NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOARD MEETING

Title	BOB ICB Primary Care Strategy		
Paper Date:	8 May 2024	**Board Meeting Date:**	21 May 2024
Purpose:	Approval	**Agenda Item:**	11
Author:	Louise Smith, Deputy Director Primary Care; Sarah Adair, Director Communications & Engagement (Acting)	**Exec Lead/ Senior Responsible Officer:**	Rachael de Caux, Chief Medical Officer

Executive Summary

Since July 2023 BOB ICB has been developing its Primary Care Strategy informed by research, analysis, and engagement. The nine-month journey, with initial support from delivery partners KPMG, has been complex but insightful, providing a glimpse of the challenges ahead for its implementation.

As part of this programme of work, extensive engagement was undertaken with a wide range of partners, stakeholders, and the public. We received written responses from the Berkshire, Buckinghamshire and Oxfordshire Local Medical Committees; the BOB Joint Health Overview and Scrutiny Committee; Buckinghamshire Council; Buckinghamshire Health and Adult Social Care Select Committee; Dementia UK; Downs Syndrome Oxford; Oxfordshire GP Leadership Group and a joint response from Healthwatch Buckinghamshire and Healthwatch Oxfordshire. These responses were shared with Board members and informed the discussion on the strategy at the April Board workshop.

The supporting documents ‘Primary Care Strategy Development Public Engagement Report' and ‘Our Response to the Feedback Report’ provide details of activity undertaken, identifies the key themes from all the feedback and how this insight has been used to inform the final version of the Primary Care Strategy.

True to its original intention the document sets out details of the ambition for a new model of primary and community-based care and describes how primary care should streamline access, provide continuity of care for those with complex conditions and focus more on prevention. In so doing it is expected that as an ICS we will improve health outcomes for our population, tackle variation and reduce inequalities, using the resources available to us across the system in the most effective and efficient way.

Integration remains at the heart of the model and the high-level priorities below have remained unchanged.

- 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. Our communities are finding it difficult to get an appointment in General Practice or with an NHS dentist, and this needs to change.
- 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.
- To help communities stay well with an initial targeted focus on our biggest killer and driver of inequalities, cardiovascular disease (CVD).

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 described in the strategy support that shift. In the final strategy document, we have developed this in more detail through the following.

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

Action Required

The board are asked to:

- Recognise the significant work undertaken by the ICB, Partners and the public to develop the Primary Care Strategy.
- Note the thorough engagement undertaken on the draft strategy and how that has been reflected in the final strategy with the ‘Primary Care Strategy Development – Public Engagement Report’ and ‘Responding to the Feedback from Engagement Report’.
- Approve the final primary care strategy to progress to implementation.

Conflicts of Interest:	No conflict identified

Date/Name of Committee/ Meeting, Where Last Reviewed:	16 April 2024 Board Workshop

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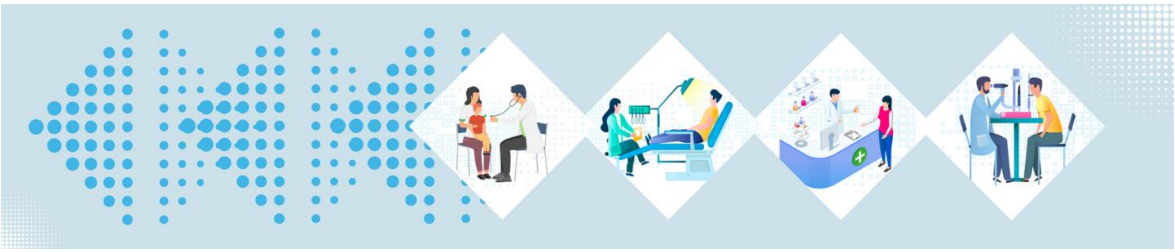
Primary Care Strategy Development – Public Engagement Report



Date: March 2024

Contents

Introduction and background

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) published its Integrated Care Strategy and Five-Year Joint Forward Plan in the summer of 2023, which sets out its ambition for Primary Care:

> To transform how Primary Care is delivered in each community/neighbourhood, enabling integrated Primary Care provision which improves the access, experience and outcomes for communities aligned to their needs. Through the mobilisation of integrated neighbourhood health and care teams, Primary Care services will become more sustainable, and patients will get the support they need when they need it.

BOB ICB is working with system partners on a programme of work to develop a Strategy and implementation plan for the future of Primary Care across Buckinghamshire, Oxfordshire and Berkshire West. Primary Care includes General Practice, community pharmacy, optometry and dentistry services. These services provide the first point of contact for patients, have an ongoing connection with local communities, and are essential to improving the 'whole person' health of our population across BOB.

The draft Primary Care Strategy was published for engagement in January 2024. The strategy aims to address the challenges faced locally in Primary Care as well as improve integration between all Primary Care services and forge a better partnership working with community services.

The draft Primary Care Strategy outlines three priority areas:

- **Priority 1:** to expand at-scale triage and navigation to appropriately direct same-day non-complex need.
- **Priority 2:** to create Integrated Neighbourhood Teams to coordinate care and support for at least one population cohort.
- **Priority 3:** to align Primary Care to support a system-wide focus on preventing cardiovascular disease.

The ICB is keen to work with local people and partner organisations to shape the future of health and social care in response to local needs. Enabling people, communities and partner organisations to get involved in the development of this Strategy, will inform plans and proposals for the future of our health and care. The Strategy has been created based on national guidance, BOB's own local plans, and ongoing insights and analysis through engagement with the local population, NHS and Local Authority partners and wider stakeholders.

1.1 Purpose of the report

The purpose of this report is to outline the two phases of public engagement that were undertaken from 17 November 2023 to 3 March 2024 for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB) Draft Primary Care Strategy.

1.2 Purpose of public engagement

BOB ICB launched a two-phase engagement process to collaborate with and seek the views of people who live or work in Buckinghamshire, Oxfordshire and Berkshire West on Primary Care provision in their local area.

The purpose of the engagement was to involve the local population and communities in reviewing and helping to refine the Primary Care Strategy, so that it works for the people who live and work in BOB, meets local needs and takes pressure off all services. The engagement activity included surveys on BOB ICB's online engagement portal YourVoiceBOB and a series of public events, focus groups and Patient Public Group sessions.

1.3 Process and methodology: Primary Care Conversation

The first phase of engagement the **'Primary Care Conversation'** launched on 17 November and continued in parallel with the draft strategy until 3 March 2024.

A survey was made available on https://yourvoicebob-icb.uk.engagementhq.com/primary-care-conversation which asked **'What are your experiences of accessing primary care? (This includes general practice, optometry (eye health), pharmacy and dentistry services)'**.

Below are details of the approach to communications activity during this period. The activity and promotional reach of these channels in shown in *Appendix 4*.

Stakeholder briefing

We developed a briefing to announce the launch of BOB ICB's **'Primary Care Conversation'** and shared it with chief executives at the five health trusts and 10 local authorities, and with leads for Health Overview Scrutiny Committees, Health and Wellbeing Boards, and Local Pharmacy Committee, Local Optometry Committee, Local Dentistry Committee.

The briefing explained the engagement work that had already taken place on transforming local primary care services and described the next stage of this initiative via the launch of the **'Primary Care Conversation'** which asked people to share their views and experiences on local primary care services in a short survey.

Communications toolkit

We developed a toolkit which included an email invite, short and a longer news item for newsletters and websites, a media release and social media messaging to help key ICB partners promote the **'Primary Care Conversation'** engagement/survey among their staff, stakeholders and wider networks and audiences. It was cascaded to the following key BOB ICB partners:

- **NHS**: Communication teams in the five health trusts including: Oxford Health NHS FT, Oxford University Hospitals NHS FT, Berkshire Healthcare NHS FT, Buckinghamshire Healthcare NHS Trust; Royal Berkshire NHS FT
- **Local Authorities**: Ten local council communications teams to raise awareness among elected members and staff.
- **Media**: regional press across Oxfordshire, Buckinghamshire, Berkshire West including BBC, ITV Meridian, independent radio stations including Star radio, Global, Greatest Hits and press outlets: Oxford Mail, Get Reading, Bucks Hearld, Banbury Guardian, Henley Standard
- **Healthwatch organisations**: covering Oxfordshire, Buckinghamshire, West Berkshire, Reading, and Wokingham to promote among patient groups.
- **Patient Groups:** patient participation group leads.
- **Charities:** totalling 77
- **BOB Voluntary, Community and Social Enterprise (VCSE) Health Alliance** which emailed 350 members with the information about the engagement/survey.
- **AGE UK:** its three organisations in Buckinghamshire, Oxfordshire and Berkshire West
- **21 local MPs** across Buckinghamshire, Oxfordshire, Berkshire West.
- **254 elected councillors** across Buckinghamshire, Oxfordshire, Berkshire West.
- **Higher Education:** universities across Buckinghamshire, Oxfordshire, Berkshire West
- **Employers:** Major companies and businesses across the patch (see table below)

'YourVoiceBOB'

We developed this engagement platform https://yourvoicebob-icb.uk.engagementhq.com/primary-care-conversation to host the survey and associated documents, easy read material and list of focus group and patient/public meetings. The platform was used over the two rounds of engagement (November/March 2024) and had 18,583 visits during this period.

A link to the '**YourVoiceBOB'** engagement platform was published on the home page of the BOB ICB website to provide quick access to this site for visitors.

Charities

We sent the toolkit to 77 local charities across BOB with the request they highlight the engagement and survey with their members. This included:

- 17 involved with learning disabilities.
- 12 supporting mental health.
- 8 supporting older people.
- 11 involved with family and children support.
- 6 addiction support services
- 11 involved with equalities.
- 5 involved with homelessness.
- 7 involved with wellbeing.

Local employers

We issued the toolkit email invite to the following major employers (see table below) across BOB ICB asking them to share details of the engagement and survey with their employees/staff.

- The University of Reading confirmed they had shared the information about the engagement and survey with staff and students in early December 2023.
- Jesus College in Oxford distributed the survey link among its students in January 2024.

• Buckinghamshire University • University of Oxford • Oxford Brookes • Reading University • Argos • Dominos • Papa Johns • Intercontinental • Hotels Group • Hovis • The Perfume Shop • Oxford University Press	• Homebase • Oxfam • BMW • Taylor and Francis • Tesco • Sainsbury's • Nielson • David Lloyd • Vodaphone • Pearson • Taylor Wimpey • Red Bull Racing

1.4 Phase 1: Primary Care Conversation

On 17 November 2023, BOB ICB launched the **Primary Care Conversation** https://yourvoicebob-icb.uk.engagementhq.com/primary-care-conversation a patient experience survey ahead of the Draft Primary Care Strategy being released. We invited people to share their experiences of Primary Care, the question we asked was **'What are your experiences of accessing primary care? (This includes general practice, optometry (eye health), pharmacy and dentistry services)'.**

In total 529 people responded, 376 answered the survey question and 121 shared comments on the ideas wall. The site remained open until 4 March 2024 and the following high-level themes were identified.

Across services

Across all services the following themes were raised:

- concerns over staff shortages
- lack of continuity in the member of staff see, resulting in a lack of personal contact and opportunity to build a relationship.
- growing waiting lists

- shortage of funding for services
- the need for more joined-up working across services.

Dentistry

There was good feedback from patients who had an NHS dentist. However, the majority stated they could not register with an NHS dentist or get an appointment. This resulted in many patients often opting to go private, register out-of-county or not attend the dentist.

General Practice

Participants commented that online booking online for non-urgent issues had made accessing a GP appointment easier. There was also positive feedback for the NHS App in terms of communication and use for prescriptions. However, some responses highlighted that the app was not always accessible for all demographics of patients.

Other themes included patients feeling that they were unable to get urgent or on the day appointments, and often stating they must wait for lengthy periods of time. Patients often felt as if they were blocked from accessing a GP by the receptionist triage booking system, with some feeling it was unnecessary/embarrassing having to explain symptoms on the phone and in person. Additionally, when they gained access to an appointment, they felt that the appointment type provided was not always tailored for the problem or need. There were recommendations for more varied opening hours and days to increase accessibility for patients, the need for adapted waited areas for those with additional needs and access to free local ear wax removal, especially for patients with hearing aids.

Optometry

Largely positive feedback for Optometry from patients who have access to the service. Although it was apparent there was some lack of awareness of NHS provision which meant people were opting to go private.

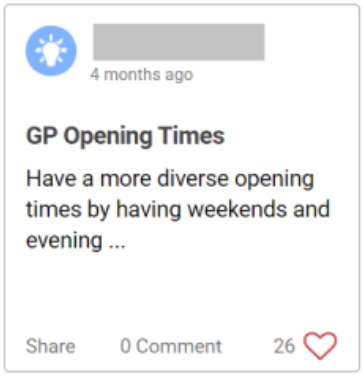
Pharmacy

Overall, there was good feedback for Pharmacy provision and respondents commented on the helpful staff. Frustrations, however, included shortages of some common medications, medication not always being ready on time, closing of local pharmacies, and frequent long queues and waiting times for medicine.

1.4.1 Phase 1: Ideas Wall

Within Phase 1 of the engagement there was an ideas wall on the EngagementHQ site where we asked people "**What is working well and what can be improved?"**

One hundred and twenty-one people responded to the question; people were able to show support for comments by liking them.



The top 5 most popular ideas, receiving over 20 likes were:

- Stop only on the day GP appointments and enforce GP practices to offer appointments in advance and provide an online booking system.
- Have more diverse opening times at weekends and evening while having some mornings closed; or could have half of GPs working from 8am – 4pm and a second wave from 12 midday – 9pm. This would mean working patients can attend appointments.
- Enable a better booking system. The lack of bookable appointments for chronic (non-acute) named GP appointments causes great anxiety. e-Consult is great for acute issues but not for trying to book for an appointment around work. There is the stress of having to take time off work at very short notice when not 'sick'. Telephone lines are endlessly busy and difficult to phone during work hours.
- Prevention and support services for frail older people could identify early issues, make referrals and prevent emergency admissions, rather than as currently, care is only available in an emergency from paramedics it seems. GPs no longer see frail older people it seems.

- Shouldn't have to book an emergency appt when you want to see a GP or be told you can only ring on certain day/time.

Other popular suggestions included:

- Connect your dental, opticians and GP record in one patient record.
- Have a QOF register for Menopause so you can track that earlier for most women when they hit 40 and manage that.
- I think each surgery in the area should use online/digital services more. It looks like the infrastructure is there, but surgeries restrict providing such services.
- Currently assessment for neurodiverse conditions is not easily accessible or not available at all. While we talk so much about neurodiversity and acceptance of neurodiverse people at work or anywhere around, we do not have the facility or access to simply have an assessment carried out.
- We desperately need more NHS dentists - at least available for all children as a start. It is a scandal to have to pay privately for an NHS dental appointment for a child.
- Make NHS dentistry available to everyone.
- Connect your dental, opticians and GP record in one patient record.

1.5 Process and methodology: Draft Primary Care Strategy

Following phase 1, where we asked people to share their experiences of primary care, we sought feedback on the Draft Primary Care Strategy from 10 January 2024 – 3 March 2024.

The draft strategy was published, which explained the rationale for the strategy, the need for change, who was involved in the work and the priorities for primary care. We made the document available on 'Your Voice in BOB' https://yourvoicebob-icb.uk.engagementhq.com/primary-care-strategy and published an easy read version a summary word version to support online translations. A glossary of terms was also published to support accessibility.

We asked the public and wider stakeholders to give their feedback via:

- An online survey https://yourvoicebob-icb.uk.engagementhq.com/primary-care-strategy
- A printed copy version of the survey with freepost
- A range of public webinars and focus groups.
- Emailing engagement.bobics@nhs.net or writing to the Communications and Engagement Team at the BOB ICB.

A range of activity was delivered to involve the local population and communities in reviewing and helping refine the Primary Care Strategy, so that it works for the people who live and work in BOB, meets local needs and takes pressure off services.

Below details our approach to our communications activity during this period. The activity and promotional reach of these channels in shown in *Appendix 4.*

Stakeholder briefing

We revised the original briefing to announce the launch BOB ICB's **'Draft Primary Care Strategy,**' looking at integrating general practice, community pharmacy, optometry and dentistry. This was shared with the following stakeholders:

- Chief Executives at five local health trusts across ICB
- Chief executives at 10 local authorities across ICB
- Leads for Health Overview Scrutiny Committees, Health and Wellbeing Boards, and Local Pharmacy Committee, Local Optometry Committee, Local Dentistry Committee across the ICB.

The briefing explained the engagement work that had already taken place on transforming local primary care services; also described our ambitions in the draft strategy around same day access, integrated neighbourhood teams and prevention.

We highlighted a new survey to get people's views on the draft strategy; and explained how we would run public/patient group webinars and focus group meetings with community organisations during this second phase of engagement.

Communications toolkit

We refreshed the original communications toolkit we developed which included an email invite, a short and a longer story for newsletters and websites, a press release and social media text to help key ICB partners promote the 'Draft Primary Care Strategy' and survey among partners, staff, stakeholders and the public. It was sent to the key BOB ICB partners (as outlined above on page 5), with the ask to help promote the engagement.

2. Key Themes

Between 10 January 2024 and 3 March 2024, 610 people fed back on the Draft Primary Care Strategy through the various routes available.

- **Survey** – 247 people who responded.

- **Focus and public groups -** A total of 22 virtual public events and focus groups were held with 161 people attending. These were aimed at under-represented communities to enable participation through presentations and discussions.

- **Public and patient panel meetings -** There were 8 public participants groups held with 157 people attending, which reviewed the Draft Primary Care Strategy through presentations and discussions.

- **Written responses -** We received 45 written feedback submissions via emails, letters and social media. These were received from both individual members of the public and organisations. Organisations included Buckinghamshire Health and Adult Social Care Select Committee (HASC), Healthwatch Bucks and Healthwatch Oxfordshire, Buckinghamshire Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee (JHOSC) and Dementia UK. Full list of organisations shown in *Appendix 3.*

All engagement and feedback were analysed, and findings are listed below.

2.1 Survey Feedback

In total, 247 people responded to the survey which was open from 10 January until 3 March 2024. This is broken down by area as follows:

- Oxfordshire – 114 people
- Buckinghamshire – 59 people
- Berkshire West – 53 people
- Other - 21 people.

High level key themes from the survey feedback include:

- Overall, most respondents stated they felt the vision sounded like a positive switch towards a more integrated response and preventative approach.
- Communication and clear signposting needed to reduce the need for multiple appointments.
- More focus on early prevention and education to promote healthy lifestyles for patients and educating patients to manage their own health conditions.
- The importance of continuity of care to build trusting relationships.
- Challenges highlighted: funding, staffing, resource, access to NHS dentists and GP appointments.
- Ensure people are not digitally excluded from accessing care.
- For the triage system to work efficiently, ensure staff are trained accordingly to guarantee patients' needs are met.
- Delivery requires all partners to work closely and efficiently together, with effectively integrated systems, to ensure patient details are shared correctly.
- Clear communication with the public is needed around the changes and what it means in reflection to their needs, to provide assurance that their health needs will be met.
- Strategy document:

- The strategy document should be written in plain English to enable people to fully understand the vision and how it will affect them.
- Strategy to include more information about how it will work in practice and timelines for implementation.
- Missing groups and areas highlighted were: diabetes, maternity and neonatal areas, women's health, cancer, asthma, COPD, heart failure, hypertension, diabetes, mental health, children and young people, net zero, unpaid carers and carers' support, identification of other fatal diseases at early stages.

See Appendix 1 for full details on the survey analysis.

2.2 Public Event and Focus Group Feedback

A total of 22 virtual Public Events and Focus Groups were held with 161 people attending. These were aimed at underrepresented communities (shown below) to enable participation through presentations and discussions.

Public Event and Focus Groups:

- Maternity and Parents
- Oxon Community Champions
- Oxon Asylum Welcome
- Age Well Services and Carers
- Ukraine Refugees
- Bucks One Recovery
- Homeless Berks West
- Young People
- CLASP (self-advocacy group those with Learning Disabilities)
- Chiltern Neuro Centre
- Gypsy Roma Travellers professionals and advocates

High level key themes from the Public Event and Focus Group feedback include:

- Strong consensus that overall people know how to access Primary Care services, however frequently stating that they often struggled to gain access due to lack of appointments and availability of services, such as NHS Dentist.
- Ensuring continuity of staff was paramount to participants, to give them the opportunity to build a consistent and trusting relationship.
- Participants welcomed a more accessible face-to-face appointment with a single point of contact.

- There were frustrations at the lack of joined-up working between services, and a strong request for enhanced record-sharing and communication between teams to reduce repetition with more use of Hospital/Health passports.
- There was an overall feeling that wait times across services can be unacceptable, and that the time to receive a diagnosis is too long.

See Appendix 2 for full public event and focus group analysis.

2.3 Other Feedback Received

Feedback was also received via other public and patient panel meetings, reports, social media, email and other communications channels. The themes raised in the feedback broadly reflected those raised through the online survey responses, with the following additional points listed below.

Public participation group feedback

There were 8 public participants groups were held with 157 people attending, which reviewed the Draft Primary Care Strategy through presentations and discussions.

High level key themes from the public participation group feedback include:

- The importance of communication with patients regarding the Strategy.
- Staff roles and how they can help patients e.g. pharmacists being trained to diagnose/treat.
- PPG/VCSE groups are keen to engage with the Strategy and help cascade information.
- The need to ensure joint organisational working and linking computer systems to share accurate and up-to-date patient data between services.
- Questions over how the Strategy will ensure there is no digital exclusion for patients.
- Worries raised over whether there are sufficient resources to meet demand for care.
- Missing groups and areas highlighted were: Diabetes, Obesity, Physio.

Analysis of written responses

We received 45 written feedback submissions via emails, letters and social media. These were received from both individuals and organisations.

High level key themes from the analysis of written responses include:

- Joint working and good collaboration working is key.
- Concerns about the resources to enable delivery.
- The importance of communication from Primary Care services and the public.

- Lack of awareness about wider pathways and the Primary Care offer.
- Reducing waiting lists will reduce the demand on Primary Care.
- Enable better access and using co-design to meet the needs of the patient.
- More focus needed on wider determinants affecting health.
- Strategy document to be reviewed to ensure the use of Plain English and is free of language and terms that may be difficult for the public to understand.
- More information needed within the Strategy around timelines, implementation dates and the role of Integrated Neighbourhood Teams.

See Appendix 3 for full details of other feedback received.

3. Appendix 1: Analysis of survey responses

In total, 247 survey responses were received online via the BOB ICB engagement platform at https://yourvoicebob-icb.uk.engagementhq.com/primary-care-Strategy.

Throughout the engagement period, the online engagement site for the Primary Care Strategy was visited more than 7,600 times. Of those visitors:

- 251* were actively involved and responded via the engagement platform

- More than 2,000 were informed (downloaded and read the documents)
- More than 5,800 were made aware (visited the site to read about the engagement)

Most activity took place in January. Over the course of the online engagement, there were:

- 858 downloads of the full Draft Primary Care Strategy
- 654 downloads of the Summary: Draft Primary Care Strategy
- 135 downloads of the easy read version

**(Additional hard copy survey responses were also received and analysed)*

3.1 Future Vision and Experience of Primary Care

Question 1: Do you understand our Future Vision for Primary Care?

244 people answered this question.

Most respondents, 78% (191 people), agreed they understand our Future Vision for Primary Care. 19.2 % (47 people) said they partly agreed, 1.6% (4 people) of respondents disagreed, and 1.2% (3 people) were not sure.

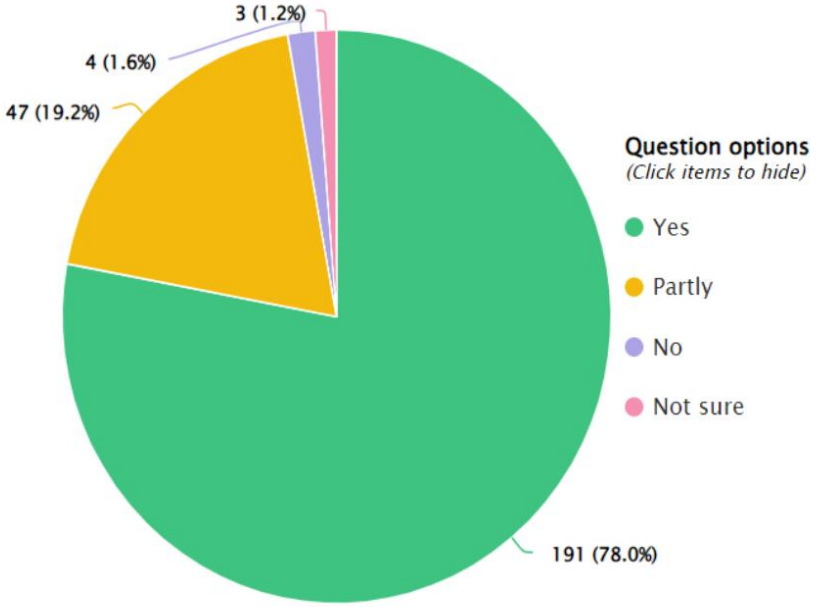


Chart 1: Pie chart showing percentage of respondents who said Yes, Party, No or Not sure to "Do you understand our Future Vision for Primary Care".

Question 2: Do you have any comments about our vision?

172 people answered this question.

Overall, the majority of respondents stated they felt the vision sounded like a positive switch towards a more integrated response and preventative approach.

> *"It is ambitious (not a bad thing); it will require huge culture changes within certain health care areas to foster working together, sharing information, sharing learning. It will also need big investment into Primary Care provision and education of the audience to reduce unwarranted requests for help."*
>
> *"Feel it is on the right lines with a switch towards more integrated responses and preventative approach. In terms of integration this must end up being a seamless experience for the patient"*
>
> *"I agree with the vision and aspects of the ways that it is likely to be applied. Integrated teams providing more 'joined up' care and support and working proactively are a really positive idea along with more of a focus on prevention. I think that in some cases enabling patients and, where relevant their families and carers, to be more proactive and feel empowered to find ways to manage their own health needs and work in partnership with the health professionals could be a way forward."*

How will it work in practice and continuity of care?

Respondents questioned how the future vision would work in practice, expressing that the triage system was crucial in ensuring a seamless experience for patients and the need to ensure staff are appropriately trained to deal with multiple health conditions. It was also raised that same-day triage could possibly have a negative impact on continuity of care.

> *"If anything like the 111-triage system then will be a disaster. Having multiple health conditions, even if I need a same day appointment that may be deemed non urgent, continuity of care with GP who knows full history and all conditions is vital."*
>
> *"If you talk to any Primary Care professional, they all say that continuity of care is essential. It improves quality, outcomes and reduces cost. This element of a strategy seems to be missing."*
>
> *"It is ambitious. Really important that there is a focus on retention and upskilling of existing staff, reducing administrative burden and improving direct access to services so that doesn't have to 'go through' GP first (which is a barrier and reduces GP capacity)."*

Strategy document and timelines

Respondents commented that, to enable people to fully understand and promote engagement, the strategy needed to be written in plain English. It was raised that the pace of delivery was not reflected, with people questioning what the milestones are and when the strategy will be delivered.

> *"The documents, even the summary, are filled with lots of consultant's words. Not many people will read this and even less will understand it. You need to engage the population with simple messages about how your strategy will affect them on a day-to-day basis, and when this will happen."*
>
> *"I think you would need a reasonable level of education to understand quite a lot of this strategy. It's full of jargon. I think the older generation would also struggle to understand a lot of this."*
>
> *"It would be helpful to have some worked examples or clinical scenarios to understand the impact on different cohorts of patients/disease types."*

Digital exclusion

There were many respondents who felt that there was significant focus on the service being supported using an App, online forms and online tools. Expressing the importance to ensure people are not digitally excluded from accessing care.

