BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Transforming Primary Care

General Practice, Community Pharmacy, Optometry and Dentistry

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We want to hear your views on this draft strategy

This draft strategy is based on research, analysis and engagement carried out in the second half of 2023. We are publishing it in draft form to seek feedback from people living and working in BOB. We would like to hear thoughts on the questions below or any aspect of the strategy.

Challenges	Do these reflect your understanding and/or experience of Primary Care?
Vision	Do you understand the vision and why it is important?
Priorities	Do you think that these priorities will start to address the challenges that have been identified?
Delivery approach	Is there anything additional you would like to see included to enhance the outlined delivery approach?

Foreword

BOB ICS has put the four pillars of Primary Care – General Practice, Community Pharmacy, Optometry and Dentistry at the heart of transformation to deliver a shared ambition and vision for a new model of care and a more integrated way of working across the system.

We are delighted to introduce our draft Primary Care Strategy, setting out how we plan to move towards a more preventative and community-based model of providing health and care services and helping people to stay well in the community. We want to thank our workforce and the public for all the input and feedback that you have given so far.

Our ambition for a new model of primary and community-based care was first outlined in our Integrated Care Strategy (published in March 2023) and then in our Five Year Joint Forward Plan (published in July 2023). Nationally and globally, a direction of travel has been set for Primary Care, including the Fuller Stocktake, which describes how primary care should streamline access, provide continuity of care and focus more on prevention.

We want to improve these areas by better integrating all pillars of Primary Care within our wider system. As a first priority, we want everyone who lives in BOB to be able to **receive the right support** when it is needed and with the right health and/or care professional. We have heard how our communities are finding it more difficult to get an appointment in General Practice or with an NHS dentist, and we are determined to make this better. Alongside this, we will continue to bring together Integrated Neighbourhood Teams to care for those people who would benefit most from **proactive, personalised care** from a holistic team of professionals, for example those at most risk of emergency hospital admissions. We want to help communities stay well and so we will also have a targeted focus on our biggest killer and driver of inequalities – Cardiovascular Disease. All pillars of primary care can make a huge contribution to supporting people to **reduce the risk factors** like high blood pressure.

So far, in developing our Primary Care strategy, we have engaged with many stakeholders across the system including those who work at the frontline of primary care. We understand the pressure on staff, and as we adopt the new ways of working outlined in this strategy, we will track the impact on staff satisfaction. Moving towards a more community-based and preventative health and care system will require a fundamental shift of activity, resource and funding, and the changes in this strategy are intended to support that shift.

Thank you for taking the time to read this strategy, your feedback is essential to help us get this right, so we can produce a final strategy that sets out an agreed shared vision for our system, with the commitment from all partners to the changes needed to get there.

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Introduction

This section outlines the work that has been done to date to develop this draft strategy. It describes research and analysis that has been carried out, and engagement that has been undertaken across all system partners and with the public – although this is just the beginning. This draft strategy is being published and shared widely to hear further feedback from people who live and work in BOB.

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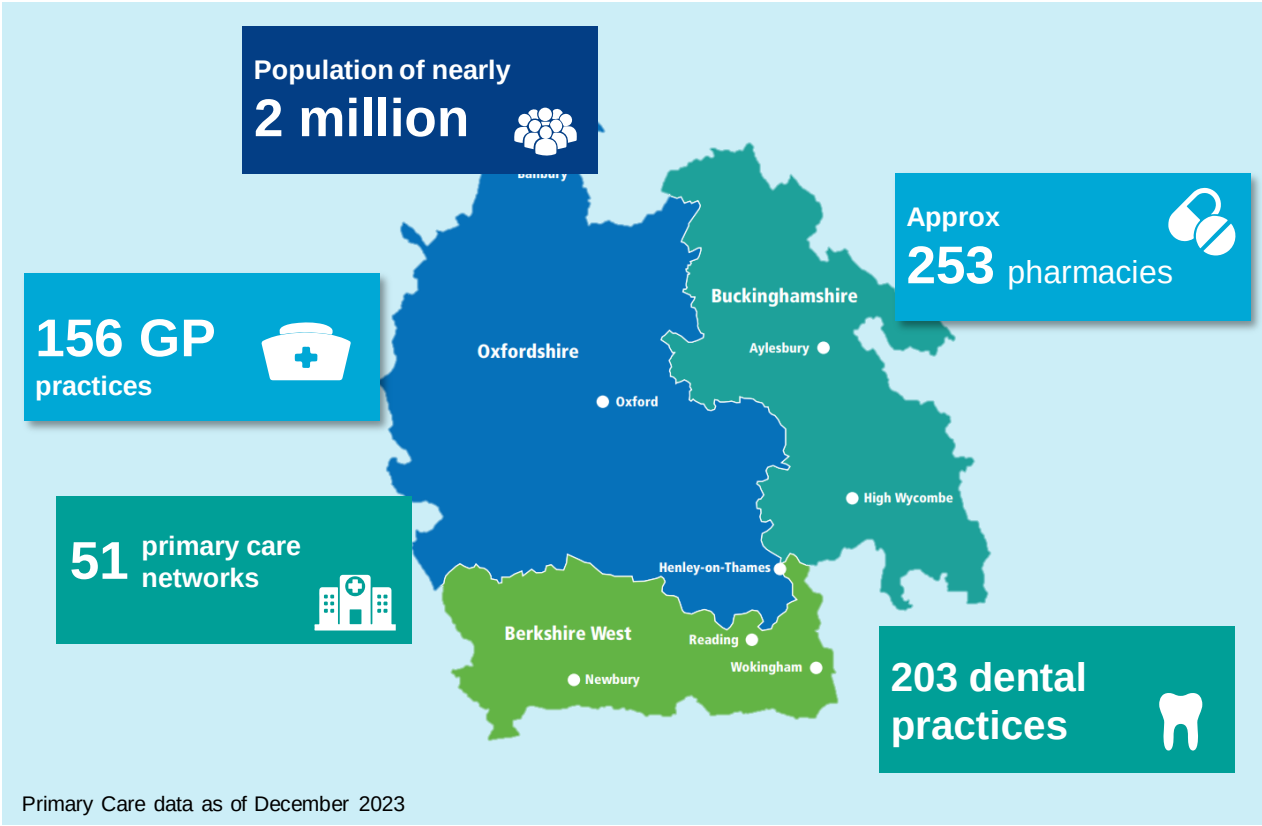
Why we need a primary care strategy

Primary Care includes General Practice, Community Pharmacy, Optometry and Dentistry services. These services provide the first point of contact, have an ongoing connection with local communities, and lead on improving the 'whole person' health of our population.



Primary Care data as of December 2023

- BOB ICS is putting primary care at the heart of our transformation, to deliver our vision set out in the Integrated Care Strategy:
- ***Everyone who lives in BOB should have the best possible start in life, live happier, healthier lives for longer and be able to access the right support when they need it.***
- We currently deliver some outstanding primary care, but services are under considerable pressure. We have inequalities in outcomes for our patients, workforce gaps and high workload.
- A national direction has been set to integrate Primary Care provision. We have developed this strategy to **address the challenges we are facing in Primary Care and improve integration between all of our pillars in Primary Care** and how they work together to deliver the new model of care. This strategy will also cover how Primary Care will work with system partners such as community services, to deliver our future vision. Therefore, this strategy is aimed at multiple different audiences – people who use Primary Care services, our staff who work in Primary Care as well as wider system partners, who will contribute to improving integration and collaboration to move to a more sustainable Primary Care system.

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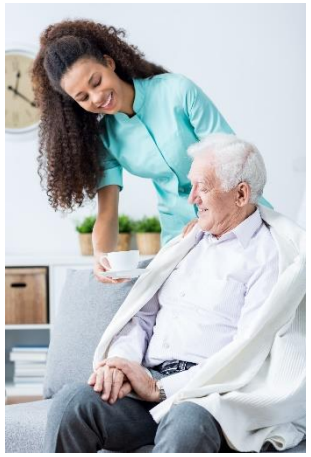
Approach to developing this draft strategy

This strategy builds from national guidance and our own local plans. We have carried out extensive engagement and analysis to inform the development of this draft primary care strategy, which we now want to refine through further engagement with system partners and those who live and work in BOB.



2022

National guidance such as The Fuller Stocktake

Spring 2023

BOB Integrated Care Strategy and Joint Forward Plan

Summer 2023

Focus Groups and Surveys

We carried out focus groups with key stakeholders - General Practice, Community Pharmacy, Optometry, and Dentistry and surveyed all pillars of Primary Care for their views.

Research on good practice

We researched global, national and local examples of good practice delivery of Primary Care services within other systems and within BOB.

Autumn 2023

System-wide workshop

Bringing together over 130 stakeholders from across the system to discuss the future vision and opportunities for Primary Care.

Data Analysis

We have analysed available data to understand how people in BOB are using services today as well as what our workforce looks like.

Winter 2023

Current State Report

Compiles documents, good practice, data analysis and views from engagement order to describe BOB's Primary Care Landscape.

Ongoing engagement

Feeding in all our research and engagement so far, we started to draft the strategy and continued to meet with key stakeholder groups to get their input and feedback.

January 2024

First draft of the Primary Care Strategy

This document summarises the key challenges facing Primary Care and how we plan to address these through a change in our model of care. We will continue engaging with system partners' and the public to hear their views.

Engagement so far

Broad engagement across the primary care system has been undertaken to understand the current landscape and test the future vision (stakeholders shown on the right). We look forward to engaging further with BOB residents to refine the strategy.

Since July 2023, we've heard from **approximately 150 stakeholders across BOB** to deepen our understanding of the challenges facing Primary Care and to discuss what the future model of care should look like.

We have been seeking the views of the public through our website. We will analyse all comments when they are received but based on what people have told us so far, some trends are emerging:

- Some patients report finding it extremely challenging to get an appointment with their GP and / or NHS dentist
- Many have positive experiences with their community pharmacy but note that at times pharmacists can be very busy
- Generally, patients have reported being happy with services provided by optometry.

We have listened and understand the immense pressure that the workforce is facing. We have heard what matters most to our staff and most importantly, to our patients. We know we can do more as a system to meet the needs of our population and to keep people healthy in their communities. Therefore, we are **making a commitment to do things differently and work more closely with partners** to deliver the best outcomes for people living in BOB.

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- Patient and public groups
- General Practice
- Dentistry
- Health and Wellbeing Boards
- Social Care
- Healthwatch
- Clinical Networks
- Acute providers
- Place Directors
- Voluntary & Community Sector (VCSE)
- Representative Bodies e.g. LMC, LPC & LDC
- Community Pharmacy
- Optometry
- Local Authorities
- Public Health
- Community trusts
- Mental Health Providers
- ICB Leads
- NHS SE Regional Leads
- Health Innovation Oxford & Thames Valley

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Primary Care in BOB today

In this section we describe the current state of primary care services in BOB. This is based on the engagement activities described on page 8 and an analysis of data showing how our population currently uses the primary care and the urgent and emergency care system.

The section describes the landscape of primary care services, highlights some of the strengths of our system in BOB, and then summarises the challenges we face. The following section then outlines how we need to work differently to address these challenges.

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Primary care supports our communities

Primary care supports our unique and varied communities with a wide range of needs and helps to tackle the health inequalities some communities experience

Our population

Our overall population size is anticipated to grow by 5% by 2042, over the same period the number of people aged over 65 is expected to increase by 37%.

Within BOB, Oxfordshire and Buckinghamshire will continue to have the highest proportion of over 75 year olds.

People who identify as white British make up 73% of residents. Although this varies from 53% in Reading to 85% in West Berkshire.

Health needs and inequalities

- c.60,000 people in BOB live in an area that is in the bottom 20% of areas nationally as defined by deprivation.
- Across BOB, 3 in 5 adults are overweight or obese. 68% of adults with a learning disability are overweight.
- Around 12% of adults have a recorded diagnosis of depression and 0.8% have a severe mental illness.
- Estimated 60% of people over 60 have one or more long term conditions.
- People in our more deprived areas develop poor health 10-15 years earlier than those in less.
- BOB has 8.8 care home beds per 100 people 75+ in comparison to the national average of 10.8 as well as a slightly smaller 16+ population with a caring responsibility.
- There is a disproportionate reliance on acute services e.g. A&E from populations living in areas of higher deprivation.

