2. Proactive approaches to care

Proactively identifying and meeting the needs of the Bracknell Forest population will improve their health and quality of life and reduce the use of health and social care resources.

5. Primary care transformation - increasing timely access to primary care. Identifying and supporting people who might otherwise be at risk of deterioration and/or the need for urgent care.

What we aim to achieve:

- Guiding appropriate patients to services outside general practice, educating patients to selfcare and use the right services next time.
- Improve access by directing patients into the most appropriate services to meet their needs.
- Better patient experience by using the enhanced features of digital telephony, such as patient call back functions.

Actions:

- Improved access to general practice.
- Reduce health inequalities: primary care networks to engage with and deliver against projects developed to reduce health inequalities.
- Integrate services with local partners.
- Provide fit for purpose estate/buildings.

6. Anticipatory and personalised care - being able to stay healthy in later life is a crucial issue for all of us. We know that sometimes, people do not feel supported to look after their own health, particularly people with multiple long-term conditions, including frailty. This has a detrimental impact on quality of life and health outcomes.

What we aim to achieve:

- We aim to provide extra support to people who are at risk of increasing frailty offering them much earlier support and help to stay in the place they call home longer.
- Increase the overall number of people accessing proactive care pathways.

Actions:

- 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
- 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.
- Develop local information for patients about the benefits of proactive care.

7. Enhanced health in care homes - extended multi-disciplinary support to care homes in addition to the primary care services provided by GP practices.

What we aim to achieve:

- To ensure that care home residents have timely access to all health (physical and mental) and care services required to support better health.
- For care home residents to receive the same level of care and support as anybody else who is part of the community.
- A range of care home support services meet regularly to identify where clinical and other support may be required and offer this to our care homes in a co-ordinated way.
- Reduction in hospital admissions and ambulance conveyances from care homes.

Actions:

- Care home residents to have timely access to health and care services by implementing a local enhanced health in care homes model. Building on existing multi-disciplinary team working, weekly home rounds and integrated pathways.
- Identify care homes that have greater input from emergency services and have higher emergency admission rates and work in partnership with care homes, multi-disciplinary team, and other stakeholders to support those care homes to reduce admissions and conveyances.
- Collaborative approach in place across stakeholders to identify local training need and deliver appropriate training and development.
- Care practitioners to be trained in competencies such as wound management, nutrition, falls and all the care elements and sub elements of the EHCH framework.

8. Technology enabled care - 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.

What we aim to achieve:

- To produce an Assistive Technology Strategy with a focus on supporting people to remain at home.
- Increase the number of care homes where remote monitoring is deployed.
- Make remote monitoring available to patients registered with all Bracknell Forest GP practices and increase the number of patients who are offered this service.

Actions:

- Assessment suite fully operational. Promote and increase utilisation by staff and residents.
- Increase assistive technology use in support planning, including linking into the support and assistive technology advisor role at Forestcare.
- To support people to remain at home using assistive technology.
- Work with care homes to implement remote monitoring.
- Make remote monitoring available to patients registered with all Bracknell Forest GP practices.

Two

3. Reactive care

Urgent care is available in a crisis to provide immediate support and prevent admission to hospital when appropriate.

9. **Urgent community response and frailty ward - Urgent community response teams provide face to face urgent care to people in their homes (including care homes) which helps to avoid hospital admissions and enable people to live independently for longer. The frailty virtual wards help prevent hospital stays by supporting people in their own home or care home if they suddenly become unwell.**

What we aim to achieve:

- Further promote use of urgent community response and frailty ward services by primary care/111 and 999 colleagues.
- Increase capacity for urgent community response and frailty virtual ward beds supported by appropriate workforce plans.

Actions:

- Scope out and implement falls management framework (using Association of Ambulance Chief Executive's Falls Response Framework as a minimum standard).
- Increase capacity for frailty virtual ward beds supported by appropriate workforce plans.
- Monthly Bracknell Forest urgent community response working groups and partner forums, to ensure collaborative working.