> *"Concern that people who find digital access difficult are not disadvantaged from accessing services."*
>
> *"Don't assume that everyone can or wants to do everything online or on their phone. I like the idea of having a single point of contact who can then direct you to the right initial contact or even better to be able to make an appointment with this team, but this should be able to be done on the phone, not just online. At the moment the only route to do this is to call the GP, and the receptionists shouldn't have to do this triage work."*

Additionally, a couple of respondents raised concerns about the quality of the vision, resourcing and funding pressures.

> *"I appreciate the vision but am concerned around the recruitment of staffing to support the vision especially regarding the lack of dentists within the BOB remit.*
> *"From a patient's perspective, this strategy will cause more problems than (much needed and overdue) solutions; will disrupt the essence of the GP model; put patients at risk; and should be reconsidered, with much more input from the public and patients. Indeed, it is of concern that such a significant*

> *change to services was not opened to a full and formal consultation. As the plans become widely known residents and patients will be angry to find they have been left out of the process."*
>
> *"It is extremely unwise to implement a system that fundamentally undermines continuity of care as a response to pressures caused by underfunding and the misguided over-prioritisation of convenience and rapidity of access over quality of care."*

Question 3: Based on your experience of Primary Care, please indicate how much you agree or disagree with the current challenges identified in the Strategy below:

246 people answered this question.

Three of the four current challenges identified in the strategy had a higher level of respondents who indicated they 'strongly agreed'. These were:

- Many primary care staff are under extreme pressure.
- There is a gap between what we can provide and patient demand.
- There are challenges with funding, recruitment, and retention of staff, together with issues around buildings and premises where patients are seen.

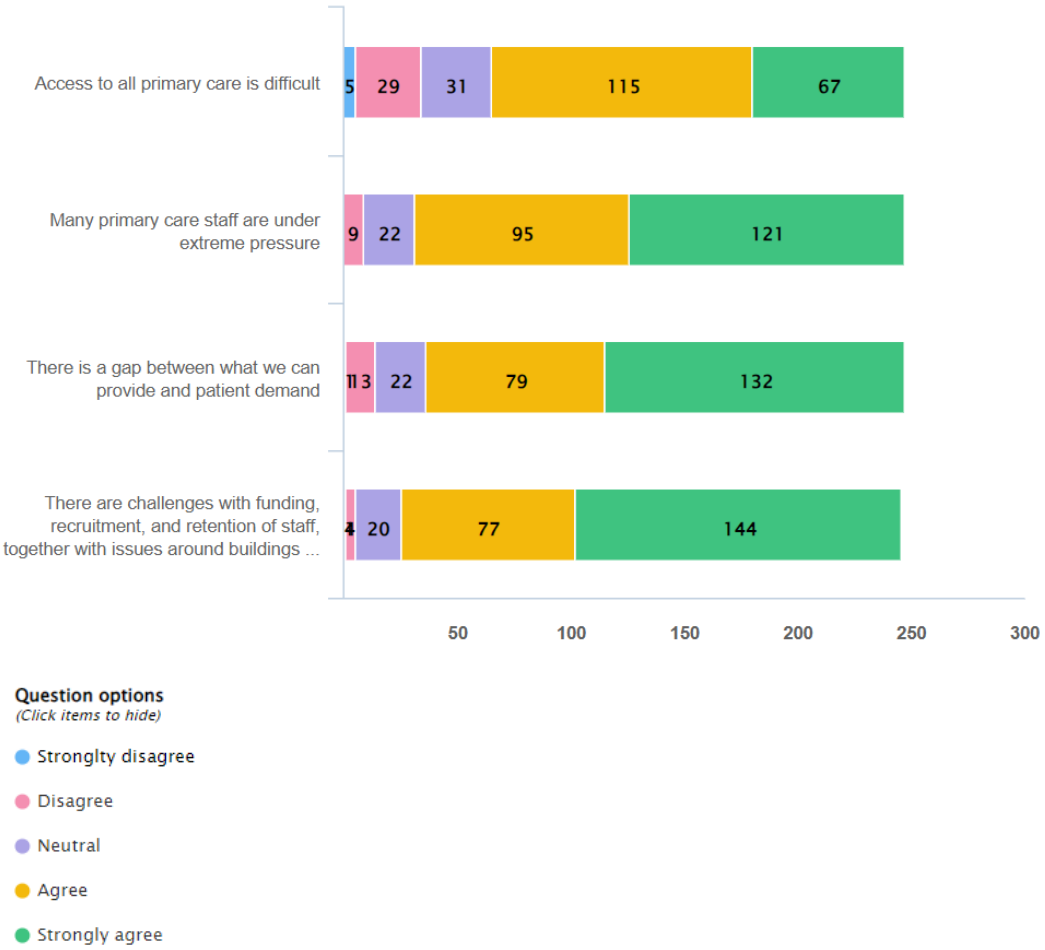


Chart 2: Ranking chart showing how respondents agree or disagree with the current challenges identified in the Strategy.

Question 4: Is there anything you would add or like to comment on about the challenges in Primary Care?

168 people answered this question.

Respondents highlighted several challenges in Primary Care, the main areas mentioned included:

- Problems accessing appointments and services.
- Recruitment and staff retention
- Lack of continuity in care
- Funding and resource pressures
- Political challenges
- The need to educate the patients on managing own health conditions.

Accessing services and continuity in care

Respondents commented on access to Primary Care services, some challenges included: NHS dentist availability and challenges getting a GP appointment, stating

that sometimes patients felt blocked from the triage system. The need for clear pathways for patients was raised, especially those with complex medical needs, as well as the need to ensure continuity of care was not compromised due to service demand.

> *"Access is trumped over continuity, when we know that continuity (of service, not just clinician) makes the most difference to patients and clinicians for those frailer / complex."*
>
> *"As somebody who has multiple health needs, I often find it difficult [to know] who to go to for help. My main concern is this comment in the outline – 'provide personalised, proactive care to patients with more than one health condition, such as frail elderly people.' While I completely understand that frail elderly people are vulnerable and need to be included in such an interdisciplinary system, I would like this system to be extended to people such as myself. A young but unwell person, I often find I am pushed pillar to post between the GP and hospitals, an interdisciplinary meeting on such matters would be helpful."*
>
> *"Important to treat the users of services as adults and tap into our understanding of our own care. There's a danger that GPs get more difficult to see behind the triaging system. I would recommend that all GPs are required to see their patients at least once a year or offer an appointment to do so. We are losing the continuity of care that used to be such a strong feature of primary care."*

Other challenges included problems accessing appointments due to restricted times, the need for more tailored GP appointments dependent on the patient's requirement and the need to ensure there are no digital barriers within systems for certain demographics.

> *"Current phone contact times can be excessive but on-line consultation provides contact with professionals in a reasonable time. Out of hours consultation form seems to default to NHS 111 or emergency, when all a patient wants is to leave a non-serious consultation request for the next day. non-serious consultation requests should be allowed out of hours."*
>
> *Many GPs to whom I have spoken across all age ranges are unhappy with the balance of F2F and telephone consultations. They feel they are losing contact with the patient as a person, and in danger of missing important symptoms and as a result may end up calling the patient in for a F2F after a telephone consult resulting waste of time.*
>
> *"Access to the right care and knowing "the system" is difficult. There seems to be an expectation that patients understand the less than easy to understand*

> *systems. There is also an expectation that everyone can use "tech". The NHS and GP online systems are not intuitive and easy to use."*

Lack of funding, resource, staff and political challenges

Across responses there was acknowledgment that there was need for more funding, resource and better software systems to support more joined-up working. It was also raised that there is a need for more staff and to ensure that current NHS staff are retained.

> *"Insufficient funding and failure to train and maintain sufficient staff - together with privatisation - underlie most current problems."*
>
> *"A massive increase in resources is required because of an increase in population and an ageing population."*
>
> *"Chronic underfunding, under-resourcing, and lack of investment in training, developing and retaining the NHS workforce, as well as the government's continuing failure to address the historical problems that beset social care, exacerbated by the swingeing cuts to LA budgets, have led to this politically motivated crisis."*

Additionally, respondents commented on political challenges and the need for government support.

> *"These challenges are politically induced via lack of appropriate funding."*
>
> *"Primary Care needs to be supported from government that using triage and seeing clinical nurse practitioners and physician associate is a recognised and valid pathway to be seen. That you cannot demand to see a GP you will be seen by the most appropriate clinician."*

Communication and education for patients

Respondents highlighted the need for an increased focus on health promotion/personal responsibility for patients' own health. It was suggested this could be enabled through sharing of information and choices for services as well as the use of supportive digital technologies.

> *"Possibly some focus on education (for even young children) about when/how to get help and how/when to help yourself. EG healthy eating, exercise, increase in PE/swimming/sports provision, managing your mental health."*
>
> *"Yes, there are challenges, but the NHS needs to also modernise and embrace digital technology. People need to be empowered by taking greater control of their own health conditions e.g. remote monitoring."*

> *"It is clear that some of the pressures on primary care services could be eliminated by signposting to clear pathways to alternative services. Currently we all still assume the GP surgery is the gatekeeper of all other treatments. As the primary care service is redefined taking the public with you by providing clear information will be vital."*

Additionally, the following areas were highlighted as having insufficient focus:

- Maternity and neonatal areas
- Women's health
- Cancer
- Asthma
- COPD
- Heart failure
- Hypertension
- Diabetes

> *"We have noticed there is very little info on maternity and neonatal areas and women's health. The public are not fully aware of all the roles in primary care. There is a perception that all primary care revolves around GPs which is not the case. This response has been collated by the wider BOB LMNS team."*

3.2 Priority 1: Feedback

Priority 1 is to expand at-scale triage and navigation to appropriately direct same-day non-complex need. The 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.

Question 5: Please indicate how much you agree/disagree with the following approaches to same day access?

246 people answered this question.

Three of the four approaches to same day access had a higher level of respondents who indicated they 'strongly agreed'. These were:

- Patients wanting to see a health professional on the same day are assessed according to their clinical need.
- Patients should be signposted to the right professional to support their health or care need, which may not be a GP.
- If the patient need does not require same-day access, they can be seen in a routine appointment in the future.

Chart 3: Ranking chart showing how respondents agree or disagree with the approaches to same day access.

Question 6: Thinking about same day access to Primary Care, please indicate how much you agree/disagree with the potential benefits identified by this priority for patients and those working in Primary Care?

244 people answered this question.

Three of the four current challenges identified in the Strategy had a higher level of respondents who indicated they ‘strongly agreed’. These were:

- Improve patient experience by making it easier to get the support they need.
- Make more appointments available so GPs can see people who have medium to high complex health and care needs.
- Enhanced staff satisfaction and retention due to better support and more variety in staff roles

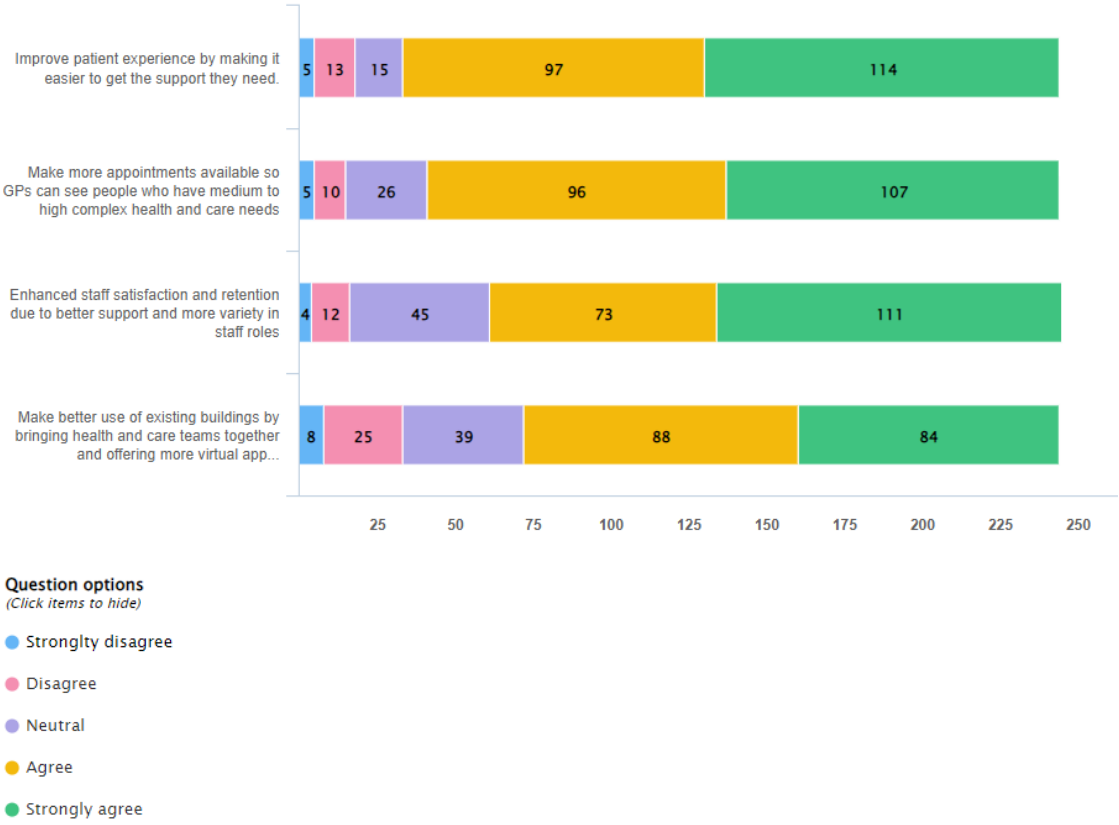


Chart 4: Ranking chart showing how respondents agree or disagree with the potential benefits identified by this priority for patients and those working in Primary Care

Question 7: Do you think same day access will reduce pressure on services by reducing multiple appointments before patients get seen by the right professional?

245 people answered this question.

Majority of respondents answered Yes 37.4% (92 people) and 31.7% (78 people) answered Partly. However, 13.8% (34 people) were not sure and 17.1% (42 people) answered No.

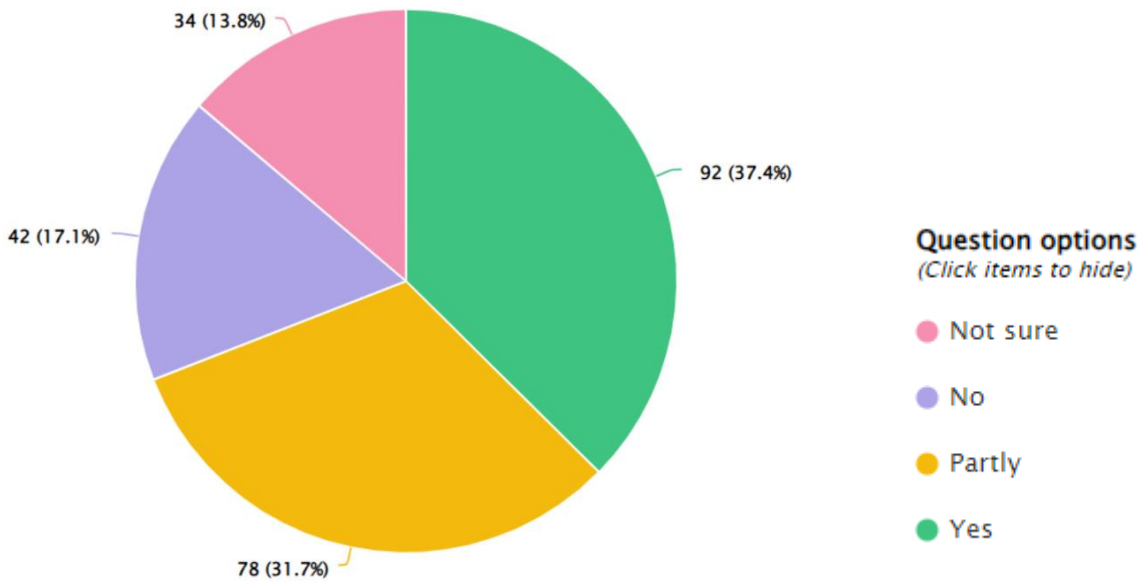


Chart 5: Pie chart showing respondents who said Yes, Party, No or Not sure to if same day access will reduce pressure on services by reducing multiple appointments before patients get seen by the right professional.

Question 8: If you disagree or don't know, please tell us why:

100 people answered this question.

Of the respondents that disagreed or were not sure if same day access will reduce pressure on services by reducing multiple appointments before patients get seen by the right professional, the main reasons given included the triage process and having appropriately qualified staff and digital exclusion.

Triage process

62 respondents referred to the triage process within their response. Stating that good triage by an appropriately trained member of staff and clear signposting is key to reducing the need for multiple appointments. However, some respondents felt that same day access removed the option for continuity of care and for the patient to build a trusted relationship with a specific individual.

> *"Sometimes the 'same day need' will be part of a larger issue that may not be identified by using this approach. It may be necessary for a patient to build up confidence or develop a relationship with an individual health professional before they can discuss ongoing issues and share important information to find the most appropriate care."*
>
> *"It depends on who is doing the triage. We need more GPs!! - they're the ones with the knowledge / experience to triage properly, plus possible higher-qualified nurses, so they need to be doing this as well as seeing the complex patients. What seems a 'simple same day' issue to a lower-qualified person*

> *might be a red flag to a doctor! (and may not be obvious on the phone or even a video call).”*

Digital exclusion

Additionally, concern was raised around patients who may struggle with apps and how they will be assisted to using technology to access care.

> *“I don't necessarily disagree, but being seen virtually is not a replacement for in-person care, so I may be stating the obvious but virtual care should only be something used by low complexity cases. The other thing that is not addressed is the aging population you are dealing with. How many 60+ are going to use a virtual tool over the phone or a walk-in? Perhaps you need to look into favoured ways of communicating in your main demographics and have (sub) teams that deal with them appropriately and efficiently so they can get the right care.”*
>
> *“Some people are not very articulate and see using a phone and being asked questions by a non-medical person as an instant barrier. I am not convinced that virtual appointments are appropriate and acceptable. You mention in your slides that if the care navigator feels a same day appointment is not necessary. This means non clinical staff making a decision?”*

Other concerns raised, were the need for more focus on communicating with patients regarding how other professionals can support, patients receiving a quicker diagnosis, and adequate staffing.

> *“There should be more focus on enabling patients to understand other professionals can support them, rather than focusing on same-day access.”*
>
> *“Patients will need to understand how the system is structured. What's a community pharmacy? Are all pharmacies the same? What is primary care as opposed to urgent care? Can a patient challenge the initial decision re appropriate care provider? How will current staff at every level be assigned their role in the new structure? Where will routine appointments - dressing change, blood pressure monitoring, regular blood tests, medication management fit in?”*
>
> *“The best way to reduce multiple appointments is quicker diagnosis by quick access to diagnostics”*

Question 9: Do you think that this priority will start to address the challenges that have been identified in our Strategy?

246 people answered this question.

Majority of respondents answered Partly 45.7% (113 people) and 27.5% (68 people) answered Yes. However, 10.1% (25 people) were not sure and 16.6% (41 people) answered No.

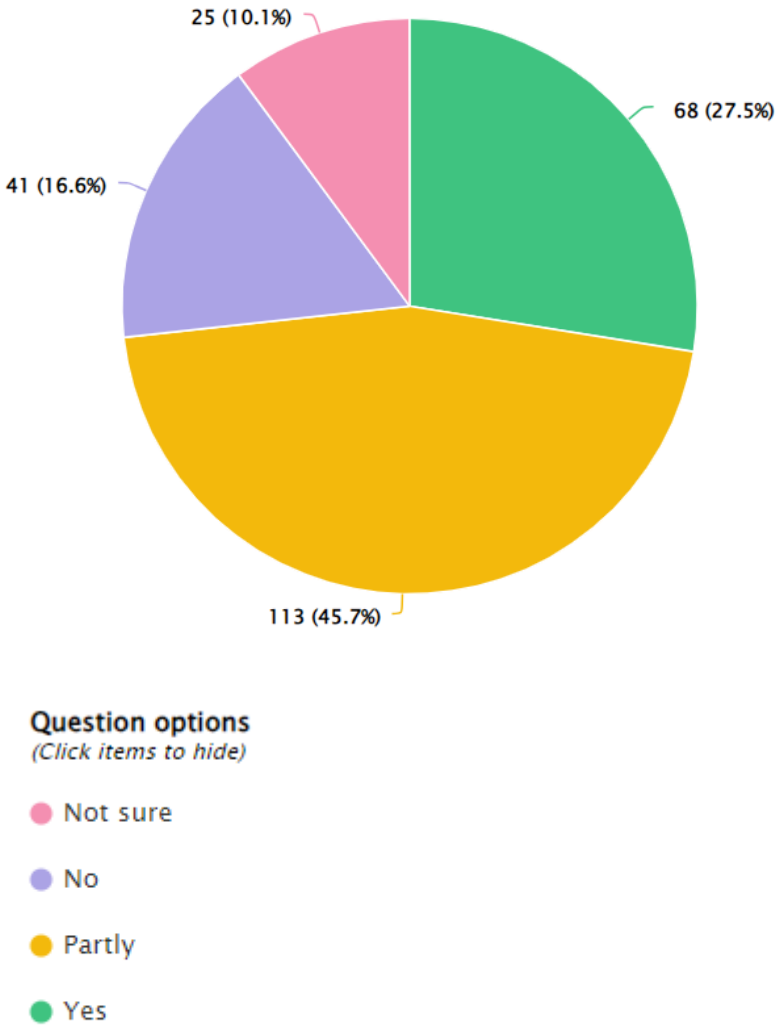


*Chart 6: Pie chart showing respondents who said Yes, Party, No or Not sure to "*Do you think that this priority will start to address the challenges that have been identified in our Strategy?"

Question 10: If you don't know or are not sure, please explain further:

67 people answered this question.

Within the responses it was clear that people felt communication with the public would be key to ensuring this priority would be successfully implemented.

The need for communication

Respondents expressed the need to ensure there was clear communication with the public around the changes and what it meant in reflection to their needs, to provide assurance that their own health needs will be met.

> *"I think that too much change at once can be counterproductive especially if it is not communicated to patients and carers in advance of them needing care. Any changes need to be carefully managed and there needs to be evidence that the new approach has been proven to be beneficial."*
>
> *"If the public adopt the approach and endorse or feel confident in the range of professionals who can address medical needs then it will work but only when the public get it."*
>
> *"I strongly believe change needs to be a two-way street i.e. the public/patients have to engage; be willing to be educated about how healthcare is delivered; etc"*

Other responses included questions around how General Practice, Optometry and Dentistry would work together, concerns it would increase GP workload, funding and adequate staffing to facilitate the changes.

> *"How are General Practice, Optometry and Dentistry going to work together? There are hardly any NHS dentists, and it is almost impossible to set up a new dental surgery, and I really don't see what the motivation of opticians to get involved in this is. If this means separate hubs to attend to same day care that are funded by the ICB to allow surgeries to concentrate on patients that require continuity, that is fine and might work. Without significant additional resource, including the movement of resource from secondary to Primary Care, this is unlikely to happen."*
>
> *"Just farming people out around the system will not address the issue of increasing and retaining the workforce - and this includes doctors and all other health professionals."*

Question 11: If you have any further comments about Priority 1, please tell us here:

77 people answered this question.

Across responses people raised concerns regarding, how the triage of care would work, staffing and resourcing pressures and the need to ensure digital inclusion.

Triage for care

Within 32 responses people referred to triage and questioned how it would work in practice. Expressing the need for Primary Care team members to have the

appropriate medical experience and training to enable patients to be reassured that they do not need to speak to or see a GP and that they are getting the right support for their needs. Respondents also raised concerns that this would promote lack of continuity of staff stating they would rather see the same person to build relationships.

> *"Often it makes sense to have a very experienced person at the triage level of first clinical assessment for safeguarding against serious diagnoses and for efficiency."*
>
> *"It does time and considerable knowledge to decide who is the right person to see a patient. Surgery receptionists and the like do not have the necessary knowledge. I have no objection to a GP or an experienced practice nurse doing the triage, but this does not necessarily save time or resources."*
>
> *"It also ignores the issue of continuity of care - seeing the same person through diagnosis, treatment and recovery - and building a trusted relationship with specific individuals over time"*

Staffing and resource

Concerns were raised around having enough funding, resource and staffing in place to enable delivery of the Strategy.

> *"Theoretically these are great priorities, but where are the staff coming from?"*
>
> *"Estates - the idea of more virtual consultations and access hubs is repeated throughout the Strategy. See comment above about virtual consultations. There is no discussion of how access hubs will be funded. If dedicated sites, then where is the investment to create these? The idea of hubs, moving between practices is impractical - practices overall do not have the space to accommodate their own staff let alone hub activity"*

Accessibility and digital inclusion

Across responses people expressed the need for accessibility for all and to ensure no one is digitally excluded from receiving the treatment they require.

> *"It is essential that any proposed changes in health care delivery are clearly communicated to all patients, and that assistance is provided to those who struggle to access the new pathways. No one should be left behind."*
>
> *"It is highly dangerous to simply refer people to a website and not everyone, especially the elderly can use these."*

> *"There should always be a route for people who do not have a smart phone or computer to get help. They can often be vulnerable and must be given a phone number to call."*

3.3 Priority 2: Feedback

Priority 2 is to create Integrated Neighbourhood Teams to coordinate care and support for at least one population cohort. The vision is to have Integrated Neighbourhood Teams (INTs) made up of a range of health and care professionals, to support people with more complex needs to stay well in their communities.

Question 12: Please tell us how much you agree or disagree with the potential benefits of this approach?

244 people answered this question.

Four out of five priorities within this area were ranked similar in terms of importance, with them all showing as mostly strongly agree or agree. However, 'Improve staff wellbeing through flexible working in different teams to put patient needs first.' was ranked slightly lower.

