BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

BOB System Workshop Outputs

November 2023

Approach and summary

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The BOB Primary Care Strategy system workshop was held on Wednesday 18th October at Adams Park Stadium, with 138 colleagues from across the system in attendance.

The purpose of the workshop was to **build a consensus on the future vision for primary and community care services**.

- The format of the day was a combination of plenary sessions and smaller, facilitated breakout sessions.
- This included a spotlight on current challenges and an interactive panel discussion.
- A key aim of the day was to ensure that all attendees had the opportunity to listen, contribute and share their skills, experience and perspective.
- The **2** break out sessions were focused as follows:

Representatives of the following stakeholders attended:

138

- ✓ Acute
- ✓ Adult Social Care
- ✓ AHPs
- ✓ BOB ICB
- ✓ Clinical Networks
- ✓ Deputy Council CEO
- ✓ Dentistry
- ✓ Community & Community Pharmacy
- ✓ Directors of Public Health
- ✓ Directors of Finance & Strategy
- ✓ FedBucks
- ✓ GPs
- ✓ Healthwatch
- ✓ LMC
- ✓ Nursing
- ✓ Optometry
- ✓ Patients
- ✓ PCN Managers & Clinical
- ✓ Place Directors
- ✓ Region
- ✓ VCSE

1

In the first breakout session, attendees were split into 9 Place-based breakout groups to discuss the Model of Care

- Buckinghamshire
- Oxfordshire
- Berkshire West

→

- Access
- Continuity
- Prevention

2

In the second breakout session, attendees were split into 9 system-wide groups with MDT representation to discuss key enablers

- Workforce
- Digital / Technology
- Estates
- Governance & Finance

Approach and summary

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Attendees had the opportunity to provide further input through a Slido which was available throughout the day.
- Following the workshop all outputs have been collated and themed together – the following slides provide further detail in relation to the 2 breakout sessions.
- The key priorities that were **consistently highlighted in each of the groups** across the breakout sessions will help to inform the development of the BOB Primary Care strategy.

The following key priorities were discussed consistently across the breakout groups:

Consistent and at-scale digital triage approach

Multidisciplinary team approach to patient care and co-location of teams

Expansion of Shared Care Record Agreement to improve patient experience

Strategic & system-wide approach to Population Health Management

More flexible models of working for staff

Better utilisation of estates available in the system

Clearer system level governance that encourages more integrated at-scale working

Attendees were invited to provide feedback on the workshop – to date 17 responses have been received. Key points included:

- 47% said they were extremely or very satisfied, and 53% somewhat satisfied with the System Workshop (with no 'not so satisfied' or 'not at all satisfied' responses)
- Most respondents said they **enjoyed networking with colleagues, understanding issues across the system and well organised breakout sessions** with rich discussions.
- With regard to areas for improvement, many suggested **more patients reps should have been in the room** and the venue.

"There was such open and honest feedback from all involved on the day from panellists to people who feedback from the breakout sessions. Some effective output in terms of the breakout rooms with a good mix of people involved"

Workshop feedback survey

Breakout 1: Model of Care - outputs

Model of Care - Access

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Across Bucks/Ox/Berkshire West all citizens will require same day access to Primary Care services at some point and patients will have different needs. The groups discussed those patients for whom a same day access model would provide the most value and discussed key features for this model.
The following four priorities were highlighted across the three Place-based groups discussing **Access**:

Consistent and at-scale digital triage approach

Across Buckinghamshire, Oxfordshire and Berkshire West, groups noted the importance of moving towards a standardised at-scale triage function, utilising digital technology to risk stratify/segment patients and support clinical decision making,. Additionally, having senior clinical decision making upfront to ensure the right person is seen by the right health and care professional, was seen as crucial.

Improved navigation to Primary Care Services

Simplify and define the complex array of services available in Primary Care to ensure the triage function is able to navigate patients effectively e.g. into Community Pharmacy and other primary care services. Understand and remove barriers between services, establishing clear pathways and protocols and more cross-sector working.

Increase self-management and care

Support local communities to self-manage conditions and collaborate with patients to increase awareness of available services and same-day access points – targeting the communities who find it most difficult to access Primary Care services.

Alignment on the current and future needs of the population

Utilise digital tools in General Practice to gain insights into changes to the local population and demand for services, and appointment trends, and use these insights to predict and better match demand and capacity. Alignment on the current and future needs of the population will enable General Practice to plan resources effectively and coordinate with the wider system to increase/share capacity if required.