1: BOB fact pack (2022); 2: BOB Joint Forward Plan (2023)

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Primary care is at the heart of our system

Not only is primary care the typical 'front door' for our population to access the health system, it also carries out 90% of all patient contacts. Below is a selection of facts about primary care activity.

01 Primary care supports a **registered population** of around 584,000- people in Berkshire West, 587,000 people in Buckinghamshire, and 816,000 people in Oxfordshire.

02 In Berkshire West, approximately **73% of the population are 'generally well'**, 19% have moderate need and 2.4% have higher need (based on Population Health Management data from Brookside Group Practice, 2023).

03 The equivalent of **19% of the population in BOB contact their practice every working week.** General practice activity levels in BOB are higher than pre-pandemic levels with **825,000 appointments** each month.

04 There are approximately **1,100 GPs, 430 nurses** and over **900 staff in the Additional Roles Reimbursement Scheme (ARRS) across BOB**, including Social Prescribers, Clinical Pharmacists, Nursing Associates and Mental Health Practitioners.

05 Across BOB, there are on average **63 dentists per 100,000 of the population** compared to a national average of 43 NHS dentists per 100,000.

06 There are **253 community pharmacies offering a range of clinical services** e.g. flu and COVID-19 vaccines, blood pressure checks, oral contraception.

1: Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14 (2016); 2: NHS Digital (2023); 3: Brookside Case study – Segmentation in Primary Care (2023); 4: BBOB LMC The Health of General Practice in BOB (2023); 5: NHS Dental Workforce statistics and NHS Digital (2023); NHS dentistry - Health and Social Care Committee (parliament.uk) 6,7: Primary Care Access and Recovery Plan (2023)

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Our primary care system has many strengths

There is much outstanding practice across primary care in BOB, and unique capabilities across its Places. Below are five highlights where the system has particular strengths that can be built upon.

01

General Practice access and quality metrics in line with or above the national average

The proportion of GP appointments seen within 14 days is **higher** than the national and regional average. Most GP practices have either good or outstanding CQC ratings. Quality and Outcomes Framework scores are just above average.

02

High uptake of the Community Pharmacy Consultation Service

BOB has the **third highest** number of referrals (per population) to the Community Pharmacy Consultation Service across the Southeast region. 122 of the 156 GP practices are 'live' and referring their patients to community pharmacists, with a further 27 preparing to start using this service (as of December 2023).

03

Strong focus on inequalities, prevention, and wider determinants of health

All three Place-based Partnerships have focused on this. For example, 'Opportunity Bucks' targets the 10 most deprived areas in Buckinghamshire. Oxfordshire work focuses on specific communities such as people who are homeless. In Berkshire West community outreach is focused on reducing premature mortality.

04

Population Health Management Infrastructure

In parts of BOB, the Connected Care model has been developed with the addition of Population Health Management tools and is enabling people to be directed to the most appropriate health and care service, based on their needs. This supports better triage and navigation, identification of people who would benefit from intensive case management, and ability to design prevention interventions.

05

Flexible dentistry commissioning for our most vulnerable populations and extended commissioning for Minor Eye Conditions

BOB has started a pilot for flexible commissioning, where 10% of the contract can vary depending on local needs. This has enabled practitioners to service patients from under served communities who require dental care. Additionally, there has been great uptake of the referrals to the Minor Eye Conditions service and patient feedback has been positive.

06

Strength of existing at-scale delivery structures

Each Place has a Placed-Based-Partnership (including local authorities, VCSE and others) which can drive and deliver transformation and integration at a local level. There are evolving Federations of General Practices established in each Place – FedBucks, PML in parts of Oxfordshire and the Primary Care Alliance in parts of Berkshire West that can lead change and deliver services for a large part of the population.

1: NHS Digital (2023); 2: Primary Care Access and Recovery Plan (2023); 3: Brookside Case study – Segmentation in Primary Care (2023)

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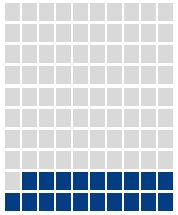
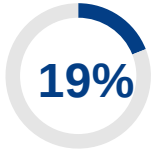
There are challenges within primary care and within the wider system that require new ways of working

Demand for primary care outstrips current capacity and inefficiencies are created (for patients and staff) where the parts of the system do not work well together. The challenges require a system response, they cannot be solved by primary care alone.

01 People report a worsening experience of accessing primary care



Since 2021, there has been a 19% decrease in positive responses with regards to the overall experience of booking an appointment.[1]



19% said there were no dental appointments available or said that the dentist was not taking on any new patients.[2]

02 Many primary care staff feel they are under extreme pressure

BOB LMC data shows that GPs are responsible for more patients, and are spending a large proportion of time on administrative tasks relating to how patients move between parts of the system. [3]

Multiple respondents to the BOB dental survey said they are under extreme pressure due to demand much greater than capacity, lack of funding and recruitment and retention challenges.

03 This is driven by a mismatch between demand and capacity across the system

BOB's growing population and changing demographic profile is increasing demand for primary care services - more than one in four of the adult population live with more than two long term conditions.[5]

14 community pharmacies closed in 2023 and 16 out of 20 100hr pharmacies reduced their opening hours (mainly the 9pm-12am slot).[6]

04 Capacity is difficult to grow due to funding, recruitment, retention and estates challenges

In the Community Pharmacy workforce survey, 67% of respondents said it is very difficult to fill vacant roles for pharmacists.[7]

There are estates pressures across the system for example, in Bucks, approximately 570,000 patients are served by a primary care estate of approximately 24,121 $m^{2.}$

1: National GP survey results, 2023; 2: BOB GP Patient Survey Dental Statistics 2023; 3: BBOB LMC The Health of General Practice in BOB; 4: BOB Primary Care Assurance Report 2023/24 Quarter 2 (2023); 5: BOB Joint Forward Plan (2023); 6: Buckinghamshire Executive Partnership Report on Primary Care July 2023; 7: Community Pharmacy Workforce Survey 2022; 8: OCCG Primary Care Estates Strategy (2020)

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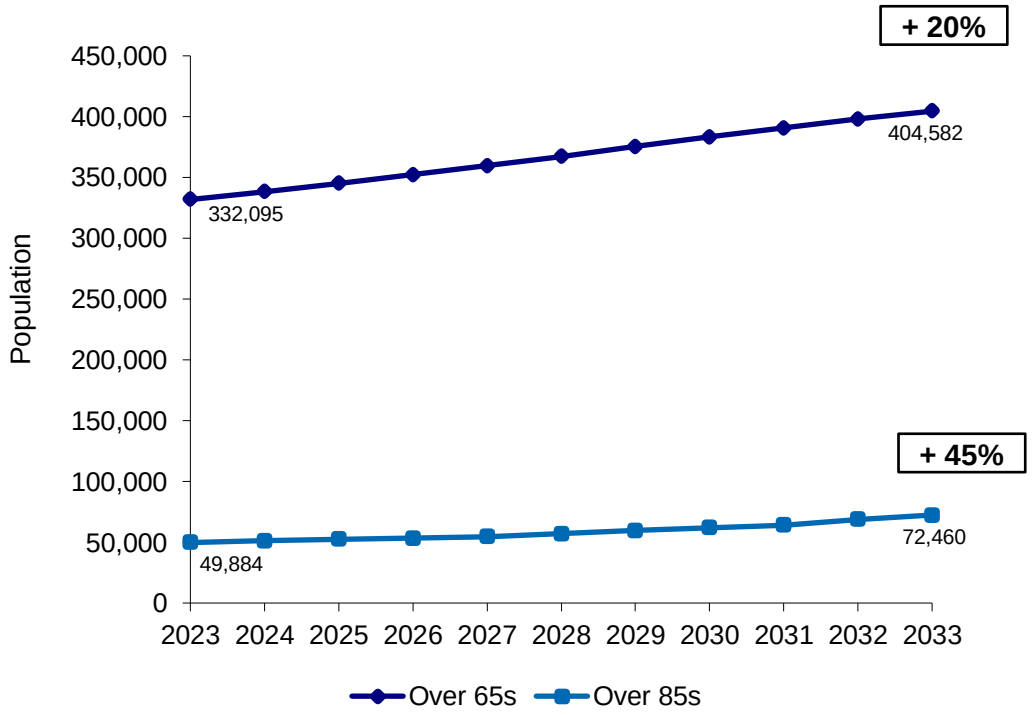
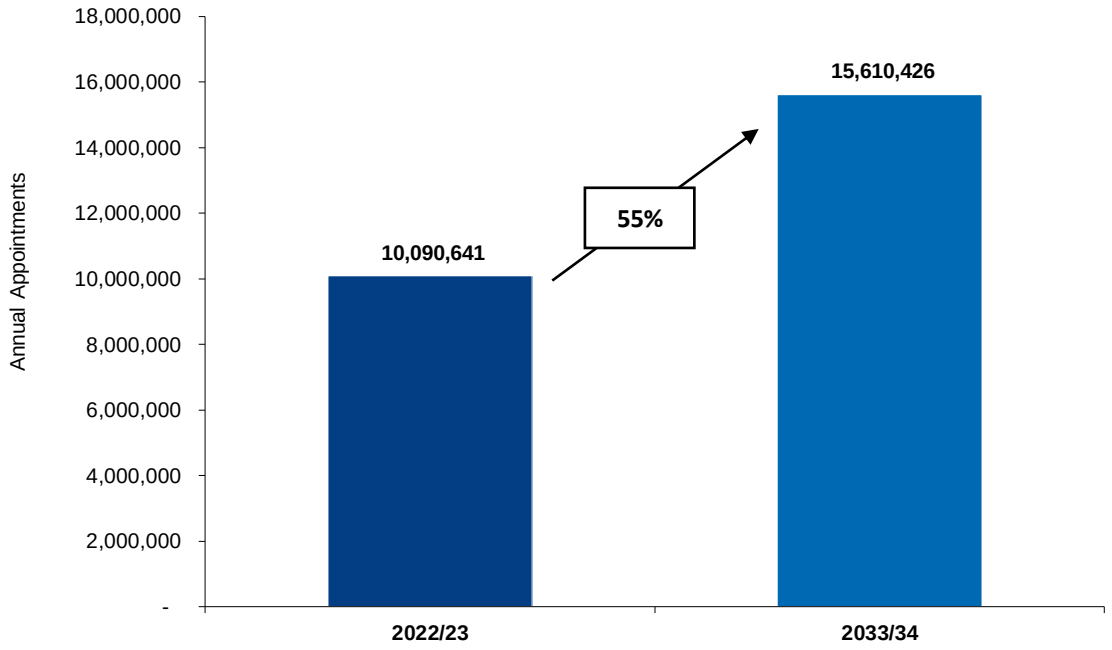
If we do nothing, the mismatch between demand and capacity will continue to grow

Over the next 10 years the population of BOB will increase, particularly the older population who make the greatest use of healthcare services. If there is no change to the model of care, based on historic trends in primary care activity and population forecasts, GP appointments would need to increase by 55%. This would represent an unsustainable level of growth in terms of available funding and workforce, and Primary Care cannot manage this demand alone. This requires a system-wide response to work in new ways and coordinate care and services differently.

BOB Forecast Population Growth to 2034 for Over 65s and Over 85s



BOB ICB General Practice Appointments (All Types – 2022/23 vs 2033/34)



KPMG analysis, based on ONS population projections

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Snapshot of what we have heard from the public so far

We listen to what patients say about primary care through a wide variety of forums including our local Healthwatch organisations. Below are the high-level themes that have emerged from early analysis of comments received via BOB ICB's public engagement website during November and December 2023.

Lots of patients mentioned they struggle to access an NHS Dentist.

Some patients said they are opting to go private or not attend a dentist due to being unable to access NHS provision.

Some patients said they are unable to get a GP appointment or have to wait for long periods of time, or are only able to call at certain times.

Patients reported a high turnover of staff in General Practice and said they are often unable to see the same doctor for treatments. This makes them feel it is hard to build relationships and results in a lack of trust.

Some patients felt like they were being blocked from accessing a GP by the receptionist or triage booking system. Some Patients stated they felt it was unnecessary or embarrassing having to explain symptoms on the phone and in person.

Overall feedback for optometry from patients who have accessed services was good.

Patients reported a lack of awareness of NHS provision for optometry (eye health).

There was positive feedback on the use of the NHS App to communicate with GP surgeries and for prescriptions.

