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.

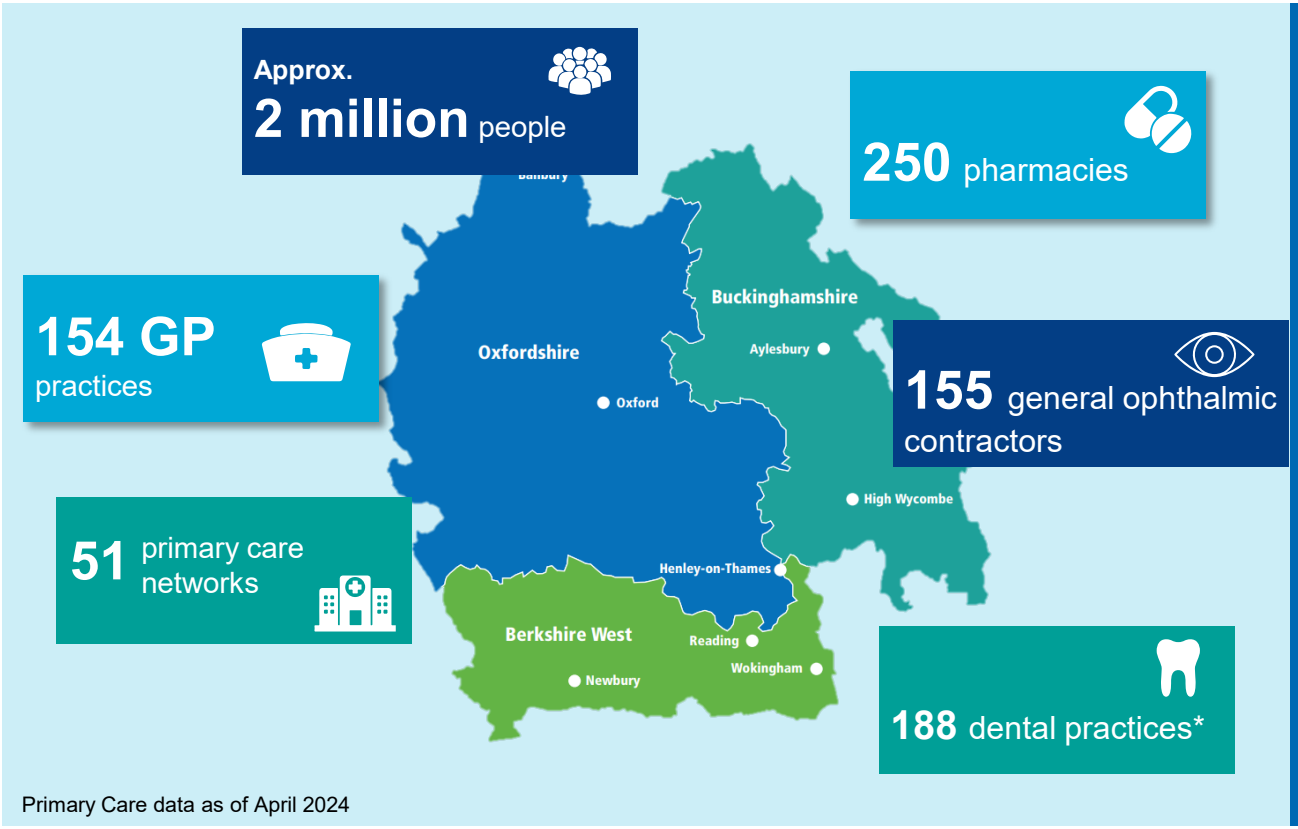
The strategy has been developed through extensive engagement with many stakeholders across the system including those who work at the frontline of primary care. We have listened to and considered the experiences and viewpoints of staff, communities and patients. This valuable feedback has shaped the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

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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

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Primary care in BOB today

In this section we describe the current state of primary care services in BOB. This is based on the engagement 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.

