Health & Adult Social Care Select Committee Agenda

Date: Thursday 11 April 2024

Time: 10.00 am

Venue: The Oculus, Buckinghamshire Council, Gatehouse Road, Aylesbury HP19 8FF

Membership:

J MacBean (Chairman), S Adoh, P Gomm, T Green, C Heap, C Jones, H Mordue, C Poll, G Sandy, A Schaefer, R Stuchbury, A Turner, N Thomas, M Walsh (Vice-Chairman), J Wassell and Z McIntosh (Healthwatch Bucks)

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Agenda Item		Time	Page No
1	**Apologies for Absence**	**10:00**	
2	**Declarations of Interest**		
3	**Minutes of the Previous Meeting** To confirm the minutes of the meeting held on Thursday 29th February 2024 as a correct record.		**5 - 12**

4 Public Questions

Public Questions is an opportunity for people who live, work or study in Buckinghamshire to put a question to a Select Committee. The Committee will hear from members of the public who have submitted questions in advance relating to items on the agenda. The Cabinet Member, relevant key partners and responsible officers will be invited to respond.

Further information on how to register can be found here: https://www.buckinghamshire.gov.uk/your-council/get-involved-with-council-decisions/select-committees/

5 Chairman's update

For the Chairman to update Members on health and social care related scrutiny activities since the last meeting.

5a Scrutiny responses to ICB's Draft Primary Care Strategy **13 - 26**

The Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview & Scrutiny Committee prepared a formal response to the Integrated Care Board's draft Primary Care Strategy. The response was submitted to the ICB as part of their key stakeholder engagement process. A copy of the response is attached.

The Buckinghamshire Health & Adult Social Care Select Committee also prepared a response to the ICB's draft Primary Care Strategy. A copy of the response is attached.

5b BOB Joint Health Overview and Scrutiny response to ICB's Digital and Data Strategy **27 - 32**

A working group of Members on the BOB Joint Health Overview & Scrutiny Committee (JHOSC) prepared a response to the Integrated Care Board's Digital & Data Strategy. The response was agreed by all Members on the JHOSC and submitted to the Integrated Care Board. A copy of the response is attached.

6 Dentistry **10:15** **33 - 52**

The Integrated Care Board recently took on the responsibility for commissioning all primary care services, including Pharmacy, Optometry and Dentistry. The ICB published its draft primary care strategy in January as part of a stakeholder engagement process which closed at the end of February. The Committee will hear from key

people involved in commissioning dental services and providing dental services for Buckinghamshire residents.

Presenters:
Hugh O'Keeffe, Senior Programme Manager – Pharmacy, Optometry and Dental Services (BOB ICB)
Nilesh Patel, Chair, Thames Valley Local Dental Network and owner of Dental Practice in Buckinghamshire

Papers:
Report attached

7	**Primary Care Networks Annual report** Following the Committee's inquiry into the development of primary care networks (PCNs), one of the recommendations in the inquiry report was to produce an annual report for the Select Committee to include an update on resourcing, staff capacity and examples of positive outcomes across PCNs. **Presenters:** Anna Markus, Head of Primary Care Integration, Primary Care Lead for Buckinghamshire Bobby Pozzoni-Child, Strategy Manager for Bucks GP Provider Alliance Philippa Baker, Place Director, BOB ICB **Paper:** Annual report attached		**53 - 64**
8	**Healthwatch Bucks update** The Chief Executive of Healthwatch Bucks will provide Members with an update on the current work being undertaken by Healthwatch. The written report focusses on Healthwatch Bucks involvement with dental services. **Presenter:** Zoe McIntosh, Chief Executive **Paper:** Update attached – focussed on dental services	**12:15**	**65 - 70**
9	**Work programme** Representatives from Buckinghamshire Healthcare NHS Trust were due to attend the April meeting to update Members on maternity services and to discuss the Trust's performance of key services. This item was deferred until	**12:20**	

the first meeting in the new council year.

A work programming session will be arranged before the next meeting to discuss issues for the forthcoming year.

10 Date of Next Meeting **12:30**

The next meeting will take place after the Council's Annual Meeting where the calendar of meetings will be agreed. The provisional date for the next meeting is Thursday 11th July 2024 at 10am.