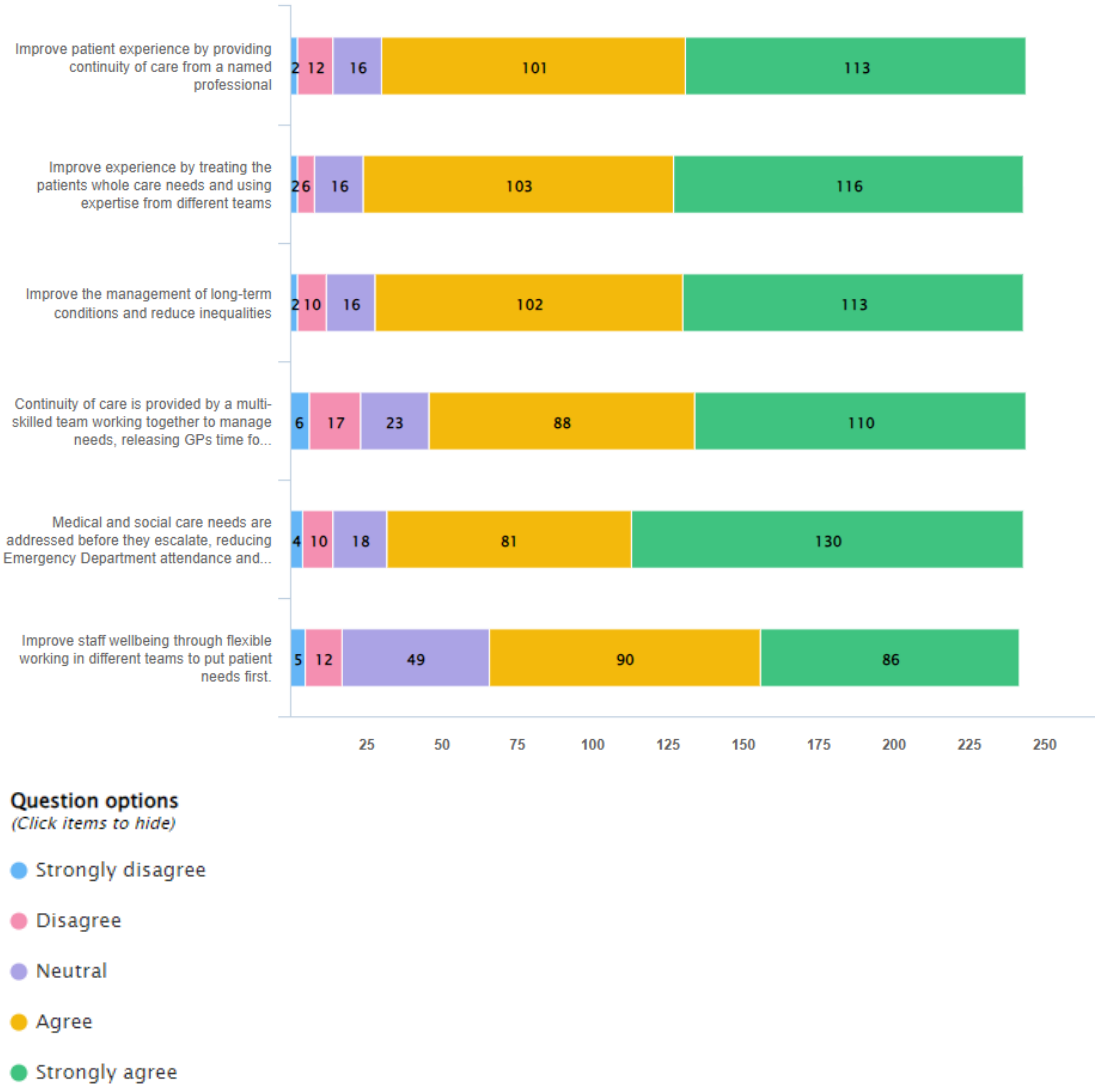


Chart 7: Ranking chart showing respondents agree or disagree with the potential benefits of Priority 2

Question 13: Is there anything else you would like to tell us about Priority 2 and our vision for neighbourhood teams?

121 people answered this question.

Overall, respondents felt that Priority 2 was a promising idea and liked the multi-faceted approach has. However, concerns were raised about the team's ability to manage the complexity of the various groups processes and the practicalities of getting this to work with available resources.

Joined-up processes and systems to enable delivery

Many respondents said that a successful delivery of the strategy would require all partners working closely and efficiently together and with effectively integrated systems to ensure patient details are shared correctly.

> *"Great idea but how do you integrate medical records systems so that the multi-disciplinary specialists have access to them"*
>
> *"Continuity of care is provided by a multi-skilled team working together to manage needs, releasing GPs time for patients with the most complex needs, the first part is true, but it relies on much better intelligence sharing and record linking than is currently in place. the second part is never going to be true until the public believe in the skills of a team and not a hierarchy where they feel their issues must be Dr led."*
>
> *"Patient involvement, robust information sharing agreements in place where necessary and evidence off all staff knowing/being able to find these, this is something that is supposed to happen but comes up time and time again when something goes wrong."*

Concerns about the resources to enable delivery

Respondents raised concerns ranging from lack of resources, staffing and funding to aid delivery of the strategy. However, they felt that if the strategy was successfully rolled out, it would have benefits for improving staff retention, reduce sickness and get great results.

> *"Depends on having enough staff! Great idea, but just doing this won't magically produce enough professionals, or produce enough care workers, or enough community hospital places, or (enough) meals on wheels-type services, or....."*
>
> *"Don't underestimate the staff who work in the NHS. Predominantly they have chosen to work in the NHS because they care for/about people. If they are freed up to do this; to make a difference you will improve staff retention, reduce sickness and get great results"*

In addition, a few comments indicated that these principles were duplicating previous approaches, and that learning had not been incorporated or evidenced.

> *"This is not a new idea and appears under various titles in many strategies around the country including locally. Why have they not been implemented earlier and what are you going to do make them work this time around?"*

3.4 Priority 3: Feedback

Priority 3 is to align Primary Care to support a system-wide focus on preventing cardiovascular disease (CVD) which is a major cause of death in Buckinghamshire, Oxfordshire and Berkshire West 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 reducing the major risk factors and tackling inequalities.

Question 14: Please tell us how much you agree or disagree with the potential benefits of this approach?

244 people answered this question.

All five priorities within this area were ranked similar, with them all showing as mostly strongly agree or agree. However, ‘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, that addresses medical and non-medical needs.’ was ranked slightly higher.

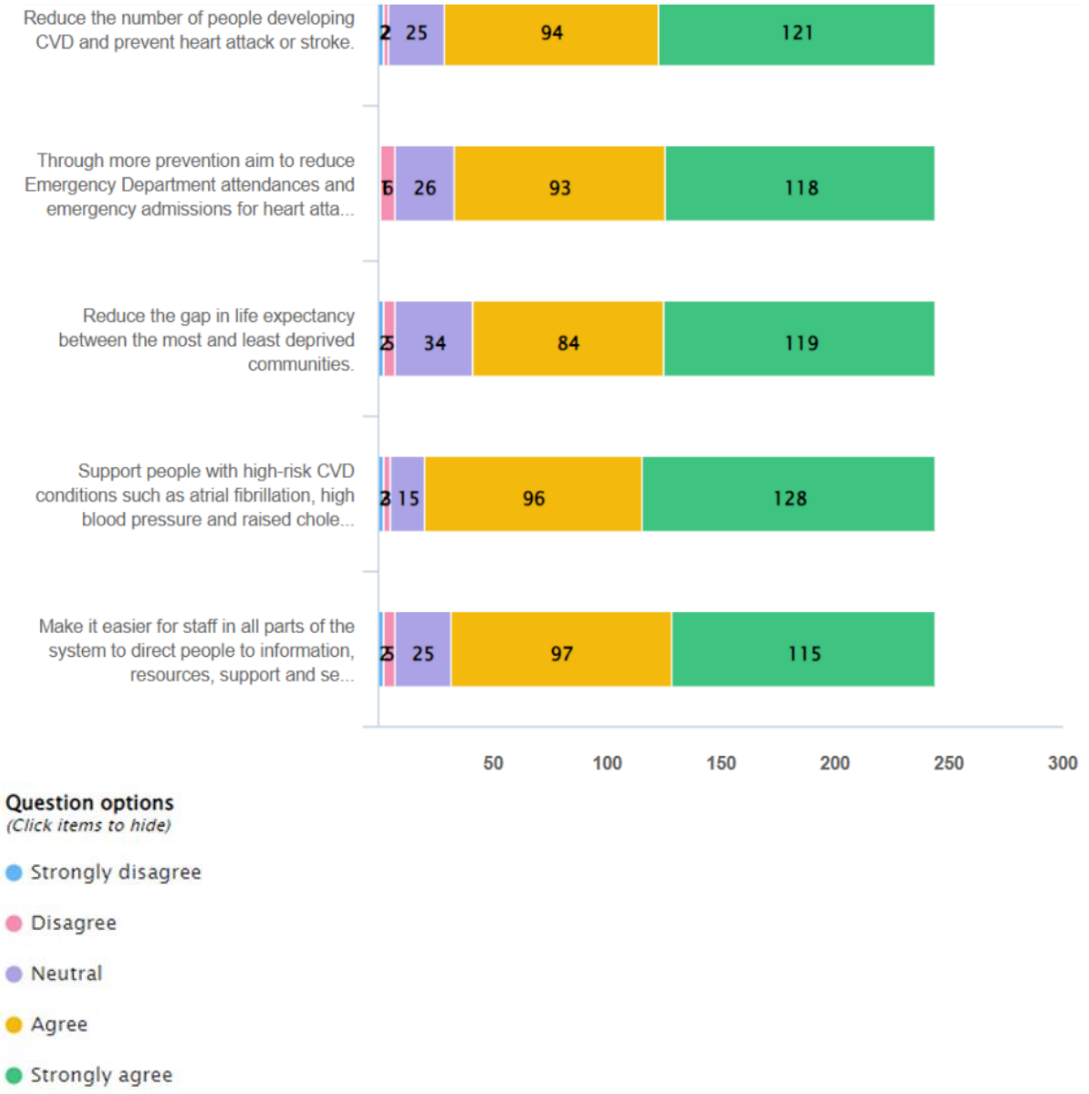


Chart 8: Ranking chart showing respondents agree or disagree with the potential benefits of Priority 3

Question 15: Is there anything additional you would like to see included to enhance the approach to Priority 3 for cardiovascular disease prevention?

107 people answered this question.

Largely, respondents felt it was a good approach for Priority 3. However, 84 people mentioned education and early prevention to promote a healthy lifestyle was key.

Education and early prevention to promote healthy lifestyles

84 respondents felt the priority needed to be more focused on early prevention and education to promote healthy lifestyles for patients. Such as promoting healthy eating, exercise, mental wellbeing and the need to focus on introducing healthy lifestyles at an early age and supporting parents and carers to support family members to adopt a proactive approach to health.

> *"I think it is important: training more nutritionists/dieticians; providing regular get-togethers for people to come together and to work on improving their diet, mental wellbeing, exercise etc. A regular hands-on approach is needed, otherwise it just isn't going to work. Changing habits is one of the hardest things to do and for people to eat healthier they need to be incentivized beyond a quick chat and a leaflet. There are so many community opportunities to improve this, there just needs to be the funding and proper support."*
>
> *"Making a wide range of activities available which are affordable, accessible and appealing to as wide a range of the population as possible. So not just traditional 'school' sports but encouraging everyone to be active in a way that works for them, and they are likely to continue or adapt at different stages in their life."*
>
> *"This work needs to be done alongside efforts to improve the environments people live in: increasing access to healthy affordable food and ensuring there are safe places to exercise with clean air including quality green spaces."*

People expressed the need to engage with target audience to manage their own health such as drop-in centres, regular groups, attending mosques, shops and the involvement of voluntary groups to share communication to support the area's most at risk of not hearing the messages. Also, a request for outside system players to be engaged - schools, food producers, food waste and benefits system.

> *"Education for patients on modifying their lifestyle so as the remain healthy. This must be subtle because no-one likes being dictated to."*
> *"Targeted work outside of 'usual health care settings'. Examples include the health on the move bus and health checks at Banbury Mosque, but also in*

> *high volume workplaces / high footfall areas / sports grounds for spectators etc."*
>
> *"All desirable aims. Lifestyle advice and actions need to diversify outside " healthcare" settings and in to supermarkets, shopping malls, gyms, sporting facilities, schools and colleges."*

Strategy approach and how it will work in practice

Other points raised were how the Strategy would work in practice and what approach would be taken to implement the Strategy stating the need for clear timelines.

> *"This is great. These illnesses are a major cause of morbidity and NHS cost. They are well understood, and amenable to management by expert teams including specialist nurses and prescribing pharmacists. A big publicity Strategy is needed to make this work as well as possible."*
>
> *"Nobody is going to disagree with wanting to do all of these things, but it's not clear HOW you're going to do this."*
>
> *"Can't disagree with the benefits of this approach - but the approach itself is only a small part of the problem, which requires a much more vigorous national Strategy to tackle the anti-health forces in our economy such as food advertising, alcohol industry and general lack of policies to deal with poor housing, opportunities for exercise, inequalities in wealth (and all the other Marmot criteria for good health)."*

Recommendation for focus on other areas

Respondents also questioned the reasoning for choosing CVD over other clinical conditions and why only one area of focus. Other conditions people felt should be considered were as follows – Cancer, Respiratory, Asthmatics and COPD, Diabetes

> *"It would be interesting to understand more about why this was chosen and what other clinical conditions were considered/weren't selected."*
>
> *"I think your concern about this one area misses a greater priority.*
> *Hoping to save 797 heart attacks over the next 4 years is an extraordinarily low ambition. There are more asthmatics and COPD patients being admitted in OCCG each year. You must remove this exclusivity of this one illness.*
> *You've already said how most of us will have multiple long-term conditions to choose one over another displays a lack of understanding in care of the elderly.*
> *CVD, bones, diabetes, respiratory all interact one worsening the other. To concentrate on CVD is an error. Please think about this."*

3.5 Additional Feedback on the Strategy

Question 16: Thinking about the challenges and priorities identified in this Draft Primary Care Strategy – do you think our proposals will deliver the vision that: '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'

Of the respondents 44.9% (110 people) answered Yes and 35.5% (87 people) answered Partly. However, 6.1% (15 people) were not sure and 13.8% (34 people) answered No.

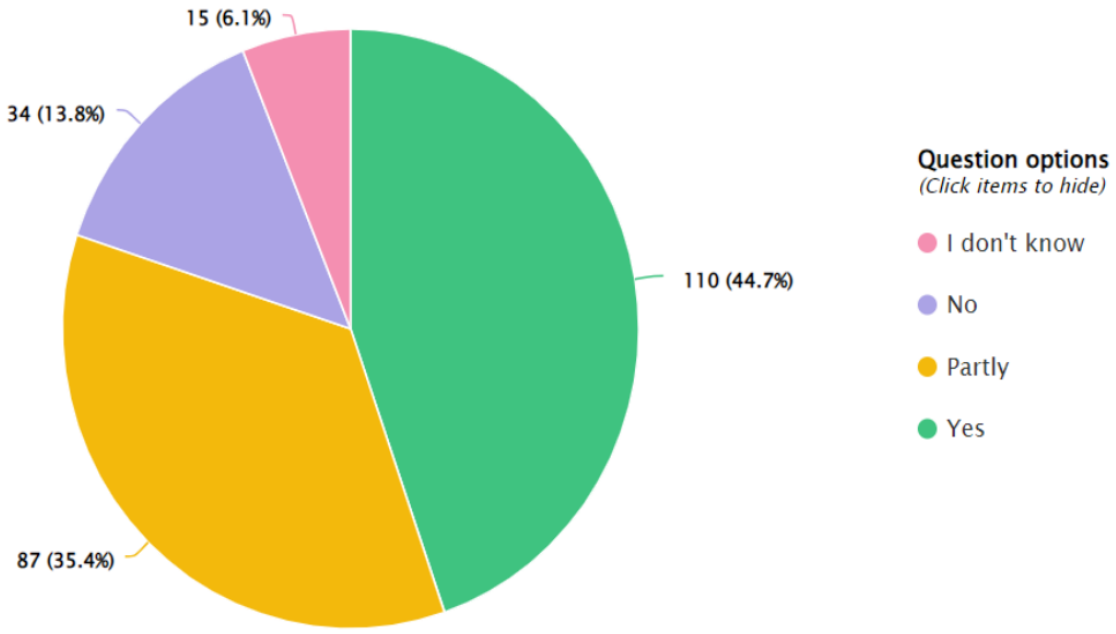


Chart 9: Pie chart showing respondents who said Yes, Party, No or I don't know to do you think our proposals will deliver the vision.

Question 17: Do you have any additional comments about our vision?

115 people answered this question.

Overall, respondents agreed with the vision and felt there were potentially life changing goals for patients. However, additional comments were raised regarding the following areas.

Inequalities and the wider determinants of health

Many of the responses raised the impact of wider determinants of health and inequalities such as, housing, financial support and education. Highlighting the need for an increased focus on health promotion and personal responsibility for patients' own health. It was suggested this could be enabled through sharing of information,

choices for services and use of supportive digital technologies for personal health and care access.

> *"Encouraging people to be 'in charge' of their life, body, etc, so when illness/medication/surgery is warranted, they are not passive receivers, but encouraged to take control, and time is taken to explain reasons for the medication, what it is expected to do, and what outcome can be hoped for."*
>
> *"We should be a National Health Service rather than an illness service " Health is a positive state and not just the absence of illness.*
> *We wish to "age well" Altering quality of life is vital particularly for those who start from a low point. But the health metrics will only change when non-medical interventions occur like housing, affordable food, better access to exercise, employment opportunities, substance use and smoking cessation. This will shift the dial more."*

Funding, Staffing and Resources

Throughout the feedback, concerns were raised around funding, staffing and resources. Stating that these were crucial in a successful roll out of the Strategy.

> *"It is a strong vision. It will take a lot of patient training and awareness to get with the program. The funding seems to be directed towards other services such as pharmacy consultations whereas all services including GP's and NHS Dentists also need more funding to deliver. I think the constraint that will not allow this vision to be fully successful is central funding from government into Primary Care just not being enough."*
>
> *"Without adequate funding, investment and resources to address the massive inequalities in our society, upstream of Primary Care, a vision - however well-intentioned- will just result in more upheaval, more involvement of expensive management consultants, and more fragmentation of services, leading to greater risks to patients."*

Insufficient focus and gaps within the vision

Respondents highlighted several gaps, noting insufficient focus for specific conditions, groups and services that were missing, including:

- Mental Health
- Maternity
- Paediatric care
- Net Zero
- Insufficient focus on children and young people.
- Unpaid carers and carers' support
- Identification of other fatal diseases at early stages

Question 18: Is there anything else that we should consider in our Strategy for Primary Care across Buckinghamshire, Oxfordshire and Berkshire West?

10 people answered this question.

Respondents raised the following recommendations to consider in the Strategy:

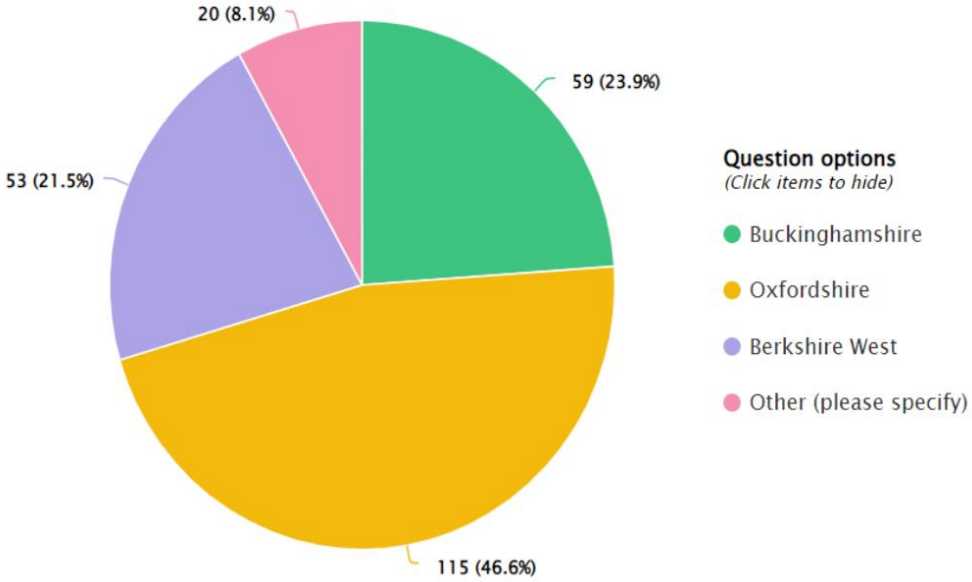
- **A greater focus on NHS Net Zero/climate change** must be a key consideration of any Primary Care focused strategy.
- **Education for the public** (especially those not online) of how to access services for this new approach to work
- **Primary Care staff are busy, and their time is valuable so having access to high quality evidence makes sense.** Clinical best practice changes all the time and healthcare professional do not have time to search for up-to-date research and guidelines.
- **Digital integration project:** The ICB vision depends on data sharing.
- **Duplication of Neurodiversity Diagnosis is wasteful**. – comment related to the neurodiversity pathway between Child and Adult transition for CAMHS.
- **Joint workforce development plan plus strategy to retain staff**
- **Ensure that basic medical care is available to the community.** The doctors do not respond to e-consults and do not call back for appointments. When you do get a response care is refused so eventually you are forced to seek help elsewhere such as A&E when it could easily be sorted by the GP
- **Closer working with Councils to identify areas of expanding population:** Have a look at the development plans in the pipeline and sit down with the relevant District/City Councils to find a solution to the imminent unmet healthcare need that the thousands of new homes will generate.
- **Make house builders/developers pay more for improvements to Primary care buildings / build new surgeries. Plus, fund levied for ongoing costs**
- **Have website/app access points in libraries for those who find using the service difficult**

3.6 Demographics

The demographics for 247 respondents were captured in response to the survey. The demographic data helps us understand more about who has got involved in this engagement activity.

Location

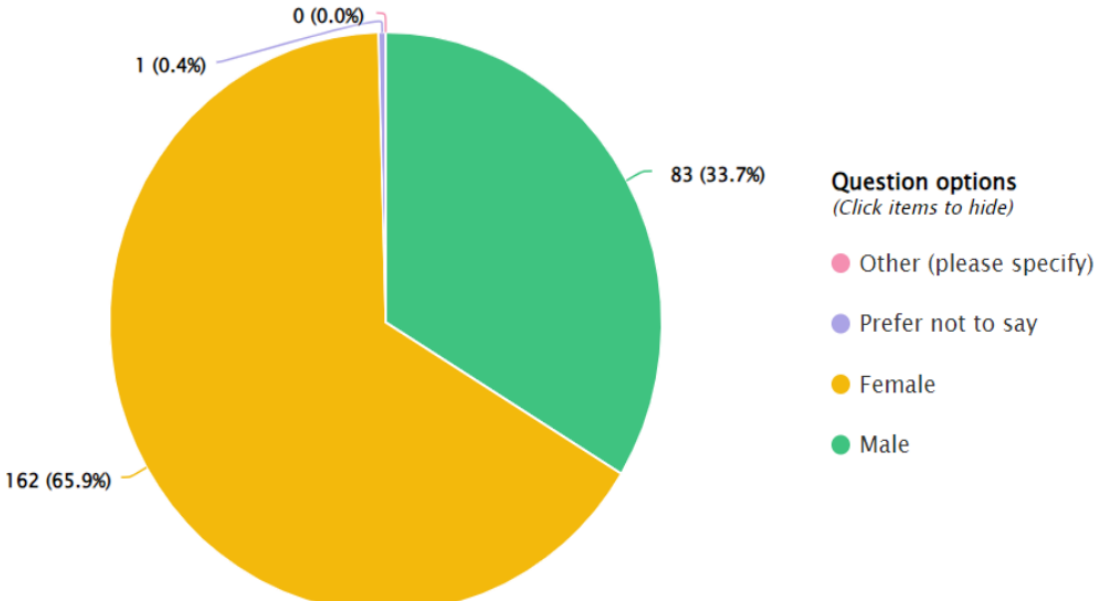
Approximately 46% (115 people) of respondents to the survey live in Oxfordshire. The remaining respondents are split across Buckinghamshire, West Berkshire and



Other.

Gender

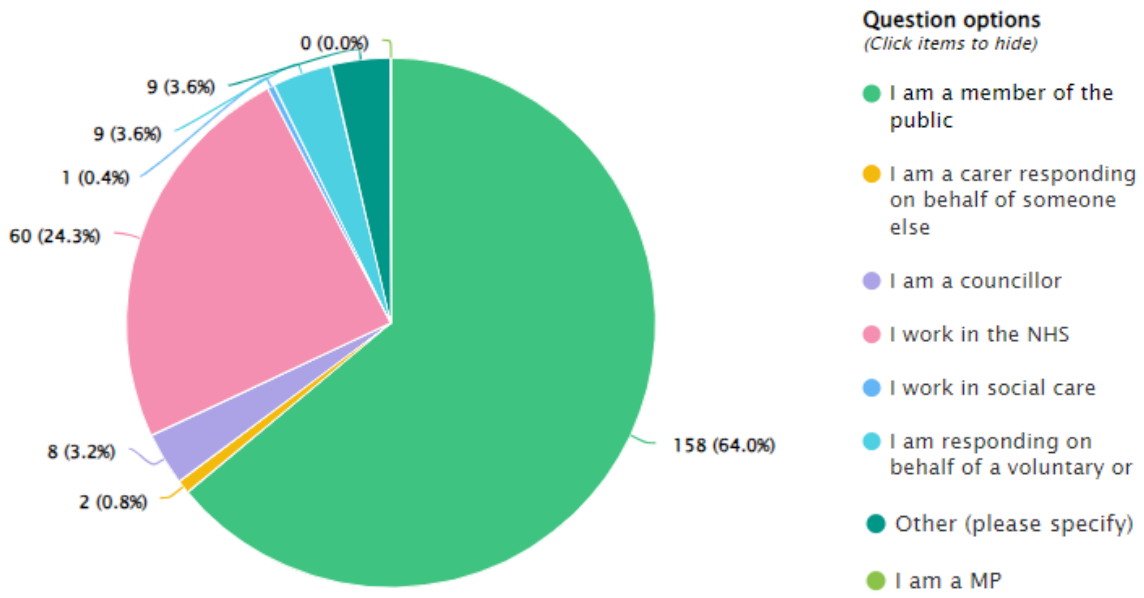
65.9% (162 people) of respondents identify as female and 33.7% (83 people) identify as male.



Respondents Capacity

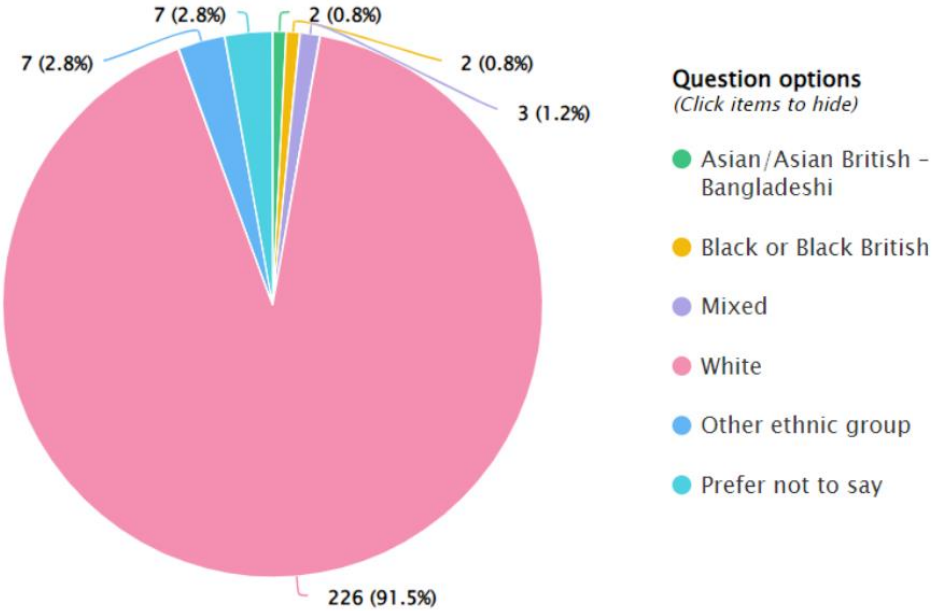
Approximately 64% (158 people) of respondents stated they were answering the survey as a member of the public with 24% (60 people) stating they work for the NHS. The remaining respondents are split across working in Social Care, being a

Councillor, a Carer / Or responding on behalf of someone else, MP, responding on behalf of a voluntary or community organisation and other.



