

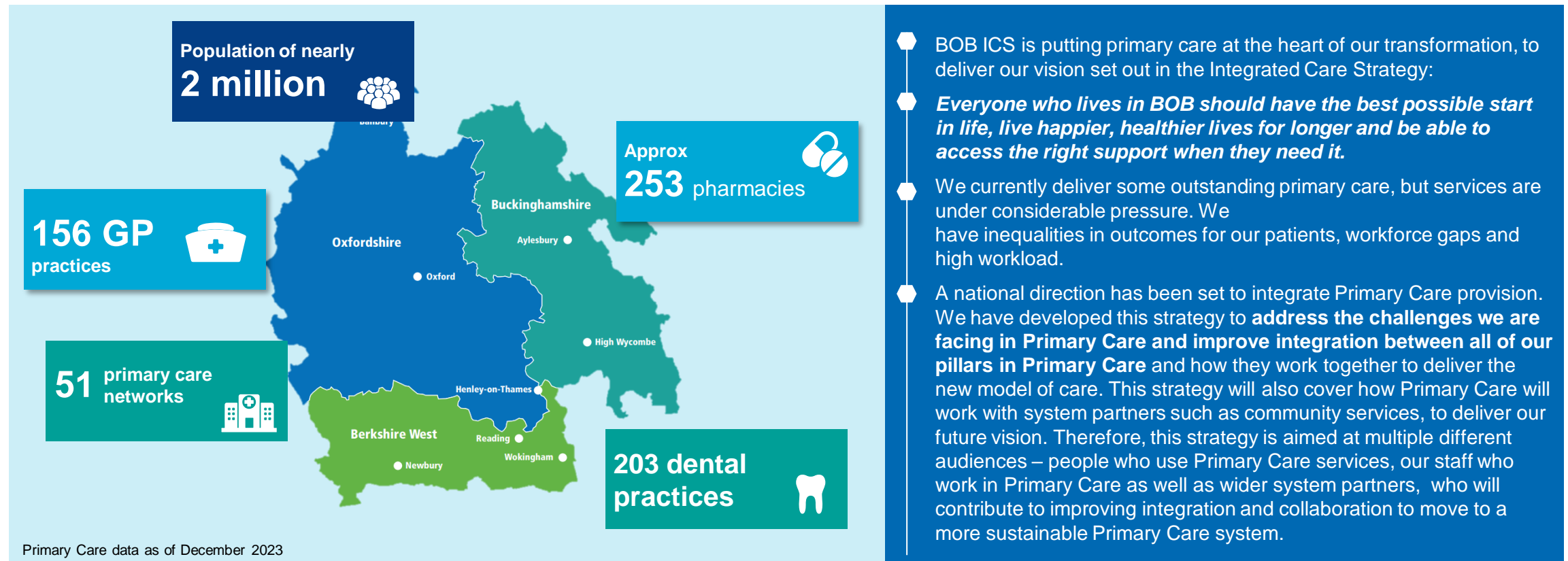
Transforming Primary Care – Executive Summary