If you would like to attend a meeting, but need extra help to do so, for example because of a disability, please contact us as early as possible, so that we can try to put the right support in place.

For further information please contact: Liz Wheaton democracy@buckinghamshire.gov.uk 01296 383856

Buckinghamshire Council

Health & Adult Social Care Select Committee

Minutes

MINUTES OF THE MEETING OF THE HEALTH & ADULT SOCIAL CARE SELECT COMMITTEE HELD ON THURSDAY 29 FEBRUARY 2024 IN THE OCULUS, BUCKINGHAMSHIRE COUNCIL, GATEHOUSE ROAD, AYLESBURY HP19 8FF, COMMENCING AT 10.02 AM AND CONCLUDING AT 12.39 PM

MEMBERS PRESENT

J MacBean (Chairman), S Adoh, P Gomm, T Green, C Heap, C Jones, H Mordue, S Morgan, C Poll, G Sandy, R Stuchbury, A Turner, N Thomas, M Walsh (Vice-Chairman), J Wassell and Z McIntosh

OTHERS IN ATTENDANCE

Mrs E Wheaton, Mr C McArdle, S Moore, Ms P Baker, Dr S Roberts, Ms S Turnbull and Mr A Timon

Agenda Item

1 APOLOGIES FOR ABSENCE

Apologies were received from Tiffany Adonis-French, Service Director, Operations (Adult Social Care).

2 DECLARATIONS OF INTEREST

Cllrs Turner and Walsh declared a non-pecuniary interest as trustees of an independent day care centre.

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 30th November 2023 were confirmed as a correct record.

4 PUBLIC QUESTIONS

There were no public questions.

5 CHAIRMAN'S UPDATE

The Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview Scrutiny Committee (BOB JHOSC) had met on 24th January 2024 to review the BOB Integrated Care Board's (ICB) draft Primary Care Strategy, consider the Communication and Engagement plan and receive updates from the Healthwatch organisations within the BOB footprint. Formal responses on the Primary Care Strategy would be submitted by the JHOSC and the HASC Select Committee.

A small group of JHOSC Members had been reviewing the ICB's Data and Digital Strategy and the formal response would be submitted to the ICB shortly.

The Chairman reported that she had attended a meeting with colleagues at the Swan Practice in Buckingham which included an update on the plans for a new development at Lace Hill. At this stage, this was not a matter for the HASC Select Committee but a close eye would be kept on this issue.

6 ADULT SOCIAL CARE TRANSFORMATION PROGRAMME

The Chairman welcomed Cllr Angela Macpherson, Cabinet Member for Health and Wellbeing and Sara Turnbull, Service Director Strategy, Improvement & Governance.

The Cabinet Member for Health and Wellbeing introduced the report, explaining that Adult Social Care (ASC) was on a journey to bring about long-term service improvements, involving transformational change across services. The report gave details on performance data relating to service users, financial planning and co-production and these aligned with the ASC's Better Lives Strategy.

The Service Director explained that the programme scope had been refreshed in the autumn to reflect the largest areas of opportunity. The national challenges around social care were immense and it was necessary to work more efficiently. The ASC Improvement Plan included short-term goals as well as longer term projects which would delivered over the next 3 to 5 years.

During the discussion, the following questions and points were made:

- The Chairman noted that the pace of delivery seemed slow and asked what the key issues were. The Cabinet Member for Health and Wellbeing explained that programmes such as shared lives and supported living were being delivered at different paces. Joint working with the housing team would be critical in the longer term to ensure successful delivery of these projects.
- A Member expressed concern that ASC had not included any capital investment in the Council's Medium-Term Financial Plan. The Cabinet Member explained that there had been no capital investment for some time and this was under consideration. The service was on track to deliver all the MTFP savings in the year 2023 to 2024. Operational efficiencies were already producing results, such as an increase in care hours. In the longer term, work would progress on finding solutions around housing.
- The Better Lives Strategy had been embedded in the Transformation Programme from the start but the emphasis had shifted towards living well, enablement and reablement.
- Innovation often came from learning about programmes in other authorities. A good example was Shared Lives which could be explained as the fostering of adults, either for short-term respite or the longer term. This brought both personal benefits and financial savings. Also under consideration was the Homeshare scheme where a person rented a room in a private house and helped the homeowner in return for a reduction in rent.
- A Member asked about the risk factors in delivering the MTFP and asked how the strategy could be delivered whilst savings were made. The Cabinet Member explained that demand for adult social care was increasing rapidly and inflation was affecting care costs but she stressed that this is a national issue. In spite of this, the service had been over-delivering on savings.
- The prevention approach had been critical – Prevention Matters had supported 700 residents via a combination of telephone calls and one-to-one visits. It was acknowledged that there was a need for wider working and partnerships with the voluntary and community sector.