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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)

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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)

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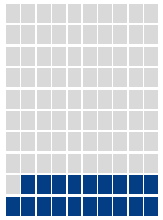
There are challenges within primary care and within the wider system that require new ways of working

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

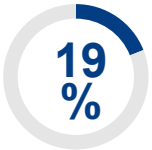
01 People report a worsening experience of accessing primary care



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

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]

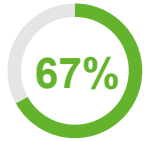
Multiple respondents to the BOB dental survey said they are under extreme pressure due to demand much greater than capacity, lack of funding and recruitment and retention challenges.[4]

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

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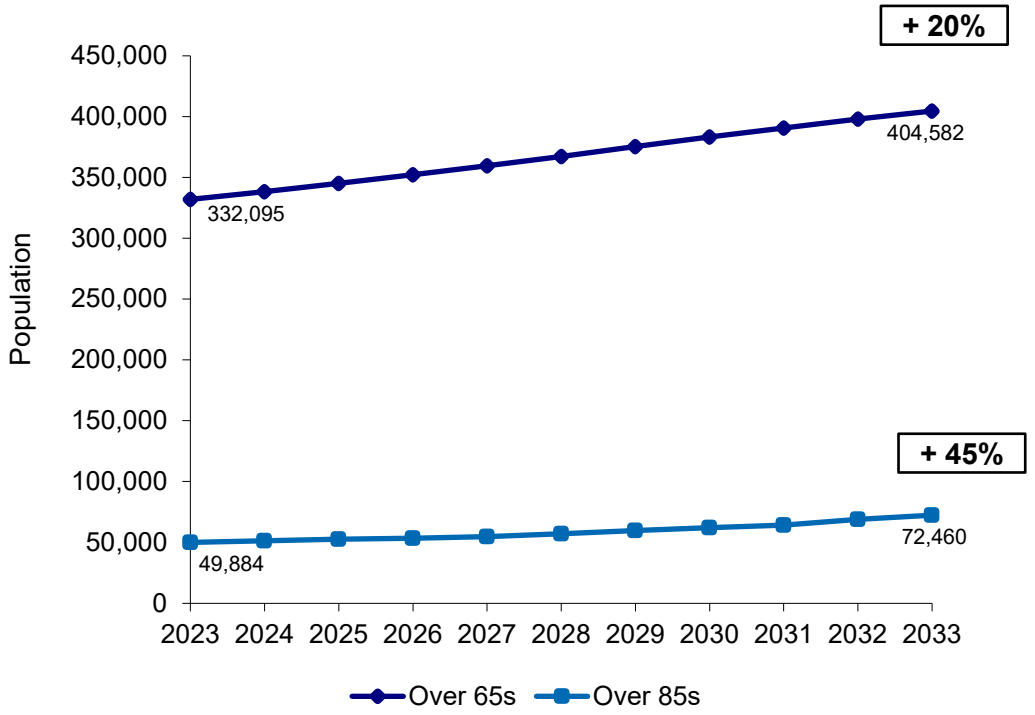
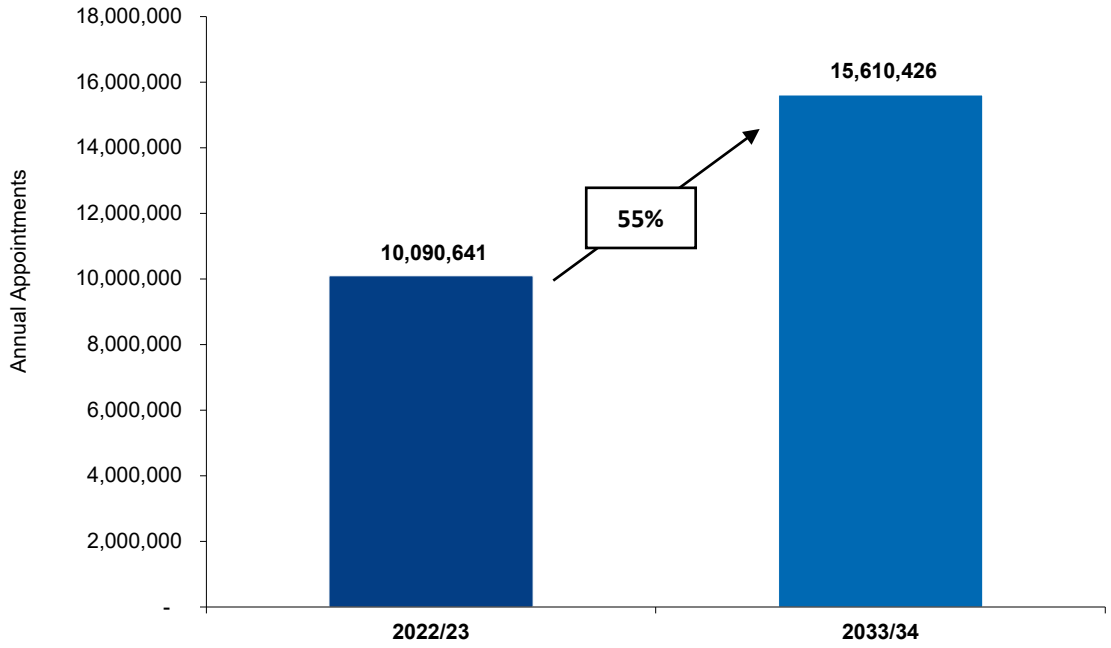
If we do nothing, the mismatch between demand and capacity will continue to grow