10. **Home first and discharge to assess - People are supported with a smooth and co-ordinated discharge when they leave hospital and helped to return home wherever possible.**

What we aim to achieve:

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

11. **Intermediate care - people are helped to retain and regain independent living skills. People often loose a degree of functioning following, for example, a stay in hospital. 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.**

What we aim to achieve:

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

Three

4. Transformation for population groups to improve health

Bracknell Forest aims to transform services to offer flexible and personalised care and support that responds to an individual's 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.

12. Dementia - people living with dementia and their unpaid carers receive timely, comprehensive and ongoing support.

What we aim to achieve:

- Bracknell Forest residents have a diagnosis rate equal to or exceeding the national target of 67 per cent.
- Bracknell Forest is dementia friendly.

Actions:

- 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.
- 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.
- Collaborative system development of an Integrated Dementia Strategy.

13. Mental health transformation - more people living with significant mental illness are supported in the community through primary care and experience better physical health.

This is about offering flexible and personalised care and support that responds to an individual's mental health needs and preferences close to home; while also increasing support for the wider factors that can impact wellbeing, such as employment, housing and physical health.

What we aim to achieve:

- More people with significant health needs are supported through primary care.
- Improved recovery rates for people experiencing mental ill-health.
- Residents of Bracknell Forest are aware of mental health services.

Actions:

- Berkshire Healthcare Foundation Trust in conjunction with the local primary care networks will recruit and employ two more mental health workers for primary care.
- Bracknell Forest community network will work with residents on their recovery to promote long term independence, admission avoidance and help with supported discharge from hospital.
- To create a mental health local access panel that will co-ordinate referrals across a variety of community organisations. This will help people reach the right service in the shortest time possible.

14. Learning disabilities and autism - people with learning disabilities and autistic people are enabled to live independently with support, and experience better physical health.

What we aim to achieve:

- People with learning disabilities and autistic people are enabled to live more independently.
- Autistic people are involved in the development of services and support provided by Bracknell Forest.
- People with learning disabilities are supported to have health checks in primary care. This includes education sessions for people (health sub-group) and working in conjunction with staff at primary care networks should issues arise.
- Develop an all-age disability needs assessment for the population of Bracknell Forest.

Actions:

- Review of the joint learning disabilities and autism service in Bracknell Forest, with the aim of further integrating the health and social care functions of the service, with appropriate governance.
- Create an annual autism plan to help develop and deliver services for people with autism in Bracknell Forest. This will include a plan to produce a full strategy which will be jointly developed over the next 10 months.
- Recruitment of learning disability and autism support manager to address local need within the primary care setting. They will plan, deliver and innovate programmes of work for learning disabilities and autism alongside primary care networks and the integrated community team for people with a learning disability.

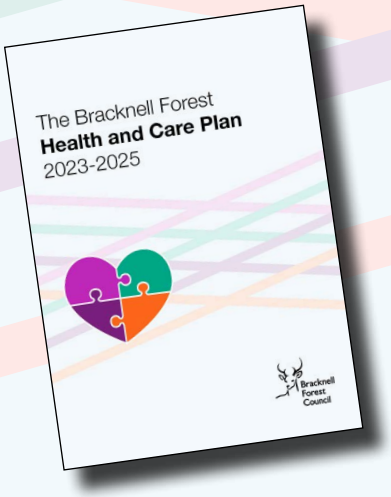
Four

Conclusion

How will we know the Health and Care Plan is working?

Each priority area has a detailed plan of actions needed to make the improvements. Partners come together on a monthly basis to review the plan by:

- Checking that the plan is up to date.
- Once a month a person responsible for leading on a priority area presents to the partners what progress they have made.
- Every second month, a report is presented to partners which highlights progress on each of the priority areas and any stumbling blocks that may be preventing progress.



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