- 23% of the enquiries coming into the ASC team were requests for information and guidance so customer service was always a top priority. The team had been learning from other authorities about disseminating information more widely. It was suggested that Community Boards could help in this. A Member suggested that a mapping exercise showing local services might be useful. The ASC team will be engaging with social prescribers across the Primary Care Networks.
- It was important to manage the transition of young people from the children's to the adult services and conversations were starting earlier with children to enable a seamless transition between services.
- Technical problems had hampered the launch of information on the Bucks Online Directory. It was acknowledged that not all residents were able to use digital services.
- A Member raised concerns about the depleted funds of self-funders and impact of this on the service. In response, the Cabinet Member explained that demand for nursing care had risen after the pandemic, with patients suffering from more complex illnesses. The council had a duty of care towards patients without their own funds. There needed to be a re-organisation of social care funding at national level but plans had been delayed until 2025. The finance department were experienced at supporting residents and taking them through the process.
- In response to a question about service user involvement in co-designing services for carers, the Service Director explained that the design of the information on the web site was influenced by workshops carried out with families. Surveys and outreach work had also been carried out with the voluntary and community sector. More engagement was planned to understand the needs of unpaid carers.
- The report stated that work on the carers' strategy had been delayed until the year 2025 to 2026 due to other priorities. The Service Director assured members that the carers project was in progress and work had been completed on carers' support planning and carers' involvement with the work around the website as an example. There was a need to estimate the total number of unpaid carers in the county and the role of unpaid carers was recognised and support needed to be provided to them. Over the last year the number of carers' assessments carried out had increased but the Cabinet Member was not satisfied with the 2026 target and wanted to discuss this further with the service.
- Greater integration with the NHS was acknowledged and a strong integrated commissioning team had overseen contract management and performance monitoring. A focus on commissioning and procurement across the whole council was key to making efficiencies.
- In response to a question about the robustness of data within the service, the Service Director explained that she was working closely with the Business Intelligence (BI) team to review performance data. A system was in place to present data in a dashboard format for managers to view. There was a rollout plan to enable all relevant teams to use the dashboard. The Cabinet Member had viewed the dashboard and suggested HASC Members might like to receive a demonstration.

Action: Service Director Strategy Improvement & Governance

- The Cabinet Member stated that it was important that health conversations started early. Residents should be encouraged to adopt healthy behaviours in their forties.
- The Chairman hoped that the Cabinet Member for Health and Wellbeing and the officers present would support the Select Committee's recent joint review into planning for future primary healthcare which was going to Cabinet in April.
- In response to a question about the provision of transport to ASC clients, the Service Director explained that providing transport for residents who had special requirements was a statutory duty. In ASC, there was a relatively small number who receive help with transport – for example those who attended day centres. The cost was £2.5 million to transport 250 residents. The supplier market was difficult and spend was unpredictable.

A manual to inform social workers of the community transport schemes available had recently been approved.

- The report highlighted the long wait that some patients had for Occupational Therapy (OT) appointments. The council had in-house Ots and the workload was not shared with the NHS. The team had been working hard to re-prioritise patients but there were challenges around recruitment.
- The Chairman stated that on page 20 of the report in the agenda pack, there are some services which were not then referred to in any detail within the report, including therapy-led intermediate care beds and aids and adaptations to help people to regain independence. The Chairman requested further information on these services so Members could understand the challenges and pressures in delivering them. The Cabinet Member agreed to share information on these specialist services.

