BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Primary Care Strategy Update

February 2025

Louise Smith – Primary Care Director, BOB ICB

Impact of Engagement

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The following changes were made to the strategy as a result of our extended engagement phase with partners and the public.

- Named partnership working as a fifth enabler describing the need for communication and coproduction with the public as well as improving the relationships and working (interface) between key providers.
- Added to the workforce enabler section outlining proposed approaches to developing and maximising training and support opportunities; investment in training; promotion of staff wellbeing and how to support a wider skill mix and alternatives workforce models to improve patient care.
- Strengthened section on primary care estates to include links with the ICS Infrastructure Strategy and the better use of public estate.
- The need for resilient and sustainable primary care has been picked up through the resources and partnership enabler sections, considering approach to resources, contracts and working at scale so that it supports resilience in providers but also benefits patients; particularly those in areas of higher deprivation and associated health needs.
- Built recognition of effective communication and engagement into the strategy and outlined key areas of work to be delivered including raising awareness of the primary care strategy and programme of work; communications campaigns to raise awareness of new roles in primary care and how to access the right care at the right time.
- Made it explicit that children and young people are included within the strategy. · Strengthened prevention and built in a commitment to work with local authority partners and public health to raise awareness of health promotion and prevention in schools and encourage healthy habits in our younger population.
- Provided reassurance on the continuation of other ICB clinical initiatives and not just CVD through our clinical networks and focus on Core20PLUS5.
- Added a slide outlining initial implementation actions and monitoring progress, more detailed timelines, action planning and final agreement of suitable measures of delivery will be picked up through the implementation.
- Included a section on what good will look like with measures to indicate how successful implementation of this strategy could be demonstrated and tracked including the benefit it will bring to our residents. These largely focus on existing measures around experience, workforce, capacity, reducing demand and providing alternative services. However more work with system partners needs to be done to collaboratively identify and agree the most appropriate ones to focus on.
- Tried to make it as simple to read and understand as possible, adding in an updated glossary and “terms explained” slide.

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- Embed a **data driven approach** to identify our most vulnerable and at-risk groups and proactively manage
- Introduce a coordinated approach to **Cardiovascular Disease (CVD) prevention**

Enablers for success

- **Workforce** – Multi-skilled extended primary care teams working in an integrated way, at the heart of the system.
- **Digital and data** – Shared patient records and connected data used for clinical decision making and to improve the patient experience
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Key Progress

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- **Governance established at system and place level** – BOB oversight group in place with risks and support requirements being escalated to BOB Primary and Community Care Strategic Transformation Oversight Group.
- **System-level working groups and place delivery established**
    - Place-level work ongoing and highlight reports with Place and priority area teams to build foundations for best practice sharing
    - First access working group was held resulting in the agreement of principles for general working and the development of same day access, as well as the establishment of a best practice sharing forum
    - Existing CVD network forum has been expanded to include additional members and to incorporate Primary Care Strategy priorities
    - First INT system-level working group has meet and needs to be followed up at pace.
- **Project management office and plans** in place including milestones and deliverables for 24/25 with agreed metrics for each priority area and highlight reports
- **Business Informatics (BI) and evaluation function is being developed to include key measures of success** Evaluating the impact of the strategy interventions is being looked at in collaboration with the Health Innovation Network (HIN) but this may require additional resource particularly if we want to link it to cost and funding.
- **Dashboards are being developed** with the data available, CVD initially and then INT & Access once metrics have been confirmed.
- **Our enablers including comms, estates, workforce, resources, partnerships and digital are to be linked into working groups** to ensure alignment

Working Group Highlights

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CVD Working Group Key Highlights

- Establishing robust messaging on hypertension performance toward QOF targets, and follow-up with practices with low scores.
- CVD Champions funded until the end of September 2025.
- Completion of Familial Hypercholesterolemia contract, finalise and secure invoicing and payment arrangements.
- Project management support with Bucks INT CVD project.
- Further development of more comprehensive approach to CVD prevention activities with Primary Care colleagues.

Access Working Group Key Highlights

- Same day access working group established and membership to be expanded to include POD as well as GP representatives. Working groups established for digital transformation, ARRS development and Pharmacy First
- The group identified the need for open sharing of approaches, successes, and challenges, fostering a collaborative atmosphere.
- Same Day Access Workshop took place on 6th January and working groups established for digital transformation, ARRS development and Pharmacy First. Each areas has an identified lead.
- All place teams have committed to providing Directory of Services and clinical pathway maps, which the working group will compile for a unified resource.