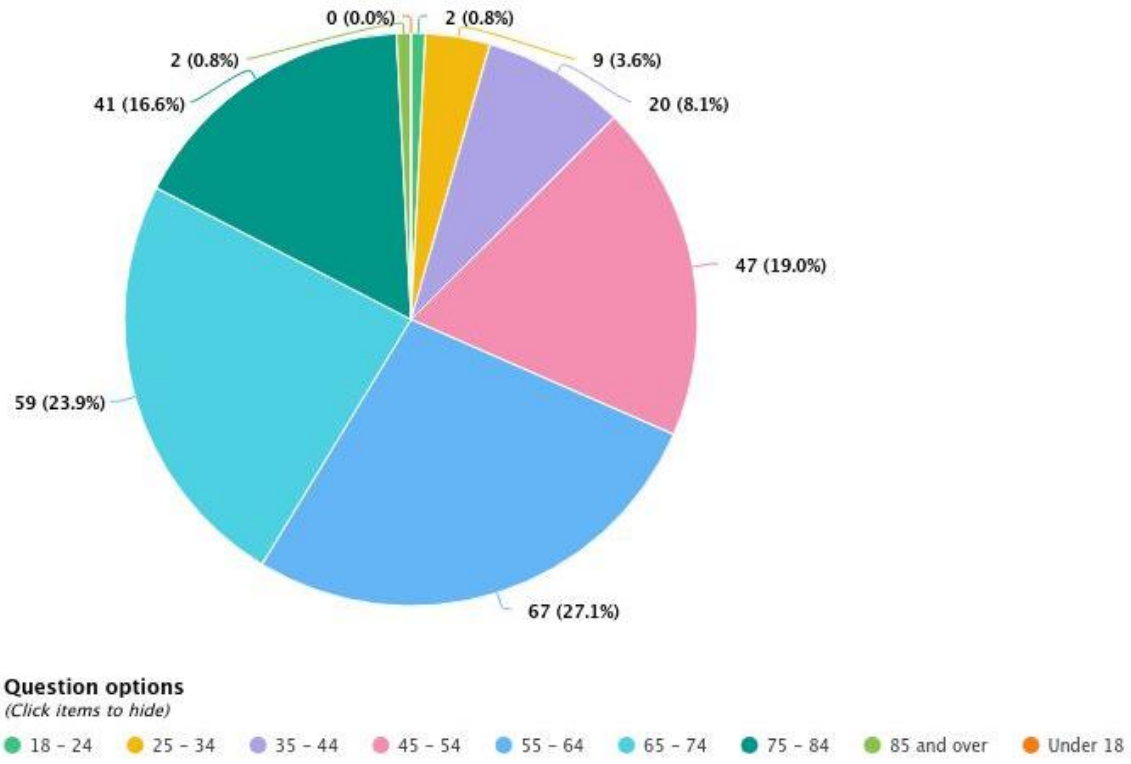
Ethnicity

Most respondents to the survey identify as White British with 6 people preferring not to say. Other ethnicities included Asian/Asian British – Bangladeshi, Black/Black British and Mixed



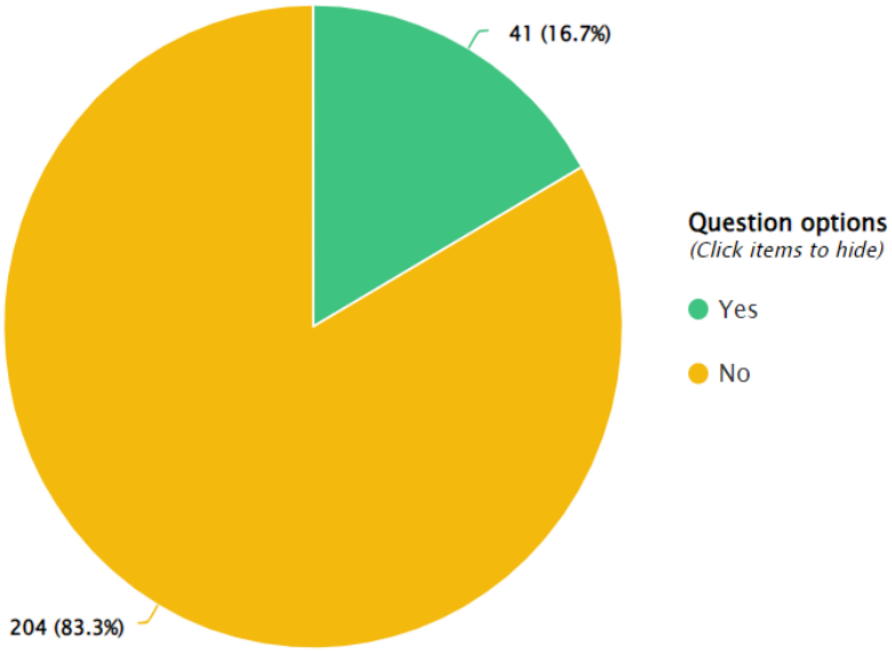
Age

Approximately 50% (127 people) of respondents said they were between the ages 55 and 78 with the remaining respondents are split across various ages.



Disabilities

Most respondents 83.3% (204 people) said they do not have a disability. 16.8% (41 people) indicated they do have a disability.



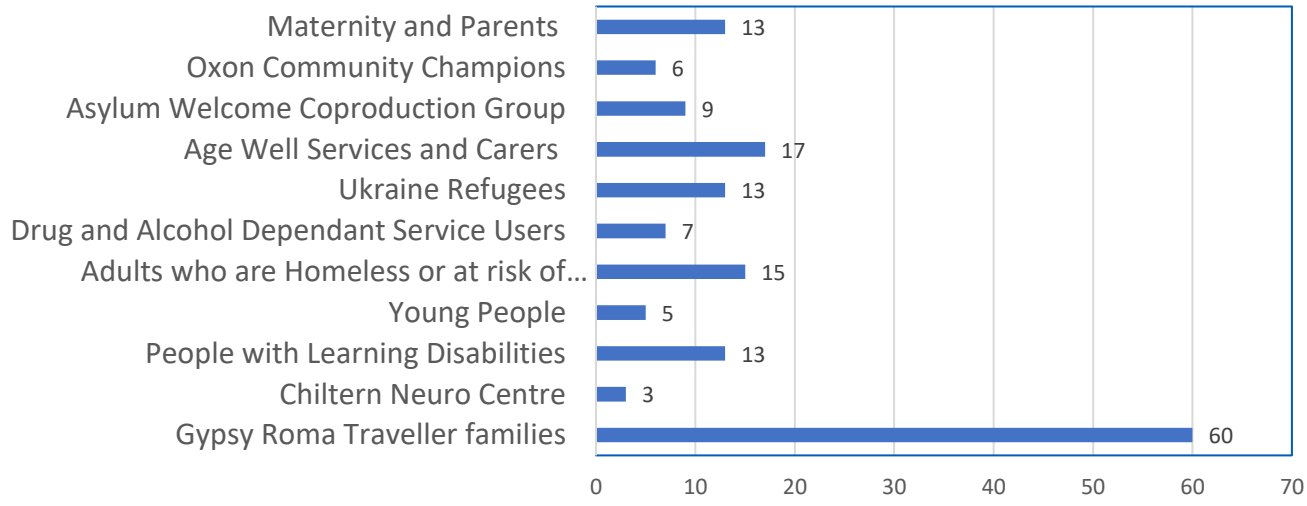
4. Appendix 2: Analysis of public event and focus group feedback

In total, 161 people attended across the 22 public events and focus groups listed below. These were aimed at hard-to-reach communities to enable public participation through presentations and discussions within these groups.

- **17, 18 & 24 January 2024** - Maternity and Parents
- **18 January 2024 -** Oxon Community Champions
- **25 January 2024** - Asylum Welcome Coproduction Group
- **26 January & 1 February 2024 -** Age Well Services and Carers
- **26 January 2024 –** The Atrium (Refugees from Ukraine)
- **26 January 2024 -** Bucks One Recovery (Drug and Alcohol Dependant Service Users)
- **1 February 2024 -** Adults who are homeless or at risk of homelessness
- **12 February 2024 -** Young People
- **27 February 2024 -** CLASP (self-advocacy group for those with Learning Disabilities)
- **28 February 2024** - Chiltern Neuro Centre
- **Various dates* -** Gypsy Roma Traveller families

**Over 9 face to face sessions took place and involved 60 participants*

Meeting attendance shown below:



During each public event and focus group, participants were asked the same set of questions. Across the 14 separate public events and focus groups there was an overarching consistency of themes raised, which we have split out for each question and listed key points raised below.

4.1 Access to Primary Care

Question 1: Do you know how to access Primary Care services?

Overall, across all 14 public events and focus groups, there was a strong consensus that people knew how to access Primary Care for themselves and people they cared for.

However, it was raised that certain groups of people may find it more challenging to know how to access Primary Care such as:

- children and adults with learning disabilities who are often reliant on a parent or carer to recognise when they need medical support
- people with spoken and written language barriers.

Further points raised were:

- lack of awareness of some speciality services – such as speciality dentists
- although participants knew how to access Primary Care services, they felt it was not always easy to do so due to limited appointments and availability.

Question 2: Do you have any challenges accessing Primary Care services?

We asked participants what challenges they have accessing Primary Care services and received the following feedback which we have broken down by service below.

Across all services people expressed the following challenges:

- The need for continuity of staff to enable people the opportunity to build a consistent and trusting relationship.
- Participants felt that a ‘toolkit’ of support and available services would be beneficial when accessing Primary Care.
- There was an overall feeling that the general wait times can often be unacceptable for appointments and treatment, and the time to receive a diagnosis can be too long.
- Parents of children with Learning Disabilities felt that they need to prewarn all appointments of their child’s accessibility requirements. It was suggested the need for a Hospital/Health passport for each child which outlines their communication needs and reasonable adjustments required.
- Apps are not always accessible due to a lack of access to digital devices, language barriers, not knowing the app exists, not understanding how to use the app, or general digital illiteracy.
- Within the Drug and Alcohol Dependant Service User and Adults who are homeless or at risk of homelessness focus group they raised awareness that felt they were not always treated fairly and well in front of other service users.
- Gypsy Roma Traveller families raised concerns related to discrimination and literacy issues when accessing primary care.

General Practice

While almost every participant stated they were currently registered with a GP; they identified the following challenges in accessing their GP service.

Staffing and Continuity

- Not being able to see the same GP regularly and lack of continuity made people feel they had to repeat their medical history at every appointment.
- Participants felt that the amalgamation of GP surgeries and use of locum GPs has contributed to a lack of personal touch and the feeling of being passed around.
- Not all the groups were aware that there may be other staff in the practice better equipped to support them than a GP.

Appointments and Opening Hours

- Participants felt it was difficult gaining access to a GP appointment, often having to wait on the phone for prolonged periods of time.
- People expressed there was a lack of on the-day appointments and often had to book appointments several weeks in advance.
- Appointment types that are given to patients are not always appropriate for the requirement, for example, not all problems can be diagnosed over the telephone. It was also raised that staff needed to be more culturally aware when booking appointments i.e. some patients struggled to get a female doctor when they asked.
- Call back services to speak to a doctor are not always practical, as not all patients wait for a call all day, especially if the patient is working. Participants felt the need for a ‘rough time’ for a call back instead of having to wait for extended periods for a phone call.
- Participants expressed the need for more varied opening hours and days. Certain appointment times were not always appropriate, i.e. within school hours are not always suitable for those with school commitments, while last-minute appointments can be disruptive for people with Learning Disabilities.

Waiting Times and Booking System

- When booking appointments via telephone, participants said they are often restricted to being able to call within certain hours, often being told they need to phone early in the morning.
- Online booking systems were not always intuitive, and some participants explained that they had problems with downloading the app and creating a log in. Concerns were also raised for those who are unable to access online systems, for example, if a patient does not have a mobile phone or computer access.

- People were not always happy disclosing information on the phone to a receptionist, feeling they had to prove the need for an appointment. Participants also often felt embarrassed, that information is not kept confidential, and often that receptionists were blocking access. Some participant stated that they opted to use 111 or visit A&E instead.

Accessibility

- Certain hard-to-reach communities expressed difficulties when registering a provisional accommodation as their address as well as being unable to register as temporary patients when travelling.
- Language barriers were often experienced due to a lack of access to translators and patients' inability to read the letters sent.
- Some groups said they felt that staff were not always experienced in communicating with those who have communication needs or Learning Disabilities.
- Participants described that they felt unable to be a parent or carer advocate and speak on behalf of a child with Learning Disabilities or someone they cared for, often noting they must complete multiple forms for the same GP to speak on behalf of the person.

Dentistry

Across all groups there was a general unhappiness with the lack of NHS dentists available, although participants who had access commented on good treatment. The challenges people faced accessing a dentist were raised as follows.

Availability

- The majority of participants expressed difficulty registering at an NHS Dentist.
- There was a frustration regarding not being able to have regular appointments with a consistent dentist, to enable people to build trust and relationships.
- People stated that they are opting to go private, resulting in expensive treatment or not visiting a dentist at all.
- Participants reported having to travel out of county to access an NHS dentist.
- Some people felt they were lost in the system during Covid and taken off registers, due to them not making appointments during lockdown.
- Participants who had an NHS dentist stated they often had their appointments cancelled multiple times and mostly last minute due to staff shortages.
- It was raised that there needed to be a way to signpost people to an NHS dentist with space for patients and for NHS dentists to use a waiting list system.

Opening times and waiting lists

- Restricted opening hours means it can sometimes be hard to contact a dentist on the phone for people with school or work commitments. Participants stated that it would be helpful if they were open some weekends/evenings.
- Participants in the young people's focus group commented on long waiting lists for orthodontists. Some teenagers are on the waiting list for years and do not get seen until they are over 18, by which point they need to pay.
- It was raised that sedation services for those who fear the dentist is only available to those with an autism diagnosis and have long waiting lists.

Accessibility

- Some participants expressed concern about not having access to a registered practice and that they wouldn't know what to do in a dental emergency.
- There can be a lack of communication and knowledge around specialty clinics such as community dentistry and how to access these.
- It was raised that not all NHS dental practices are accessible to the elderly or disabled, as they often have stairs.
- Gypsy Roma Traveller families had accessibility concerns due to not having a fixed address however, stated the service is BorehamWood is known to the community for their support.

Pharmacy

There was general positive feedback in relation to pharmacy access and a general acknowledgement that pharmacists are well-trained and helpful. However, the following issues have arisen for participants when accessing pharmacy services.

Availability

- Frustration over local pharmacy closures and staff shortages.
- Cost of prescriptions i.e. Individuals with No Recourse to Public Funds (NRPF) are unable to afford their medication.
- Pharmacies often having shortages of some common medications.

Wait times and opening hours

- The need to be able to submit repeat prescriptions at the pharmacy instead of having to do it online or at a GP, as well as concerns raised with a three-day wait from drop-off of a prescription at the surgery.
- Restricted opening hours and closure of pharmacies over a lunchtime period often making it difficult for people to attend.
- Collection times being all at the same time for everyone. For example, it was raised within the Bucks One Recovery focus group that collection time for Methadone prescriptions is the same for everybody, which can make it difficult

to avoid triggers, people meeting, and getting caught up in a cycle of drug abuse.
- People having to queue twice for different medications and prescription errors, with reports of being given the 'wrong' medication.

Communication and knowledge of service

- Messages from service not always correct i.e. pharmacy saying prescription is ready to be collected, but, when the patient arrives, this is not the case.
- Not all groups were aware that pharmacists could support in other ways, and there was a lack of knowledge of medicine reviews
- Communication between GPs and Pharmacy needs to be improved to stop the burden on the patient to sort out issues.
- If an alternative medication is given, more information would be useful to ensure the service user understands why.
- Some participants were unaware of Pharmacy First.

Optometry

Overall, there were mostly positive experiences reported by participants accessing optometry services and they felt it was easy accessing free eye tests and prescriptions in local opticians. The challenges people raised are as follows:

Awareness and Communication

- Some participants stated they had a lack of knowledge of NHS provision.
- People were unable to access appointments and going private.
- A few participants stated they felt they were bounced between Specsavers and hospital which causes stress and multiple appointments.
- Relevant information to book appointments is sometimes hard to find.
- It was often raised that optician prescriptions can be expensive

Question 3: What can the NHS do to help you access Primary Care?

Participants were asked what the NHS can do to help them access Primary Care. The feedback we received has been broken down into the following areas:

Workforce

- Consistency of staff to help reduce anxiety, build relationships, and gain trust.
- Cross-organisational working and sharing of information between services to prevent start-and-stop care.
- Ensuring continuity between childhood and adult care.
- Develop an integrated health service, which would be able to provide a care coordinator or a designated health care service.

- To improve trust in Primary Care services, conduct outreach work in the community and, where possible, assign service users with Primary Care workers of similar cultural backgrounds.

Medical records

- Ensure patient records are up to date, for example, making sure they are noting the fact a child is a young carer on patient records.
- Join up electronic records on to one service. Having them across multiple platforms makes it complicated and causes things to be missed.
- Hospital/Health passport to be more available for people with Learning Disabilities and would include all relevant information and state a list of requirements, such as lighting, noise, communication style etc. This would avoid parents having to go over requirements and needs at each visit and help reduce anxiety.
- Ensure that Primary Care services registration processes are accessible for people without a fixed address, who do not speak English, who are digitally excluded, with immigration status, etc.
- Request to allow more free text under “Other sections” in forms to describe conditions.

Booking systems

- Using the same appointment scheduling service would enable services to see patients’ future appointments, prevent double bookings and have a better overview of the person’s health.

Education

- Signposting to existing services in the community to further encourage engagement and to prevent patients falling through the gaps i.e. schools, local businesses, community centres.
- Assistance with lifestyle, nutrition, prevention advice and an overall holistic approach to health.
- Community advocates and partnership forums to help with training and knowledge for Primary Care services.

Communication and Accessibility

- Clearer communication when signposting patients to other services.
- Use diverse ways of communicating with patients for example, using a digital first approach (texts, emails, and letters) and ensure details are up to date.
- Include more information on NHS app, online services, what is available to patients and how to access it.
- Adapted appointment times and waiting areas for people with Learning Disabilities

- Create an information bank, incl. video and audio material, to bridge the literacy gap (in relevant languages), for medical information, for example:
    - How to register with a GP
    - Vaccinations (adults & children)
    - How to access translators at appointments
    - Information about transport to appointments
    - Guide to booking appointments (both telephone and online)
    - Guide to using NHS/GP surgery apps in different languages
    - Reproductive health services (statutory and voluntary)
    - Mental health services (statutory and voluntary)
    - First aid training

4.2 Integrated Neighbourhood Teams

Question 4: What is important to you when receiving support for your health needs?

The public events and focus groups had an overall positive response to the idea of Integrated Neighbourhood Teams, expressing that consistency was paramount to participants and welcomed a more accessible face-to-face appointment with a single point of contact.

Participants wanted to receive help at first time of asking and communication was thought to be key to this. They liked the idea that faster diagnosis or support could be achieved from a consistent multidisciplinary team.

There were clear frustrations at the lack of joined-up working between services, and a strong request for enhanced record-sharing and communication between teams to reduce repetition and length of time to diagnosis. Other views are as follows:

Accessibility

- The need for the option of a home visit for patients.
- Ensure children and adults with additional needs are given space to feel comfortable to enable positive health and care experiences.
- The option of a longer appointments to discuss more than one issue.

Communication

- Patients need to be made aware of neighbourhood teams.
- The need to ensure there is no bottleneck of information between pre-existing services and the GP. For example, loss of blood pressure results.
- Communication between services to be improved.

- The need to simplify information provided to the patient and ensure all information is shared.
- To provide up-to-date information about pathways, so patients know what comes next e.g. providing a clear pathways map to help explain what to expect.
- The need to ensure the transition of care between paediatric and adult services.

Recommendations

- That a two-tier service may be more appropriate for triage.
- A paediatrician in each PCN.
- Look into ways of being efficient with training and assess pre-existing services to see if there are additional checks that can be done to relieve strain on GPs.
- The Parent and Maternity group were interested in how neighbourhood teams would be able to support with maternity and post-natal care due limited support currently for those who have experienced a miscarriage. The group felt it would be important that someone in the INT was specially trained in supporting those who have experienced a miscarriage and were likely to have questions.
- Ensure that pathways are reviewed and that services are not duplicating roles.
- Within the Carers focus group participants expressed that they felt nobody is caring for the carers and that this needs to be the starting point to a whole service approach to work across the whole sector.
- People would like to see PPGs up and running again.

Question 5: How do you feel about seeing other healthcare professionals to support your health and care needs such as:

- patient nurse, physiotherapist or other staff member
- a multidisciplinary team of generalist and specialist skilled health and social care professionals.
- other partners in the neighbourhood, e.g. police, mental health services and local housing associations.

Overall, across all public events and focus groups, the response to seeing other healthcare professionals was positive. However, participants stated consistency of staff was the most important. Other views that came across were:

- Majority of people were happy to see other healthcare professionals.
- The need for staff to have a good understanding and background about the patient's situation and medical record.
- Services to work more collaboratively and share information.
- Wait times for appointments need to be within a reasonable time.

- The need to put more resources into educating staff about different hard-to-reach communities and how their healthcare entitlements differ.

Other service specific feedback was as follows:

Paramedics

Positive feedback and praise for paramedics, some members stating they often prefer to see them instead of a GP. This is because they can get quicker treatment as they come with equipment such as an ECG machine.

Mental Health

It was highlighted that people felt that mental health services need more support and that there also needs to be more focus on the mental health of young people. Participants who attended the 'adults who are homeless or at risk of homelessness' group had overwhelmingly negative experiences accessing mental health services. There was a subsequent general reluctance to engage and a feeling that they would only receive help in a crisis. Gypsy Roma Traveller families expressed concerns about accessing mental health services both due to culture but also due to concerns around privacy.

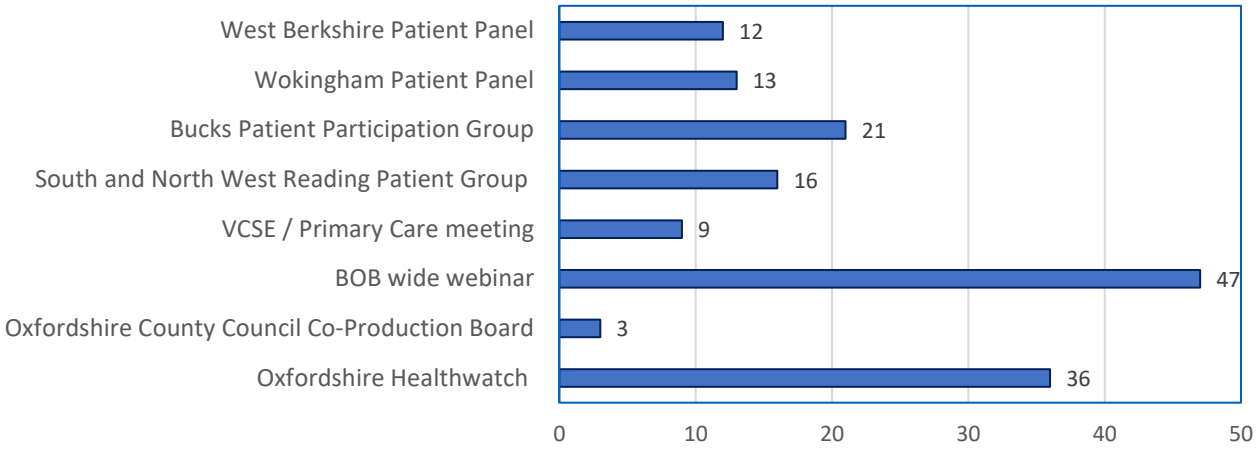
5. Appendix 3: Analysis of other feedback

5.1 Public participation group feedback

In total, 157 people attended across the 8 public participant groups listed below. These were aimed to discuss the Draft Primary Care Strategy through presentations and discussions.

- **18 January 2024** - West Berkshire Patient Panel
- **25 January 2024** - Wokingham Patient Panel
- **30 January 2024** - Bucks Patient Participation Group
- **6 February 2024** - South and North West Reading Patient Group
- **22 February 2024** - VCSE / Primary Care meeting
- **21 February 2024** - BOB wide webinar
- **23 February 2024** - Oxfordshire County Council Co-Production Board
- **28 February 2024** - Oxfordshire Healthwatch

Meeting attendance shown below:



West Berkshire Patient Panel (18 January 2024)

Key points raised from West Berkshire Patient Panel were:

- Overall, the group welcomed the strategy and felt there were positive things in it.
- They felt it was hard to understand how the strategy will be driven.
- There were concerns with how the information will be communicated to the public, the group called for a united communications strategy and asked if PPGs could help support.
- There was uncertainty about how digitally challenged people will be informed and engaged with.
- The biggest Primary Care issue in West Berks was the lack of NHS dentistry.
- Integrated Neighbourhood Teams are being described as quite flexible, but the group questioned who drives, owns, staffs, and manages the contracts without someone central deciding all this.

Wokingham Patient Panel (25 January 2024)

Key points raised from Wokingham Patient Panel were:

- Will the Primary Care budget will increase as part of the development of the strategy.
- What obstacles there might be around creating a joined up, integrated care system.
- Communication of the plan is needed to explain about the new way of working for patients and staff and reassure local people.
- The need to involve patients in the design of Integrated Neighbourhood Teams.
- Dealing with obesity must be the priority.
- The need for better pharmacy provision.
- How can PPGs help around the proposals?

Bucks Patient Participation Group (30 January 2024)

Key points raised from Bucks Patient Participation Group were:

- The need for joint working and linked computer systems to share accurate patient data between services.
- Concerns the strategy has analysed the problem but has not offered solutions.
- Whether the ICB have a vision for the role it would like patient groups to fulfil within the strategy and how they plan to communicate the strategy to patients.
- The need to ensure the Primary Care Strategy is communicated and shared widely.
- The biggest challenge raised from patients is getting an appointment and getting to see a GP and there was a question over whether all GP access will be offered via the Integrated Neighbourhood Team.
- How will ICBs monitor that GPs are following the strategy and how will the success of the strategy be measured?

South and North West Reading Patient Group (6 February 2024)

Key points raised from South and North West Reading Patient Group were:

- Overall, the group felt that the Strategy looked promising, however some felt that the strategy was incoherent to some users.
- The need to ensure continuity of care and shared responsibility of the patient to stop them falling through the gaps.
- Ensure that a shared approach is raised regularly within communication, to ensure this is accepted as part of the new patient/professional culture.
- The need for communication around roles and how they can help the patient, for example, pharmacists being trained up to diagnose and treat.
- The main concern with the strategy is assurance and how the public are being assured of the robustness of the changes.

BOB wide webinar (21 February 2024)

Key points raised from BOB- wide webinar were:

- Concerns over non-complex same day care and use of physician associates (PA).
- There being no mention of funding for public health.
- The need to make better use of optometry services, and a feeling that eye care is currently a post code lottery.
- Diabetes is not listed as a priority in the draft strategy.
- The need for more support for homeless in final strategy.
- Concerns that GP workload might increase with a new strategy.
- NHS App cannot be accessed by all patients.
- What is the role of Primary Care Networks in the strategy?
- Will Primary Care services be part of Primary Care Networks?
- Role of Integrated Neighbourhood Teams need to be defined in more detail.

VCSE / Primary Care meeting (22 February 2024)

Key points raised from VCSE / Primary Care meeting were:

- The need to identify needs and refer people earlier within the pathway.
- Concerns that the services on offer turn over frequently due to short-term contracts. This results in the feeling it is difficult to assume that all services will continue
- The feeling that funding is uncertain, making social prescribing harder.
- Voluntary sector resource needs to be considered in planning for Primary and Community Care.
- The need to consider models and examples of innovative ideas and practice.
- Whether there is a role for the VCSE with the strategy.

Oxfordshire County Council Co-Production Board (23 January 2024)

Key points raised from Oxfordshire County Council Co-Production Board were:

- Whether the proposals will become mandatory across BOB ICB.
- The need to raise the profile of prevention, especially in weight management.
- The need to work more closely with voluntary sector as part of Integrated Neighbourhood Teams roll out.
- The need for more emphasis on informal patient care which is not urgent or complex.
- The need to improve the NHS physio service.
- The need to share patient data more efficiently.
- How will the draft Strategy support people with more informal care?
- The need to improve support for people with neurodiversity.