Model of Care - Continuity

Access | **Continuity** | Prevention

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Across Bucks/Ox/Berkshire West there will be many patients with Long Term Conditions (LTCs), medical and social complexity who will benefit greatly from continuity in Primary Care. Key steps to consider to ensure continuity of care includes: identification of cohorts of patients with similar needs, assessment and risk stratification and coordinated multidisciplinary management– building personalised care plans and wrapping an MDT team around the cohort & Programme Evaluation.
The following four priorities were highlighted across the three Place-based groups discussing **Continuity**:

Multidisciplinary team (MDT) approach to care

Continuity of a multidisciplinary team was emphasised as an important way of improving continuity of care for patients with long term conditions. Developing a MDT approach that incorporates primary, secondary, social, community care and others' input was seen as central to delivering greater continuity and would help to remove duplication that patients often face in the system.

Co-location of teams

Co-location of MDTs to help break down organisational barriers and siloed working and to improve community-based care. Building strong relationships and having a mutual understanding of system partners' different ways of working and challenges is important and therefore, measures like co-location of teams can have a significant effect. Better use of the NHS estate or other partners' estates e.g. local authorities, can also support more integrated care.

Improve care coordination

Case management of patients with complex conditions to integrate all necessary services around the needs of people with long term conditions. Proactively identify patients with long term conditions, have an upfront GP for clinical decision making of case-level risks and assign a team or individual responsibility for the case.

Expand Shared Care Record

Continue to implement shared care records to enable more integrated working across Primary, Secondary and Community care. Joining up information from across organisations for each individual, will make health and social care planning everyone's business, improve patient experience and the continuity of care provided.

Model of Care - Prevention

Access | Continuity | **Prevention**

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

To develop from a reactionary system focused on treatment towards a truly proactive system that focuses on prevention, a more strategic approach will be required, using Population Health Management to inform decisions about health and care for the population. Key steps to consider to ensure people are able to live a healthy and well life include: 1) Population segmentation and risk stratification of priority cohorts 2) Opportunity analysis of key interventions, 3) Intervention Selection, 4) Implementation of interventions and 5) Commissioning and incentive alignment.
The following four priorities were highlighted across the three Place-based groups discussing **Prevention**:

Increased focus on early years prevention

Groups emphasised the importance of building strong foundations for a person's future health and wellbeing in the early years of their life and therefore wanted to see more focus on prevention for children and young people across the system. This includes support to mothers during and after their pregnancy, with targeted support in the first 1000 days, to educate and empower a healthy lifestyle. Additionally, more focus on dental hygiene for young children.

Utilise Population Health Management data to improve outcomes

Spread the existing PHM tools across the system and support partners to understand their population groups, including those who experience health inequalities. Utilise the data and insights to target resources, design and plan local interventions and empower populations to self-manage their conditions as part of primary prevention initiatives.

Expand community outreach

Building more community outreach capability within the system, involving all health and social care professionals or services, to groups of people who experience inequalities in access, outcomes or experience of those services. Suggestion to test an outreach project using an Integrated Neighbourhood team, evaluate benefits and the potential to scale (if positive benefits achieved).

Working across organisational boundaries

All system partners to increase collaboration and communication with Public Health, Local Authorities, Social Care, Community Care and VCSE. Co-develop a comprehensive strategy with agreed joint prevention aims for their local communities, define success measures and agree communication plans to population groups.

Breakout 2: Enablers – Outputs

Workforce

Key question: ***What are the enabling workforce requirements to support new models of care in the future?***

The following four priorities were highlighted across the **two** system-wide groups discussing **Workforce:**

Joint workforce planning to remove barriers to integrated working

System-wide approach to workforce planning that considers the impact of technology, new models of care and new integrated working patterns that span primary, secondary and community care. Build trusted relationships amongst system partners to increase collaboration and joint planning.

Improve workforce retention through offering more flexible ways of working

Develop flexible models of working across the system, provide remote working opportunities and joint training and rotation programmes. The IT infrastructure needs to support flexible models of working where it currently is a barrier, one group suggested a workforce passport would enable staff to move more freely between roles / locations of work. Other barriers such as cultural barriers also need to be addressed to improve retention.

Utilise existing workforce more effectively to address skill gaps

Central resourcing, talent management and planning to support better utilisation of staff, particularly where the skills needs for roles are not clearly understood. This will support development of the workforce and help staff to feel more valued and improve their experience of working in Primary Care.

Provide greater training opportunities and routes into Primary Care professions

Apprenticeships, international courses, training hubs, fellowships, and foundation schemes were all methods suggested to increase the number of staff in Primary Care. Additionally, there should be structured career pathways and accreditation for all staff across the system, including routes into employment for those working in the voluntary sector.