General Practice, Community Pharmacy, Optometry and Dentistry



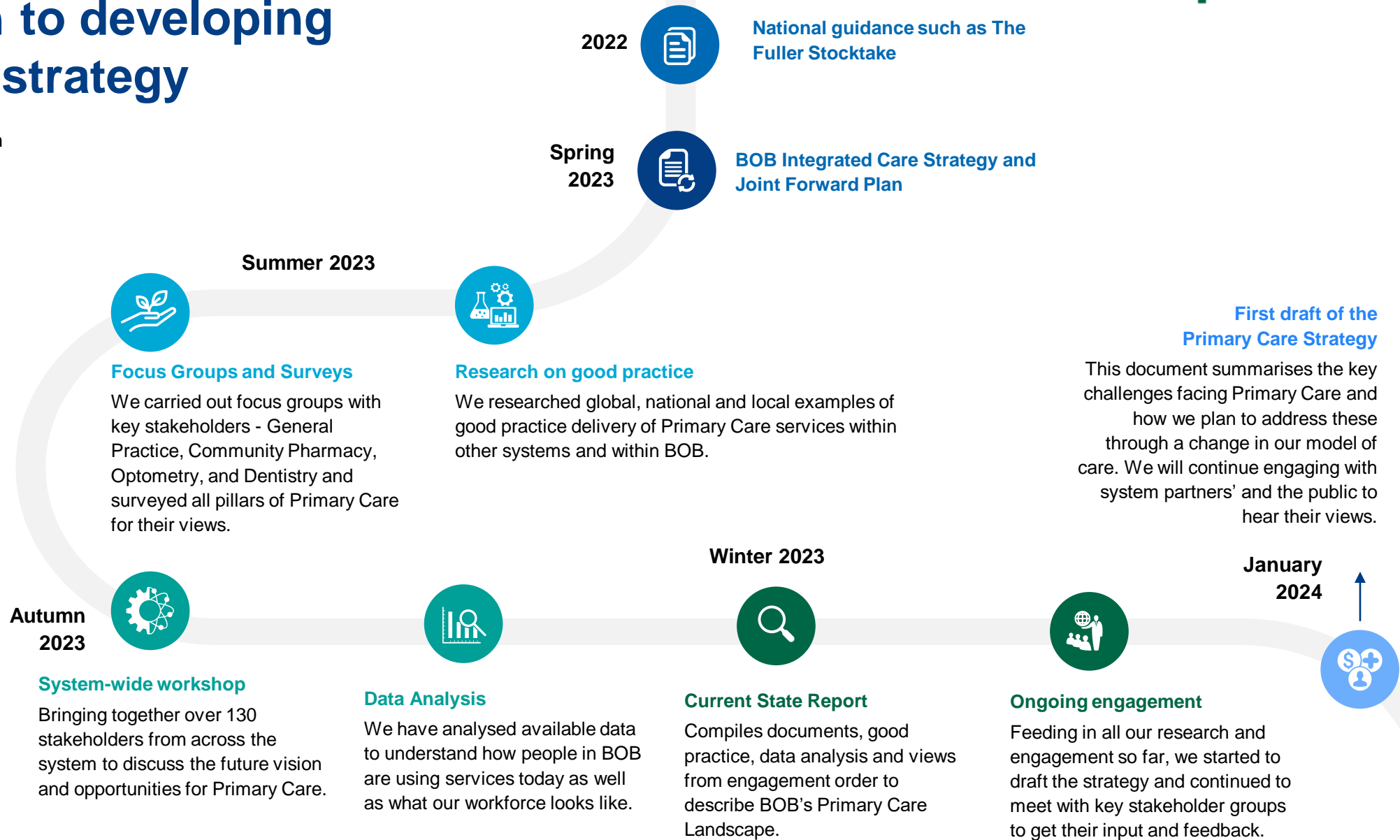
Why we need a primary care strategy

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.



Approach to developing this draft strategy

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



Our primary care system has many strengths

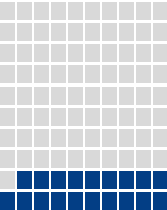







There is much outstanding practice across primary care in BOB, and unique capabilities across its Places. Below are five highlights where the system has particular strengths that can be built upon.

<p>01 </p> <p>General Practice access and quality metrics in line with or above the national average</p> <p>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.</p>	<p>02 </p> <p>High uptake of the Community Pharmacy Consultation Service</p> <p>BOB has the third highest number of referrals (per population) to the Community Pharmacy Consultation Service across the Southeast region. 122 of the 156 GP practices are 'live' and referring their patients to community pharmacists, with a further 27 preparing to start using this service (as of December 2023).</p>	<p>03 </p> <p>Strong focus on inequalities, prevention, and wider determinants of health</p> <p>All three Place-based Partnerships have focused on this. For example, 'Opportunity Bucks' targets the 10 most deprived areas in Buckinghamshire. Oxfordshire work focuses on specific communities such as people who are homeless. In Berkshire West community outreach is focused on reducing premature mortality.</p>	<p>04 </p> <p>Population Health Management Infrastructure</p> <p>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.</p>	<p>05 </p> <p>Flexible dentistry commissioning for our most vulnerable populations and extended commissioning for Minor Eye Conditions</p> <p>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 underserved 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.</p>	<p>06 </p> <p>Strength of existing at-scale delivery structures</p> <p>Each Place has a Placed-Based-Partnership (including local authorities, VCSE and others) which can drive and deliver transformation and integration at a local level. There are evolving Federations of General Practices established in each Place – FedBucks, PML in parts of Oxfordshire and the Primary Care Alliance in parts of Berkshire West that can lead change and deliver services for a large part of the population.</p>
--	---	--	--	---	--