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

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



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



KPMG analysis, based on ONS population projections

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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.

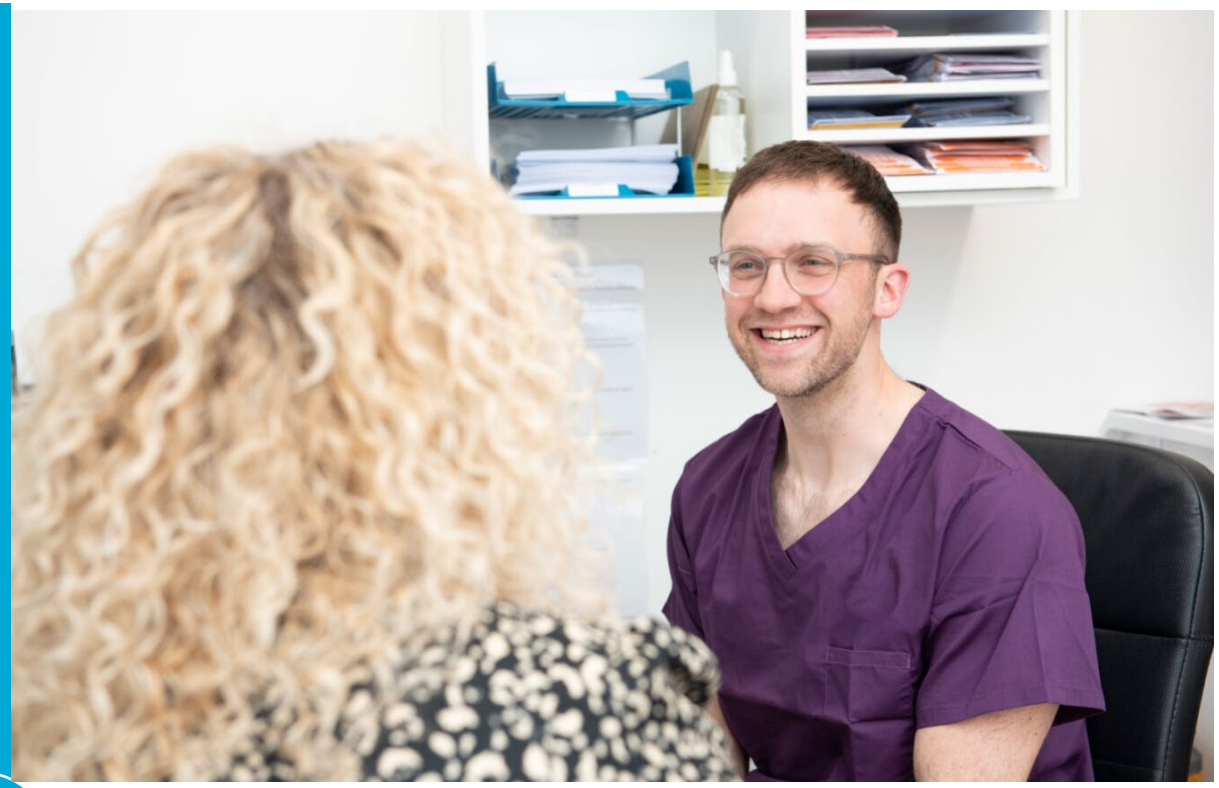
Multiple attempts to make appt for my child. Declined as not urgent. Situation became urgent but receptionist would not escalate concerns. Urgent private appt paid for with another surgery and child found to have [condition] and needed [medication].