Patients often stated long queues and wait times at their Pharmacy.

Patients stated that online GP booking is not always accessible for certain demographics of patients.

> ***I have had a lot of experience accessing PC on behalf of my elderly mother. There is a lack of joined up services following hospital discharge and provision of care at home for a 97 year old.***

> ***Getting to see a nurse at the surgery is adequate but GPs are still difficult to see in person. More needs to be done at surgery level so those of us not living in Oxford don't have to do a five hour round trip on buses to get to the "local" hospital.***

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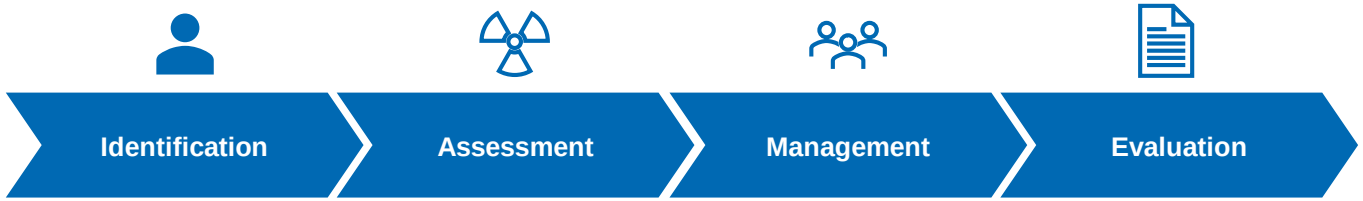
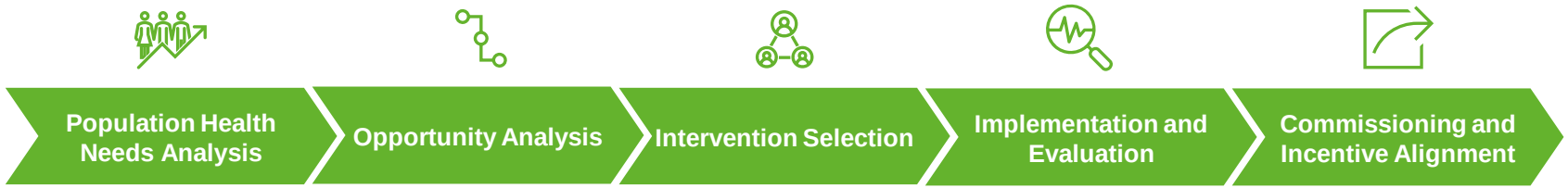
We are learning from other systems who have tackled these challenges

We have reviewed good practice from other systems globally, nationally, and locally to understand the key features that have enabled them to tackle the same challenges we face. These features are summarised here, and the next page shines a spotlight on one particular example.

Systems tended to emphasise high-quality trusted information and digital tools to support people to self-care. People can access services in many ways but are triaged to ensure they reach the right part of the system, and their initial contact can be with a broad range of multi-skilled professionals. Pathways are standardised across system and supported by digital tools.



Systems tended to have a standardised approach to identify patients with or at risk of medical or social complexity, provide regular holistic assessments, co-develop personalised care plans and regularly evaluate outcomes and experience for this cohort.



Systems tended to have a strategic and data-driven approach to prevention that identifies population groups with similar risks, identifies and selects interventions to improve the outcomes of all groups, evaluates to see what has worked, and aligns financial and other incentives to help scale successful interventions.

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Learning from the Clalit System

Within BOB we have taken particular inspiration from the Clalit system in Israel, which has produced impressive outcomes by taking a primary care led approach. Some of the key features of the system are described here, and as a system we must take the learnings and coordinate a system-wide approach.

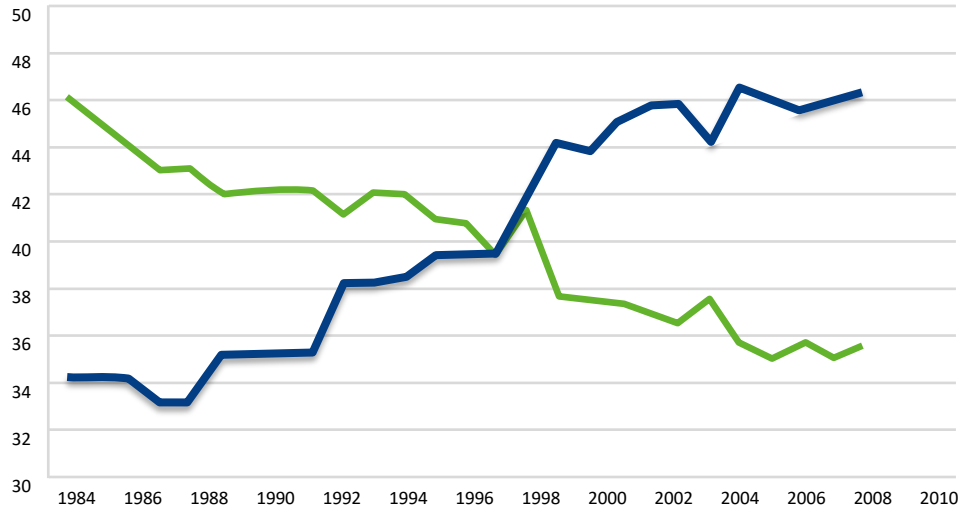
Israel's life expectancy is 0.9 years higher than in the UK, while national health expenditure is 7.8% of Gross Domestic Product (GDP), compared to 9.8% in the UK (2019 figures). The Israeli model is primary care led, and accounts for a greater proportion of expenditure than hospital care.

The Israeli healthcare system provides universal coverage through four not-for-profit Health Maintenance Organisations (HMOs), which can be compared to the UK's Integrated Care Systems. The largest HMO is Clalit.

Key features of the Clalit system:

- Integrated GP community clinics, including all professionals in one setting
- Direct hospital-to-community communication, enabled by fully interoperable data sharing system including online health records and results
- Proactive nurse-led health and wellness activities informed by health data
- Use of population health metrics to determine health policy decision making
- Payment is on a salaried or capitated basis, to incentivise the management of the population's health as effectively as possible in the lowest cost setting.
- Clinicians are paid more to work in rural or areas, which typically in Israel are home to more vulnerable groups.

Hospital vs. community care, percentage total health expenditure



Israel Central Bureau of Statistics

Professor Ran Balicer, MD, PhD, MPH, Director, Health Policy Planning, Clalit Health Services

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Our Shared Vision for Primary Care

This section sets out the way in which we need to change our model of care and work differently to address the challenges described. It is based on reviewing how those systems that deliver the best outcomes for their populations work, and engaging with those working and using services in BOB.

We describe both the components of the new model of care and the enablers that need to be in place to deliver these. The new model of care aims to achieve specific outcomes and we have developed a scorecard (section 5) to track our performance against these outcomes.

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Our shared system vision for primary care

The challenges – and opportunities – facing primary care result from complex system-wide factors and a whole system response is required. BOB's Joint Forward Plan commits the system to developing new models of care and primary care is at the heart of that. This is our future vision for primary care, but it requires other system partners to also work differently to deliver it.

Our Shared Vision:

Everyone in BOB has the support they need from primary care, working within a coordinated and integrated health and care system that supports people to stay well.

Model of Care

Primary Care

General Practice	Pharmacy	Optometry	Dentistry
We ensure people get to the right support first time to meet their needs	We provide personalised, proactive care for people with complex needs, supported by Integrated Neighbourhood Teams	We design targeted support for everyone to stay well by understanding our population by a review of the information	

Enablers

Workforce – Multi-skilled extended primary care teams work in an integrated way, at the heart of the system, and as part of integrated neighbourhood teams; flexible working is maximised; and workforce wellbeing is prioritised

Digital and data – Shared patient records are being used across the system to aid safe and effective clinical decision making based on real-time information

Estates – We are making the best use of Public Estate and community assets to support primary care delivery.

Resourcing – Resources have shifted from hospital settings into community settings and our contracts are joined up and based on outcomes that integrated services deliver.

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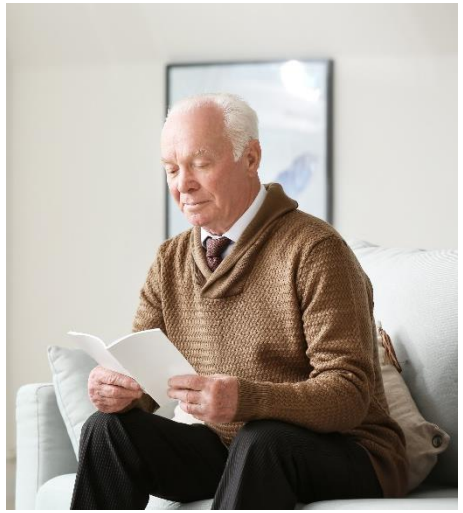
How will it feel for primary care staff?

Consultants in general practice

- I have had a mixed week with a higher level of complexity overall but no more than 12 consultations per session.
- My patients are appropriately and efficiently triaged. This is increasingly via digital triage although phone and walk in are also available.
- I have experienced a large reduction in interface work as all providers can complete their bloods/requests/investigations.
- I am supervising a team of allied health professionals regularly each week, to manage risk and support their development.
- Administrative tasks are now completed by non-clinicians who work as part of a dedicated team to answer patient queries.
- I have the option to subspecialise and work in the same day access hub covering a larger geography.
- Some other GP colleagues are part of an Integrated Neighborhood Team, managing patients with complexity. Overall there is much greater access to secondary care consultants in line with the neighbourhood way of working.
- I have greater influence over the community around us. I see the development of community infrastructure as the first line response for more issues, rather than general practice or another acute setting.



Community Pharmacist

- I feel so much more empowered when patients come to me with health issues.
- I can use my health care knowledge to assess their condition.
- I am now able to prescribe them with medication such as oral contraception.
- I also now carry out hypertension management of many more patients as part of a local cardiovascular prevention scheme with my system colleagues.
- As part of this, I have the resources for health promotion to help educate those I see. I can even point them in the direction of local services like weight loss management in the community.
- The system I use is so much more simple now. I can view the patient notes and update their record – if a patient I see appears to be high risk, I can easily refer them to the GP.
- I also sit as part of an INT weekly meeting where I build personalised care plans for a local frail population cohort who we are managing closely to prevent them going to hospital.

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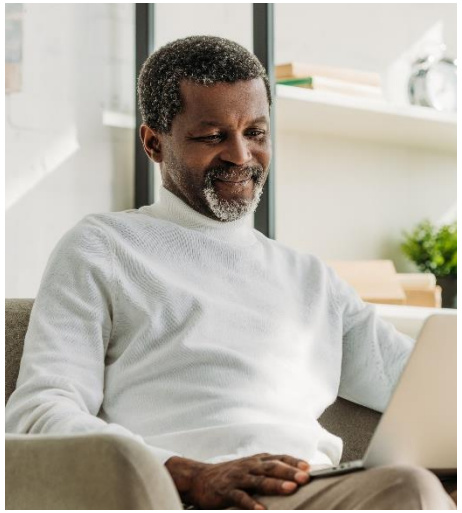
How will it feel for primary care staff?



Optometrist

- A patient comes to my practice for a routine sight test.
- They tell me that they are diabetic now and that their medication has changed - they can't remember what the exact changes are.
- I have a view of their patient record and can see their diabetic status is accurate and can see what medication they are now on for diabetes and blood pressure.
- I can update my records accurately and be on the look out for diabetic retinopathy or hypertensive changes.
- I can notify the GP easily through the shared record interface of any retinopathy or ocular side effects of their medication.
- I can also highlight if the patient is overdue a diabetic check.
- It is so much easier having access to a digital patient record. Without it you have to go by what people remember and what they feel is relevant.
- Communicating directly with the GP digitally improves the accuracy of information and therefore patient care.

Dentist

- As part of my role, and as part of the wider prevention agenda, I support CVD/Diabetes screening, deliver dentistry in care homes, and also provide prevention advice for young children.
- I have educational resources to provide my patients and can point them in the direction of activities going on in the community such as Local Stop Smoking Services to support with their broader health and wellbeing.
- The system I use has been updated and I can update my patients' notes and view their drug histories. There are also easier referral pathways into secondary care.