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

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

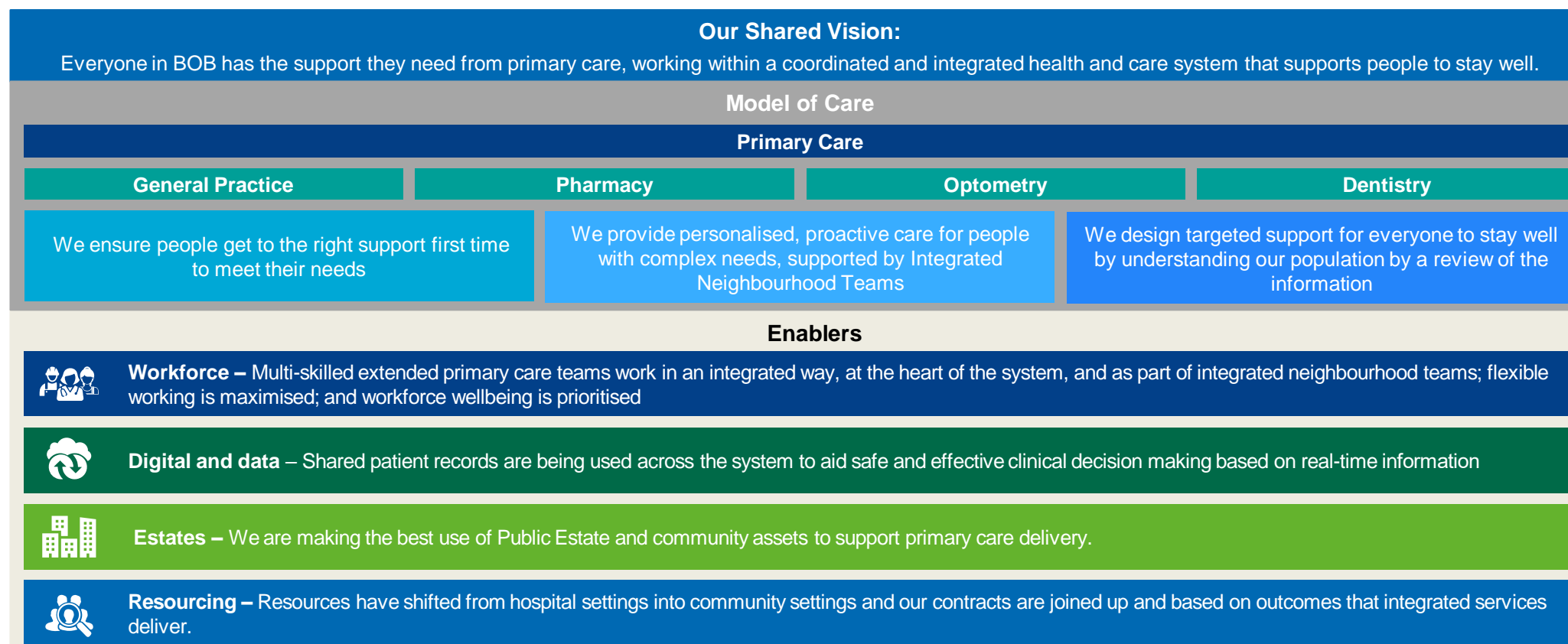
Demand for primary care outstrips current capacity and inefficiencies are created (for patients and staff) where the parts of the system do not work well together. The challenges require a system response, they cannot be solved by primary care alone.

<p>01 People report a worsening experience of accessing primary care</p>	<p>02 Many primary care staff feel they are under extreme pressure</p>	<p>03 This is driven by a mismatch between demand and capacity across the system</p>	<p>04 Capacity is difficult to grow due to funding, recruitment, retention and estates challenges</p>
 <p>Since 2021, there has been a 19% decrease in positive responses with regards to the overall experience of booking an appointment.¹</p>	 <p>BOB LMC data shows that GPs are responsible for more patients, and are spending a large proportion of time on administrative tasks relating to how patients move between parts of the system.³</p>	 <p>BOB's growing population and changing demographic profile is increasing demand for primary care services - more than one in four of the adult population live with more than two long term conditions.⁵</p>	 <p>In the Community Pharmacy workforce survey, 67% of respondents said it is very difficult to fill vacant roles for pharmacists.⁷</p>
 <p>19% said there were no dental appointments available or said that the dentist was not taking on any new patients.²</p>	 <p>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.</p>	 <p>14 community pharmacies closed in 2023 and 16 out of 20 100hr pharmacies reduced their opening hours (mainly the 9pm-12am slot).⁶</p>	 <p>There are estates pressures across the system for example, in Bucks, approximately 570,000 patients are served by a primary care estate of approximately 24,121 m².</p>