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.

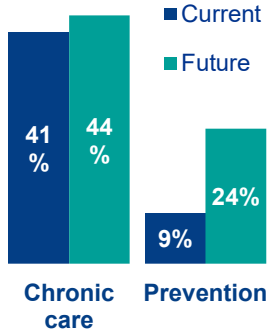
The challenge today – using general practice as an example

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.

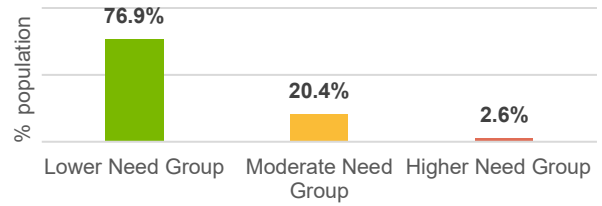
1:BOB GP National Survey (2023); 2: Survey shared with General Practices across BOB as part of Primary Care Strategy work

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

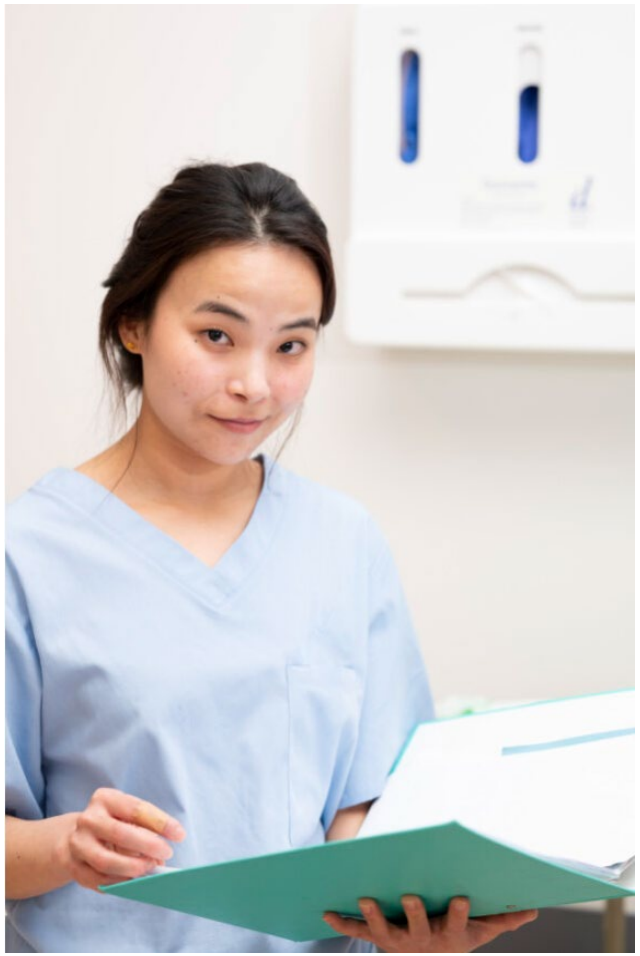
- Brookside Group Practice use data to understand the needs of their population.
- As shown below, 77% of Brookside's population has generally low needs – these people tend to have a non-complex requirement when they contact their GP, for example, a Urinary Tract Infection (UTI).
- Brookside call this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