Community District Nurse

- I provide nursing assessments and care for housebound patients with a physical healthcare need. We see patients at home and in residential care settings.
- I work with colleagues across the system on a day to day basis to manage patients with complexity, as part of an Integrated Neighbourhood Team
- I regularly communicate with the clinical lead when I have a complex case.
- I enjoy being part of MDT meetings as we proactively manage care for patients and also provide more personalised care.
- I can access, update and share my patients' notes with the other team members I am working with.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

How will it feel for patients?

- My husband has dementia and has recently become very ill with more symptoms - he is completely dependent on me and struggles to communicate.
- Over the past month, I have been supported by a team to care for my husband.
- I now have a direct line to the Care Coordinator and we have regular calls so I can share any of my concerns or let the care coordinator know if anything has changed.
- The Care Coordinator liaises closely with my usual GP and Proactive Care Nurse and arranges visits as necessary This team regularly updates my husband's care plan, using any information I have shared with them.
- It has been a really difficult time with my husband becoming very unwell, but to some extent my worries are eased knowing I have direct contact with the same team on a regular basis who know my husband well and can consider any personal factors in his care.
- Additionally, just the other day, a volunteer from a local charity visited to chat with me and has connected me to other people living as a carer / have family members with dementia locally.

Susan, aged 82

Danielle, aged 25

- I have a UTI and am experiencing painful symptoms. I contact my GP via an app downloaded to my mobile phone.
- I have requested to see my GP as I think I might need antibiotics after experiencing symptoms for a couple days .
- The app has told me I can go straight to my local pharmacy which is convenient for me as I can walk there during my lunchbreak.
- I visited my local pharmacy and they gave me antibiotics.
- My patient record is automatically updated so my GP knows I have received this treatment.

Sonny, aged 8

- My child has high needs and is at a specialist educational needs setting.
- Healthcare professionals are carrying out preventative health checks at the school.
- A mobile dental unit has visited the school to provide dental and oral health services which is convenient.
- A Community development worker recently visited my family at home to provide additional information, advice and guidance.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We ensure people get to the right support first time to meet their needs

Our vision is that people who contact the health system will be directed to the right health and care support to meet their needs first time – so that might not necessarily be a GP but the right health care professional and in the right place.

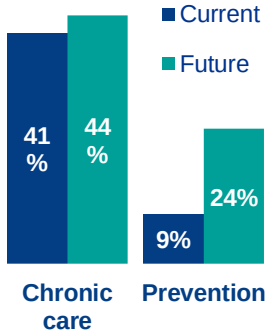
The challenge today – using General Practice as an example

People report a worsening experience getting to the primary care support they need and are frustrated when they feel they are 'bounced around the system'.

Across BOB, patients having a good experience of making a GP appointment has decreased by 19%

Staff feel under extreme pressure and some of the burden comes from a lack of smooth processes as people move between different parts of the system and can end up requiring multiple appointments before they get to the right place.

Staff in General Practice in BOB would like to spend more time on prevention and chronic disease management:



When people find it difficult to get a GP or dentist appointment, they report that they sometimes go to A&E.

In the BOB ICS GP National Survey, people said:

10% went to A&E when they couldn't get a GP appointment

30% visited A&E instead when the GP practice was closed

Our future vision

Self-management

Supporting all our communities to access the high-quality information available on the NHS website.

Signposting to this from community centres, health services, GP websites and apps, and through targeted outreach.

Triage & navigation

When people request support (e.g. through GP online form, by calling 111) care coordinators can triage the request – with clinical supervision – and direct it to the right place.

Supported by digital triage tools, some of which use Artificial Intelligence, and backed by Population Health data that helps teams understand the health needs of the person requesting care.

Initial contact

Initial contact is with the right professional / service, which could be a virtual or face to face appointment with a (for example):

- ✓ GP, Nurse, Physio or other staff member
- ✓ Community Pharmacist, Optometrist or Dentist
- ✓ Urgent Care/Treatment Centre for minor injuries
- ✓ Weight management, audiology, or podiatry service
- ✓ VCSE and mental health services

Supported by digitally-enabled communication between these different clinicians and services.

1:BOB GP National Survey (2023); 2: Survey shared with General Practices across BOB as part of Primary Care Strategy work

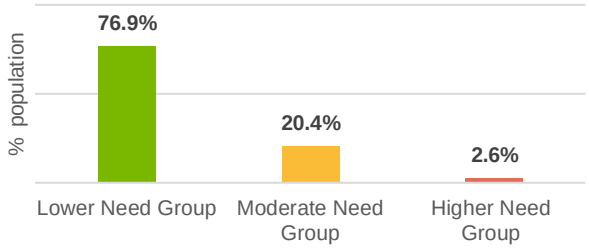
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Changing how we work so people get the right support first time

There are lots of examples in BOB that demonstrate how we better navigate people to the right support. Below, we have described two initiatives already in place that help to ensure people get to the right care and support, first time.

Using data to get patients the right support in Brookside

- Brookside Group Practice use data to understand the needs of their population.
- As shown below, 77% of Brookside's population has generally low needs – these people tend to have a non-complex requirement when they contact their GP, for example, a Urinary Tract Infection (UTI).
- Brookside call this group 'green' patients and support them through an urgent care team or by directing them to community pharmacy.
- Shifting 'green' activity to other places has allowed General Practice to spend more time seeing people with more complex needs. This reduces demand for primary care and A&E because their health is better managed.
- This approach has increased staff satisfaction as skills and interests can be matched with particular work, and they have the option to rotate between teams for more variety.



Population proportion by patient need group

Directing patients to Community Pharmacy

- The NHS Community Pharmacist Consultation Service (CPCS) supports patients to access a same day appointment at their community pharmacist for minor illness or with urgent requests for routine medicine. The service also enables pharmacists to refer patients to an alternative service should it be required.
- This approach is well-utilised in BOB, which has the second highest number of referrals in the South East, relative to population, with over three-quarters of practices using this scheme to refer their patients to Community Pharmacists. There was a 5% increase in the number of referrals that were made in September 2023, with BOB the only ICB to see an increase.
- This service has multiple benefits for the system:
  - Increases patient access to primary care services;
  - Is more convenient where community pharmacies are often closer to patients' homes;
  - Helps to ease pressure on GPs and emergency departments; and
  - Contributes to improving staff satisfaction where the service utilises the skills and medicines knowledge of pharmacists.

Brookside Case study – Segmentation in Primary Care (2023); NHS Community Pharmacist Consultation Service (CPCS) – integrating pharmacy into urgent care; BOB Primary Care Assurance Report 2023/24 Quarter 2 (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We provide personalised, proactive care for people with complex needs, supported by Integrated Neighbourhood Teams

Our vision is to have Integrated Neighbourhood Teams (INTs) made up of professionals from a range of disciplines, operating at the appropriate scale, to support people with more complex needs to stay well in their communities.

The challenge today

People's health needs are changing and many live with multiple long term conditions where traditional disease-specific care is not the best model.

"More than one in four of the adult population live with more than two long term conditions"[1]

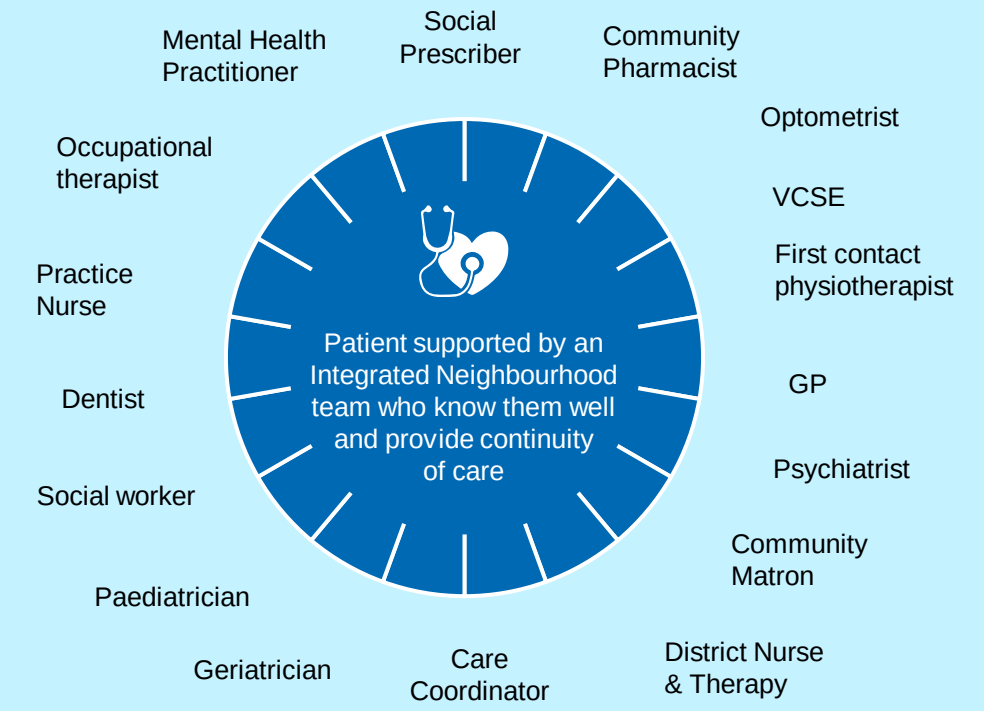
Many issues that affect people's health are not purely medical and require input from multiple parts of the public sector, for example housing, benefits.

"The Buckinghamshire population have higher levels of social isolation"[2]

Where people's needs are not well-managed, they often end up requiring more urgent and costly treatment, that doesn't provide a positive experience or improve longer term outcomes. Groups from more deprived areas tend to end up using the emergency care system more.

"Higher acuity patients now make up a greater proportion of A&E activity than 4 years ago"[3]

Our future vision



Team of colleagues from a range of contributing organisations

To manage the challenges on the left, we need to move towards a more community-based model. This will require the system to shift resource from secondary care into the community and will impact the way the whole system works, especially secondary care with Primary Care. INTs will be the delivery vehicle for this model and our specialist workforce e.g. secondary care consultants, mental health, social care providers, VCSE sector, primary and community care, will have a key role to play in the INT. We will need to ensure job plans are aligned and resources and time commitment are agreed upfront.

INTs will support a defined group in the population who have complex needs and are at risk of experiencing the poorest outcomes. They work together with the individual to develop and deliver a personalised care plan, making sure they can access the support (medical and non-medical) they need.

System partners work together to provide resources (staff, estates, funding) to these teams that come together regularly (daily or weekly), virtually and physically.

The footprint for these teams will be determined locally – with input from a range of system partners – using population health data to identify cohorts who will benefit the most.

1: BOB Joint Forward Plan (2023); 2: BOB fact pack and BOB Integrated Care Strategy (2023); 3: BOB ICB ECDS Data V2 (2023)

Changing how we work so people with complex needs receive personalised, proactive care

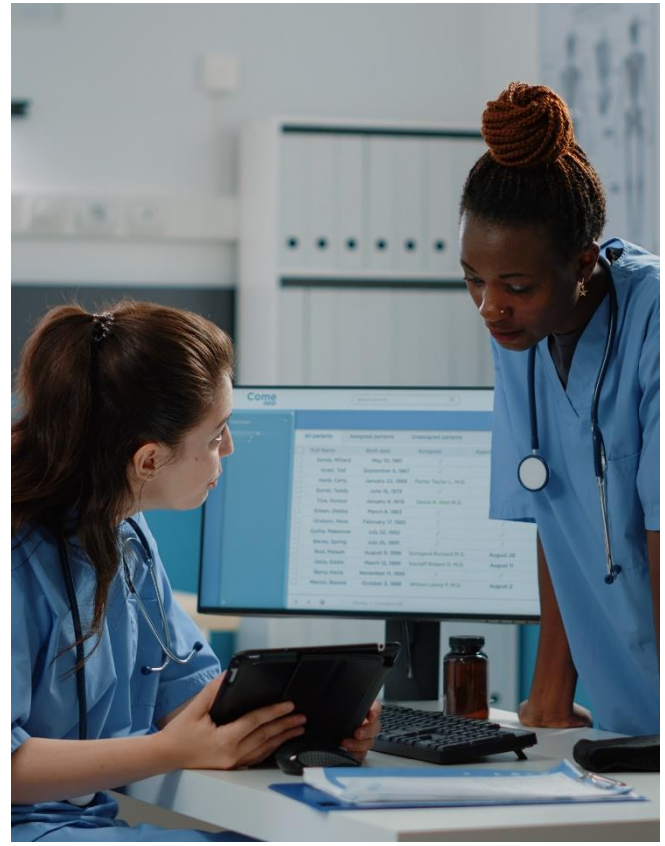
Below, we have described two initiatives already in place that are providing integrated holistic support to people with complex needs.