INTs Working Group Key Highlights

- Testing models of Care - INT current state assessment at each of the 3 BOB Places:
  - Oxfordshire/Buckinghamshire – INT projects underway and governance structures aligning
  - Berkshire West – MDT working baseline assessment underway, promoting and embedding of segmentation to support future INT development
- Place level review of ICB funding streams available to support INT development ongoing across BOB
- Early engagement with Connected Care team to develop aligned data and informatics intelligence across INT projects
- BOB ICB working group established and looking to develop an ICS INT framework (incl principles of INT working, maturity matrix, and measures of success) to support INT development across BOB.
- Enablers: Embedding of the digital team [slide 15] and co-produced communication campaign to raise awareness of how to access the right care at the right time [slide 13].

Pharmacy, Optometry and Dentistry (POD) updates

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Community Pharmacy

Roll out of the **Pharmacy First** initiative so patients can access some prescription medicines without needing to visit a GP –102k Pharmacy consultations of which 35k were for one of the 7 common conditions that can be treated by a Pharmacist saving many appointments with a GP. Remaining consultation linked to minor illness and urgent medicine supply (data Feb to Sept 24)

A **dedicated PCN Community Pharmacy** lead has been recruited **for every PCN (47)** in BOB with the aim of working with local GP practices to embed community pharmacy pathways including Pharmacy First and oral contraceptive into general practice tirage processes.

GP Connect is now in place to enable Community pharmacy to input directly into the patients record. Work is now underway to enable this operability

Delivery of **winter vaccination programme** including flu and covid (210k appointments booked from 30 Sept to 4 Nov 2024) with acceleration of uptake across BOB due to the number of pharmacies offering vaccination

Optometry

Process to implement **sight tests and oral health checks in Special Educational Needs Schools** from April 2025 started.

Electronic referral platform in place to allow community optometrists to send urgent and routine referrals directly to the patients chosen single point of access with over 3000 referrals made via this route in August 24

Dentistry

An additional **70,000 units of dental activity commissioned** to improve access to high street dentistry

Golden Hello offer to practices struggling with recruitment of NHS dentists

Flexible commissioning scheme expanded to include pregnancy and nursing mothers and patients needing a dental checkup as part of a hospital appointment

Financial assistance scheme launched for those practices struggling to provide NHS services

Engagement in national pilot CVD Prevention pilot – **Hypertension case finding** in dental practices – see slide 12

Further commissioning with increased focus on **Children's Oral Health** Improvement

Primary Care Resilience

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The Primary Care Strategy was developed to ensure sustainable and resilient primary care. Outside of the three priority areas of access, INT working and CVD prevention, BOB ICS is actively working to ensure primary care stability through:

Workforce 	• The ICB is continuing to support the **New to General Practice Fellowship Programme** and currently has 76 fellows participating in the programme, which is a key retention programme that the ICB is investing in • The ICB has funded **25 practices to register with the skilled worker sponsorship programme**, which is allowing practices to employ GPs and other healthcare professionals through this route • PCNs are being supported to become **Learning Environments** which will support the expansion of GP training places in primary care
Digital 	• Developed and using tool in partnership with LMC to support review of **demand and capacity** within primary care • BOB is ensuring continuation of digital tools that support **interoperability** and working across providers, such as EMIS clinical services
Resourcing 	• BOB continues to invest in **Locally Commissioned Services** and decreasing variation of services provided at each place • **Post-operative wound care** is an area that has recently been identified as a commissioning gap, and a system-level working group has been established to identify the pathways needed and how to support primary care providing this service to patients

Access – Case study

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Embedding Segmentation for same day triage

Berkshire West (BW)

- Brookside Medical Practice are using *segmentation* (see next slides), a method of risk stratifying patients to understand underlying health conditions and better triage patients to the right place
- Staff triaging have a spreadsheet listing conditions, which gives instructions on where to book and signpost depending on the patient's segment and presenting condition
- This supports getting less complex patients the care they need as well as providing better continuity of care for more complex patients
- Segmentation is helping the practice to also review their capacity vs. demand and how to better allocate resources, such as ARRS practitioners

Urgent Care Centre

Reading

- For area of need, the Berkshire West Place team and system partners are collaborating to form an Urgent Care Centre (UCC) in Reading
- **The new service** launched on 1 October, maintaining some capacity at the current UCC location in Broad Street Mall while simultaneously providing a co-located, primary-care led service based at Royal Berkshire Hospital.
- An average of **36 patients per day** throughout October were streamed from ED into the new service at RBH, put on by the GP federation in BW.
- When reviewing UCC and out of hours activity, it demonstrates an average of **9%** of ED attendances per day are **streamed out of ED** into the two clinical services
- The service has started building up a **strong core primary care workforce** including, General Practitioners, Advanced Nurse Practitioners, Prescribing Paramedics, Pharmacists and Physician Associates.
- We will actively consider in addition to options for ED to send patients from overnight to same day access opening up and including 111 and also to practices ensuring maximum utilisation of appts.

