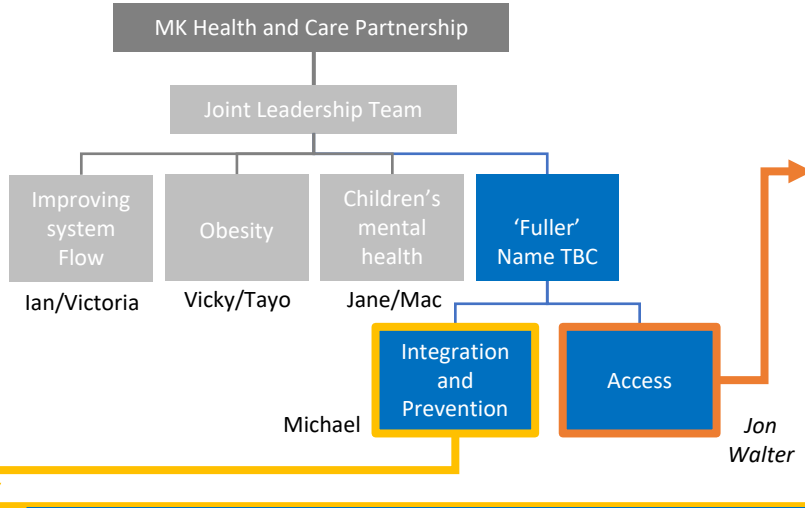

This work overlaps with the 2023/24 DES requiring practices to submit Access Improvement Plans in May 2023 and linked to the national Primary Care Recovery Plan

A Streamlining access to care and advice — City-wide

Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it

Next steps…

1. Increase pharmacy access
2. Improving Clinical Navigators training to signpost to appropriate service for advice and care
3. Improve practice website navigation and signposting
4. All GP practices to be on the same cloud based telephony system
5. With ISF improve access to resources for reducing hospital admission, access to palliative care & access to MH services
6. Increase access to remote consultations
7. Broaden the clinical roles in primary care so that a patient gets seen by the most appropriate clinician

B1 Proactive, personalised care with a multidisciplinary team of professionals — Bletchley pathfinder

Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions

Next steps…

1. Complete a workforce audit in the area and map existing multi-disciplinary team arrangements
   Primary care, community and mental health, local authority, town councils, police, voluntary sector, schools
2. Agree what case management approaches will be used to identify and support specific groups
3. Develop the operating model for the teams
   What will the remit be? How many teams? How will they operate? How will we build relationships and ownership?
4. Work out how they will inter-relate to city-wide services, like the hospital
5. Decide what indicators of success would be appropriate

B2 Helping people to stay well for longer — Bletchley pathfinder

Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

Next steps…

1. Develop a plan to increase use of Bletchley Leisure Centre, especially amongst inactive residents
2. Pilot a health and wellbeing coach role focused on behaviour change (smoking, weight management)
3. Work out how to develop the VCS and their contribution to helping people stay well for longer
4. Expanding PCN inequality and prevention plans and the role of pharmacies.
5. Decide what indicators of success would be appropriate

Cross cutting

1. Enhance the Bletchley community profile
2. Decide the leadership arrangements
3. Agree the governance and work out how people from out of area can be involved to share learning
4. Gain final agreement from the MK Health and Care Partnership to commence pilot on 13 June 2023

We are taking a pilot approach as we do not have capacity to do *everything, everywhere all at once.*
3 month development period (April to July), followed by an 18 month delivery project starting September
Based on a 'test and learn' approach

WORK IN PROGRESS
Fuller (Version 3)