Bicester Integrated Neighbourhood Team

- The INT has been in development since October 2021 and consists of 2 funded GPs who cover 7 sessions a week.
- The team is comprised of staff members from Oxford Health, social services, community services, community therapies and others
- The INT provides two streams of care: 1) enhanced care for patients who have been discharged from hospital and require care to avoid readmission and 2) proactive care to improve access to patients who can't access services easily e.g. frail patients with acute illness.
- The team conduct a daily ward round to understand who has been seen the previous day and who needs support. Staff are able to call Oxford University Hospital if they have any patient cases with medical complexity and need expert advice and guidance.

Frimley's Integrated Care Model

- To improve seamless access to care and support, Frimley Health and Care introduced an integrated care model. The integrated team is proactive, providing in-reach into hospitals to enable people to return to the community as soon as they're ready.
- The INT model has a single point of access with a joint triage and assessment mechanism.
- INT meetings are focused on supporting people at high risk of hospital admission and with complex needs.
- The team consists of key roles such as GPs, mental health workers, social workers, nurses and rehab practitioners. Input is included from the voluntary sector, ambulance service, pharmacists and psychology.
- Outcomes that have been achieved so far are: care home admissions have been reduced by 12%, GP referrals into hospitals reduced by 13% and elective admissions to hospital reduced by 5%.



1: Future of General Practice, Oxfordshire event slides; 2: frimley-case-study.pdf (nice.org.uk)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We design targeted support for everyone to stay well by understanding our population by a review of the information

Our vision is to share and use data to inform targeted approaches to improve our population's health, working in partnership with our Local Authorities and making every primary care contact count.

The challenge today

- 60,000 living in a deprived area, who develop poor health 10-15 years earlier than those in less deprived areas.
- Approximately 11% of BOB's population are active smokers, with nearly 8% of pregnant women actively smoking.
- Across BOB, 3 in 5 adults are overweight or obese. 68% of adults with a learning disability are overweight.
- Nearly 18% of BOB's population undertake less than 30 minutes of physical activity per week.
- In BOB, there were 115k alcohol attributable admissions to hospitals between 2016/7 and 2020/21.

Our future vision

Primary Care supports people from the beginning to the end of life, and prevention and health promotion are key throughout. Whether it's stopping people becoming unwell in the first place, preventing ill health progressing, or minimising the impact of poor health.

All four Primary Care pillars – General Practice, Community Pharmacy, Optometry and Dentistry – have a critical role to play in prevention activities and the promotion of living a healthy life in local communities. With the right data being shared and discussed between all system partners, including Local Authorities, there is an opportunity to maximise preventative activities and deliver more personalised care. These include opportunistic activity – like blood pressure monitoring during eye checks, and proactive activity – like community pharmacy reaching out to those who may have undiagnosed high blood pressure, or dental checks in early years settings. There is also an opportunity to tackle the social, economic and environmental factors that affect health by supporting people to live healthier lives – like increasing access to tobacco dependency services and weight management services. However, we recognise the need to release capacity, before we can optimise our workforce's full potential to deliver more preventative activity. Our future integrated model of care should help overcome this barrier.

In order to make and sustain a shift towards a more preventative system, we will use data to drive our decision making. We will embed a strategic and system-wide Population Health Management (PHM) approach to allow us to understand the health needs across our system and identify our most vulnerable and at risk groups - those who experience the poorest outcomes and inequalities. With this understanding, we will work with communities to design the right support for the population group we are looking at. We'll evaluate and scale what works and stop or change what doesn't.

1: BOB Joint Forward Plan (2023); 2: Fingertips Public Health Data (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Changing how we work so we can use data to understand our population, and to design targeted support for everyone to stay well

There are lots of examples in BOB that demonstrate how we can use data to drive prevention activity. Below, we have described two initiatives already in place where system partners are working together to make a difference to specific communities and tackle inequalities.

Nepalese community prevention activity

Population health data analysis of people with Type 2 diabetes pinpointed poorer outcomes for some patients in South Reading in the Nepalese community who had a lower uptake of the standard NHS diabetes education offer.

Working with the Greater Reading Nepalese Community Association, a programme was created that:

- Provides group consultations and education, delivered in Nepalese
- Hosted a Pressure Station at a football tournament to encourage visitors to get a blood pressure check and further support - the GPs, along with their surgery staff and local volunteers conducted 90 mini health checks over the course of the tournament, measuring BMI, blood glucose and blood pressure.
- Has promoted health and preventative healthcare advice and identified new cases of possible hypertension and diabetes.

A specialist nurse, who is Nepalese and understands some of the cultural variants within that community, delivers the programme.

Oral health outreach in Oxfordshire

The Community Dental Services team in Oxfordshire take a proactive approach to offering services, particularly in the ten most deprived wards.

They have visited parent sessions at primary schools, Banbury Mosque, Health walks, Dementia support group (online), Community Hubs, food banks, children's classes, weight management groups, clinics in the John Radcliffe, and the Health on the Move Bus.

They have developed their online presence and promotion of national campaigns linked to oral health including National Smile Month and Mouth Cancer Action Month.

The messages, advice and resources that they shared between April 2022 and March 2023 have been used, seen and accessed over two and half million times.

The team also produce a free monthly newsletter which contains social media content around oral health to encourage partners to also share their content – this has 157 subscribers.

1: Reading Football Festival Supports “Know Your Numbers Week” (2023); 2: Oxfordshire Oral Health Needs Assessment (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Four enablers are essential to delivering this vision

Focusing on the activities described over the next two pages should be a priority for the system, as workforce, digital and data, estates and resourcing are critical to deliver the future model of care.

Workforce

- Fully understand current and future workforce skills gaps and challenges around recruitment and retention particularly in rural areas
- Develop longer term local plans, building partnerships to develop a sustainable supply of locally recruited and trained staff.
- Maximising uptake of apprenticeship roles developing the workforce through the apprenticeship levy.
- Expansion of the coaching and mentoring and 'looking after you' programmes for all primary care staff and ensuring access to health and wellbeing support.
- A greater focus on continuous professional development and protected learning time across primary care. Specific learning being commissioned according to training needs analysis, local and national priorities.
- Enable staff to move seamlessly between provider organising using the 'BOB' staff passport' making shared and rotational roles much easier, which in turn results in an increase in staff retention as they have a better employment experience.
- Looking at Dentistry specifically, exploring different types of contract models to encourage recruitment, reviewing the skill mix model to align with new prevention priorities and the training required for this, and review of commissioning training courses to grow dental workforce.

Resource

- In common with the rest of the country, funding is constrained in BOB Integrated Care System, and we need to look at ways to use the existing resources we have differently. Where possible, will look at how we use funding to focus on areas of higher deprivation.
- We know that other systems globally that achieve excellent outcomes for their populations have health and care systems that spend a far greater proportion of their budgets on primary care activities than we do, and this is a shift we are committed to making in BOB.

We plan to do this in two ways:

- By changing the location and type of work our staff do, regardless of who they are employed by. For example, a respiratory consultant spending time each week with an Integrated Neighbourhood Team supporting people experiencing breathlessness.
- By changing the way we commission services so that we consolidate funding to support providers working together to deliver the best outcomes for a defined population – we will begin piloting this approach in 2024.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Four enablers are essential to delivering this vision

Digital & data and estates are key enablers to underpin the successful delivery of our future model of care.

Digital and data

Enhancing our digital capabilities across the system will enable us all to work differently, release capacity by minimising existing administrative pressures and ensure people have a more seamless journey through the system. Building on the ICB's Digital and Data Strategy we will:

Digitise Our Providers – deliver the minimum digital foundations across our providers

- Optimise digital triage tools within General Practice to free up time for staff from manual administrative tasks e.g. processing incoming requests for patients. This will include training for both clinical and administrative teams to ensure they get the full benefits out of digital tools.
- Carry out engagement on the requirements of GP principle clinical systems in readiness for the closure of the GP IT Futures framework that will support the ongoing development of our Electronic Patient Records.

Connect Our Care Settings – use digital, data and technology to connect our care settings

- Enable providers both within primary care e.g. GP, community pharmacy, optometry, dentistry and between primary and secondary care to digitally share patient records. This capability should support effective clinical decision making and enable smooth navigation of patients to the right part of the system.
- Sharing information in this way will reduce administrative burden e.g. for primary care teams, and empower secondary care providers to update medication changes on discharge from care automatically via the NHS Electronic Prescribing Service (ePS) and send a notification to the patient's pharmacy to dispense medication in the community.
- Unlocking interoperability and shared record capabilities will support other digital technologies such as remote monitoring tools to empower patients, and their carers, to play a greater role in their care.

Transform Our Data Foundations – deliver the data foundations to provide the insights required to transform our systems and better meet the needs of our population

- Continue to spread and scale the existing Population Health Management infrastructure that exists in BOB across the entire system.
- Advance our data sharing agreements so we continue to benefit from the capabilities within the Thames Valley and Surrey Shared Care Record, and continue to work with clinical system providers to enable data sharing features within the BOB system.

Estates

- Make greater use of virtual consultations and 'hub working' (with multiple professionals in same space) for non-complex same day care.
- As part of the ICB plans for a shared estates strategy, set a clear expectation that both same day access hubs and Integrated Neighbourhood Teams should make use of the best available public estate. For example, this could mean a same day access hub located at an Urgent Care Centre, or an INT located in a community health centre.
- Explore opportunities for partnership working between the ICB, Primary Care providers and wider local system partners, in particular local councils, to optimise use of public sector estate and community assets, and take opportunities to put health on the high street

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Approach to Delivery

In this section we set out our plans to deliver our shared vision. We have proposed a delivery approach based on the principles of Quality Improvement that we know can drive change. Given the pressure and limited capacity in the system, we have set out three priorities that as a system we commit to delivering.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our approach to delivering this strategy

We are committed to ensuring this strategy turns into action and makes a difference to people living in BOB. The ICB will oversee delivery of the strategy at a local level, whilst empowering our staff working in primary care and system partners to make the required changes. These principles underpin our approach to delivering this strategy.

1 Create Focus

To achieve our vision, we need to prioritise a small number of high impact actions. Acknowledging our system is under pressure and capacity is limited, the actions we focus on must have the biggest impact on the challenges we are trying to address.

2 Delivery Programme Approach

Our delivery approach is underpinned by the continuous improvement principles outlined in NHS IMPACT. This approach will be bespoke for the three priorities and enable teams to:

- ✓ Understand the problem and biggest opportunities for improvement
- ✓ use data to drive decision-making
- ✓ test small incremental changes for our priority actions
- ✓ share learnings and learn from experience
- ✓ Create a ‘bottom-up’ culture of improvement

3 Local Design

Primary Care is a complex landscape of mostly independent contractors which means we cannot implement a “one size fits all” model. We need to ensure the detailed design of the model of care takes place at a neighbourhood level, where those working on the frontline of Primary Care are making the decisions, with their communities, about changes in the way we work.

4 ICB Support

We recognise the need for the ICB to lead delivery of the strategy and to support the changes in the way we work. The ICB will act as a “convenor”, bringing together Primary Care with system partners to have meaningful discussions on how we deliver our priority actions and better meet the needs of our population. Further support will be given in enabling areas such as workforce, to ensure neighbourhoods are supported to drive the changes.

5 System partner Support

To deliver this strategy and enable a shift in the model of care, all system partners will be required to work in new and innovative ways. For example, acute providers will need to identify members of their workforce who can work in the community alongside primary care colleagues. All partners will need to identify opportunities to work more flexibly and share resources, including estates in new ways.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our priorities for delivery

We have identified three areas where we can make a real impact on improving people's health and wellbeing and reducing pressure on staff. Where possible, we will focus on working with communities that experience the most inequalities. In line with BOB's overall system strategy, we have focused on aligning the priorities with two of our system goals and introducing more joined-up ways of working between services – rather than discrete priorities with one area like dentistry or general practice. The priorities are described in more detail on later pages.