Oxfordshire Healthwatch (28February 2024)

Key points raised from Oxfordshire Healthwatch webinar were:

- Concern about whether triaging was carried out by qualified clinicians.
- The need to make better use of NHS buildings and premises to provide healthcare.
- Audiology and chiropractic services should be part of Primary Care services.
- The need to speak to more PPGs about changes.
- The need to explain the lack of funding for new health projects to the public.
- The need for better workforce recruitment and to maximise their skills.
- Whether there are sufficient resources to meet demand for care.

5.2 Written responses

In addition, we received 45 written feedback submissions via emails, reports, letters and via social media. These were received from both members of the public and organisations.

The organisations included:

- Ashbury Parish Neighbourhood Plan Group
- Oxford Patient Network
- South East Palliative and End of Life Clinical (PEoLC) Team
- Buckinghamshire Health and Adult Social Care Select Committee (HASC)
- Buckinghamshire Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee (JHOSC)
- Healthwatch Bucks and Healthwatch Oxfordshire
- 3W Health Patient Participation Group
- Dementia UK
- Charlbury Participation Group Steering Committee
- Wantage Town Council Health Committee
- Unity Health Patient Participation Group, Princes Risborough Surgery
- Haddenham Medical Centre Patient Participation Group
- Wallingford Medical Practice Patient Participation Group Committee
- Wokingham Borough Council Autism Service
- Haddenham Medical Centre Patient Participation Group
- SeeAbility
- Ashbury Neighbourhood Plan Group
- Deaf Oxfordshire

Joint working and good collaboration organisational working is key

This was a strong theme across responses that working together, and good collaboration, was key to delivering excellent care was as a priority. The need for more linked clinical systems both within BOB and the wider areas to join up care was raised. Also raised was the importance of ensuring young people transitioning to adult services are dealt with correctly to ensure no one is missed or falls through the gaps.

> *"Please also connect with clinical systems beyond the BOB geographical borders. Many patients are cared for by Primary Care in BOB, but their nearest Acute Trust/location for Primary Care blood test results lies beyond the BOB border."*
>
> *"[There is a] need for an interface between Primary Care and specialist community providers with an aim to allow roles/ responsibilities and the communication processes, to be discussed and defined and reviewed."*
>
> *"All young people transitioning to adult services, who do meet criteria for adult palliative and supportive care registers (last 6-12 months of life) should have this highlighted by paediatric services at the point of handover. This could be stated clearly in a discharge letter from paediatric services."*

Concerns about the resources to enable delivery

Concerns about the resources to enable delivery of the Strategy was raised within the feedback, alongside the need to fully understand current and future workforce skills gaps and challenges around recruitment and retention. These concerns included lack of NHS staff, dentists, pharmacy and funding.

> *"There is a severe shortage of NHS dentists, and many people cannot access an NHS dentist at all. NHS website does not always provide up to date information about which NHS dentists are accepting new patients. There is a confusion about whether there is a right to 'register' with a dentist. Inequalities in access exist, compounding other health inequalities."*
>
> *"Pharmacies are closing and yet the expectation is that they will increase their offer to patients with Pharmacy First scheme."*
>
> *"Workforce capacity across the wider system to support the Integrated Neighbourhood Teams remains a concern and we would like to see evidence from partner organisations, such as the police, adult social care, community health providers and mental health providers, that they have the capacity to support the development of these teams."*

The importance of communication of Primary Care services and the public

Across the feedback there was strong emphasis on ensuring regular, ongoing communication with the public and Primary Care services to enable transparency and buy-in. Also raised was the need to ensure there is no digital exclusion of certain demographics when providing communication.

> *"Please ensure tools and comms are in place to reach the digitally marginalised, those with disabilities and impairments (including dementia) who will need additional support to navigate a more digitised Primary Care landscape (so they don't become further 'left behind' regarding their health outcomes)."*
>
> *"How will patients be supported to clearly understand and navigate the new pathways to care to ensure its success?"*
>
> *"We would like to see robust comms and engagement programmes as an integral part of each delivery plan, to ensure everyone is part of this ambitious transformation programme and has an opportunity to help shape the plans as they are developed."*

Many respondents noted the need for more awareness about wider pathways and the Primary Care offer. Also raised was the need for more communication with patients regarding how certain services can support patients with their health. These concerns included lack of knowledge of Community Pharmacy, Pharmacy First and Social Prescribers.

> *"There is lack of awareness and understanding about the wider pathways and Primary Care offer beyond seeing a doctor. For example, people tell us they do not always understand how and when to use a community pharmacy or understand what Social Prescribers offer in terms of support."*

Reducing waiting lists will reduce the demand for Primary Care

Across feedback people commented on long waiting lists and felt that reducing waiting lists would reduce the demand for Primary Care.

> *"Long secondary care waiting lists for both diagnostics and for elective planned procedures mean that an ever-increasing number of patients are recycling around in Primary Care for ongoing "management maintenance" of their worsening conditions. This is adding an unnecessary and unquantified volume of complex activity to Primary Care."*
>
> *"Delayed discharges from secondary care. It is well documented that such delays have the effect of backing up the whole health system."*

Enabling better access and using co design to meet the needs of the patient

Improving access to services was an important theme across feedback received. This included specific services such as dental, mental health and GP. Some of the barriers that need to be addressed included digital exclusion, communication barriers (such as hearing and language), physical access, adapted care for people with Learning Disabilities, growing population and cultural factors. Many respondents suggested that co-designing services through engagement would help ensure they meet the needs of patients.

> *"While premises are usually wheelchair accessible, consulting rooms often aren't big enough and for anything invasive or using specialist equipment, you never know if it will be accessible. Most places don't have a hoist, so treatment needs to be done in the wheelchair, which isn't always possible."*
>
> *"Inequalities may be experienced around accessible information and interpretation and translation. People are not aware that they can ask for appropriate communication means, and this is not always offered. There is also variation in access to technology and in digital literacy."*

Detection of the impact of the wider determinants of health

Many of the respondents raised the impact of other factors on an individual's health and the need for a greater focus on prevention of illness. The impact of the current cost-of-living crisis, long-term impacts of Covid, as well as other wider determinants of health such as housing, transport, education, digital exclusion etc were highlighted as having a significant impact on health inequalities and access to services.

> *"Please consider greater focus on prevention of illness in the most deprived areas/cohorts and proactively reach out to underserved communities (e.g. those who cannot read, whose English is limited, who cannot hear or see) to get their views on the strategy. Get them embedded in contributing to the design of more digitised services to ensure reduction in health outcome inequalities are actually achieved by further digitisation."*
>
> ***"**Whilst acknowledging the key role of Primary Care practitioners in health promotion and illness prevention, the reality is that GPs, pharmacists and dentists spend most of their time responding to illness."*

Primary Care approach and Integrated Neighbourhood Teams

There was an overall positive response to the Primary Care approach and the idea of Integrated Neighbourhood Teams, and that consistency was paramount when receiving care. However, concerns were raised over ensuring they are set up correctly and that they do not duplicate existing services or work in silos. Respondents felt that the success of this Strategy relies heavily on positive buy-in from all primary care providers, social care, mental health providers, the police and community health providers.

> *"We welcome the Transforming Primary Care Draft Strategy and the focus on prevention, integration of services, neighbourhood level working, and addressing health inequalities. We are not against Neighbourhood Teams, but they are hard work to set up and keep going. The NHS operates in silos, or tribes, and supportive leadership needs to be in place to allow people, money, and resources to cross boundaries."*
>
> *"Integrated Neighbourhood Teams look well-chosen and are themselves useful in illustrating the advantages of the Primary Care approach."*
>
> *"We feel that the communications around this need to be strong and very clear about how the teams work together for patients within their communities."*

More details required for timelines and implementation

The need was raised for a simple and clear description of how the new complex and non-complex pathways will work for patients. It was also raised that there is a need

for a draft timescale for staff developing the delivery plans for each priority and a summary of the key pieces of work to be undertaken in each priority area. In addition, it was felt that a timeline for the public was required, identifying what will be different and when they can expect to see changes to enable patient/public buy-in and understanding.

> *"Final strategy should include a clear provision for patient/public engagement in developing the detailed plans at place and neighbourhood, including consultation on the boundaries of INT [Integrated Neighbourhood Teams] hub areas where it is proposed they differ from PCN boundaries and including patient engagement with hubs once they are established."*
> *"I approached this document with great interest and anticipation because the problems are well acknowledged, and as we all agree, need addressing urgently. But as I read it, I was discouraged because, excellent though the ideas are in principle, they are unlikely ever to be implemented, since there is no timetable – no dates for beginning each task – weeks – months? And no deadlines for completion, even tentative ones, not even for the most straightforward of the plans.*
> *Without deadlines the whole document ceases to be a strategy."*
>
> *"Whilst recognising that the strategy is in draft format and feedback from key stakeholders may lead to refinement and revisions, we feel that the draft strategy stops short on the next steps. We would welcome a draft timescale for developing the delivery plans for each priority and a summary of the key pieces of work which need to be undertaken in each priority area."*

Engagement process and accessibility of the strategy document

It was felt by couple of respondents that process, route and communication for patients and public on engagement in the Primary Care Strategy was not clearly mapped from the start. It was felt that learning, evaluation and reflection of the process will be key to building better patient engagement when developing future strategies and programmes.

The use of easy read and summary versions of the strategy were welcomed. However, people felt that the main Draft Primary Care Strategy document could be reviewed to ensure the use of plain English and is free of language and terms that may be difficult for the public to understand.

> *"The process, route and communication for patients and public on engagement in the Primary Care Strategy was not clearly mapped from the start. Public involvement was initiated well into strategy development. Learning, evaluation and reflection on this process will be key to building better patient engagement by the system when developing future strategies and programmes."*

> *"The strategy starts with no information setting out the context and giving a clear explanation of what 'BOB ICB' is or its responsibilities. The use of the term 'system' and 'system wide response' is used throughout - but without a clear explanation of who, what, where the system is and involves. There is limited reference throughout to Social Care for example, or reference to the setting of Primary Care within this wider context."*
>
> *"Some statements could be clearer in their meaning, making use of common terms and language."*
>
> *"For many people, primary care means access to their doctor and the services provided at their surgery. We suggest that a clear explanation of all the services across primary care is made at the beginning of the strategy to provide clarity for all readers, particularly members of the public."*

Additionally, the following groups were identified to be more explicitly considered and addressed within the strategy:

- Dementia
- Dental provision
- Cardiovascular disease prevention
- Mental health
- Obesity
- Patients with palliative and end of life needs
- Children with 'frailty' or palliative and end of life care needs

6. Appendix 4: Activity and coverage

6.1 First round of engagement (17 November – 10 January 2024)

BOB ICB press release about the launch of the **'Primary Care Conversation'** appeared on local health, council and partner websites including:

- BOB ICB see here
- Healthwatch Oxfordshire see here
- Oxford Health see here
- Oxford University Hospitals Trust see here
- Royal Berkshire Foundation Trust see here
- Berkshire Healthcare Trust see here
- Oxfordshire Couty Council's *Let's Talk Oxfordshire* engagement platform see here
- Age UK Oxfordshire website see here

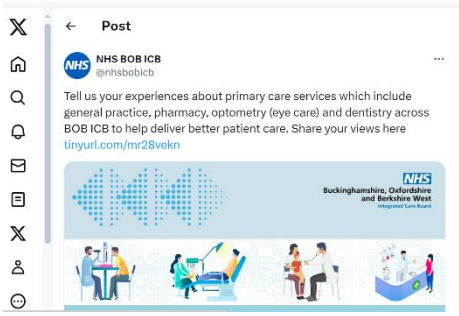
Publications

Details about the engagement and survey featured in:

- 'GP Bulletin' (23 November 2023- issued to all practices across the patch)
- 'Oxfordshire Stakeholder Briefing' (24 November 2023) see here ***'Join the Primary Care Conversation'***
- BOB Buzz (issued to over 300 staff – January 2024) ***'Still time to join the Primary Care Conversation'***

Social media

34 organic posts were scheduled on all BOB ICB Facebook and X channels including in each of our Place accounts in Buckinghamshire, Oxfordshire and Berkshire West between 17 November to middle of December 2023. These links were shared with all our health, local council and other partners to use on their platforms.



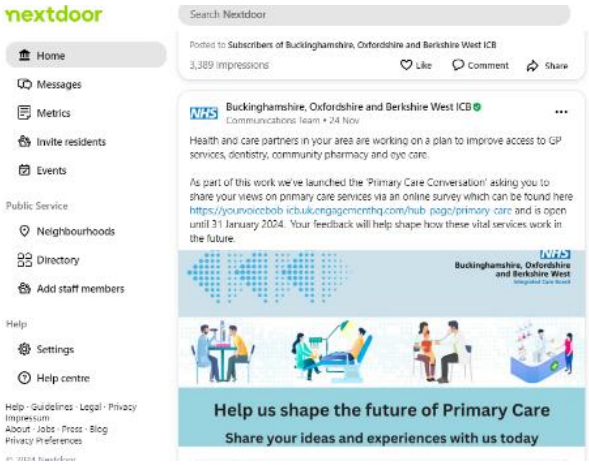
See below for social media results:

Facebook	Posts	Reach	Reactions	Post link clicks (unique)
Total	16	8,183	10	147

X (formerly Twitter)	Posts	Impressions	Engagement	Link clicks
Total	18	19,917	333	129

Nextdoor

We published two posts on this messaging platform which has 306,000 registered members across BOB. Our posts attracted a total of 23,200 unique views/opens/clicks during the phase of our engagement.



This included:

- 24 November – share your views on primary care services with link to the survey (9,600 unique views/opens/clicks)
- 18 December - share your views on local pharmacies with a link to the survey (13,600 unique views/opens/clicks)

Partner promotion

- BOB Voluntary, Community and Social Enterprise (VCSE): Information on the engagement issued to 350 members across BOB.
- Active Oxfordshire sent information about the engagement and survey to all partners.
- Oxford Health highlighted the engagement and survey each week in its staff newsletter which is distributed to around 6,800 individuals across the organisation.
- Oxford City Council published the engagement/survey in the councillor bulletin in December 2023.

Oxfordshire County Council promotion

- Published details of the engagement and survey on the ***'Let's Talk Oxfordshire'*** platform see here: Join the 'Primary Care Conversation' to transform services | Let's Talk Oxfordshire
- Issued email invite to 63 elected members on 24 November 2023 and included this information to 15K staff also in November.

6.2 Second round of engagement (10 January - 3 March 2024)

Our media release about the launch of the '**Draft Primary Care Strategy'** appeared on local websites across BOB helping to raise awareness of the survey.

It was published at the following websites:

- BOB ICB see here
- Healthwatch Oxfordshire see here
- Oxford Health see here
- Oxford University Hospitals Trust see here
- Royal Berkshire Foundation Trust see here
- Berkshire Healthcare Trust see here
- Buckinghamshire Healthcare Trust see here
- Age UK Oxfordshire website see here
- Healthwatch Oxfordshire see here

Publications

Details about the engagement and survey featured in:

- BOB ICB weekly GP Bulletin (12 January, 1 Feb and 15 Feb)
- BOB ICB Stakeholder newsletter – issued to all health and local authority partners and wider stakeholders (in three editions: January, February and March 2024)
- CEX Nick Broughton's blog on 16 February – issued to over 550 staff
- BOB Buzz ICB staff newsletter.
- Promoted the Healthwatch Oxfordshire webinar on 28 Feb via social media and in the BOB ICB stakeholder newsletter (February edition).

Media

Our press release generated the following news stories:

- National Health Executive published a story on 17 January 2024 ***'New draft strategy to transform primary care launches'*** highlighting BOB ICB's vision to integrate primary care services and bring local health and care partners closer together – quotes Dr Abid Irfan, read here: https://www.nationalhealthexecutive.com/articles/new-draft-strategy-transform-primary-care-launches

- BBC Radio Oxford interviewed Rachael de Caux (pictured) the ICB's Chief Medical Officer about the Draft Primary Care Strategy on 24 January 2024 to explain the reasons behind it. Interview was broadcast on news bulletins.

- BBC South ran a story on 1 February 2024 on the Draft Primary Care Strategy highlighting the multi-disciplinary team at the Manor Surgery in Oxford to explain the ambitions in the draft strategy. This included an interview with **Dr Abid Irfan** the ICB Director of Primary Care outlining the reasons for developing the draft strategy.

- BBC news (Oxford) published an online story on 1 February 2024 ***'Oxford: NHS pressures eased by case meetings, GPs say'*** on the Draft Primary Care Strategy highlighting the multi-disciplinary team at the Manor Surgery in Oxford to explain the ambitions in the draft strategy with a link to the survey – see article https://www.bbc.co.uk/news/uk-england-oxfordshire-68146461

- The Oxford Mail published a story on 22 February 2024 headline ***'Share your views on future of primary care in Oxfordshire'*** urging people to fill in the BOB ICB survey about the Draft Primary Care Strategy by the end of the month see here: https://www.oxfordmail.co.uk/news/24135264.share-views-future-primary-care-oxfordshire/

Paid for social media adverts

Two paid adverts were posted on the BOB ICB Facebook page between 14 -18 February 2024. Two ad sets, one targeting those aged 18-30 asking for their views on using more digital tools in accessing health care.

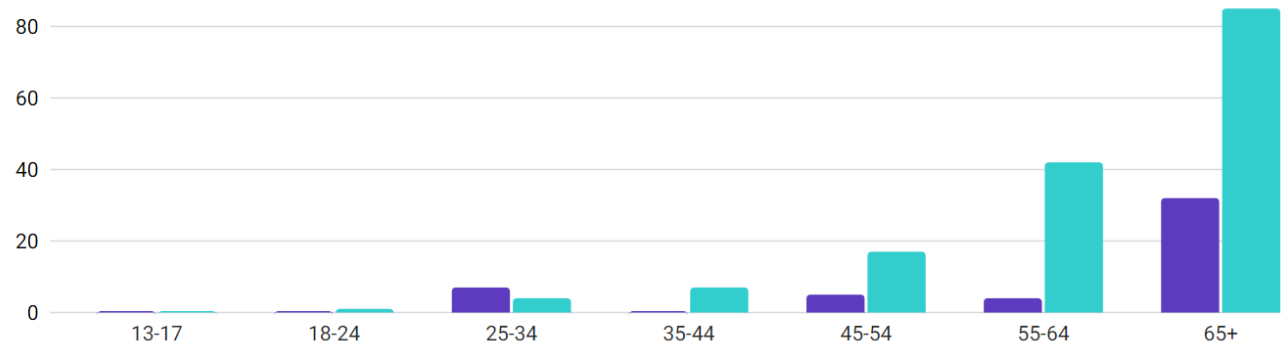
The other advert was aimed at people aged 40 plus asking for their views on our ambitions on reducing the risk of having cardiovascular disease (CVD) by tackling smoking, obesity and high blood pressure. In both ads we targeted people with specific interests related to the advert to make them more cost effective.

Analysis shows the number of surveys submitted by people aged 45 and over by 7 February was **108** and by 3 March was **214**. For those aged 18 to 34 the number of responses submitted by 7 February was **5** and by 3 March was **11**.

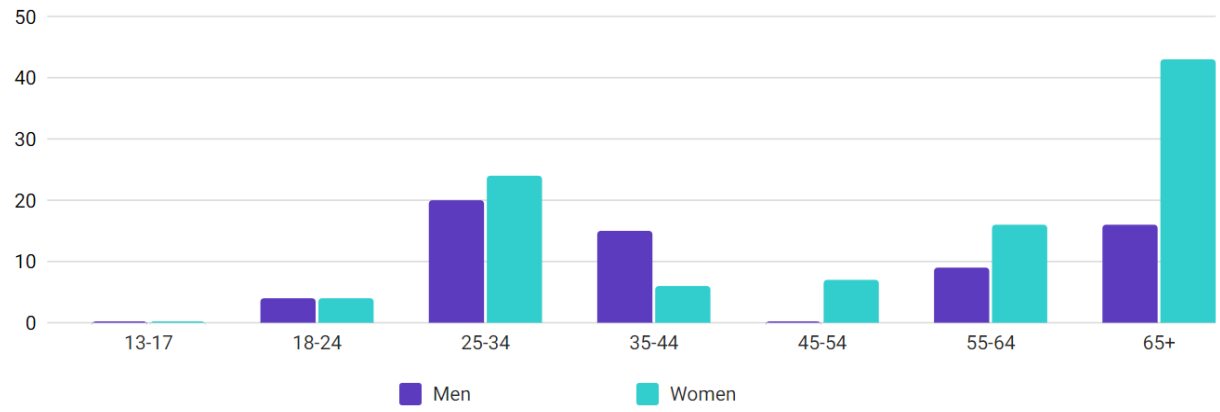
The campaign resulted in the following overall statistics

Ad set name	Results: link click	Reach	Impressions	Schedule
40+	206	7,341	10,083	15 – 18 Feb
18 – 30	165	11,453	14,236	14 – 18 Feb
Totals	**371**	**18,794**	**24,319**	

The bottom line on the chart below shows the age and gender distribution for the paid advert aimed at 40 plus age range with the number of clicks shown on the left-hand column.

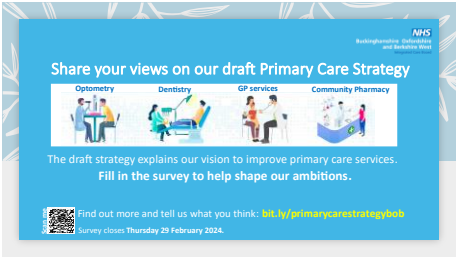


The bottom line on the chart above shows the age and gender distribution for the paid advert aimed at 18/30 age range plus with the number of clicks shown on the left-hand column.



GP digital screens and posters

We created a slide for GP practices to promote the draft strategy and survey via their digital screens in practices. It was made available for GPs to use via the BOB ICB **GP Bulletin** on 15 February 2024 – the slide was also sent directly to Buckinghamshire GP practices for use on their screens.



We also designed a **poster** for all 156 GP practice waiting rooms across ICB to raise awareness of the draft strategy and survey. It was made available in the GP Bulletin on 15 February and was also distributed to dentists, pharmacies and opticians across the ICB to display in their public waiting areas.

Social Media

Organic posts were scheduled on all BOB ICB Facebook, X channels and LinkedIn including each Place account (Buckinghamshire, Oxfordshire and Berkshire West) between 10 January to 3 March 2024 to promote the engagement survey and the patient webinars we held during this time (see review of this in the table below). These links were shared with all our health, local council and other partners to post on their platforms.

Facebook	Posts	Reach	Reactions	Link clicks
Total	31	7,831	23	121
X (formerly Twitter)	**Posts**	**Impressions**	**Engagement**	**Link clicks**
Total	30	31,216	472	170

LinkedIn	Posts	Impressions	Reactions	Link clicks
Total	1	374	5	14

Promoting patient webinars

We promoted the BOB ICB wide patient webinar held on 21 February and the Healthwatch Oxfordshire patient webinar held on 26 February via social media, on Nextdoor (see below), in the BOB Stakeholder Newsletter (February edition see here) issued to all our health, local authority and other partners. It was also publicised on the following sites:

- Berkshire Health Trust (21 February) website see here
- Healthwatch Oxfordshire (21 February) see here
- Healthwatch Oxfordshire included details of both webinars in their fortnightly news brief newsletter and emailed PPGs and practice managers.

GP webinars

We promoted four webinars taking place in February and March aimed at GPs and practice health professionals to discuss the Draft Primary Care Strategy (which included a link to the survey) in the GP Bulletin on 15 February.

Nextdoor

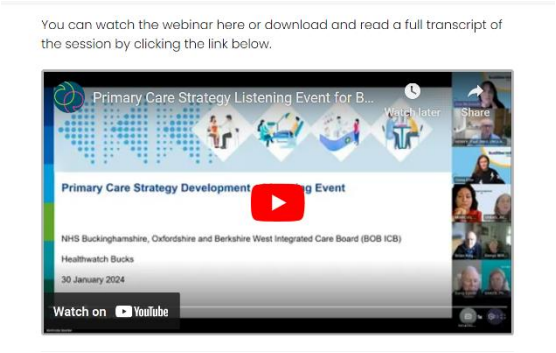
We published five posts on this messaging platform which has 306,000 registered members across BOB ICB. Our posts attracted a total of 70,000 unique views/opens/clicks. This included:

- 17 January – launch of draft strategy with link to the survey (12,300 unique views/opens/clicks)
- 26 January – share your views of draft strategy via a survey (12,800 unique views/opens/clicks)
- February – promoted BOB ICB wide webinar on 21 February with link to survey (10,400 unique views/opens/clicks)
- 16 February – share views on use of digital tools to improve access to health care (18,600 unique views/opens/clicks)
- 16 February - share your views on smoking, obesity, high blood pressure to stay well and risk of cardiovascular disease with a link to draft strategy and survey (15,700 unique views/opens/clicks).

Partner promotion

- **Buckinghamshire Healthwatch** thanked people who took part in their webinar with BOB ICB on 1 February.

[Primary Care Strategy Listening Event for PPGs a great success! – Healthwatch Bucks]



West Berkshire Council

- Engagement information and survey link emailed to elected councillors and staff on 2 February.

Reading Council

- Survey shared in residents and councillor newsletters.

Buckinghamshire Council

- Engagement information and survey link issued to elected councillors via their ***'Member Update'*** on 26 January.

Oxfordshire County Council

- Promoted the engagement to staff via internal comms channels and with elected councillors via the BOB ICB Stakeholder newsletter.

Berkshire Healthcare NHS FT

- Promoted in the staff newsletter.

Oxford City Council

- Engagement information and survey link issued to elected councillors via weekly members newsletter.

Royal Berkshire NHS FT

- Details of the draft strategy went in their staff bulletin, POG newsletter and members magazine.

Buckinghamshire Healthcare NHS Trust

- Team Brief presentation which are sent to all leaders to cascade to their teams

South Oxfordshire and Vale of White Horse District Councils

- Draft strategy promoted in their councillor newsletter on 26 January and 12 February.

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Buckinghamshire, Oxfordshire and Berkshire West Primary Care Strategy

Responding to the feedback from engagement

1. Background

During 2023/24 the ICB started working with health and care partners to develop a strategy and implementation plan for the future of primary care. This includes general practice, community pharmacy, optometry (eye care) and dentistry across BOB. The work aims to:

- Build a shared understanding of the current state of primary and community services and present a case for change.
- Build a consensus on the future vision for primary care and its integration with community services.
- Design the way we deliver this care (operating model) and other tools such as digital healthcare support.
- Test the practical application of the new model through projects.
- Capture learning and build capability for phased roll-out of the final strategy.

As part of this programme of work, extensive engagement was undertaken with a wide range of stakeholders through various routes including (but not an exhaustive list):

- General Practice, Community Pharmacy, Optometry and Dentistry (POD) focus groups and on-going conversations

- 2 x 1-day system workshops (colleagues from across the system including primary care, NHS hospital, community and mental health providers, local authorities, Healthwatch, voluntary / community sector (VCSE) and GP patient participation group representatives) in order to have a collaborative discussion regarding the opportunities for the future model of care.
- Sessions with GP Chairs, and representatives from VCSE, Acute, Community, Digital and Data, workforce and estates to co-develop the Primary Care Strategy content.
- Attending NHS provider Boards and Governor, Integrated Care Partnership and Health and Wellbeing meetings
- Public engagement undertaken between 17 November 2023 until the end of February 2024 through surveys, ideas forum, focus groups, online public events and through the ICB's online engagement portal Your Voice in BOB. A comprehensive public engagement report has been published in a separate document: Primary Care Strategy Public Engagement Report.