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

Our shared system vision for primary care

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



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

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

The challenge today – using General Practice as an example

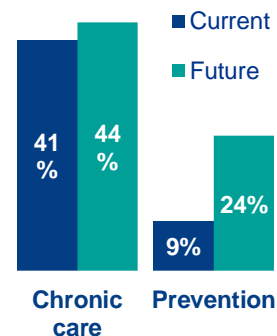
People report a worsening experience getting to the primary care support they need and are frustrated when they feel they are ‘bounced around the system’.

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



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

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



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

In the BOB ICS GP National Survey, people said:

- 10%** went to A&E when they couldn't get a GP appointment
- 30%** visited A&E instead when the GP practice was closed

Our future vision

Self-management

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

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

Triage & navigation

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

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

Initial contact

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

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

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

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

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

The challenge today

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

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

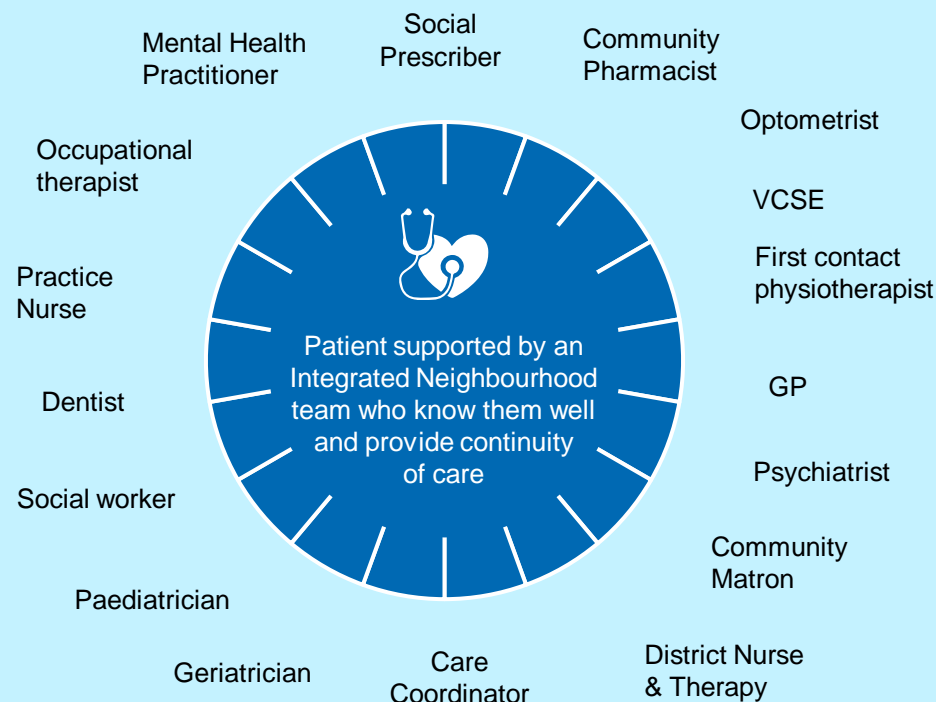
Many issues that affect people's health are not purely medical and require input from multiple parts of the public sector, for example housing, benefits.

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

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

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

Our future vision



Team of colleagues from a range of contributing organisations

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

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

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

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

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

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



The challenge today



60,000 living in a deprived area, who develop poor health 10-15 years earlier than those in less deprived areas.



Approximately 11% of BOB's population are active smokers, with nearly 8% of pregnant women actively smoking.



Across BOB, 3 in 5 adults are overweight or obese. 68% of adults with a learning disability are overweight.



Nearly 18% of BOB's population undertake less than 30 minutes of physical activity per week.



In BOB, there were 115k alcohol attributable admissions to hospitals between 2016/7 and 2020/21.