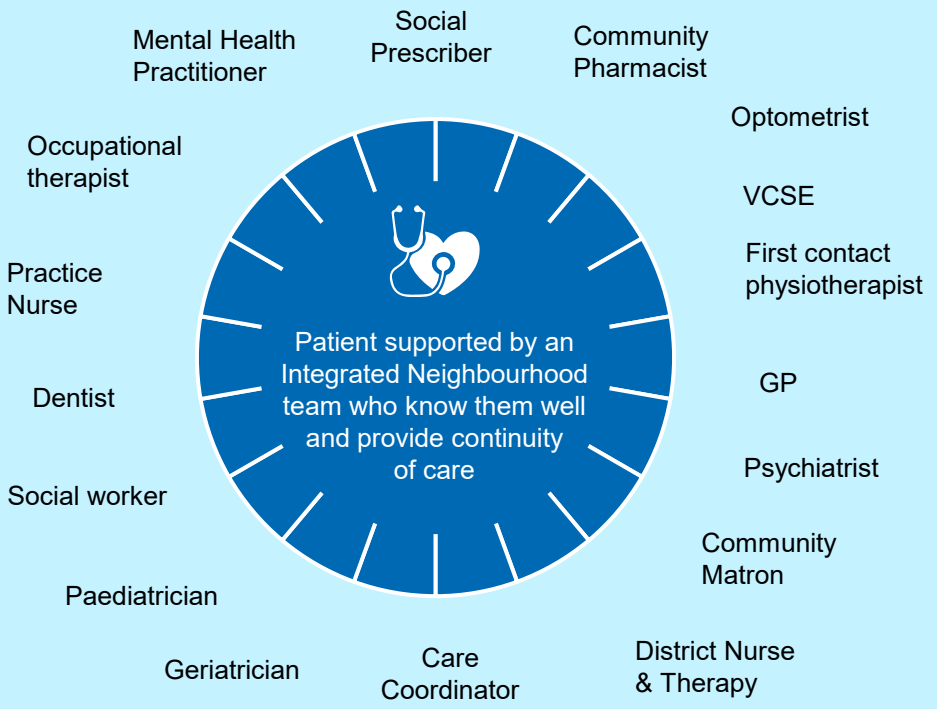
Many issues that affect people's health are not purely medical and require input from multiple parts of the public sector, for example housing, benefits.

"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

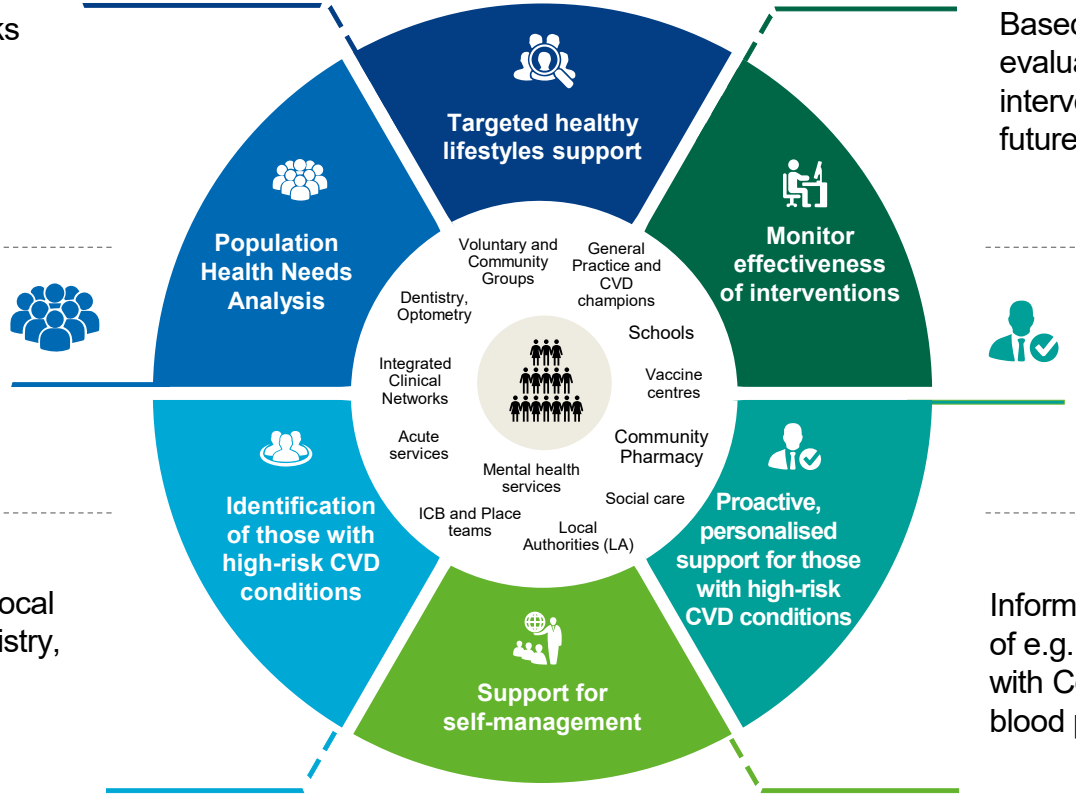
Example future integrated local approach to CVD prevention

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.