2. Purpose of this report

The wealth of insights from this engagement has informed the final version of the Primary Care Strategy. This report has been produced to give an overview of the changes that have been made to the Strategy in response to the feedback raised through the engagement process. Both the detail in the engagement report and the key themes have been used to inform the development of the strategy.

3. Summary of changes made to the draft Primary Care Strategy in response to feedback raised through engagement

Overall, most respondents to the public survey asking about the strategy stated they felt the vision sounded like a positive switch towards a more integrated response and preventative approach. Respondents also agreed or strongly agreed with the strategy priorities (with caveats e.g. same day access is not always appropriate for people who are not ill but have an issue they wish to see their GP about and have an appointment at a later more convenient time so they can take time off work / arrange childcare)

It is important to note that a significant amount of feedback reflected what is already in the primary care strategy and identified the issues the strategy is trying to resolve.

Theme	Feedback we received	Our response to the feedback
Workforce	Workforce recruitment, retention and training are a concern.	Like other healthcare services primary care are dependent on a fully trained multiskilled workforce that are supported to deliver care whilst maintaining a good work life balance. To give this focus we have added a section in the strategy outlining our proposed approaches to developing and maximising training and support opportunities; investment in training; promotion of staff wellbeing and how to support a wider skill mix and alternatives workforce models to improve patient care.
Prevention	A focus on prevention was welcome but there was concern about other long-term conditions being discounted with the focus on (cardiovascular disease) CVD. More focus on early prevention and education to promote healthy lifestyles for patients and educating patients to manage their own health conditions.	The focus for prevention in the strategy is CVD because of the huge impact it has on patient outcomes and system resources. It has been identified as one of the key system priorities and will allow all system partners and pillars in primary care to collaborate closely, use health data to focus on health inequalities and deliver tangible health benefits for our population. This will include the early prevention and education initiatives. We have added a section to clarify that primary care and partners will continue to focus on other long-term conditions. This includes working on new transformative patient pathways to support prevention, early identification and treatment.
Estates	While there was some information in the strategy about primary care estates. Issues with primary care estates were raised; it was felt this needed to be reflected more in the final strategy. Questions were asked about the longer-term strategy and new developments and also issues with existing estates of primary care and the impact on service delivery.	We recognise the importance of primary care estate across BOB in providing resilience particularly to general practice by supporting additional capacity and helping with the increased demand through new housing developments. As a result, we have strengthened our section on primary care estates to include links with the ICS Infrastructure Strategy and the better use of public estate.

Partnerships	Health and care partners need to work better together to improve patient experience and provision of a joined-up service.	Through the BOB Primary Care Strategy, we aim to ensure that all people across BOB – from infants and young people to frail and elderly - receive the coordinated support they need from primary care and partner organisations, to stay healthy. Working with system partners like public health and community groups we will be able to design the right support for the specific population groups. We also intend to improve partnership working in general and have added an additional slide to the strategy to reflect this working not only between providers but with our public.
Integrated Neighbourhood Teams (INT)	Questions were raised on what an Integrated Neighbourhood Team (INT) is. Concerns that while primary care will play a leading role in the development and provision of INTs, making them a reality will require commitment from system partners.	The strategy clearly outlines what an INT could look like. However, the specific makeup and dynamic of that team could vary depending on the needs of the patient population. One of the first actions of our implementation plan, will be to define the principles of an INT. The commitment from system partners to delivering INTs in partnership with primary care was a reason behind the extensive engagement. It is felt that this now needs to be made a reality through implementation.
Resilience and sustainability	Resilience concerns with primary care and how we as a health and care system are approaching resourcing was a key theme of the feedback from both primary care providers and the public. Concerns were raised throughout the engagement process about resourcing services given increased demand for care, particularly workforce resilience, and the ability to recruit / retain in the current environment.	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. Given this and the feedback we have included a section on resources which considers our approach to resources, contracts and working at scale so that it supports resilience in our providers but also benefits patients; particularly those in areas of higher deprivation and associated health needs.
Interface between system partners	It was felt that the interface between system partners was not addressed enough in the strategy.	Close partnership working across all system partners is important in driving the implementation and delivery of the primary care strategy.

	There were frustrations from the public at the lack of joined-up working between services, and a strong request for enhanced record-sharing and communication between teams to reduce repetition.	As a result of this feedback, we have added a new enabler labelled Partnership working.
Implementation	Multiple questions were raised on how the strategy will be implemented and risks to its delivery.	Slides have been added to the strategy outlining actions that could be taken to start implementing the strategy and progress monitored.
Public awareness	There was widespread feedback that public are not aware of the different roles within primary care; how to access which services for what care; how to navigate access as well as understanding what the NHS app has to offer. Clear communication with the public is needed around the changes and what it means in reflection to their needs, to provide assurance that their health needs will be met.	We recognise we need to work with people and communities across BOB to deliver change. Effective communication and engagement are key to achieving the priorities in the strategy. As such we have built recognition of this into the strategy and outlined some key areas of work to be delivered including raising awareness of the primary care strategy and programme of work; communications campaigns to raise awareness of new roles in primary care and how to access the right care at the right time.
Priority areas	There was broad agreement with the vision within the strategy and the priorities areas but there was feedback that we were missing areas – those highlighted included: diabetes, maternity and neonatal areas, women's health, cancer, asthma, COPD, heart failure, hypertension, diabetes, mental health, children and young people, net zero, unpaid carers and carers' support, identification of other fatal diseases at early stages.	We acknowledge the feedback on missing areas and have been more explicit in referencing some of them within the revised strategy. Whilst an additional slide has been added regarding the long-term conditions other conditions are covered within health inequalities and supporting the delivery of Core20plus priorities which are maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis and hypertension case-finding. While areas may not be specifically included within the strategy work across the system is on-going in a number of areas including the implementation of a women's health strategy; support for children and young people with special education needs, environmental sustainability and developing maternity services. This work is illustrated in the ICB's annual report which will be available on our website.
Access and	A key theme from the public feedback was access	We understand the importance of access and continuity of

continuity of care	and continuity of care including NHS dentist availability and challenges getting a GP appointment, stating that sometimes patients felt blocked from the triage system. The need for clear pathways for patients was raised, especially those with complex medical needs, as well as the need to ensure continuity of care was not compromised due to service demand.	care, that is why our first priority is to expand at-scale triage and navigation to appropriately direct same-day non-complex need. This 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. We believe this way of working will: • 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.
Engagement	The public fed back that as services were changing, engagement and involvement were key to the successful delivery of the strategy; patients and the public need more involvement and proactive engagement with primary care.	While the ICB would endeavour to work with the public to develop services we have built this explicitly into the strategy section on how it can be successfully delivered. We will also provide tools to support primary care to deliver engagement at a local level; conversation and co-production are not necessarily best delivered at an BOB wide system level.
Early prevention	A key theme from the feedback was there needed to be more focus on prevention and education from an earlier age to promote healthier lifestyles	Prevention of ill-health is all our system partner's responsibility. However, we have built in a commitment to the strategy to work with local authority partners and public health to raise awareness of health promotion and prevention in schools and encourage healthy habits in our younger population.
Metrics	One area of feedback centred on how we would know if we were successful implementing the	We have revamped the original measures included in the strategy, focusing on metrics that more directly tied to the

	strategy and the need to have clearer measures of success on the strategy.	three priority areas, including goals on where we wanted to be as a system on each of those measures. While we have clearer targets for the access and CVD prevention areas, more work with system partners needs to be done to identify measures around INTs that will be relevant to the INTs areas of focus. Lastly, with the pressures we know our system will face over the next few years, sustainability of the system will be the final area we measure and monitor to ensure primary care has a strong foundation to support the transformation efforts highlighted in the strategy.
Accessible documentation	People felt the strategy document needed to be written in plain English to enable people to fully understand the vision and how it would affect them. Respondents to the engagement survey commented that, to enable people to fully understand and promote engagement, the strategy needed to be written in plain English.	We acknowledge the documents is lengthy and has complex information within it. We have tried to make it as simple to read and understand as possible. In addition, we have added an updated glossary and “terms explained” slide.

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Transforming Primary Care

General Practice, Community Pharmacy, Optometry and Dentistry

Contents

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

Foreword

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System is made up of NHS, local authority, community and voluntary sector organisations that together serve our population of approximately 2 million people.

Primary care services are described by NHS England (NHSE) as the first point of contact in the healthcare system, and act as one of the 'front door' services to the rest of the NHS. Effective primary care services are the foundation of much of the care and support provided within our system and carries out 90% of all patient contacts in BOB.

Our Primary Care Strategy for 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.

Across BOB we have much to celebrate in our primary care provision – the proportion of GP appointments seen within 14 days is higher than the national average, uptake of community pharmacy consultation is high, our clinical teams are using data to identify patients at risk of getting ill and intervening early and many other successes. However, our primary care services are challenged. People are reporting a worsening experience of accessing primary care services, our primary care staff feel under increasing pressure, demand for primary care services is growing as our population gets older, sicker and more numerous. The current model of primary care is not sustainable.

We need to change how we work

In March 2023, the Integrated Care Partnership (ICP), which represents partner organisations in the system, agreed an Integrated Care Strategy for BOB. This included an ambition to transform primary care services. Later in 2023, NHS partners published a 5-year delivery plan, including a specific goal to develop a Primary Care Strategy that would provide greater resilience. These local ambitions for primary care in BOB are built on global best practice, national reviews of core primary care components such as workforce and the partnership model, as well as national policy that describes how primary care should streamline access, provide continuity of care and focus more on prevention.

Our priorities are based on three areas of change:

- Everyone who lives in BOB will be able to receive the **right support when it is needed** 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.
- We will help those with more complex needs through **proactive, personalised care** from a holistic team of professionals through the development of Integrated Neighbourhood Teams and manage their conditions in the community setting for longer.
- We will help people and communities **stay well and prevent ill health**, initially targeting interventions on our biggest preventable killer and driver of inequalities – cardiovascular disease (CVD). All pillars of primary care can support people to reduce the known risk factors like high blood pressure.

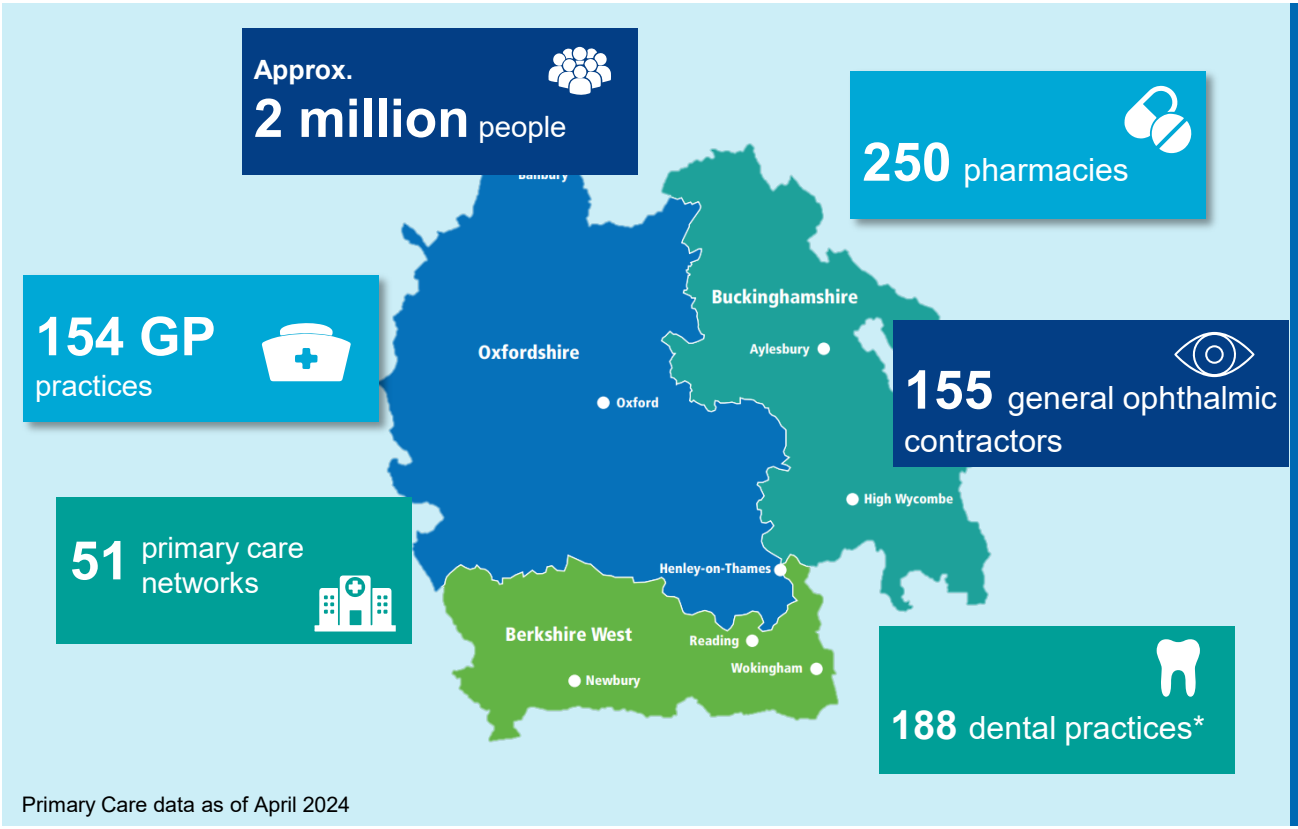
The strategy has been developed through extensive engagement with many stakeholders across the system including those who work at the frontline of primary care. We have listened to and considered the experiences and viewpoints of staff, communities and patients. This valuable feedback has shaped the final version of the published strategy.

This strategy sets our ambition and plan for delivery. It has been written at a time when the NHS is experiencing a high degree of volatility, and the BOB system is significantly financially challenged. For this reason, delivery against plan will be reviewed regularly to ensure that it remains in line with system priorities and is affordable. That said, this is an exciting time, this is the start of the journey which aims to ensure that all people across BOB – from infants and young people to frail and elderly - receive the coordinated support they need from primary care and partner organisations to stay healthy. We intend to continue to work with local people and organisations in BOB as these plans are developed and refined.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Introduction: 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 April 2024

- 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 (Next steps for integrating primary care: Fuller Stocktake Report, 2023) . We have developed this strategy to **address the challenges we are facing in primary care and improve integration between all 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 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.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Population

Primary care supports our unique and varied communities with a wide range of needs and helps to tackle the health inequalities some communities experience. This supports our Core20plus 5 priorities which are maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis and hypertension case-finding.

Our population – Growth & Diversity

Growth - 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%.

Varied diversity - 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 with 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.**
- **Around 1 in 5 children in Reception year and 1 in 3 children in Year 6 are overweight or obese**

1: BOB fact pack (2022); 2: BOB Joint Forward Plan (2023)
3: BOB ICB Equality Duty Annual Report

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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 with the public and professional services to evaluate the current state as well as 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.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Primary care is at the heart of our system

As the 'front door' for our population to access the health system, primary care 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 587,000 people in Buckinghamshire, 816,000 people in Oxfordshire and 584,000- people in Berkshire West.

02 Approx **400,000 NHS sight tests** are carried out in BOB per year with approximately 25,000 referrals into secondary care

03 **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 Across BOB there are approximately **1,100 WTE GPs, 430 WTE Nurses** and over **900 WTE staff in the Additional Roles Reimbursement Scheme (ARRS)**, including Social Prescribers, Clinical Pharmacists, Nursing Associates and Mental Health Practitioners. We have an **average of 42.6 GPs per 100,000 patients** compared with the England average of 44.

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

06 There are **250 community pharmacies offering a range of clinical services** e.g. flu and COVID-19 vaccines, blood pressure checks, oral contraception and healthcare advice.

1: Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14 (2016); 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)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our primary care system has many strengths

The value base for primary care is the provision of care from cradle to grave, providing a holistic approach where the whole person is looked after and not one disease or a single episode of care. This comes with the enabling of a lifelong medical record, provision of continuity of care where needed and managing the whole person and, in the case of general practice, providing care based on a registered list. Below are six additional highlights where our system has 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 Pharmacy First

BOB has seen a high number of sign ups by Community Pharmacists to delver Pharmacy First. Indication from the first three months of data suggests that General Practice continues to refer high numbers of patients for this service

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

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

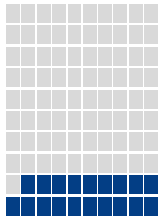
1: NHS Digital (2023); 2: Primary Care Access and Recovery Plan (2023); 3: Brookside Case study – Segmentation in Primary Care (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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.

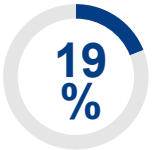
01 People report a worsening experience of accessing primary care



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

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

02 Many primary care staff feel they are under extreme pressure



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

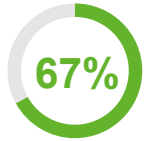
Multiple respondents to the BOB dental survey said they are under extreme pressure due to demand much greater than capacity, lack of funding and recruitment and retention challenges.[4]

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 today – BBO LMC data has shown that GP practices should be delivering double the number of sessions to cope with demand.[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 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 currently 154 GP practices operating out of 223 practice sites. 41 of these sites are pre 1948 and many are converted houses. Very few have room to expand to absorb housing growth or accommodate increasing number of staff.

05 Funding streams are not keeping pace with growth in costs, threatening sustainability

According to a 2024 survey, two-thirds of GP surgeries are concerned about short and long-term financial viability amidst rising cost pressures and inflation.

In dentistry, the reimbursement rates (units of dental activity, or UDA) are too low to attract young dentists to work in the NHS and make experienced dentists reluctant to leave the private sector

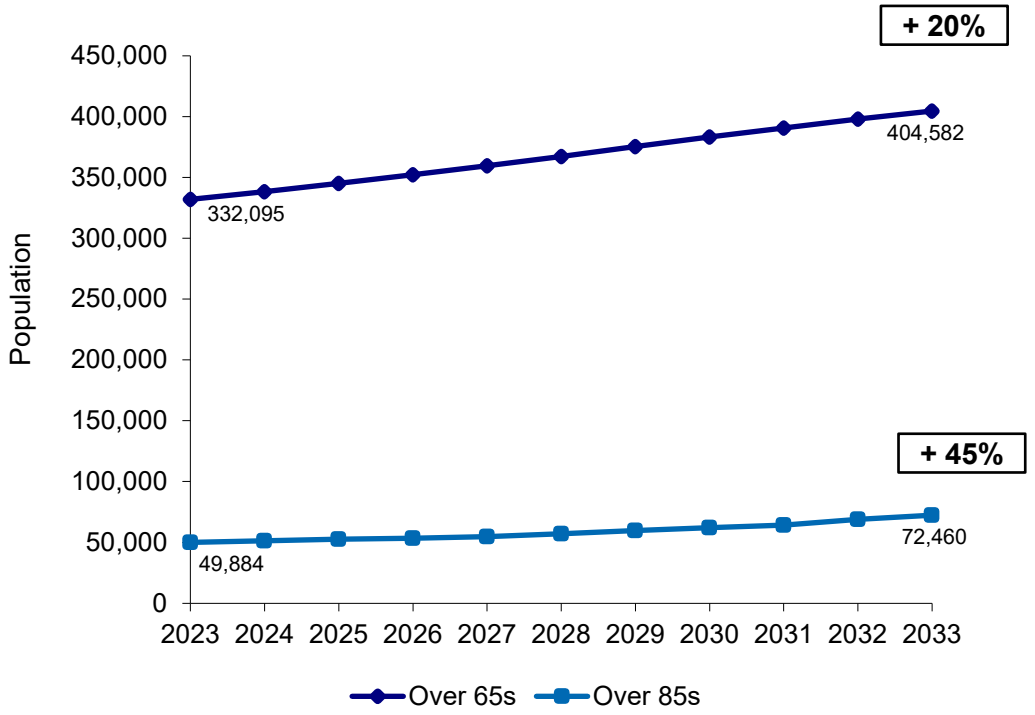
1: National GP survey results, 2023; 2: BOB GP Patient Survey Dental Statistics 2023; 3: BBOB LMC The Health of General Practice in BOB; 4: BOB Primary Care Assurance Report 2023/24 Quarter 2 (2023);
5: BOB Joint Forward Plan (2023); 6: Buckinghamshire Executive Partnership Report on Primary Care July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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

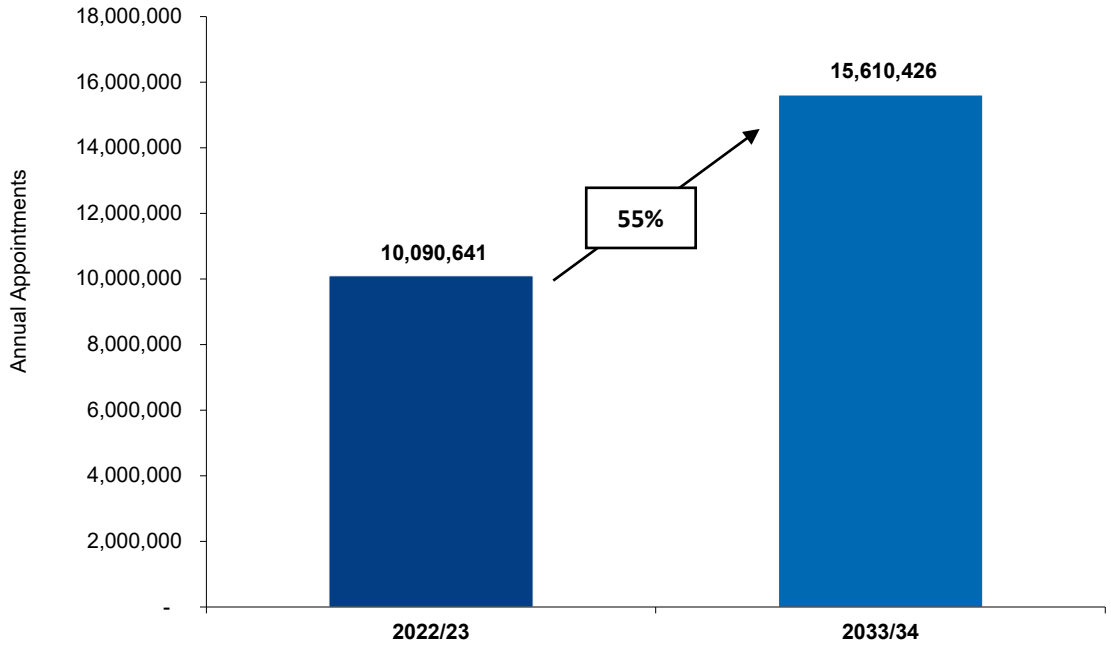
If we do nothing, the mismatch between demand and capacity will continue to grow

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

What the public think of primary care across BOB

We listen to what patients say about primary care through a wide variety of forums including complaints and compliments, our GP Patient Participation Groups, national and local satisfaction surveys and our local Healthwatch organisations.

The positives . . .

When I do get to see a GP she is attentive and compassionate. Once you reach a GP, the level of care and professionalism is as you would hope - excellent.

I went in to collect my prescription, and the staff were extremely friendly and always willing to help me get the items I needed even when the GP hadn't signed off my prescription to send it, they went above and beyond to try and help me. I asked for an item they didn't have in their shop, and they ordered it for me without hesitation.

Recent experience of access to GP has been very good with prompt helpful email response and ordering of prescription via the NHS app.

At every interaction I was treated with kindness and professionalism (even some humour when the occasion called for it!) and all my healthcare needs were met.

Pharmacy services locally are good and I have a very good relationship with my local pharmacy

What could be improved. . .

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.

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.

The services are inadequate. They lack the capacity to meet demand. So far as I am aware there is no access to NHS dentistry and NHS optometry is restricted to a mediocre selection of frames.

Access to the right care and knowing "the system" is difficult. There seems to be an expectation that patients understand the less than easy to understand systems. There is also an expectation that everyone can use "tech". The NHS and GP online systems are not intuitive and easy to use.

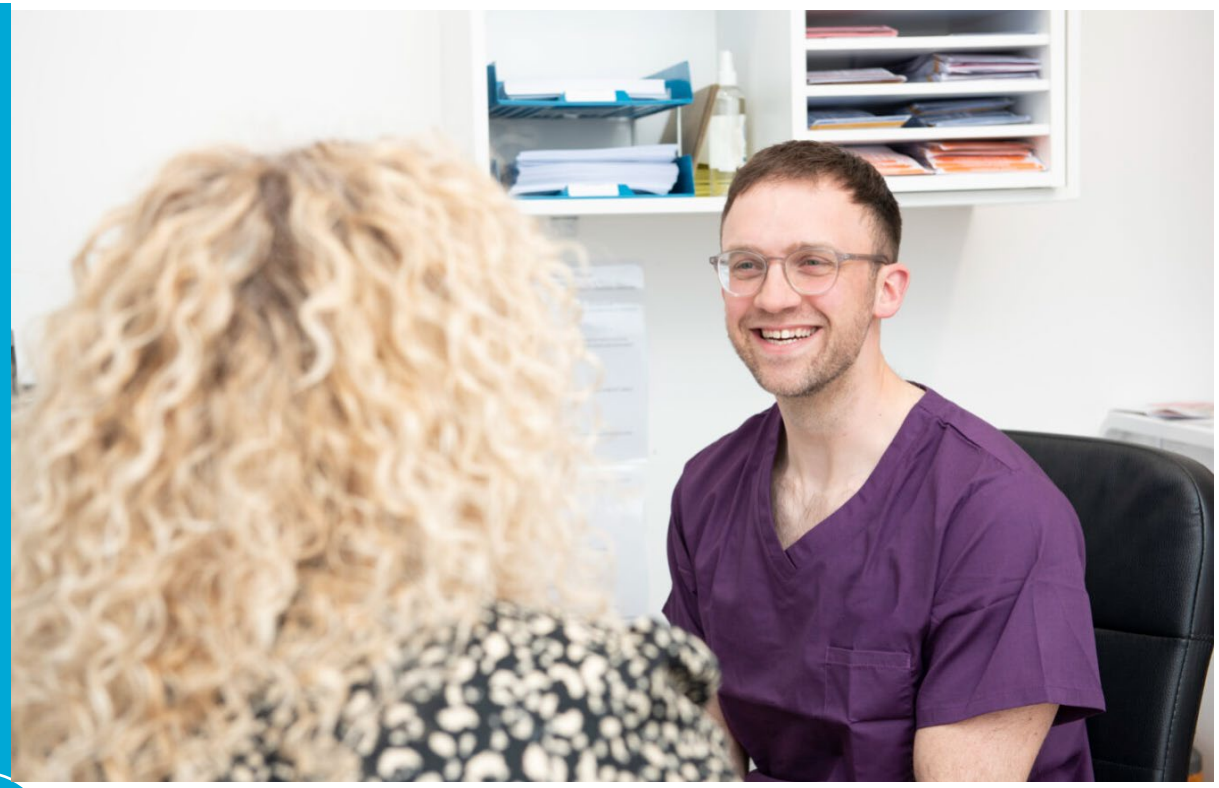
Multiple attempts to make appt for my child. Declined as not urgent. Situation became urgent but receptionist would not escalate concerns. Urgent private appt paid for with another surgery and child found to have [condition] and needed [medication].

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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 measurable outcomes and we will describe and track these over time so that we know when we are making a positive impact and are able to make changes if we have not (section 5).



Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our shared system vision for primary care

Our Primary Care Strategy for 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.

This is our future vision for primary care:

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.