1 Non-complex same-day care

General Practice, Community Pharmacy, Optometry and Dentistry will work together, with 111 and Urgent Care, to **better manage those who require support that day, but whose need is not complex.**

Around 70% of population health need is low complexity, and this makes up approx. 50% of GP activity.

Impact:

- Improved patient experience as they get the urgent support they need.
- Release capacity in General Practice to focus those with more complex needs.

John Hopkins ACG System

2 Integrated Neighbourhood Teams

General Practice, Community Pharmacy, Optometry and Dentistry will work together with community, mental health, acute and VCSE services to provide **proactive, personalised care to a defined population group with more complex needs**, for example, frail older people.

Around 70% of health and social care spending is on long term conditions.

Impact:

- People's health conditions are better managed reducing their need for unplanned hospital care.
- System capacity better coordinated and directed at need leading to greater staff satisfaction.

Long-term conditions and multi-morbidity | The King's Fund (kingsfund.org.uk)

3 Cardiovascular Disease (CVD) prevention

General Practice, Community Pharmacy, Optometry and Dentistry will work together with Local Authorities, VCSE and the wider health system to **reduce the risk factors for Cardiovascular Disease (CVD)** including smoking, obesity and high blood pressure.

CVD is one of the most common causes of ongoing ill-health and deaths in BOB.

Impact:

- Reduce 797 heart attacks and 290 strokes (CVD events) in the next 4 years.
- Reduce demand on General Practice and Secondary Care and reduce the overall societal cost.

BOB Size of Prize 2023

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We will continue to focus on other improvements in addition

Our three priorities focus on those areas where we need a system-wide focus to tackle the biggest challenges. There are other areas where work has been and will continue to be undertaken to make improvements to realise our vision. These align with our priorities in the BOB Joint Forward Plan and the Integrated Care Strategy, and we have highlighted a number of areas below.

General Practice

- Support the public to **optimise use of the NHS app** so that they can see their medical records, order repeat prescriptions, manage routine appointments and see messages from their practice.
- **Improve the ways in which patients contact and interact with their GP and navigate care**, including the 111 service - support provided to GPs through national and local improvement programmes.
- Continue to **strengthen the primary care workforce** including recruitment, retention, supporting staff practice to the top of their license.
- **Improve the interface between primary and secondary care –** to streamline processes and touchpoints for patients.

Community Pharmacy

- Roll out of the **Pharmacy First initiative in 2024** so that patients can access prescription-only medicine without needing to visit a GP e.g. for UTI treatment.
- Upskilling of community pharmacists in line with upcoming new policy so that more **pharmacists are able to provide assessments of patients and make prescribing decisions** without patients having seen their GP first.
- Continue to expand vaccination service e.g. flu and covid
- **Expand GP Connect** to enable GP practices and authorised clinical staff (e.g. pharmacy professionals) to **share and view electronic health records information and appointments information.**

Optometry

- **Implementation of an electronic referral platform** which will allow community optometrists to send routine referrals directly to the patients' chosen hospital or single point of access**.**
- **National intent to extend and roll out 'in school' eye testing** in all schools from April 2024, with certain schools given priority for the rollout.
- **National minor eye condition service to be expanded in early 2024** which aims to improve equity and accessibility for patients with most eye conditions seen at eye units and by GPs.

Dentistry

- Further expansion of the Flexible Commissioning scheme which provides **care for patients from underserved communities.**
- Continuing to undertake oral **health assessments and increase dental hygiene in children and young people -** targeting prevention interventions.
- Exploring implementation of **mobile dental units**.
- Building dental clinical workforce resilience
- **Proactive management approach** to dentistry though better oversight of access, quality and performance challenges.

Community

- **Expanding hospital at home approach and redesigning hospital discharge** model - integrating with local councils so more services and care can be moved into the community.
- **Enabling patients to have direct access to community services** such as musculosketal, audiology, weight management and community podiatry without needing to go to the GP first.
- **Improve community-based support for those suffering with Mental Health** e.g. The Thames Valley Link Programme (TVLP) has been established to provide extra support to children and young people who are often described as having 'complex needs' .

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

ICB and Place support for local delivery

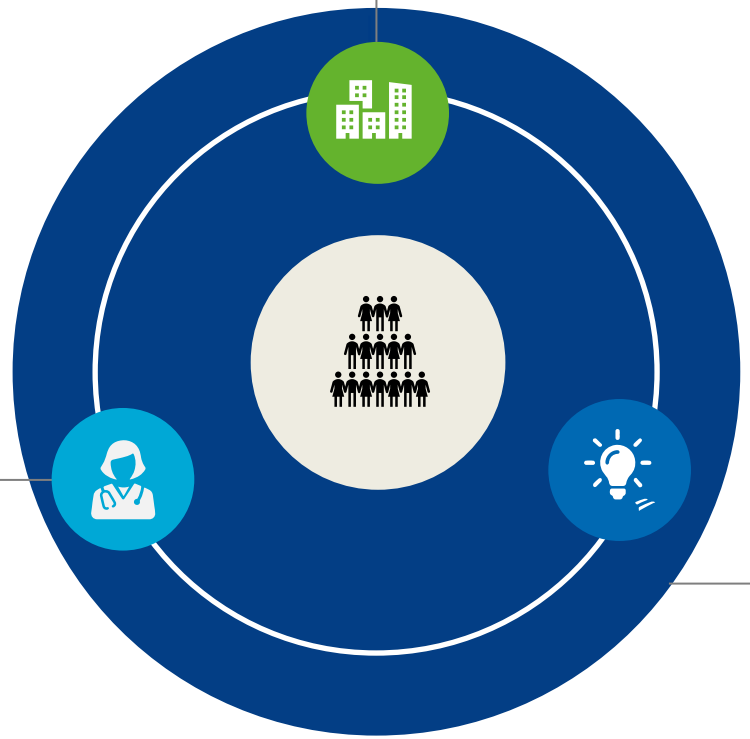
Clinical and operational teams, working with their communities, will be the ones who drive new ways of working. The ICB and Place teams will provide dedicated support to focused Local Action Teams working on our three priorities within an overall Primary Care Delivery Programme.

Place-level

- Place-based Partnerships are **accountable** for delivery of the priorities
- Place Delivery Teams will be established to be **responsible** for delivery and first line of support for Local Action Teams

Local Action Teams

- Clinical and operational teams working with communities
- **Footprint** determined locally as appropriate – could be PCN, Local Authority, other
- **Members** determined and may differ for each priority but include all pillars of primary care and wider system partners
- **Leadership** of teams must be clearly agreed for each priority



The delivery structure will need to align to the overall BOB ICB Operating Model that is being developed.

ICB-level

- The BOB ICB Primary and Community Care Strategic Transformation Coordination Group is **accountable** for delivery of the priorities
- The Primary Care Team is **responsible** for delivery of the priorities, working closely with ICB leads for Workforce, Digital & Data, Estates and Resourcing.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

A phased approach working with cohorts across the three priorities

The Primary Care Delivery Programme will bring together multidisciplinary teams from across Neighbourhood, Place and ICB levels to deliver our three high impact actions, across a three year period. Our Placed-Based-Partnerships will be key to supporting delivery of this approach and driving improvement. Two of our priority workstreams are aligned with our wider system goals on CVD Prevention and Integrated Neighbourhood teams.

Priority workstreams	2024	2025	2026
1 Non-complex same-day care	Cohort 1: March – August 2024, Three sites in each Place	Cohort 2: September 2024 – February 2025, Up to six sites in each Place	Cohort 3: March – August 2025, Up to nine sites in each Place
2 Integrated Neighbourhood Teams	Mobilisation; Co-design blueprint of INTs in each Place	Cohort 1: September 2024 – February 2025, Three sites in each Place	Cohort 2: March - August 2025, Up to six sites in each Place; Cohort 3: September 2025 – February 2026, Up to nine sites in each Place
3 CVD Prevention		Cohort 1: March - August 2025, Three sites in each Place	Cohort 2: September 2025 – February 2026, Up to six sites in each Place; Cohort 3: March – August 2026, Up to nine sites in each Place

'Site' = Neighbourhood level team e.g. Primary Care Network (PCN), or multiple PCNs working together or any appropriate scale at a local level.

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Action plan to establish the Primary Care Delivery Programme

We want to work with all partners in primary care in a new way, utilising the continuous Quality Improvement approaches that we know can drive change and make an impact.

1
- Establish **Place Delivery Teams** to lead this work from March 2024.
- Place Delivery Teams membership to be determined, but for example: GP Chairs, other clinical leadership as determined from primary care pillars, Place Directors and ICB primary care team

2
- Establish the Governance structure, reporting up to the **Primary & Community Transformation Board**.
- Performance and outcomes for each of the priorities to be monitored through the **Primary Care Strategy Scorecard.**

3
- Determine local footprints for this work in each Place – these will be the **'Local Action Teams'** taking part in the Delivery Programme.
- Footprints will need to be determined for each of the 3 priorities: 1) same day- access, 2) Integrated Neighbourhood teams and 3) CVD Prevention

4
- Place Delivery team and Placed-based Partnership to hold launch event of the **Primary Care Delivery Programme** - to explain programme objectives, timeline and rollout.
- **All neighbourhoods** will be required to participate in this programme of work, but it will be tailored to their circumstances.

5
- Undertake **baseline assessment** to understand starting point and specific needs of the Local Action Teams – like current state of triage and navigation functions across Primary Care and whether they have already adopted a multidisciplinary way of working with system partners.

6
- Support access and use of **population health management (PHM)** data to understand which population cohorts experience the poorest outcomes and are from the most deprived areas – to inform selection of neighbourhoods for each cohort.

7
- Use the baseline assessment to identify three Local Action Teams in each Place to take part in the **first cohort** of the Delivery Programme, (same-day access) – the teams should be a mix of those already working in new ways and those who are yet to begin.
- Use the assessment and PHM data to identify 3 teams in each Place to take part in the **second cohort** (INTs). Majority of the teams should be from deprived areas.

8
- Place Delivery Team to hold introductory **mobilisation calls** with the Local Action Teams in each cohort, to agree team members and ensure their time has been allocated to participating in the programme .

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Priority 1

Non-complex same-day care

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1

Our first priority is to expand at-scale triage and navigation to appropriately direct same-day non-complex need

This is the first priority as it will directly address the biggest concern of our population – access to care – and can also rapidly reduce pressure on staff by reducing people needing multiple appointments before they get to the right place.

Approximately half of General Practice activity is same-day care and a large proportion of this is for non-complex needs, like Urinary Tract Infections. In these cases, speed of access is generally more important than continuity of care.

Non-complex needs can often be directed to other primary care services such as community pharmacy or virtual/physical access hubs (where practices collaborate to triage and treat same-day need).

This way of working is emerging in parts of BOB and is in line with national direction of travel around at-scale working. Working at-scale (e.g. through same-day access hubs) can help to improve access as it involves a multidisciplinary way of working, utilising a varied workforce to deliver a wide range of services e.g. a hub could have pharmacists, physician associates, dentists and specialist nurses. This can help manage demand more effectively in a local area.

What impact will this way of working have?

- **Improve patient experience** by making it easier to navigate to the support they need.
- **Release capacity for GPs** to see people who have medium to high complex needs
- **Enhanced staff satisfaction and retention** due to at-scale supervision models that make it easier to provide appropriate oversight and support to ARRS roles, and possibility to rotate in and out of hub roles providing more variety
- **Make better use of current estate** through hub working and an increase in virtual consultations.

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1

An example of a future same-day access pathway

Self management → **Triage & navigation** → **Initial Contact**

Same Day Access Hub Front Door

Patient feeling unwell

Self Care / Management

If appropriate the patient tries to resolve through publicly available, regulated information, advice and guidance e.g. from NHS Website/App, or goes to the pharmacy

Patient requests support

The patient decides they need further support and requests through their preferred route (most often likely to be **their local GP** surgery):

- **Online**
- **Phone**
- **Walk-in**
- **111**
- **Community Pharmacy**

Patient is seeking **'same day'** which they can request via **cloud telephony**, **online consultation,** or **speaking with staff member**.

This redirects them or their online form directly to the hub.

Triage & Navigation

Patient is triaged based on need - by the Same Day Access Hub Care Coordinator (who has support from a clinician when needed). Patient segmentation RAG rating pops up on screen to assist triage. Information will be captured by a **consistent digital tool** whether on the phone or online. If a same day appt is required this will be scheduled in to the Same Day Access Hub.