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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

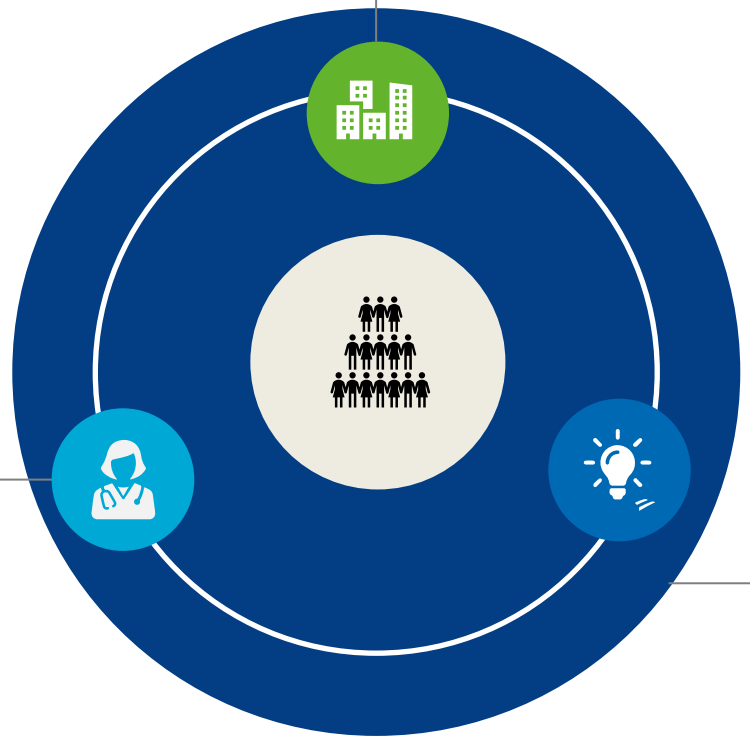
Clinical and operational teams, working with their communities, will be the ones who drive new ways of working. The ICB and Place teams will provide dedicated support to focused Local Action Teams working on our three priorities within an overall primary care Delivery Programme.

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

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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.