What we want to achieve

1. People get to the **right support first time** to meet their needs
2. **Joined up, personalised, proactive care** for people with multimorbidity and complex needs
3. Support to **help people stay well**, **prevent ill health** and minimise the impact of poor health

Actions we will take

- Improve access to information to **encourage self-management**
- Strengthen our approach to **triage** and **directing people to the right support**
- Ensuring people get the **right support to meet their needs**
- Introduce **Integrated Neighbourhood Teams (INTs)**, made up of professionals from a range of disciplines, to support people with more complex needs to stay well in their communities.
- Embed a **data driven approach** to identify our most vulnerable and at-risk groups and proactively manage
- Introduce a coordinated approach to **Cardiovascular Disease (CVD) prevention**

Enablers for success

- **Workforce** – Multi-skilled extended primary care teams working in an integrated way, at the heart of the system.
- **Digital and data** – Shared patient records and connected data used for clinical decision making and to improve the patient experience
- **Estates** – Effective use of Public Estate and community assets to support primary care delivery.
- **Resourcing** – Shift resources into community settings. Contracts focus on outcomes that deliver integrated services.
- **Partnerships** – Creating effective partnerships across providers that support efficiencies and improve the patient pathway.

1 We will 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.

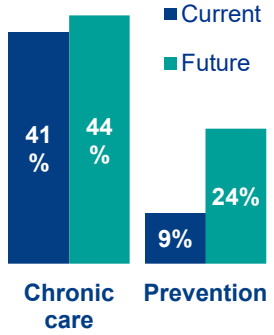
The challenge today – using general practice as an example

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.

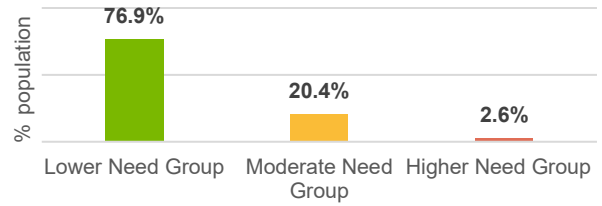
1:BOB GP National Survey (2023); 2: Survey shared with General Practices across BOB as part of Primary Care Strategy work

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

There are 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

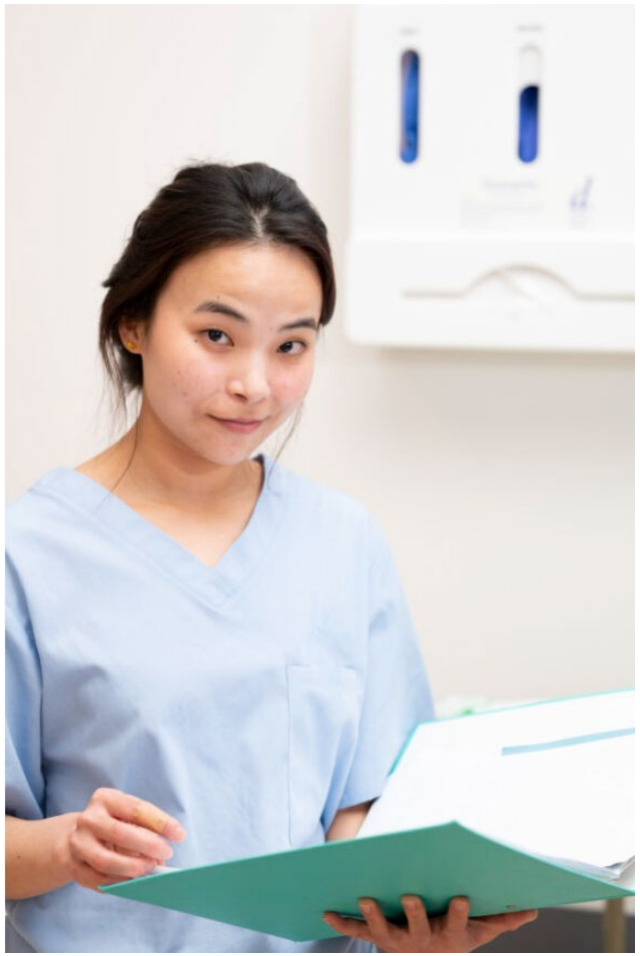
- Brookside Group Practice use data to understand the needs of their population.
- As shown below, 77% of Brookside's population has generally low needs – these people tend to have a non-complex requirement when they contact their GP, for example, a Urinary Tract Infection (UTI).
- Brookside call this 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.
- This service has now been replaced by the Pharmacy First scheme



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)

2 We will 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]

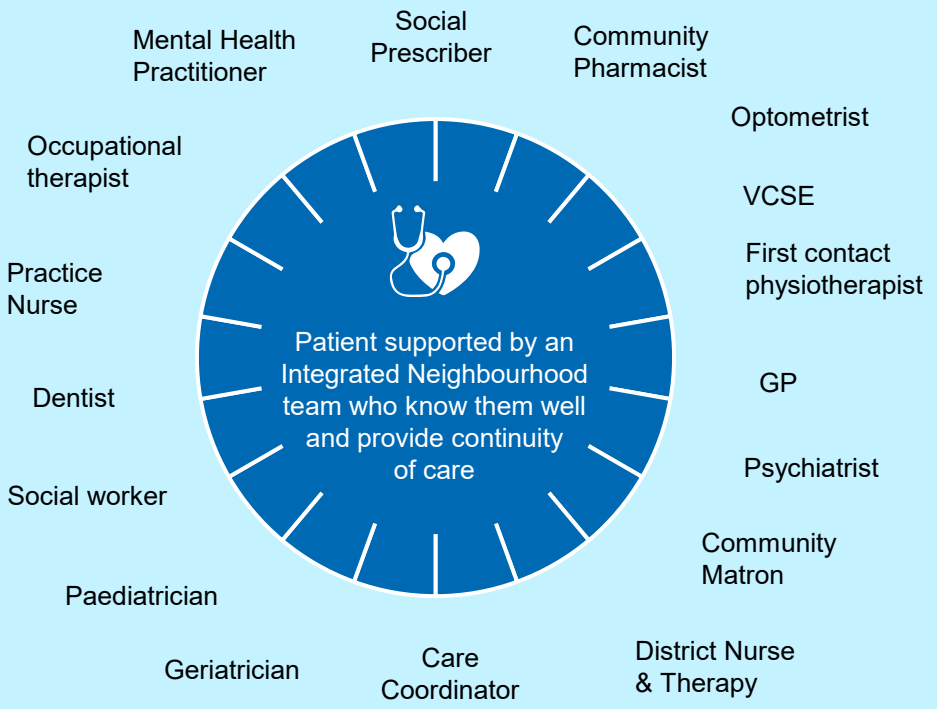
Many issues that affect people's health are not purely medical and require input from multiple parts of the public sector, for example housing, benefits.

"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



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 will involve all system providers – from primary care and community care to secondary care consultants, mental health, social care providers, VCSE sector. We will need to ensure job plans are aligned and resources and time commitment are agreed upfront.

Principles of INT working will include:

- Keeping people well in the community for as long as possible
- Care that is comprehensive and holistic
- Care that is rooted in the community
- Personalised care that is shaped by the population and person's need
- Outcomes driven

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

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

We recognise Integrated Neighbourhood Team working is not new and has been happening across BOB in some capacity. We have described two examples 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 in 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 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)

3 We will provide support for people to stay well by using information to focus on those with greatest needs

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. This can be stopping people becoming unwell in the first place, preventing ill health progressing, or minimising the impact of poor health.

From the data available we know that in BOB the clinical area that we can make the biggest impact on through prevention activities is **cardiovascular disease**. This will be a focus for our strategy.

All four primary care pillars (general practice, community pharmacy, optometry and dentistry) have a critical role to play.

- Prevention - blood pressure monitoring during eye checks or dental checks in early years settings.
- Living healthier lives - increasing access to tobacco dependency and weight management services.

To do this well we will need to release capacity from a stretched primary care workforce and our future integrated model of care will help to do this.

To enable this preventative approach to care we will also need health and care data to inform decision making. Using a system-wide Population Health Management (PHM) approach will allow us to understand the health needs of our population, identifying our most vulnerable and at risk who experience the poorest outcomes and inequalities. Working with system partners like public health and community groups we will be able to design the right support for the specific population groups. 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)

3 Changing how we work to use data to design targeted support for people 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 10 most deprived wards.

Children and Young people: They have visited parent sessions at primary schools and attended children's classes, to promote better oral hygiene and reduce oral health inequalities.

Community: They have visited Banbury Mosque, Health walks, Dementia support group (online), Community Hubs, food banks,, weight management groups, clinics in the John Radcliffe, and the Health on the Move Bus.

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

Newsletters: 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.

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.

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

Enablers: Workforce

Like other healthcare services primary care are dependent on a fully trained multiskilled workforce that are supported to deliver care whilst maintaining a good work life balance. Below we describe current or aspirational approaches to enabling this locally. Some of these can be done within the system resources available whilst others may be subject to investment as available.

1. Workforce

Develop and maximise the use of support offers	• **Work with partners** to scope, review and prioritise support offers for Primary Care workforce • Fully **utilise emerging national, regional and local support offers** such as GP Improvement Programme; GP retainer scheme; coaching and mentoring: New to Practice Fellowship scheme
Invest in training and development at all levels	• **Invest in training and education programmes** to attract and retain skilled healthcare professionals in Primary Care who are able to support the essential services • Put primary care leaders on a secure footing by investing, allowing them to develop further and expand their scope of work, enabling parity with other system leaders in terms of access, involvement, and decision-making • Support Continuing Professional Development (CPD) by **continuing to offer protected practice learning time**. Allow practices to both deliver in-house training and come together for system-wide learning events. • **Review and develop Coaching and Mentoring offers** to help primary healthcare providers develop strategies for overcoming adversity and managing stress effectively.
Promote Wellbeing	• Support the implementation of **workplace wellbeing initiatives** • **Sharing good practice** such as flexible scheduling of clinics allowing those with home commitments to work hours that suit their other daily responsibilities outside of work
Enable alternative workforce models & skill mix	• **Diversify the workforce** to maximise support for patients • Optimise use of **Additional Role Reimbursement Scheme (ARRS) funding** and support staff to work at the top of their licence • Maximising **uptake of apprenticeship roles** developing the workforce through the apprenticeship levy • Enable staff to move seamlessly between provider organisations using the **'BOB staff passport'** making shared and rotational roles much easier, which may increase staff retention • Looking at Dentistry specifically, exploring different types of contract models to **encourage recruitment**, reviewing the skill mix to align with new prevention priorities and the training required for this, and review of commissioning training courses to grow dental workforce.

Enablers: 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 care journey through the system. By enhancing and putting processes in place to reduce our emissions from digital technologies we will become more environmentally sustainable. How far we can go with our digital capabilities, however, will be dependent on the system's financial position. Building on the ICB's Digital and Data Strategy, we will:

2. Digital and Data

Digitise Our Providers: Delivering digital foundations across our providers	• **Optimise current digital triage and PHM tools** and provide training to support primary care teams • Ensure **high quality software is available**, allowing flexibility through a small number of strategically determined providers. • Engage on the requirements of GP principle clinical systems to influence the ongoing **development of our Electronic Patient Records**.
Transform Our Data Foundations - to target population needs	• Continue to develop, spread and scale the existing **Population Health Management infrastructure** across the entire system. • Advance our **data sharing agreements** so we continue to offer better patient care through having more comprehensive data
Improve efficiency - through technology and new ways of working	• Explore a **universal offer for providers** which underwrites liability for data-sharing in a healthcare setting and promote joint working • Implement **at-scale back-office processes** to reduce workload and strengthen business continuity (details to be determined locally)
Connect Our Care Settings: using digital, data and technology to connect our care settings	• Enable providers to **digitally share patient records** to support effective clinical decision making and care navigation, within primary care and between primary and secondary care • **Share information digitally** to reduce administrative burden • **Resolve interoperability** to support other digital technologies such as remote monitoring tools to empower patients, and their carers, to play a greater role in their care.
Improve & maximise digital inclusion	• Work closely with BOB ICB Health Inequalities Team and other partners to **identify those digitally isolated** • **Improve digital inclusivity through proactive interventions** such as training, primary care digital champions, digital cafes and technology recycling projects like the Reuse Laptop Project. • Use **research and feedback** from patients to inform the approach • **Maintain non-digital healthcare and access routes** as required • Harness the **opportunity of an IT literate youth** to create a **generational culture change**, maximising their awareness and use of digital healthcare tools via education in schools and other settings.

1. ICB Digital and Data Strategy [2023]

Enablers: Estates

Viable health care buildings underpin the successful delivery of our future model of care. It is an area that is complex and requires significant financial investment that we will not always be able to support, and we will therefore need to find ways of working smarter and in partnership at place and system level. Estates transformation is also fundamental to the delivery of a Greener NHS, therefore we are assisting primary care buildings to be more environmentally sustainable by supporting the oldest and least sustainable to decarbonise while also ensuring all new developments incorporate sustainability from design onwards.

3 Estates

Improve virtual consultations and 'hub working'	• Make **greater use of virtual consultations and 'hub working' (**with multiple professionals in same space) for non-complex same day care • Work at place to **identify the best solution for non-complex same day care** including identifying suitable locations for hub working where that is the appropriate delivery vehicle. Where a physical hub is not the appropriate solution, for example in rural areas, then plans need to include alternatives such as digital solutions
Shared estates strategy	• Develop an **ICS infrastructure strategy** which sets a clear expectation that system partners will work together to utilise the public estate and community assets to deliver the priorities of this Primary Care Strategy and support primary care resilience. The ICS infrastructure strategy will aim to describe opportunities to provide primary health care in alternative settings • The ICS infrastructure strategy will have a clear expectation that both same day access hubs and Integrated Neighbourhood Teams should **make use of the best available public estat**e. 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
Improve Partnership working	• 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 (One Public Estate). • Ensure that the **voice of primary care i**s present and heard at place, to represent the needs of primary care in relation to estate and advise on how local systems can best support its development. In particular, Local Councils should involve ICB and primary care providers in discussions about planning and the best use of developer funding

1. BOB ICS Green Plan [2022]

Enablers: Resources

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. As part of this we will consider our approach to resources, contracts and working at scale so that it supports resilience in our providers but also benefits patients; particularly those in areas of higher deprivation and associated health needs.

4. Resources

Work differently	• Create **flexibility regarding location and type of work our staff do**, regardless of who they are employed by. • **Streamline work** between services, such as in optometry with direct referrals to secondary care rather than requesting referrals through General Practice
Contracts	• Contracts offered at individual business unit level unless a compelling reason to commission at scale, with the aim of giving partner organisations more **financial security t**o attract core clinicians. • Consider **flexibilities around contracts** that enable risk sharing or innovative services e.g. options for GPs to hold their core contracts in limited companies and dental surgeries to maximise the NHS offer. • **Expand flexible commissioning models** in dentistry where possible, to improve access and provide care to specific groups • **Develop local contracts** that can meet the needs of providers in areas of greater deprivation and health inequalities where their finances may be negatively impacted by the national funding formula, and it may be difficult to attract clinicians.
Shift funds to communities and enable more prevention	• Commission services that **consolidate funding** to support providers working together to deliver the best outcomes for a defined population. • Consider **outcomes-driven payment schemes** and financial incentives that promote integration and support services to go beyond illness support and **focus on prevention and keeping people well** in the community longer. • Follow the examples of international systems to invest more in community-based support and shift budgets to alternative settings which are more cost-effective if provided in the community setting.
Invest in strong foundations	• Prioritise **investment in infrastructure** including technology upgrades, facility maintenance, and equipment purchases, where able, to support efficient and effective service delivery, including digital communication such as text message solutions and remote support. • **System wide consideration of the impact** of changes (project, pathway or policy) on system partners including primary care.

Enablers: Partnership working

Close partnership working across all system partners is important in driving the implementation and delivery of the primary care strategy. We would like to see health and care services across BOB operating in an integrated manner with clinicians and organisations collaborating to provide seamless high-quality care for patients. By improving the primary care interface with acute care; community care; mental health; social care; our voluntary sector as well as relationships across each of General Practice, Pharmacy Optometry and Dentistry we will enable more joined up care and improve the patient experience.

6. Partnership working

Within Primary Care (general practice, pharmacy, optometry and dentistry)	• Promotion and use of the **Pharmacy First scheme** to improve access for patients and release appointments in general practice. • Enable **digital referrals between the four pillars of primary care** (general practice, community pharmacy dentistry and optometry). • Creating a sense of **shared responsibility for aspects of health** e.g. dental hygiene and impact on general health and wellbeing, opportunistic health screening e.g. blood pressure readings. • Making the most of **skills and capacity in different providers** e.g. optometry to receive referrals and treat minor eye conditions where there is no other service providing this in primary care
Between general practice and Acute Trusts	• **Implementation of national guidance** to improve working across primary care and secondary care [1]. • Share learning and experiences across providers to build a strong culture of co-operation and integration • Develop **pathways of care around the patient experience** e.g. whole system prescribing and system wide shared care monitoring systems • Develop an educational tool for use across primary and secondary care to improve working across the interface
Utilising system partner strengths acr oss the system	• Use **system partner expertise** to assist primary care where there is a lack of capacity or skills • Develop alternative services which support providers for when the system is under pressure or when providers collapse
Enable transparency between system partners	• Enhance local system understanding of the current state of primary care and capacity to manage patient demand, by facilitating the uptake of relevant tools e.g Local and National OPEL systems and practice 'Temperature Check'. Use this information to provide support options.
Patients & Public	• When designing patient pathways, where possible **co-design and produce pathways together with patient** representatives Co-production • As models of care evolve, develop **communication and engagement plans together with patient groups** to share how the of accessing services, for example, may be adapting

1. AOMRC: General practice and secondary care Working better together [2023]

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Primary Care Strategy will have a wide impact

The Primary Care Strategy recognises the challenges and aims to address them. The strategy also recognises the connections with other parts of the system and the impact our primary care teams have within our diverse communities. Therefore, the strategy is ambitious to have a positive impact on our local populations and patients, with our local primary care providers, and across the wider whole health and care environment in BOB.

Our Primary Care Strategy will support:

Patients and communities

Primary Care providers

BOB health and care system

The impact our strategy will have:

- A more positive experience of using our primary care services
- A more proactive and preventative approach to health
- More joined up support across organisations to get the right care first time
- Patients included in shaping how we make improvements

- Increasing sustainability and resilience of our primary care services
- Involving the right professional at the right time
- Stronger relationships between our primary care organisations and other health and care providers
- Prioritised and targeted investment in primary care provision

- More coordinated services in communities, close to where people live and work
- Preventing the escalation of people's care needs and reducing their use of more acute services
- Using data and information effectively across organisations for improved decision making
- More collaborative working between organisations to reduce waste and avoid duplication

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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.

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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. We will also implement each element with environmental sustainability in mind, as the co-benefits of environmental sustainability such as increasing efficiency and low carbon treatment, are pivotal to a more generally sustainable healthcare system. Some of our aspirations are ambitious and will be dependent on our system's financial position, which we will seek to prioritise as far as we are able. 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 System Delivery 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, and service set-up is different in each Place in BOB. Principles that we will use when testing models at Place-level:

- ✓ We need to ensure the detailed design of the model of care happens at Place and neighbourhood level
- ✓ We cannot implement a "one size fits all model" - each Place will need to test what works locally
- ✓ Each Place to identify key priorities and outcomes it will measure and monitor

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 and communicate with the public and stakeholders on how the care model is evolving. 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.

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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 People get to the **right support first time** to meet their needs

2 **Joined up, personalised, proactive care** for people with multimorbidity and complex needs

3 Support to **help people stay well**, **prevent ill health** and minimise the impact of poor health

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 care is non-complex and may not necessarily require a GP yet this work 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.

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 multimorbidity and 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.

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.

John Hopkins ACG System

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

BOB Size of Prize 2023

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Priority 1

Non-complex same-day care

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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 [UTIs]. 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 is an evolving model of care and as it does so the ICB will ensure that the public are clear on how they can access services.

This way of working is emerging in parts of BOB and is in-line with the 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 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, the public and staff working in multiple clinical areas may benefit from some consistent features. Ongoing engagement with the public will be critical to how the model of care evolves and can be accessed. Some potential features of the model are summarised below.

01

Patient to request same day care in a way that suits them - on their GP website/app, NHS app, telephone, by walking into their Community Pharmacy or calling 111.

02

Patient information is collected via an online form to support triage and clinical decision making – this could be a standard form across a neighbourhood and completed by the patient, or practice receptionist or care coordinator.

03

Triage (the sorting of patients according to the urgency of their need for care) is undertaken once – either by the practice, 111 or a same day access service.

04

Patient Segmentation - Digital tools that use patient data to understand health risk will be used to support triage and clinical decision-making.

05

Triage will determine in which healthcare setting you will be seen - if triaged as benefitting from **general practice care,** the patient will be booked directly and will not need to make a new request.

06

Triage will determine in which healthcare setting you will be seen - if triaged to be seen **outside of general practice** (Urgent Care/Treatment Centre, community pharmacy, dentist or optometrist), agreed clinical pathways will be used to ensure patients are booked in to the right service directly with accompanying clinical communication.

07

Same day general practice access could be resourced by multi-skilled staff from practices and the wider system, who will contribute staff by agreement, potentially based on list size. Face to face as well as virtual appointments should be offered. This could be in existing estate by rotating around practices, or in an existing dedicated space if available.

08

Documented Standard Operating Procedures and Clinical Governance could be used for same day access as agreed with practices and/or partners

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Priority 2

Integrated Neighbourhood Teams

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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 are 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 starting with a focus on one defined population cohort. 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.

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.

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 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.
- Reduced demand for GP appointments will avoid **unnecessary carbon emissions**

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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 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. Mental Health services and Local Housing Associations.
- Actively involve and engage the local community in planning and decision-making to ensure services align with population needs.
- Have a designated clinical lead with protected time.
- Have other specialist teams 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 or weekly 'huddle' - where patient notes are reviewed, next steps for priority patients discussed and plans for home-visits agreed.
- Data is used to identify the people who could benefit the most from the service, and lists of patients are regularly reviewed together across services
- Any community-based care that is required for patients should be allocated to the most appropriate team e.g. district nursing.
- A shared care plan for people to support more coordinated care.
- Community teams will have regular contact with the clinical lead in the INT to ensure any complex issues are resolved and there are clear escalation paths to resolve complex cases.

Where

- Determine a local footprint for the INTs in each Place, guided by the service pathways and populations served.
- 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

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Priority 3

Cardiovascular Disease (CVD) Prevention

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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.

BOB Joint Forward Plan (2023)

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.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3

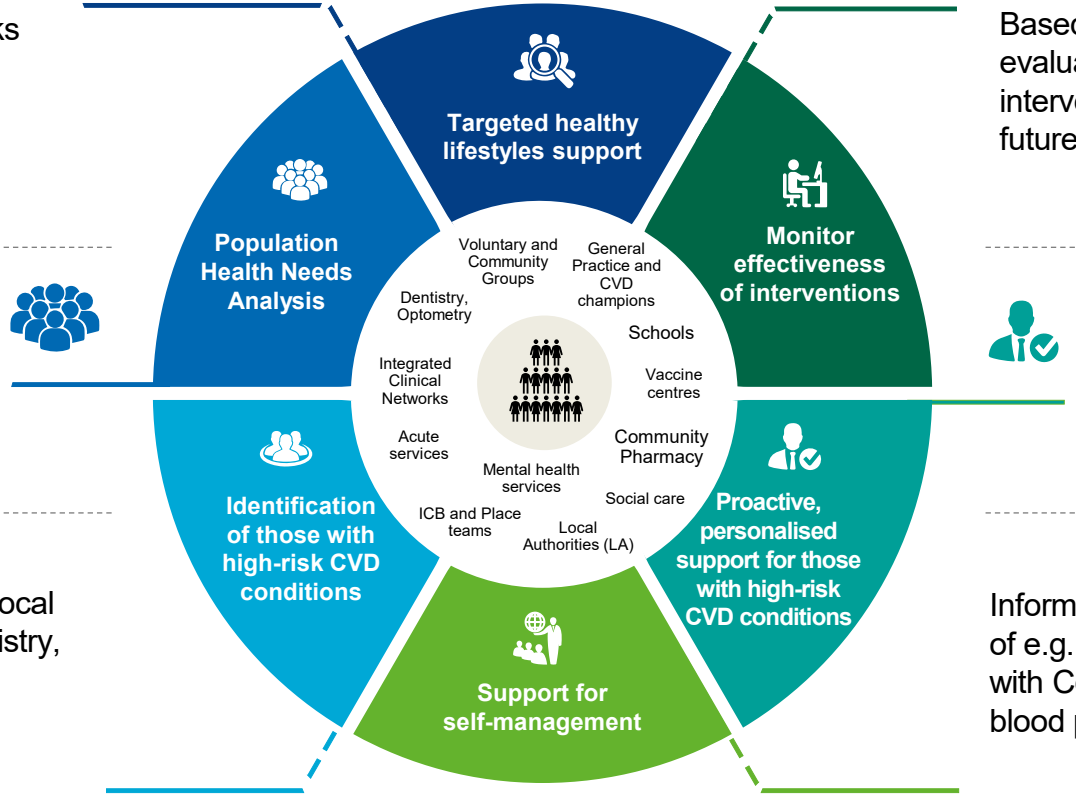
Example future integrated local approach to CVD prevention

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, Local Authority 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 Local Authority, 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.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Environment for Change

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 set out how we will track progress and know we have made a positive change for our population and our staff.

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Action plan to establish the Primary Care Delivery Programme

For each of our three priorities, we want to work with all partners in primary care in a new way, utilising the bottom-up continuous quality improvement approaches that we know drive change and make an impact. We will take a phased approach initially working with interested cohorts at place to deliver on one of the three priorities that will make most impact. It will take several years to roll out and embed the changes described. Some initial actions are summarised below.

1
- **Establish Place Delivery Teams** to lead this work from summer 2024.
- Place Delivery Team membership is to be determined, but could include primary care leaders, those delivering services in member providers, place directors and ICB primary care team

2
- **Establish the Governance structure,** including any reporting to the relevant ICB and / or place board.
- Consider focus areas, action planning and anticipated outcomes for each of the priorities.

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
3) CVD Prevention

4
- Place Delivery team and Placed-based Partnership to hold launch event of the **Primary Care Strategy Delivery Programme** - to work through 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 Local Action Teams in each Place to take part in **one of the Place's priority focus areas** – 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 teams in each Place to take part in the **second priority** for that Place.

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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ICB and Place support for local delivery

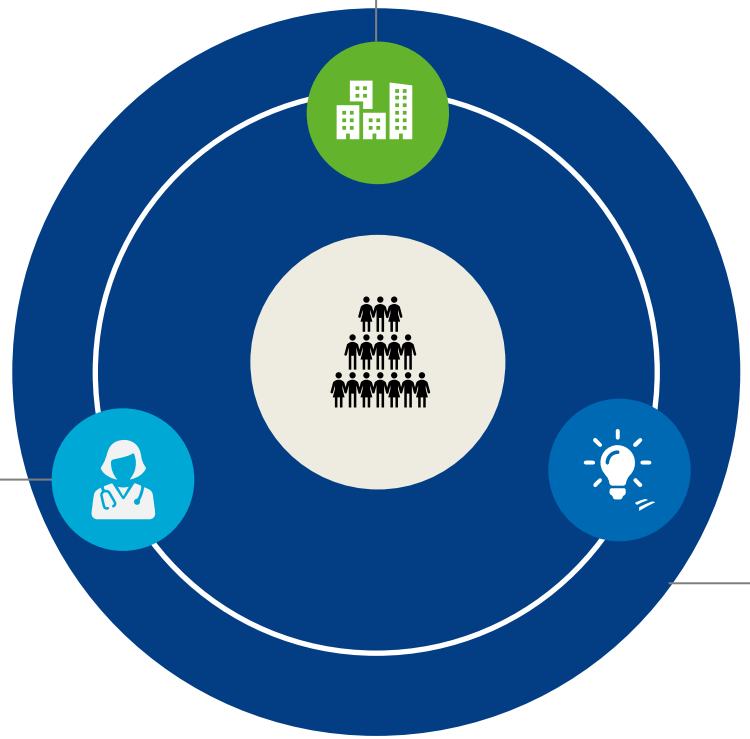
Clinical and operational teams, working with their communities, will be the ones who drive new ways of working. The ICB and Place teams will provide dedicated support to focused Local Action Teams working on our three priorities within an overall primary care Delivery Programme.