Our future vision



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

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

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

Four enablers are essential to delivering this vision

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

Workforce

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

Resource

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

We plan to do this in two ways:

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



Four enablers are essential to delivering this vision

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

Digital and data

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

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

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

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

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

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






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

Estates

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




Our approach to delivering this strategy

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

<div data-bbox="152 442 560 535" style="background-color: #004a99; color: white; border-radius: 15px; padding: 5px; display: flex; align-items: center; justify-content: center;"> 1 Create Focus </div> <p data-bbox="165 556 560 806">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.</p> <div data-bbox="394 1199 547 1299" style="text-align: center;">  </div>	<div data-bbox="611 442 1019 535" style="background-color: #004a99; color: white; border-radius: 15px; padding: 5px; display: flex; align-items: center; justify-content: center;"> 2 Delivery Programme Approach </div> <p data-bbox="624 556 1019 742">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:</p> <ul data-bbox="624 756 1019 1199" style="list-style-type: none"> ✓ 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 <div data-bbox="853 1199 1006 1299" style="text-align: center;">  </div>	<div data-bbox="1070 442 1477 535" style="background-color: #00a0e3; color: white; border-radius: 15px; padding: 5px; display: flex; align-items: center; justify-content: center;"> 3 Local Design </div> <p data-bbox="1082 556 1477 963">Primary Care is a complex landscape of mostly independent contractors which means we cannot implement a “one size fits all” model. We need to ensure the detailed design of the model of care takes place at a neighbourhood level, where those working on the frontline of Primary Care are making the decisions, with their communities, about changes in the way we work.</p> <div data-bbox="1312 1199 1465 1299" style="text-align: center;">  </div>	<div data-bbox="1528 442 1936 535" style="background-color: #76c73a; color: white; border-radius: 15px; padding: 5px; display: flex; align-items: center; justify-content: center;"> 4 ICB Support </div> <p data-bbox="1541 556 1936 1028">We recognise the need for the ICB to lead delivery of the strategy and to support the changes in the way we work. The ICB will act as a “convenor”, bringing together Primary Care with system partners to have meaningful discussions on how we deliver our priority actions and better meet the needs of our population. Further support will be given in enabling areas such as workforce, to ensure neighbourhoods are supported to drive the changes.</p> <div data-bbox="1770 1199 1923 1299" style="text-align: center;">  </div>	<div data-bbox="1987 442 2395 535" style="background-color: #00a09a; color: white; border-radius: 15px; padding: 5px; display: flex; align-items: center; justify-content: center;"> 5 System partner Support </div> <p data-bbox="2000 556 2395 999">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.</p> <div data-bbox="2229 1199 2382 1299" style="text-align: center;">  </div>
---	---	---	---	---

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.

<p>1 Non-complex same-day care </p>	<p>2 Integrated Neighbourhood Teams </p>	<p>3 Cardiovascular Disease (CVD) prevention </p>
<p>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.</p> <p>Around 70% of population health need is low complexity, and this makes up approx. 50% of GP activity.</p> <p>Impact:</p> <ul style="list-style-type: none"> • Improved patient experience as they get the urgent support they need. • Release capacity in General Practice to focus those with more complex needs. 	<p>General Practice, Community Pharmacy, Optometry and Dentistry will work together with community, mental health, acute and VCSE services to provide proactive, personalised care to a defined population group with more complex needs, for example, frail older people.</p> <p>Around 70% of health and social care spending is on long term conditions.</p> <p>Impact:</p> <ul style="list-style-type: none"> • 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 	<p>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.</p> <p>CVD is one of the most common causes of ongoing ill-health and deaths in BOB.</p> <p>Impact:</p> <ul style="list-style-type: none"> - 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 \(kingsfund.org.uk\)](https://www.kingsfund.org.uk)