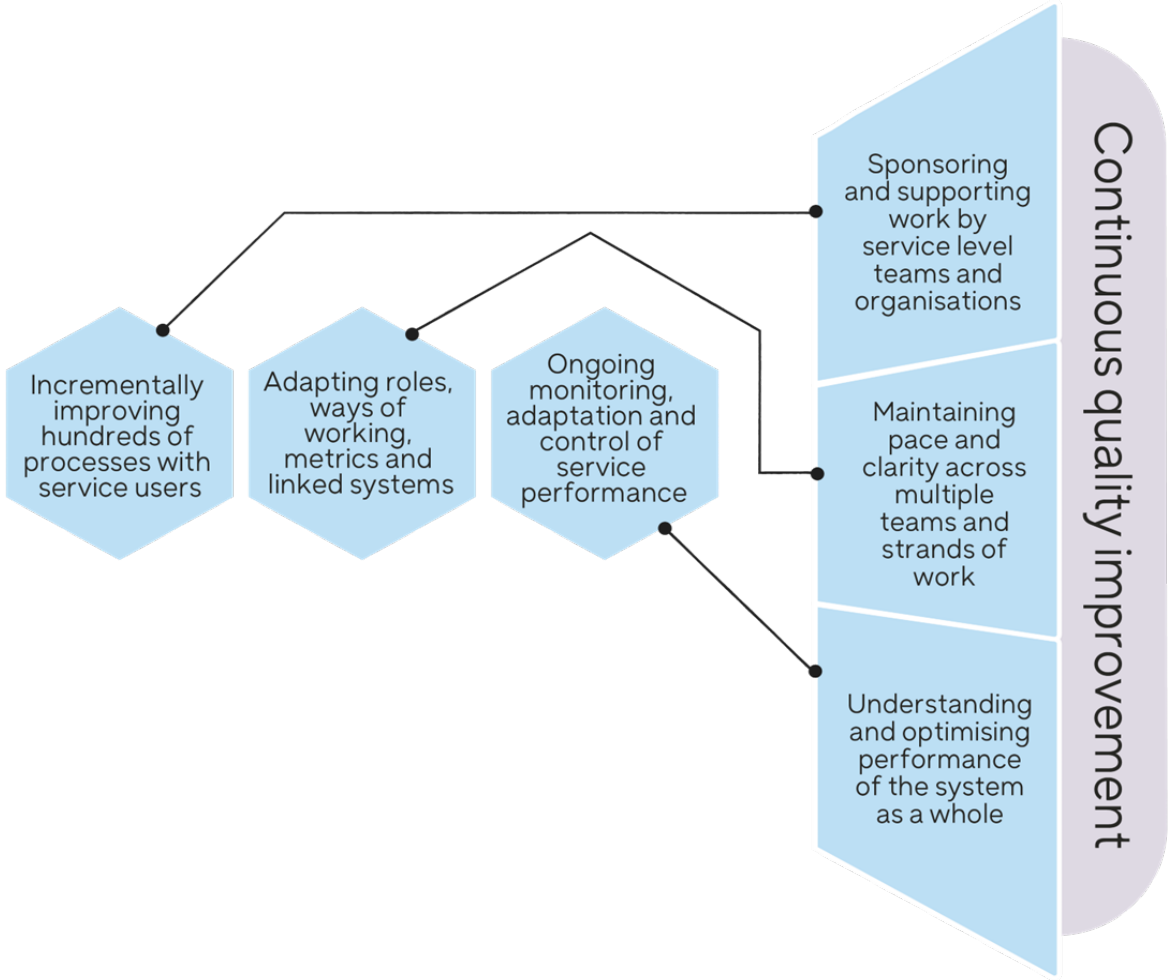

Diagram - taken from Improving across health and care systems: a framework, The Health Foundation (2023) - slide 55

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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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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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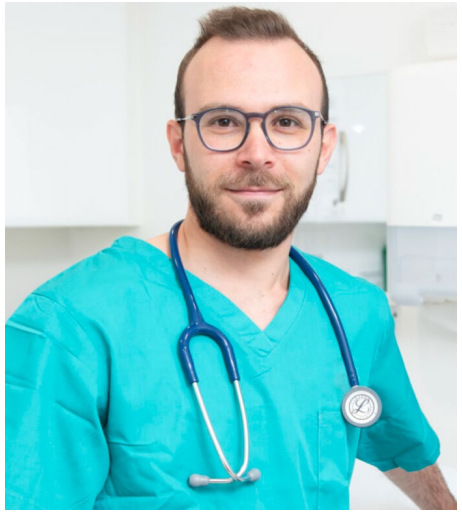
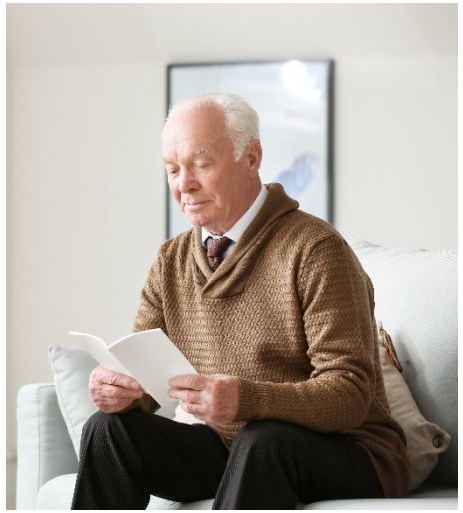
How will it feel for primary care staff?



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.

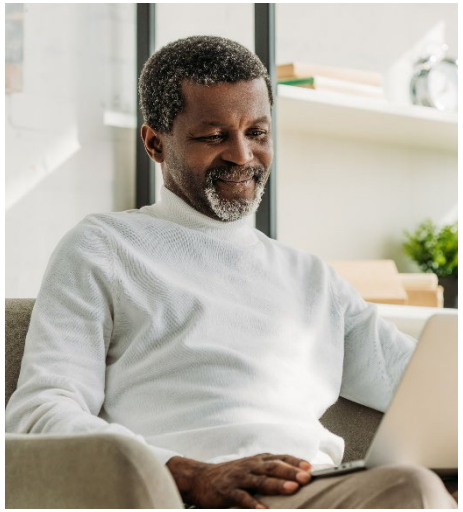


Community Pharmacist

- 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.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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' .

