age Integrated Dementia Strategy.	Senior Commissioner, Integration	Approved action plan with outcomes framework

Learning Disabilities and Autism Priority outcomes: Autistic people are involved in the development of services and support provided by Bracknell Forest; reduction in health inequalities		
Action	Lead	Quantifiable measures
Sign off and publication of All-Age Integrated Autism Strategy.	AD Commissioning	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	Approved action plan
Deliver and innovate programmes of work for people with learning disabilities and autism alongside Primary Care Networks and the	Learning Disability and Autism Transformation Manager, ICB	Progress against programmes of work

Integrated Community Team for People with a Learning Disability.		
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	Percentage of people with learning disabilities on the learning disability register having health checks – target 75%

Transitions for young people with Special Educational Needs and Disabilities (SEND) Priority outcomes: 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		
Action	Lead	Quantifiable measures
Scope and co-produce an Integrated Bracknell Forest Transitions Strategy, using the operating model as the foundation and ensuring alignment with Thames Valley ICB priorities.	CTPLD	Publication of an Integrated Transitions Strategy following public consultation

Those who are frail and those at risk of frailty Priority outcomes: 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		
Action	Lead	Quantifiable measures
Increase number of frailty patients being reviewed at MDT	Associate Director of Out of Hospital Care & BF ICB Integration Lead	Number of frailty patients being reviewed at LAP & Cluster meetings (MDTs)
Work with PCN teams to streamline the process of identifying Frailty patients	Associate Director of Out of Hospital Care & BF ICB Integration Lead	Number of frailty patients identified from the 1.1 & 1.2 cohort lists
Address variability of care planning within PCNs and access resource where appropriate (for example, Thames Valley Innovation Fund frailty bid)	Associate Director of Out of Hospital Care & BF ICB Integration Lead	TBD

Better Care Fund		
Action	Lead	Quantifiable measures
Data quality action plan action plan to be shared with region, to ensure alignment between local data and nationally published data.	BCF Programme Manager	Completed data quality action plan
Complete an action plan to address deterioration in residential admissions rate. Evidence of prioritisation of plan deliverables and outcomes driven by Population Health Management, with route to measure and monitor impact.	BCF Programme Manager	Completed action plan
Baselining and understanding of Reablement metric to be developed, to ensure ambitions for improvement in future plans.	BCF Programme Manager	Baseline data to be incorporated in Health and Care Dashboard
Enhanced review of productivity and value for money, to include benchmarking, the impact of NHS productivity targets on local ambitions and completion of structured review as indicated.	BCF Programme Manager	TBD

Ensure decision making responsibilities across governance meetings are clearly defined and opportunities to share learning are utilised.	BCF Programme Manager	TBD
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