BOB Size of Prize 2023

We will continue to focus on other improvements in addition

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

- |  General Practice |  Community Pharmacy |  Optometry |  Dentistry |  Community |
|--|--|--|---|--|
| <ul style="list-style-type: none"> Support the public to optimise use of the NHS app so that they can see their medical records, order repeat prescriptions, manage routine appointments and see messages from their practice. Improve the ways in which patients contact and interact with their GP and navigate care, including the 111 service - support provided to GPs through national and local improvement programmes. Continue to strengthen the primary care workforce including recruitment, retention, supporting staff practice to the top of their license. Improve the interface between primary and secondary care – to streamline processes and touchpoints for patients. | <ul style="list-style-type: none"> Roll out of the Pharmacy First initiative in 2024 so that patients can access prescription-only medicine without needing to visit a GP e.g. for UTI treatment. Upskilling of community pharmacists in line with upcoming new policy so that more pharmacists are able to provide assessments of patients and make prescribing decisions without patients having seen their GP first. Continue to expand vaccination service e.g. flu and covid Expand GP Connect to enable GP practices and authorised clinical staff (e.g. pharmacy professionals) to share and view electronic health records information and appointments information. | <ul style="list-style-type: none"> Implementation of an electronic referral platform which will allow community optometrists to send routine referrals directly to the patients' chosen hospital or single point of access. National intent to extend and roll out 'in school' eye testing in all schools from April 2024, with certain schools given priority for the rollout. National minor eye condition service to be expanded in early 2024 which aims to improve equity and accessibility for patients with most eye conditions seen at eye units and by GPs. | <ul style="list-style-type: none"> Further expansion of the Flexible Commissioning scheme which provides care for patients from underserved communities. Continuing to undertake oral health assessments and increase dental hygiene in children and young people - targeting prevention interventions. Exploring implementation of mobile dental units. Building dental clinical workforce resilience Proactive management approach to dentistry though better oversight of access, quality and performance challenges. | <ul style="list-style-type: none"> Expanding hospital at home approach and redesigning hospital discharge model - integrating with local councils so more services and care can be moved into the community. Enabling patients to have direct access to community services such as 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 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'. |

ICB and Place support for local delivery

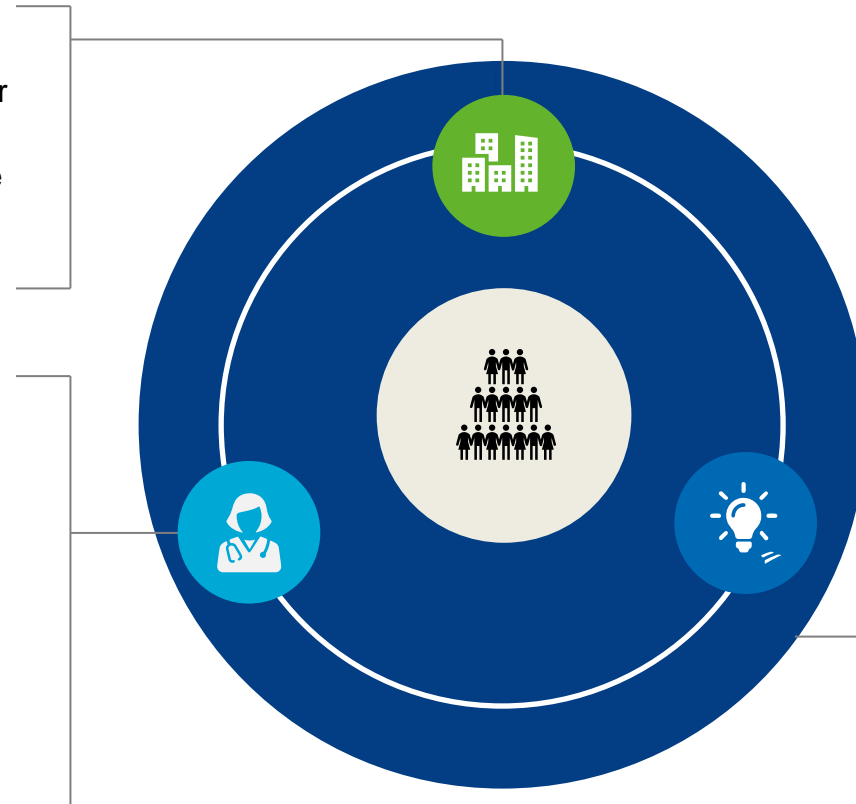
Clinical and operational teams, working with their communities, will be the ones who drive new ways of working. The ICB and Place teams will provide dedicated support to focused Local Action Teams working on our three priorities within an overall Primary Care Delivery Programme.

Place-level

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

Local Action Teams

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



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

ICB-level

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

A phased approach working with cohorts across the three priorities

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

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

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

BOB

Buckinghamshire, Oxfordshire
and Berkshire West
Integrated Care System

**Thank you for reading this draft strategy
(summary version).**

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

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