Same day appointment not needed

If a same day appointment is not needed, the hub care coordinator will either:

a) Book the patient in for a routine appointment in the coming days at their home practice by accessing the local GP **EPR system**, or

b) Direct them elsewhere e.g. 111, Community Pharmacy, dentist, community service, mental health service etc.

c) If the care coordinator feels they need to speak directly to their home practice reception, they can divert them back through cloud telephony

Initial Contact

A patient is seen in either:

- ✓ A same-day face to face or virtual appt with a GP
- ✓ A same-day face to face or virtual appt with another member of extended general practice/ primary care network team
- ✓ Redirected to Community Pharmacy, Optometry, Dentistry or UTC
- ✓ Redirected to community services such as audiology or mental health services
- ✓ Redirected to VCSE

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1

Triage and navigation will be designed locally but with common features

The specifics of the model of care must be determined at local level to reflect the differing needs of populations, existing workforce and estate, and configurations of partner providers. However, patients and staff will benefit from consistent features.

01

Patients continue to request same-day care in a range of ways that suit them – on their GP website/app, NHS app, by phoning their GP, walking into their community pharmacy, or calling 111.

02

Data is collected to support triage through an online form – filled in by the patient or receptionist/care coordinator – that is consistent across the neighbourhoods. Online tools are used to support clinical decision-making.

03

Triage is undertaken only once – either by the practice, 111 or, ideally and over time, by the same day access hub.

04

Over time, triage can be backed by prior patient need and risk stratification to support clinical decision-making.

05

Where triage determines that the patient should be seen by their home practice, either due to complexity or because routine appointment is more appropriate, they are ideally booked directly or transferred back to the practice (i.e. they do not need to make a new request).

06

Where triage determines the patient should be seen outside of General Practice – e.g. Urgent Care/Treatment Centre, community pharmacy, dentist or optometrist, agreed clinical pathways will enable this. Patients will be booked in to the right service e.g. into urgent dental slots, transferred by phone, or clearly directed, ideally with accompanying clinical communication.

07

The same day access hub is resourced by multi-skilled staff from practices and the wider system, who will contribute staff by agreement, likely based on list size. The hub should offer face to face as well as virtual appointments – this could be in existing estate by rotating around practices, or in an existing dedicated space if available.

08

The hub will use Standard Operating Procedures agreed with all practices and partners, and will have documented approach to Clinical Governance.

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1

Action Plan for same-day non-complex care

Primary care is at different stages of adopting this way of working, and the detailed design of same-day access pathways must build from where neighbourhoods are starting from. Place Teams will support a Quality Improvement approach to delivery.

The **ICB and Place Teams will**:

- ✓ Bring teams together for focused sessions to progress activities on the right – enabling them to **share learning**, do things once where **consistency** makes sense, and support each other to **overcome blockers**
- ✓ Provide **resources** based on national, global and local good practice on same day access
- ✓ Work to enable **patient records to be shared** across all of Primary Care and broader system and improve ability to **communicate and refer** between all primary care professionals (digitally).
- ✓ Make available the ICB Expert teams responsible for **key enabling areas** like workforce, digital, data and estates to provide updates, help unblock issues, escalate where needed and provide extra support, as required.
- ✓ Support the setting of **clear outcome metrics** and the tracking and collation of these to demonstrate impact
- ✓ Ensure **involvement of system partners** in co-designing pathways, and promote visibility of new ways of working across their Place
- ✓ Roll out **Population Health Management tools** to help segment our population into groups based on their needs and identify those most likely suitable for same-day non-complex care.

Local Action Teams will be supported to:

Existing pathways

- ✓ **Map current access pathways** that exist e.g. across GP, Pharmacy, Mental Health etc.
- ✓ Identify where the **biggest improvements** can be made and set measurable outcomes.
- ✓ **Agree and test a small number of changes** to the pathways on a small scale, discuss how all system partners could support these changes.
- ✓ Capture and **analyse impact** of the change, collecting data and tracking the impact against the outcome measure.
- ✓ If the changes demonstrate sustainable improvement, agree plans for **implementation of changes at a wider-scale.**

New pathways

- ✓ For new pathways e.g. **same-day access hub, Minor Eye Conditions** etc, map future state, set outcome metrics and conduct small-scale test of change.
- ✓ Capture and analyse impact of the change, spread scale if improvement is demonstrated.

Supporting discussions:

- ✓ Identify **enablers required** to support best use of pathways – Standard Operating Protocols, digital interoperability of patient records and appointment booking systems
- ✓ Estimate impact of **increased referrals to Community Pharmacy** and build into plans for Pharmacy First – look to increase referrals from A&E and UCC using EMIS.
- ✓ Review **demand and capacity modelling**, agreeing capacity required in same day access hub and workforce contributions from each practice.
- ✓ Identify enablers required to support at-scale working – rotational or dedicated use of existing estate, interoperability of systems (cloud telephony, EPRs, triage tools etc).

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Priority 2

Integrated Neighbourhood Teams

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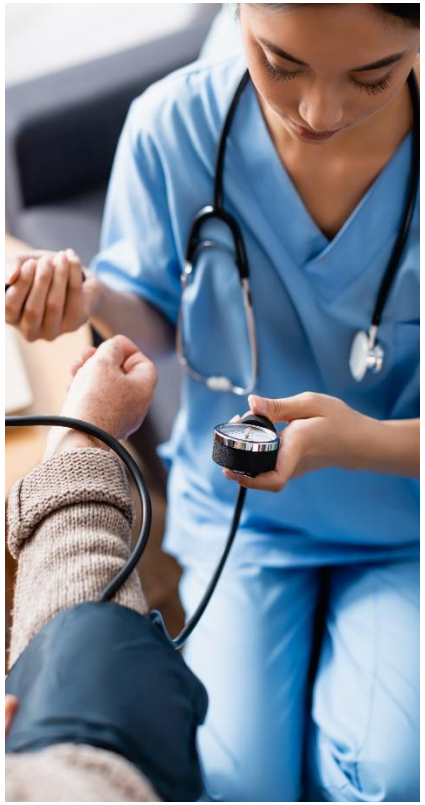
2

Our second priority is to create Integrated Neighbourhood Teams to coordinate care and support for at least one population cohort

As a system, we're committed to making a reality of integrated neighbourhood working, and this priority means we will begin that work by establishing Integrated Neighbourhood Teams in all areas beginning with a focus on one defined population cohort.



An integrated community-based model can make the biggest difference for those who have (or are at risk of having) complex medical or social issues. Often this is associated with multiple long term conditions, and inequalities in access, experience and outcomes.

We want to put primary care at the core of this model, with Integrated Neighbourhood Teams as the delivery mechanism to implement this way of working. All neighbourhoods will work to design and develop an INT to bring professionals from across the system to work together in the community (virtually and physically) to provide holistic support to **at least one population cohort** e.g. frail older people, children with health conditions.

There are already some Integrated Neighborhood Teams operating in BOB and lots of plans underway. Developing relationships and building trust amongst system partners will be key to the success of this approach.

What impact will this way of working have?

- Improve **patient experience** by providing continuity of care from a named professional, who can coordinate a holistic approach to meeting needs, combining expertise from different teams.
- Improve **outcomes** especially in the management of long-term conditions and reduce inequalities in outcomes.
- Reduce **demand for GP appointments** as continuity is provided by a multi-skilled team working together to manage needs, releasing capacity for GPs to focus on the most complex needs and prevention.
- Reduce **Emergency Department attendance and emergency admissions** as issues (medical and social) are addressed before they escalate.
- Improve **staff wellbeing** through development of a collaborative culture that puts patients needs first and supports flexible working in different teams.

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2

Defining an Integrated Neighbourhood Team for BOB

We recognise that INTs are not a new concept, but rather an evolution and extension of Multi-disciplinary Teams that have already been operating. Each INT will look different, based on the population it is focused on and the partners involved. As a system, we have developed core principles to guide how we build INTs that will make it easier for us to explain INTs to our population and staff, and learn from each other as we develop new ways of working.

Who

INTs are the delivery vehicle for a community based model. They will:

- Be a multidisciplinary team of generalist and specialist skilled health and social care professionals.
- Work with other partners in the neighbourhood – e.g. police, mental health services and local housing associations.
- Actively involve and engage the local community in planning and decision-making to ensure services align with actual population needs.
- Have a designated GP clinical lead with protected time.
- Have secondary care consultants aligned to support and deliver services to the population cohort.
- Be established from existing resources and infrastructure.
- Integrate into service and community development in neighbourhoods, with all pillars of Primary Care part of the offer.

What

Teams will develop their own standard working practices that may include:

- A daily call 'huddle' - where patient notes are reviewed, next steps for priority patients discussed and plans for home-visits agreed.
- A weekly INT meeting is scheduled to discuss high risk patients in more detail and create personalised care plans
- Any community-based care that is required for patients should be allocated to the most appropriate team e.g. district nursing.
- The secondary care consultant will provide specialist advice to the team and help resolve complex cases.
- Community teams will have regular contact with the clinical lead/ GP in the INT to ensure any complex issues are resolved.
- Across some teams, senior GPs may serve as the 'consultant in General Practice', providing holistic expert care to a population cohort.

Where

- Determine a local footprint for the INTs in each Place, which may be based on PCN or multiple PCNs.
- Teams do not have to be co-located in the same premises to work successfully but opportunities to engage in person, alongside virtual meetings are preferable

Supported by:

PHM tools to identify, understand and define a cohort to focus on

High degree of trust and a culture of collaboration between health and care teams and professionals

Virtual and physical space to come together

Ability to share patient records among system partners

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2

Action Plan for Integrated Neighbourhood Teams

Primary care is at different stages of adopting this approach to delivering care, and the detailed design of INTs must build from the Local Action Teams that are developing this team, alongside their system partners. Place Teams will support a Quality Improvement approach to delivery.

The **ICB and Place Teams will**:

- ✓ Support the determination of a **local footprint** for INTs, based on PCN or neighbourhood.
- ✓ Identify the **Local Action Teams** to take part in each cohort of the Delivery Programme, ensuring an early focus on deprived areas.
- ✓ Bring teams together for focused sessions – enabling them to **share learning**, do things once where **consistency** makes sense, and support each other to **overcome blockers**
- ✓ Make available ICB teams responsible for **key enabling areas** like workforce, digital, data and estates to provide updates, help unblock issues, escalate where needed
- ✓ Support the setting of **clear outcome metrics** and the tracking and collation of these to demonstrate impact
- ✓ Ensure **involvement of system partners** in the Integrated Neighbourhood Team approach e.g. ensuring specialist secondary care consultants job plans are aligned with this way of working, and promoting visibility of new ways of working across their Place.
- ✓ Roll out **Population Health Management tools** and support use of these to identify initial population cohort that each INT decides to focus on
- ✓ Continue to **expand shared care record** to enable patient records to be shared across all of Primary Care and broader system

Local Action Teams will be supported to:

- ✓ Review population health data to **agree a population cohort to focus on** based on the principles of tackling inequalities and reducing system pressure.
- ✓ Lead conversations with system partners (including primary, secondary care, community services, VCSE, social care and others) to **agree roles in the INT**, securing the required capacity and commitment.
- ✓ Work with providers to ensure Pharmacy, Optometry, Dentistry and others are appropriately involved and aligned to the team, **maximising the capacity of the whole system** to meet the needs of the population cohort.
- ✓ Define the **core capabilities of the INT and interactions** between all providers.
- ✓ Agree **ways of working** with INT core members e.g. daily huddles, weekly MDT meetings to review patients and care plans.
- ✓ Identify appropriate **virtual and physical space**
- ✓ Establish **Standard Operating Procedures** for referrals into and out of INT, clinical governance etc.
- ✓ **Test new way of working** with small segment of the population cohort - conduct daily and weekly calls, review patients and actions required.
- ✓ **Track and evaluate benefits**, share learnings and tweak processes (where required).
- ✓ **Scale** approach to whole population cohort once improvements are demonstrated.