Place-level

- Place-based Partnerships are **responsible** 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

ICB-level

- The BOB Primary & 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, Resourcing and Partnership working.

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Working with our local population to deliver change

To support implementation of the primary care strategy we need to work with people and communities across BOB to deliver change. Effective communication and engagement are key to achieving the priorities in this strategy. To help us do this we, the ICB and primary care will seek opportunities to engage at the most effective geographical level, whether this be system - in other words, across the whole BOB population, at Place or at local neighbourhood level through Primary Care Networks and individual services.

We want to work differently with our people and communities going forward to ensure they are involved in the design of services and indeed communication campaigns directed at them.

1 Co-production

- Build effective relationships with the people and communities we serve and support the creation of an environment where the voices of stakeholders can be heard as part of the design process at the most appropriate level (neighbourhood, Place or system).
- Work with people and communities who use primary care services in equal partnership and engage groups of people at the earliest stages of service design, development and evaluation.

2 Communication

- Raise awareness of the new primary care strategy and ensure people are aware of further opportunities to participate in its implementation
- Co-produce communication campaigns to raise awareness of:
  - New roles within primary care
  - How to access to the right care at the right time including use of the NHS app
  - What to expect from each pillar of primary care
- Work with system partners to identify and focus communication with people who would benefit from support to change behaviours that put them at more risk of CVD
- Work with local authority partners and public health to raise awareness of health promotion and prevention in schools and encourage healthy habits in our younger population

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Enabling a clear mandate to deliver

We will build a strong delivery infrastructure that empowers frontline teams to own, design and deliver changes to their models of care, and enables the ICB to mobilise resources and unblock issues across the system. Below is an example of how accountability and responsibility can work between ICS partners but is dependent on further discussion and consensus during the mobilisation phase.

Level	Accountable	Responsible
ICB **Holds overall accountability for delivery of system transformation**	**Primary & Community Care Strategic Transformation Coordination Group** • 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 with the Primary Care Strategy	**Primary Care Team** • Delivery of overall plan: - With Place-based Delivery Teams for Model of Care - With ICB leads for Enablers - With GP and POD leadership group • 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** (representative group of different place-based provider staff able to influence and act with support from ICB Primary Care team) • 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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How we will know we have made a difference

Whilst the whole system embarks on this transformation journey, we need a way to regularly monitor progress against our priorities. Where possible we will look to simplify and combine outcome measures and incentives, using those already in existence and ensuring simple mechanisms for data capture.

Where additional measures would add value, they must align to the following design principles:

Codesigned	We will work collaboratively across the system with partners and patients to agree metrics upfront.
Timely	Metrics will be agreed prior to launch of a change project to understand measures of success from the outset.
Meaningful	Success may not just be determined by the increase or decrease of a particular measure but may be compared against a baseline position or control group.
Simple	To capture, with a few indicators that show the highest impact areas and guide the transformation efforts.
Comprehensive	With a mix of qualitative (process and outcomes e.g. ED performance) and quantitative (patient/staff experience) measures.
Analytical	Statistical Process Control (SPC) and similar tools will be used as appropriate to understand variation.

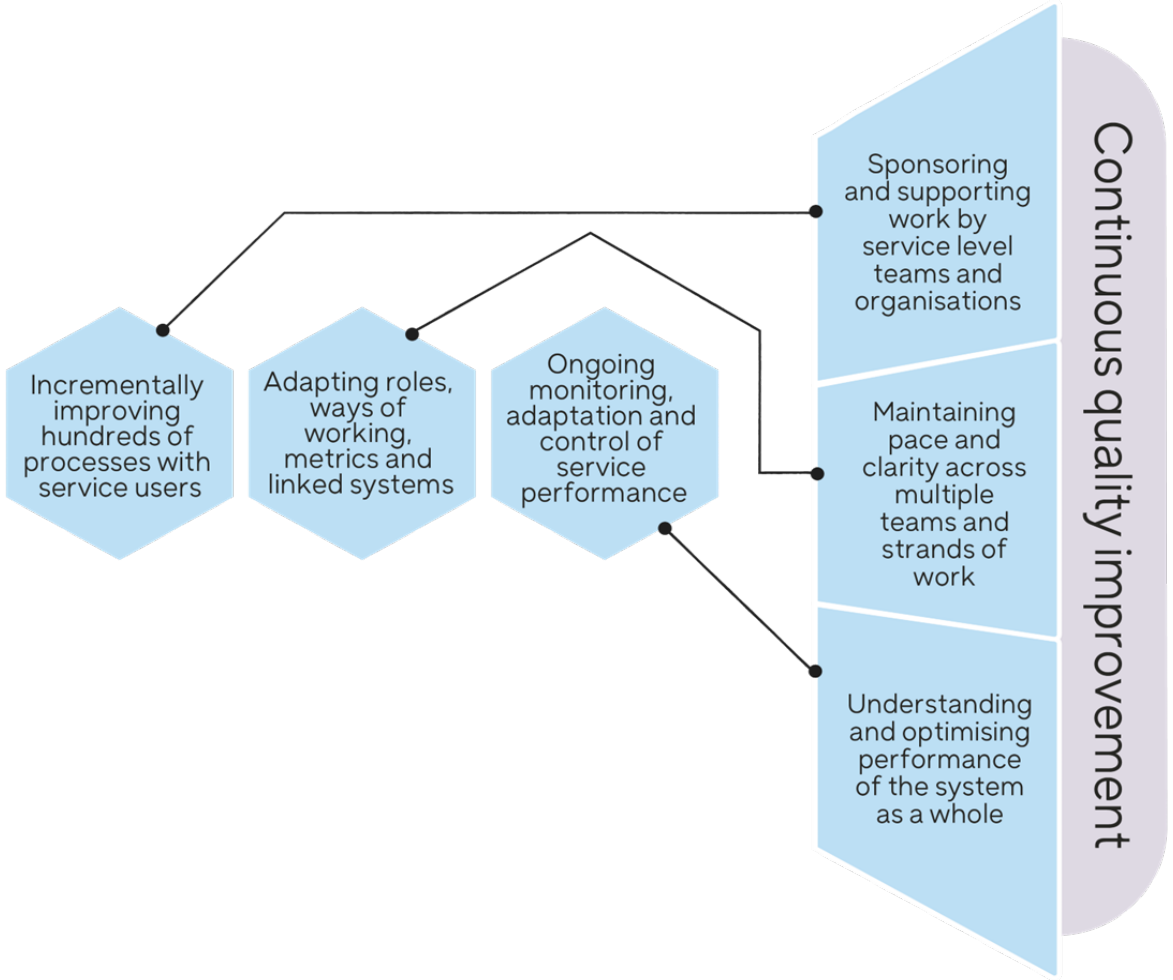

Diagram - taken from Improving across health and care systems: a framework, The Health Foundation (2023) - slide 55

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Known measures - Priority 1 & 3

Below are some of the existing measures that are in place influenced nationally through the Primary Care Access and Recovery Plan (PCARP), Quality Outcomes Framework (QOF) and others. These metrics are for guidance and further work will be carried out to ensure that they are appropriate, defining alternatives and identifying where there is data to support.

Outcomes	Current Measure	Where we are today	Where we will be by 2025	Where we will be by 2027
Priority 1 - People get to the right support first time to meet their needs	1. Pharmacy First consultations [commenced 31 Jan '24] * 2. No. of self-referral pathways accepting referrals 3. Improve patient experience of accessing primary care services ** 4. Use of NHS App 5. No. of unique adult patients seen by an NHS Dentist 6. No. of unique children patients seen by an NHS Dentist 7. Improve capacity in primary care to enable those who need it most to be seen with easier access***	2,000 / month* 57% TBC** 60% 490,000 215,000 TBC***	4,000 / month* 85% TBC** 65% 515,000 225,000 TBC***	5,000 / month* 100% TBC** 80% 528,000 235,000 TBC***
Priority 3 – Supporting people to stay well, prevent ill health and minimise the impact of poor health, CVD Focus	1. People 18+ with hypertension managed to treatment target 2. Cumulative decrease in CVD-related adverse events: heart attacks [MI] and strokes [CVA] 3. Increase referrals to NHS Diabetes Prevention Programme 4. Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies 5. Increase in NHS health checks**** 6. Increase in number of people identified earlier with hypertension****	66% 82 fewer MI 124 fewer CVA 4,464 / year 55%	70% 121 fewer MI 181 fewer CVA 4,700 / year 58%	77% 210 fewer MI 313 fewer CVA 4,900 / year 60%

*There were 11,000 CPCS consultations in 23/24
** Metrics to be developed with new benchmarking surveys
*** Metrics to be developed with primary care partners
**** These are system-wide targets and require further discussion. We will partner with Public Health colleagues as well as primary care to determine a baseline and a trajectory for these measures

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Measures for development – Priority 2 & Sustainability

Outcomes	Considerations	Indicative Measures
Priority 2 – Joined up, personalised, proactive care for people with multimorbidity and complex needs, INTs	For INTs, the outcome ambition will be dependent on the population identified; their needs, and type of service developed to support them. As such any measurement of outcomes and data to create a baseline will be dependent on that group. Therefore, we will not have an established baseline in the same way as we do for same day access and prevention, but rather will have a menu of measures and outcome options that INTs can choose to focus on, allowing the form and function of the INT to be determined locally but with guiding outcomes to achieve. The INT outcomes will be focused around: 1. Increased proactive prevention services and care to keep people well for longer, rather than waiting for illness to set in 2. Levelling up of outcomes e.g. people in deprived areas to experience better outcomes, equivalent to those in other areas 3. Reducing the need to access emergency or other unplanned health services because patients are provided integrated, personalised care in the community setting	These outcomes may look like the below and will be determined at Place and by service. 1. Increase in preventive service provision for target population 2. Proportion of people with long term conditions with shared care plans and increased enablers for the improved sharing of those care plans 3. Reduction in unwarranted variation in population outcomes 4. Increase alternative services to reduce emergency admissions 5. Reduction in emergency admissions for target population
More sustainable and resilient primary care	Whilst the BOB system like other parts of the country is under significant pressure in terms of workforce, funding and estates etc, supporting a more sustainable system is going to be critical to the delivery of the strategy, ensuring strong foundations so that primary care can thrive, and our population receives high quality care. Measuring sustainability will require further engagement with system partners to determine the priority areas that we want to impact and monitor and will be built into the delivery plans. Areas that we may choose to focus on could include: 1. Workforce – Making primary care a good place to work, recruiting and retaining staff; staff satisfaction with their work; fewer sickness absences and newly qualified leavers 2. Funding – shifting resource from acute providers to the community to invest in keeping people in the community for longer 3. Estates – efficient use of space for staff and services to support our growing population 4. Efficiency – reducing the administrative burden on providers so that teams have more time with patients	These outcomes may look like the below and will be determined at Place and by service. 1. Clinician (incl GPs) retention and growth rates 2. Patient overall satisfaction with primary care 3. ARRS % budget utilisation 4. Sickness absence rates 5. Leaver rates among newly qualified staff 6. Retirement rates 7. Higher proportion of clinical vs. administrative average number of EMIS entry types 8. NHS Staff survey (when introduced for primary care)

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 Activity
UTC	Urgent Treatment Centre
VCSE	Voluntary, community or social enterprise

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Terms explained

Term	Explanation
Additional Roles Reimbursement Scheme (ARRS)	A financial scheme that enables Primary Care Networks (PCNs) to recruit additional complimentary professional healthcare roles into their existing workforce to expand its capability and capacity. The roles eligible for funding include clinical pharmacists to social prescribing link workers.
Cancer Standards	Faster diagnosis standard (FDS) – A diagnosis or ruling out of cancer within 28 days of referral (set at 75%) 31-day treatment standard – Commencement of treatment withing 31 days of a decision to treat for all cancer patents (set at 96%) 62-day treatment standard – Commencement of treatment withing 62 days of being referred or consultant upgrade (set at 85%
Co-morbidity	The presence of two or more diseases or medical conditions in a patient.
Complex needs	A term used to describe the health and care needs of individuals who often have multiple requirements often as a result of a single of multiple disease states
Connected Care	A digital care record system which contains information held at GP practices, hospital departments, community services, mental health trusts, out of hours services and local authorities. Supporting the identification of patients, and groups of the population, who could benefit from additional support or a different approach
Core20PLUS5	Link here. An NHS approach to informing and taking action to reduce healthcare inequalities in the most deprived 20% of the population (CORE20) and the PLUS population groups including ethnic minorities, inclusion health groups, learning disabilities, those with multimorbidity and protected characteristics etc. The approach defines a target population group (Core20PLUS) and then identifies 5 focus clinical areas requiring accelerated improvement (maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis and hypertension case finding).
NHS IMPACT	NHS ImPaCT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. By creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients and give better outcomes.
Operational Pressures Escalation Levels (OPEL)	The NHS system used to effectively understand and manage day to day variations in demand and capacity across the health and care system, where OPEL 1 is low level pressure on NHS services and the system is functioning normally and level 4 is high pressure requiring additional intervention and action.
Opportunity Bucks	The Buckinghamshire Local Authority programme to improve opportunities for people in underperforming areas of Bucks in response to the Levelling Up White Paper published in February 2022 that sets out 12 national missions designed to improve everyday life and life chances across the UK.
Patient Segmentation	The use of health and care data to divide a patient population into distinct groups based on specific needs, characteristics, or behaviors which then allows care delivery and policies to be tailored for these groups
Population Health Management [PHM]	A data driven tool / methodology that brings together data to understand and identify specific patient populations including their state of health and some of the factors that may drive this, so that health and care systems can design and prioritise particular services to support these.
Primary Care Network (PCN)	Groups of practices working together to deliver patient care to the local population who often have shared characteristics and supporting health and care services.
Quality & Outcomes Framework [QOF]	A voluntary annual incentive programme for general practice aimed at resourcing good practice. It looks at disease prevalence and markers of care quality known as indicators.
Triage	Sorting of patients according to the urgency of their need for care.
Units of Dental Activity (UDA)	The unit of payment / value given to a course of dental treatment. E.g. simple course of treatment such as an examination is 1 UDA. A treatment involving fillings or extractions is 3 UDAs. A course of treatment that needs lab work such as dentures or crowns is 12 UDAs.
Voluntary Community and Social Enterprise (VCSE)	An incorporated voluntary, community or social enterprise organisation that serves communities and is seen as an important partner for statutory health and social care agencies as it plays a key role in improving health, well-being and care outcomes.

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Useful Resources

Resource	Link to Document
Fuller Stocktake Report: Next steps for integrating primary care [2022]	Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)
BOB ICS Green Plan [2022]	04_20220701-bob-icb-board-item-09-green-plan-annex-1.pdf
BOB Joint Forward Plan [2023]	Joint Forward Plan | BOB ICB
Watson Review [2019]	gp-partnership-review-final-report.pdf (publishing.service.gov.uk)
NHS Dentistry [2022-23]	NHS dentistry - Health and Social Care Committee (parliament.uk)
BOB ICB Public Sector Equality Duty [2023-24]	20240319-bob-icb-board-item-12-public-sector-equality-duty-annual-report.pdf
ICB Digital and Data Strategy [2023]	ICS Digital & Data Strategy - May 2023 (icb.nhs.uk)
AOMRC: General practice and secondary care Working better together [2023]	GPSC_Working_better_together_0323.pdf (aomrc.org.uk)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Thank you for reading our strategy.

We are grateful to all those in the BOB Integrated Care System who have helped to shape this document and look forward to working with you to deliver on this vision.

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.

Susan, aged 82

- 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.

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.

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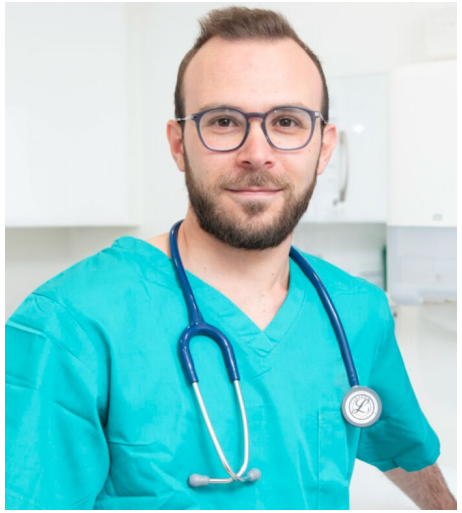
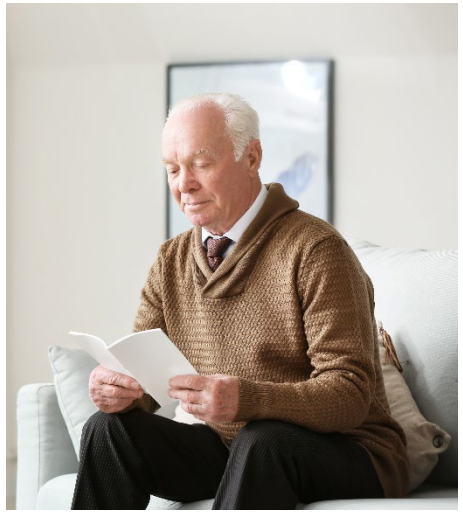
How will it feel for primary care staff?



General Practitioner (GP)

- I have had a mixed week with a higher level of complexity overall but no more than 12 consultations per session. This has enabled me to see all the patients that need to be seen with sufficient time for each one whilst not needing to work significant additional hours.
- 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 sub-specialise 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 support community initiatives to improve the health and wellbeing of my patients.



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 simpler 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 work with a multidisciplinary group of professionals to build personalised care plans for individual local frail elderly residents who we are managing closely to prevent them going to hospital.

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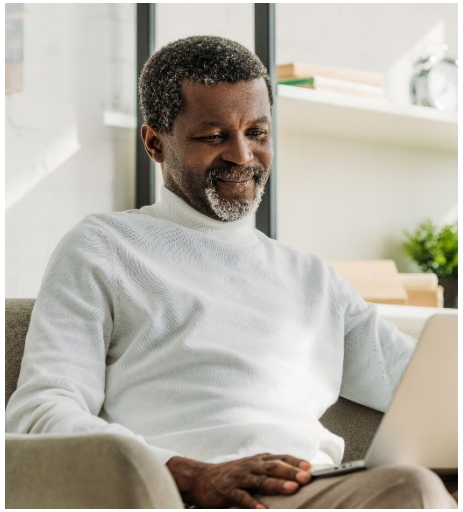
How will it feel for primary care staff?



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 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

Continued focus on service improvements in primary care

Our three priorities centre on those areas where we need a system-wide focus to tackle the biggest challenges. There are other areas where work is being 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 several areas below.

General Practice

- Support the public to **optimise use of the NHS app;** to view their medical records, order repeat prescriptions, manage routine appointments and see practice messages.
- **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 and 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 the **Pharmacy First initiative in 2024** so patients can access some prescription-only medicine without needing to visit a GP e.g. for UTI treatment.
- Upskilling of community pharmacists so more **can provide assessments of patients and make prescribing decisions** without patients having seen their GP first.
- Explore the e**xpansion into further services** e.g. vaccination (flu and covid), blood pressure management.
- **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

- **Implement an electronic referral platform** which will allow Community Optometrists to send urgent and routine referrals directly to the patients' chosen hospital or single point of access**.**
- **Children and Young people: Intention to extend and roll-out 'in school' eye testing** in all schools from April 2024, with certain schools given priority for the roll-out.
- **National minor eye condition service to be expanded in early 2024** which aims to improve equity and accessibility for patients with most eye conditions

Dentistry

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

Community

- **Expand hospital at home approach and redesigning hospital discharge model** - integrating with Local Councils so more services and care can be moved into the community.
- **Enable patients to have direct access to community services** such as musculoskeletal, audiology, weight management and community podiatry without needing to go to the GP first.
- **Improve community-based support for those suffering with mental health issues** 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' .

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Continued focus on improvements in the care for those with long-term conditions (LTC) and multimorbidity

We need to tackle factors that influence people's health and support individuals to make healthy changes to their lifestyle. Our ambition is to act sooner to help those with preventable long-term conditions, to stay well and independent, and provide quality care for those with multiple needs as the population ages. Below are examples of work currently being delivered.

Cardiac

- **Focus Cardiovascular Prevention (reduce strokes and heart attacks)** Improve hypertension case finding, improve control of hypertension, targeted work with population with health inequalities, increase NHS health check uptake in those with Serious Mental Health & Learning Disabilities, targeted smoking cessation for patients with long term conditions & accessible public education/information resources and better lipid management
- **Heart Failure** – earlier detection, optimising treatment, reduction in hospital admissions & re-admissions
- **Cardiac Rehabilitation** – deliver enhanced Cardiac Rehabilitation, to support after a cardiac event

Diabetes

- **Improve management of Type 2** diabetics and reduce variation through a consistent approach
- **Improve access to Diabetes technologies** (e.g. continuous glucose monitoring and hybrid closed loop systems)
- **Increase NHS Diabetes Prevention Programme referrals** & participation
- **Increase staff training & patient education**
- **Focus management of Type 2 diabetes in young patients age** 18 -39 (T2day)
- **Increase referrals to T2DR pathways** which is the pathway to potential remission for Type 2 diabetics

Respiratory

- Implement **evidence-based model of care** for people suffering from breathlessness
- **Enable early, accurate diagnosis of respiratory conditions** in primary care
- **Expand Pulmonary Rehabilit**ation to support patients with lung disease who experience symptoms of breathlessness
- **Plan for and manage winter respiratory pressure**
- Continue to **develop Long COVID assessment** services for adults and children
- Focus on the **Core20Plus5 population with Chronic Obstructive Pulmonary Disease** driving uptake of COVID, flu and pneumonia vaccines
- **Improve patient education and self-management**

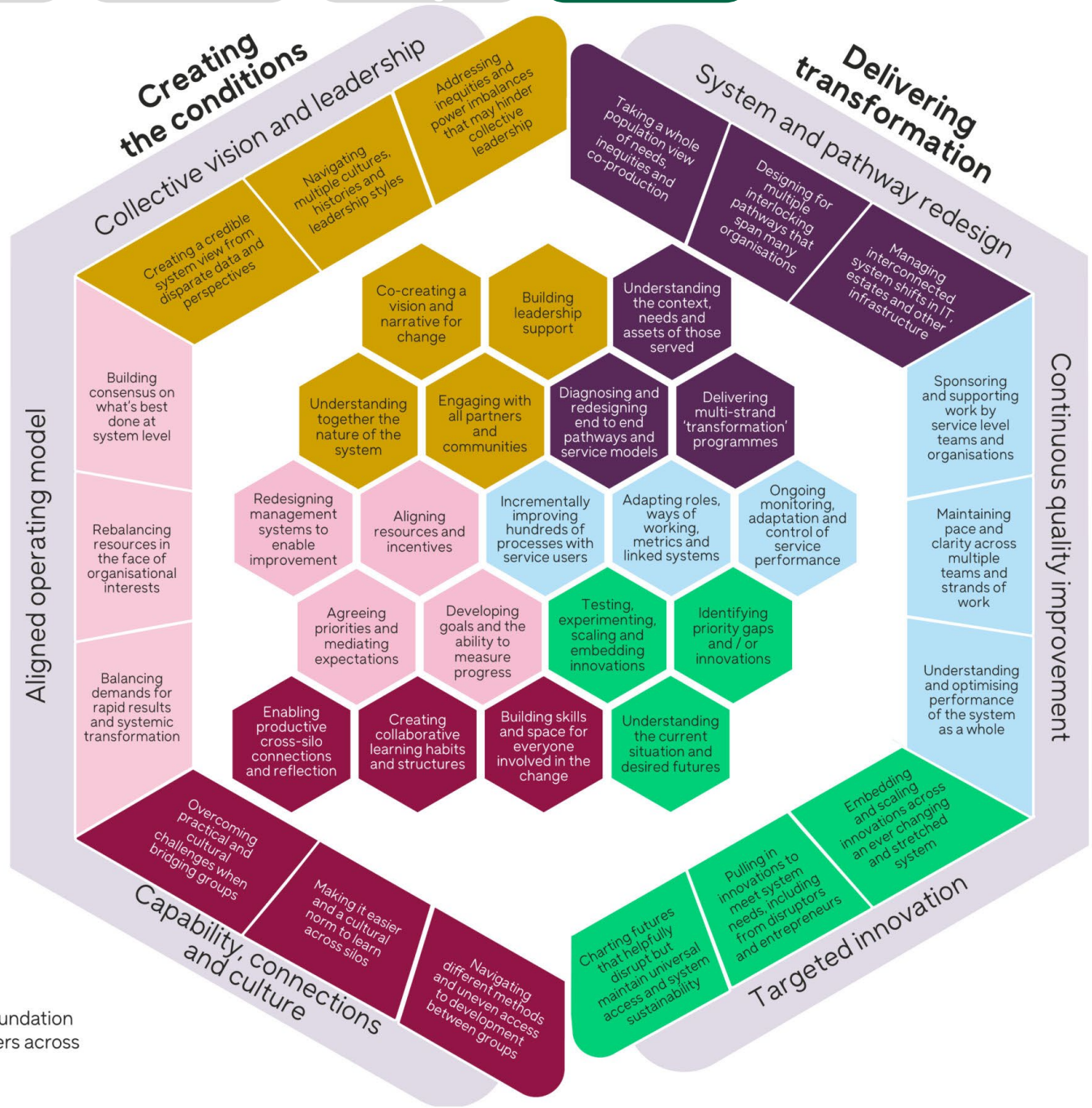
Stroke

- **Reduce unwarranted variation in hyperacute/ acute stroke care**
- Enable 24/7 access to **Mechanical Thrombectomy** (treatment for strokes to remove blood clots)
- **Reduce variation in access to stroke rehabilitation** services- helps restore patients after a stroke to optimal health, functioning, and well-being.
- **Improve Atrial Fibrillation detection** rates (a heart condition that causes an irregular and often abnormally fast heart rate)
- **Improve signposting to smoking cessation** services for stroke patients

Cancer

- **Continue to achieve the national cancer standards**; Faster Diagnosis Standard (FDS) of 28 days, 31-day & 62-day treatment standards - alongside sustainable operational performance
- **Early Diagnosis;** improving access, take-up and awareness of screening programmes and understanding of cancer common signs and symptoms. Reduce inequalities through roll out of targeted lung health checks, supporting PCNs to implement DES, targeting areas of known inequalities & high deprivation, increase screening uptake and primary care education)
- **Treatment plans and personalised care; psychological** support for all patients and early needs assessment to improve access to personalised care interventions, prehab, improve cancer patients experience and personalised stratified follow-up

Improving across health and care systems: a framework



Key

Inner hexagons
Key activity areas
(Relevant to improvement at all levels)

Outer boxes
Distinctive considerations when improving across large systems

The Health Foundation | Q is led by the Health Foundation and supported by partners across the UK and Ireland