Digital/Technology

Workforce | **Digital / Technology** | Estates | Governance & Finance

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Key question: ***What are the enabling digital requirements to support new models of care in the future?***

The following five priorities were highlighted across the **three** system-wide groups discussing **Digital/Technology:**

Standardised digital front door which supports both triage and streaming of patients

A standard portal for patients which enables patients to access care across the system e.g. book appointments and also provides health and care information to support patients to self-care. This will also allow effective triaging of patients. This service must be designed with the end user in mind.

Population Health Management Approach

Embed a strategic and system-wide approach that facilitates data driven planning and decision making across all system partners – enabling risk stratification and population segmentation. Develop and establish the right analytical capability within the system to analyse and translate the data and to support PCNs to reach a common level of digital maturity.

Expand Shared Care Agreement

The shared care record provides a more detailed picture of population health needs but needs to be expanded geographically (to include all Places) and technically (to include all service providers e.g. Acute, Community Care and POD). Interoperability within Primary Care is a priority and ICB to encourage uptake of the NHS app to support the sharing of medical records across the system.

Increase the adoption of Electronic Prescribing Service (EPS)

Encourage uptake of EPS in secondary care settings and across Primary & Community Care to enable the prescribing and dispensing process to be more efficient for patients and health care workers. Develop the functionality to track the status of a prescription through the NHS App and maximise development of this, where possible.

Workforce training and patient education

Provide training to clinicians on use of digital systems and help PCNs to move to a higher level of digital maturity. Digital training should support ways of working to become standardised across different Trusts, Place and PCN level. Additionally, support the public to use the NHS app and increase utilisation of it.

Estates

Workforce | Digital / Technology | **Estates** | Governance & Finance

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Key question: ***What are the enabling estates requirements to support new models of care in the future?***

The following four priorities were highlighted across the **two** system-wide groups discussing **Estates:**

Integrate health services into local high streets and communities

Integrate care into neighbourhoods with accessible centres on high-streets, bringing health and social care together. Expand the use of school health units to include POD and to provide health checks and care navigation.

Share back-office functions and co-locate office space

Co-location of office space would encourage collaboration and create a more integrated working environment. Consolidation of back office functions at a PCN level e.g. procurement, finance, and others, could encourage the move to more at-scale working. More system discussions on roles which could be remote and which roles won't be suitable for remote working.

More effective use of current estate available

Increase understanding of primary and community care estate available – map and analyse where utilisation is low, where there is a potential to re-purpose the estate and whether the estate is fit for purpose, for the growing population. Explore where digital opportunities could be applied and opportunities for remote service delivery to reduce any unnecessary physical use of primary care estate. Investigate opportunities to co-locate services within existing community hubs.

Shared Service Estates Professionals

Build a network of shared service estates professionals within the system, working with commissioners and providers to establish this. Align this shared estates service to strategic delivery plans and ICB to coordinate delivery at a local level.

Governance & Finance

Workforce | Digital / Technology | Estates | **Governance & Finance**

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Key question: ***What are the enabling governance and finance requirements to support new models of care in the future?***

The following four priorities were highlighted across the **two** system-wide groups discussing **Governance & Finance:**

Clarity on governance structure and roles in the ICB

Review the current governance structure for the ICB and provide further clarity on key roles, governance groups and their purpose.

Long-term funding strategy which is transparent and has system buy-in

Proactive 'whole system' planning and management of budget spend. To involve Primary Care groups such as the LMC in changes proposed by the ICB. Increase transparency of finance for each service and ensure adequate time for consultation.

Join up and co-design

Ensure clear communication takes place with system partners when changes arise or new models of working are discussed – all partners who are providing the service to provide input and agree localised actions to be taken forward.

Review of primary and community commissioning to encourage integrated working

Develop contracts at a system level with outcomes and payment mechanisms that would incentivise different groups of staff to work together in an integrated way, for example setting joint targets.

Next Steps

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Many thanks to all of those who participated in the workshop. We appreciate the time and effort that all colleagues gave to this and in sharing their skills, knowledge and experience.

- The outputs that have been captured in this document will inform the future design of the model of care and the Primary Care strategy. There were many great ideas/priorities captured in the workshop that could help relieve the unsustainable and extreme pressure that Primary Care is facing in BOB, as well as some innovative ideas that the system can look to implement.

- Over the course of the next 7 weeks, the ICB will continue to engage with stakeholders across the system on these priorities that arose in the workshop. We will work to refine the future vision, agree outcomes for primary care, the design of the future model and the priorities to take forward in the first few years.

- Discussions will take place with stakeholders to agree an approach to delivery of the strategy, in particular defining the roles and responsibilities of ICB, Place and PCNs in changing the model of care and moving towards our agreed outcomes.

Thank you