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Priority 3

CVD Prevention

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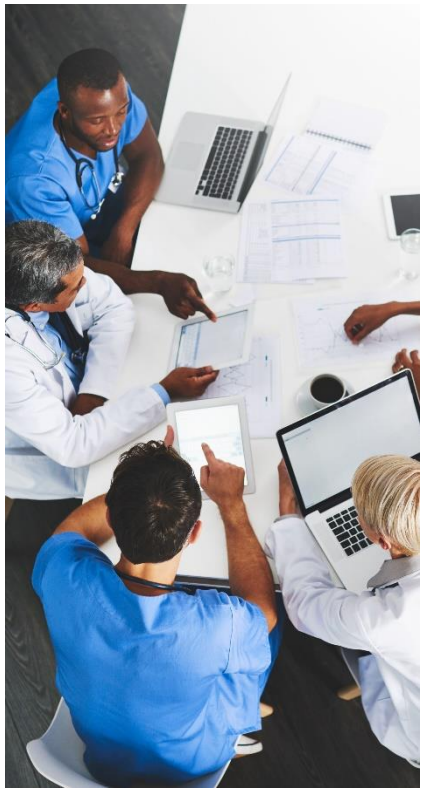
3

Our third priority is to align primary care to support a system-wide focus on preventing Cardiovascular Disease

Cardiovascular disease (CVD) is a major cause of death in BOB and is a key driver of the life expectancy gap between people living in our most and least deprived areas. To reduce the number of heart attacks and strokes, we need a system-wide focus on intervening to reduce the major risk factors, and tackle inequalities.



All four pillars of primary care are already leading the fight against CVD, by targeting the high risk conditions (high blood pressure, Atrial Fibrillation (AF), high cholesterol and heart failure). This includes encouraging healthy lifestyles, identification of those at risk, and effective clinical management of those with high risk conditions.

We want to build on that work and take the opportunity to target those efforts strategically where they will have most impact – by using data about our population's health to focus on those communities at highest risk, including deprived areas, some ethnic minority groups, and those with severe mental illness, learning disabilities or neurodiversity.

With CVD prevention as a system priority across BOB, primary care's efforts will be enhanced by working in an integrated way with system partners – like public health teams and local councils. This should reduce duplication, maximise value for our population and enable us to deliver more proactive and personalised care.

What impact will this way of working have?

- Reduce the number of people developing CVD, and prevent people from having a heart attack or stroke (CVD events).
- Reduce Emergency Department attendances and emergency admissions for heart attacks and strokes.
- Reduce the gap in life expectancy between the most and least deprived communities.
- Support people with high-risk CVD conditions such as atrial fibrillation, high blood pressure and raised cholesterol to better manage their health with convenient, community-based support.
- Make it easier for staff in all parts of the system to direct people to information, resources, support and services that can help them to adopt healthy lifestyles.

BOB Joint Forward Plan (2023)

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3

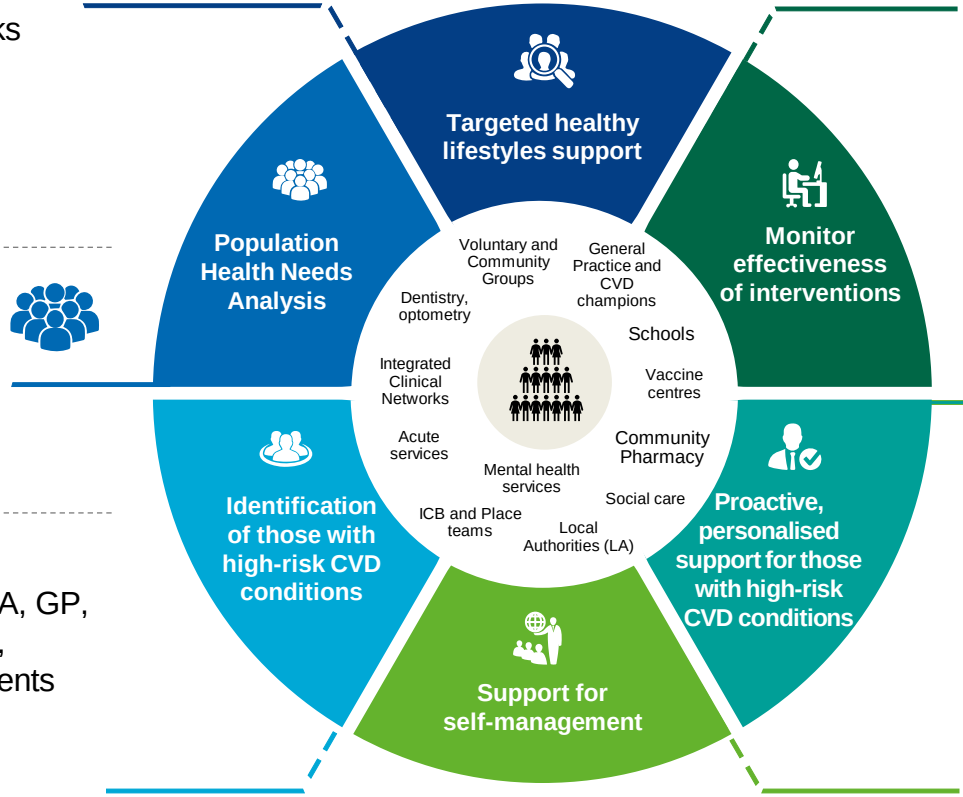
Example future integrated local approach to CVD prevention

This slide shows an example of how all parts of the system come together at a local level to take a data-driven approach to CVD prevention, supported by system-wide shared training.

Produce and share population risks for CVD at system, Place, LA and PCN level. Do community engagement for a deeper understanding.

Agree local plans with all partners e.g. signposting to smoking services. Others include obesity, physical inactivity, healthy diet and alcohol use.

Health checks undertaken by LA, GP, pharmacy, dentistry, optometry, vaccine centres, community events



Based on agreed outcome metrics, evaluate success or otherwise of intervention, share findings, and build into future planning

From primary to secondary care, integrated clinical pathways for proactive management hypertension, AF, high cholesterol

Information provided for self-management of e.g. simple hypertension, in partnership with community pharmacy, automated blood pressure stratification.

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3

Action plan for Cardiovascular Disease prevention

Whilst all aspects of primary care already undertake CVD prevention activity, ICB and Place Teams will support this focus, working with cohorts of Local Action Teams through a Delivery Programme approach.

The **ICB and Place Teams will:**

- ✓ Support access to **PHM data** where not yet available, support all to use the data to draw out actionable insights.
- ✓ Put in place 'one ICS' **education and training** on CVD prevention so multidisciplinary teams attend together to drive collaboration.
- ✓ Provide **educational resources** based on national, global and local good practice on CVD prevention, working with Integrated Clinical Networks
- ✓ Bring teams together for focused sessions to progress activities on the right – enabling them to **share learning**, do things once where **consistency** makes sense, and support each other to **overcome blockers.**
- ✓ Support the setting of clear **outcome metrics** and the tracking and collation of these to demonstrate impact.
- ✓ Ensure **involvement of system partners** in co-designing pathways, and promote visibility of new ways of working across their Place.

Local Action Teams will be supported to:

- ✓ Map CVD prevention activity **already planned or being implemented** across the site by all partners, including Public Health.
- ✓ Explore and debate the **population health information** shared and use this to prioritise and shape three local actions, that all partners will work on with the community to reduce risk factors for CVD
- ✓ Use data to identify where the **biggest improvements** can be made and set measurable outcomes.
- ✓ Actions might include for example, targeted smoking cessation interventions, increase in NHS health checks, expansion of hypertension case finding by community pharmacies.
- ✓ Agree and test interventions on a small-scale, collecting data and **tracking the impact** against the outcome measure.
- ✓ If the changes demonstrate **sustainable improvement**, agree plans for implementation of changes at a wider-scale.
- ✓ Identify key enablers such as **workforce and estates** requirements, including how to strengthen **CVD champion** roles and make use of opportunities at community events.

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Oversight of Progress

In this section we set out our plans to build a strong delivery structure based on Quality Improvement principles to ensure accountability is clear and we make progress on delivering our vision. We also include a scorecard that we will use to track measurable progress for our population and our staff.

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We will ensure accountability for delivery is clear, based on quality improvement principles

We will build a strong delivery infrastructure that empowers frontline teams to design and deliver changes to their models of care, and enables the ICB to mobilise resources and unblock issues

Level	Accountable	Responsible
ICB	**Primary and Community Care Transformation Board** • Set overall plan as per this strategy • Monitor delivery against outcome metrics • Allocate resource appropriately • Troubleshoot when issues are escalated **Digital and Data Oversight Group** • Set overall primary care digital and data plan as per digital and data strategy • Monitors progress being made against the digital and data plan that will interlink this strategic	**Primary care team** • Delivery of overall plan: - With Place-based Delivery Teams for Model of Care - With ICB leads for Enablers • Track progress and report to P&C Transformation Board • Allocate team members to each Place-based Delivery Team
Place	**Place-based-Partnerships** • Monitor delivery in their Place • Allocate resources • Troubleshoot when issues are escalated • Ensure learning is widely shared	**Place Delivery Teams** (including alliance / federation staff as appropriate, ICB primary care team members, others to be determined) • Agree sequencing of Local Action Teams to join programme • First line of support for Local Action Teams • Track progress and escalate issues to ICB level for resolution
Neighbourhood	**Local Providers** • Corporate and clinical accountability rests with established providers / groups of providers working together e.g. in alliance or federation structures • Appropriate memoranda of understanding or other constructs put in place to enable contribution to Local Action Teams	**Local Action Teams** (Clinical and operational teams working with their communities) • Design new local models of care to deliver the priorities in the strategy, supported by Place Delivery Team • Engage with Primary Care Delivery Programme at the appropriate time, take advantage of the resources and peer learning available • Escalate issues to Place Delivery Team

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We will develop a scorecard to track progress

Whilst the whole system embarks on this transformation journey, we need a way to regularly monitor progress against our outcomes. We have developed this scorecard to translate the strategy into operational terms and focus on a set of key measurements. The scorecard will provide a quick, but comprehensive snapshot of the Primary Care system.

Outcomes	Success metric*	Frequency of measure
Improve patient experience	1. GP Patient Survey for overall satisfaction 2. % of positive responses on Friends and Family test	Annual Monthly
Improve outcomes for Long Term Conditions	1. QOF indicators – for diabetes, respiratory, cardiac (hypertension) 2. Hypertension 18+ managed to target 3. 18+ Q risk score of 20+ and need lipid therapy 4. Proportion of people with long term conditions with care and support plans 5. Reduction in emergency admissions for chronic ambulatory care sensitive conditions	Monthly data from CSU
Improve staff wellbeing	1. Sickness absence rates 2. Leaver rates among newly qualified staff 3. Retirement rates 4. NHS Staff survey (when introduced for primary care)	Monthly Annual
More sustainable system	1. Average number of EMIS entry types – clinical vs administrative 2. Community Pharmacy Consultation Scheme uptake and outcomes	Monthly

*Please note that this data is an example only and we will do more work to define the metrics as an ICB and identify where we have data that we could measure each of these.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Glossary of terms

Term	Definition
A&E	Accident and Emergency
AF	Atrial Fibrillation
ARRS	Additional Roles Reimbursement Scheme
BOB	Buckinghamshire Oxfordshire and Berkshire West
CAS	Clinical Assessment Services
CVD	Cardiovascular disease
CPCS	Community Pharmacy Consultation Service Scheme
EMIS	Education Management Information Systems
EPR	Electronic Patient Records
EPS	Electronic Prescription Service
ED	Emergency Department
F2F	Face-to-face
FTE	Full-time Equivalent
GP	General Practitioner
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
INT	Integrated Neighbourhood Team

Term	Definition
JFP	Joint Forward Plan
KPI	Key Performance Indicator
LA	Local Authority
LDC	Local Dental Committee
LPC	Local Pharmacy Committee
LMC	Local Medical Committee
LTC	Long Term Condition
MECS	Minor Eye Condition Service
MDT	Multidisciplinary team
PBP	Place Based Partnerships
PROMS	Patient Reported Outcome Measures
POD	Pharmacy Optometry Dentistry
PHM	Population Health Management
PCN	Primary Care Network
QI	Quality Improvement
QOF	Quality and Outcomes Framework
UCC	Urgent Care Centre
UDA	Unit of Dental Actvity
UTC	Urgent Treatment Centre
VCSE	Voluntary, community or social enterprise

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Thank you for reading this draft strategy.

We are grateful to all those in the BOB Integrated Care System who have helped to shape this draft strategy.

We need your views and feedback to help agree our final strategy, so please do share your thoughts via **engagement.bobics@nhs.net**