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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**

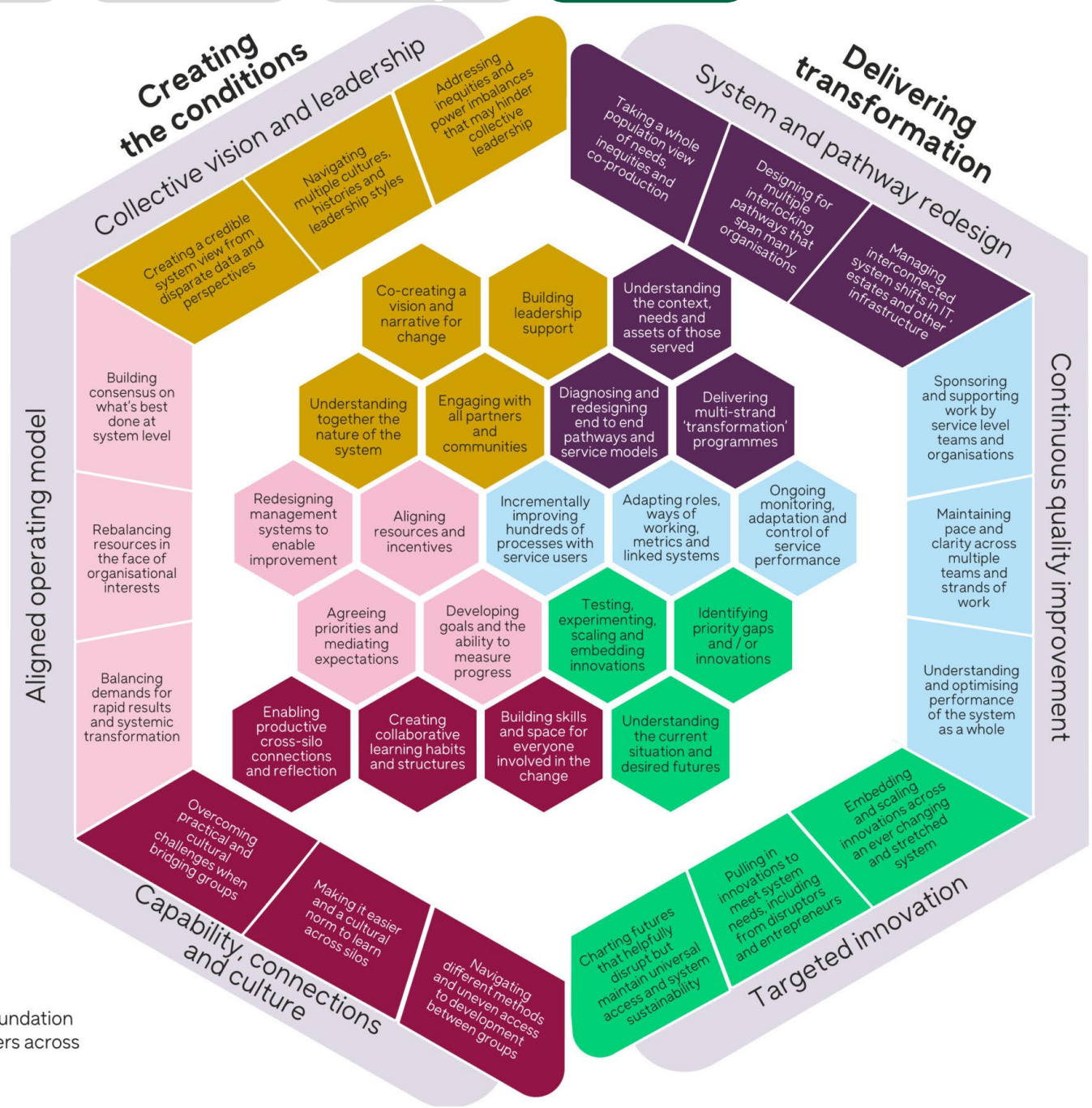
Stroke

- **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

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