Integrated Neighbourhood Teams [INT] – Case Study

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Early Years
Buckinghamshire

- Wycombe is an area of Buckinghamshire which has patients living in high deprivation
- An INT is forming to identify patients who have declined or not engaged with child one-year health reviews and/or childhood immunisations to understand barriers and improve uptake
- Outcome measures the INT seeks to impact include: increased uptake of 1 year child health development checks and childhood immunisations by non-attendees as well as improved awareness, engagement and access to wider CYP/family/parental support services and offers
- The INT includes PCNs, Healthwatch, Family Hubs, Education and Health Visitors
- Interventions explored include partner communications campaign, MDT approaches outside of the usual health locations

Reducing Health Inequalities
Oxfordshire

- There are INTs across the three deprived areas in Banbury and some of the areas of deprivation within Oxford City.
- The two PCN's in Banbury are focusing on those who meet the frailty criteria or those with long term conditions who live within one of the three deprived areas.
- One aspect of the project in Banbury, is a focus on all those who had an admission to hospital for their respiratory condition, looking at the EPC rating of their house and other variables to assess the skills set of those who need to carry out a home visit.
- The Banbury INTs have expanded to include people from Cherwell District council, Public Health, Primary Care, and the community specialist nursing teams. In additional diagnostics for assessing people with respiratory conditions will start in November within one PCN but will take referrals from both PCN's.
- Oxford City, the Brazilian model has been implemented to look at a wider range of issues within people's home environment.
- One PCN within Oxford city which covers the most deprived area within the city, is focussing on children and young people who have been referred to CAMH's. This INT will provide additional support with social prescribers and those who have the skill set to support the young person (YP) and their family. The aim is to reduce the need for the YP to be seen by CAMH's, promote the well being of the person and their family and create capacity within CAMH's for those who will benefit the most from it.

Cardiovascular Disease (CVD) - Case Study

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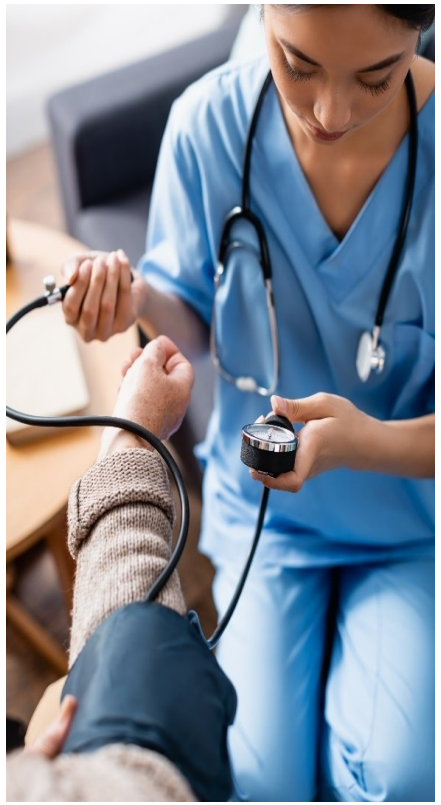
Hypertension Case Finding in Dentistry

BOB-wide



- In 24/25, BOB is piloting hypertension case finding in dental settings through a national award supporting this work
- The aim of the work is to improve overall detection of hypertension in the population and offer an alternative route to have blood pressure checks outside of other routine health and care settings
- This work is also aimed at reducing inequalities in BOB for the 150,000+ people living in areas that are in the bottom 20% of deprived areas across the country
- BOB has received £50,000 to carry out this work. This covers start up equipment costs to purchase blood pressure monitors, training, communications campaign, and incentivising blood pressure case findings in oral health teams

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Enabler spotlight

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Partnership Working – Primary & Secondary Care

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Background

- As part of the strategy engagement period, frustrations were raised about the interface between system partners and the **lack of joined-up working between services, patients and the public.**
- Recognising this feedback, **a fifth enabler** has been included in the strategy - **Partnership Working**.

Scope – Primary & Secondary Care

After a deep dive engagement event, consensus emerged to focus on **Oxfordshire** for an initial phase to establish a primary secondary interface group, given that Buckinghamshire and Berkshire West both have robust, established interface working groups

Progress to date – Primary & Secondary Care

- Core members of the interface group include Oxford University Hospitals (OUH), the GP Leadership Group (GPLG), the Local Medical Committee (LMC) and the ICB
- Learning has been sought from the experience in the Berkshire West and Buckinghamshire Interface Groups to inform the work in Oxfordshire
- Oxfordshire was supported in their successful application to participate in the **Interface Improvement Collaborative at NHS Confederation**.
- One project to promote interface working is to **develop a video training resource** on the primary/secondary care interface. OUHFT have committed to using the resource as **part of its mandatory training requirements for its staff** and it will also be shared with General Practice.

Partnership Working - Communications & Engagement

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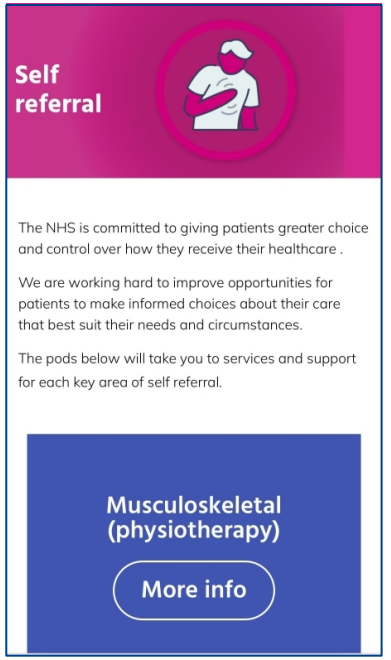
Progress to date – Communications & Engagement

- We have started work to co-produce a communications campaign raise awareness of:
  - New roles within primary care
  - How to access to the right care at the right time including use of the NHS app
  - What to expect from each pillar of primary care (GP services, pharmacy, optometry & dentistry)
- We are supporting the delivery of the national pharmacy first campaign launched 11 November
- Work on-going across BOB to support people to use the NHS App through digital cafes and support sessions in libraries
- Shortly launching communication around self-referral
  community-based services with the aim of
  general practice



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Enabler spotlight

Enabler Spotlight – Digital

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Background

In January 2025, as part of the end of the BOB ICB consultation, a new Primary & Community Transformation team was formed within Digital, Data and Technology (DDaT). We have structured the team to support each of the three priorities with an SME lead for each: Access, INTs and CVD Prevention

Our focus has been on transitioning to the new team and beginning to scope with the relevant strategy leads the scope of work we are looking to support in the next 12 months.

	Access	INTs	CVD Prevention
Lead	Angela White	Nadia Kuftinoff	Phil Thomas
Key digital priorities	• Segmentation roll-out • NHS app uptake • Cloud based telephony • Online consultation	TBC	• Lipid Optimisation • AF • Hypertension • NHS Health Check • Smoking Cessation
Progress update (Jan 2025)	• OC reprocurement project underway • 65% of BOB patients registered on NHS App	• SCW CSU User Research team initiated discovery phase of project • Facilitating focused engagement with PCNs as part of research • Provided oversight into digital landscape across general practice in BOB • Stakeholder meetings to be established at end of sprints	• Meeting on HF Monitoring 20/1/25 • Meeting with R Johnson on Stroke Shared Care data 21/1/25 follow up arranged. • Meeting with R Johnson and S Claridge on CVD Strategy follow ups arranged.

Cross-Cutting – Segmentation Boost

- **Update:** Obtained timelines for connecting 4 BOB ICB GP practices who use TPP to the TVS Care Records platform
- Approved public-facing comms materials to meet data sharing legal requirements
- Engaged with several practices keen on adopting the platform
- Drafted benefits use case slides that define the key use cases for the platform

% live: BW=74%, Bucks=28%, Oxon=0%

Looking Ahead

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- Managing our risks to delivery – changing ownership of delivery, collective action, estates
- Further developing the **communication plan for co-designing campaigns** with service users, such as how to access primary care services within the evolving model of care
- Development of an **Evaluation Plan** to assess what is having a positive impact on patient outcomes and experience
- Further refine Place **engagement and priorities** as well as planning for 25/26