Action: Cabinet Member for Health and Wellbeing

- A Member referred to the 63% figure for the number of commissioned providers who had a CQC rating of Good or Outstanding and asked what the target figure was. The Service Director explained that this figure was lower than neighbouring authorities. The Commissioning team had produced a new provider quality framework. Placements were not made into providers where the rating was below adequate. An annual survey collects feedback from services users. The Chairman asked to see more detail on the feedback and information on the different engagement methods.

Action: Service Director Strategy, Improvement & Governance

The Chairman thanked the Cabinet Member for Health & Wellbeing and the Service Director Strategy, Improvement & Governance for their presentation and for responding to Member questions.

7 HEALTHWATCH BUCKS UPDATE

Zoe McIntosh, Chief Executive of Healthwatch Bucks, introduced the update. She made the following points:

- Healthwatch Bucks had publicised the ICB's draft primary care consultation. Healthwatch had submitted its response to the ICB on 28th February 2024. This had included reports on primary care, including the lack of awareness of social prescribing.
- The Continuing Health Care (CHC) report was published on the Healthwatch website. This stemmed from a BOB ICB Task & Finish group on "Hearing People's Voices" which was carried out in 2023. The Healthwatch team had spoken to 11 people who had not been deemed eligible for continuing healthcare. There had been a great deal of confusion about the process with some health professionals also having limited understanding of continuing healthcare. The report made a number of recommendations including the need for more clarity of the initial CHC process and patients should be made aware of the advocacy service, Beacon Continuing Healthcare.
- A Member complimented Healthwatch on its work in communicating with the public and asked about feedback on child mental health services. The Chief Executive of Healthwatch explained that it encourages feedback on services by various means and always passed feedback on to providers and commissioners. Healthwatch Bucks were in the process of setting their 2024-25 priorities with a view to children and young people, and their health (including mental health) being a priority for the year.

The Chairman thanked Healthwatch Bucks for its invaluable work in ensuring the patient voice was included in all health and social care discussions.

8 JOINT REVIEW WITH THE GROWTH, INFRASTRUCTURE AND HOUSING SELECT COMMITTEE

REPORT - PLANNING FOR FUTURE PRIMARY HEALTHCARE IN BUCKINGHAMSHIRE

The Chairman explained that four members of the HASC committee had participated in the joint review alongside four members from the Growth, Infrastructure and Housing Committee. The Chairman thanked all the Members and the officers involved. This was echoed by Committee Members. The Chairman stated that the report and recommendations would not solve the problems in planning for future primary healthcare but it was hoped it would be used to help accelerate important conversations.

- Cllr Poll thanked healthcare partners, the Committee and Democratic Services officers for their work on the report.
- A Member expressed concern about the lack of data collection from some GP surgeries. Some GP surgeries had opted not to provide patient data which lead the review group to conclude that this was leading to an unclear view of what the needs were across the county.
- Recommendation 4 of the report was discussed and it was noted that the council considers town and parish councils as strategic partners in their capacity as landowners.
- It was noted that the report needed to be discussed by both Cabinet and the Integrated Care Board as the recommendations were aimed at both.

The committee agreed the report.

9 DEMENTIA REVIEW - 6 MONTH RECOMMENDATION PROGRESS MONITORING

The Chairman welcomed the following people to the meeting:

- Dr Sian Roberts and Adrian Timon, Co-Chairs, Dementia Strategy Group
- Philippa Baker, Place Director, Integrated Care Board
- Craig McArdle, Corporate Director, Adults & Health

The Cabinet Member for Health and Wellbeing introduced the 6-month progress report on the Dementia Review. More information would be given at the 12-month review but several action points had seen major progress.

During the discussion, the following questions and points were made:

- A Member noted the progress made in a relatively short timeframe and said that there was information in the update which she was not aware of, including the workshops run with Buckinghamshire Culture on ageing well. The Member was not sure how these events were publicised. The Cabinet Member for Health and Wellbeing explained that there was now an Ageing Well Partnership Board. She agreed that it was important to share information and would take these points on board.
- The Chairman asked if there were any changes to the Dementia Strategy Group. Adrian Timon explained that the group had been expanded and now included colleagues from Public Health. The expansion of the group had led to a loss of strategic focus so they were developing a process which meant key members could attend and give an overview of their area of work, when required.
- Funding was a constant challenge and a Member asked where funding would come from in the future. The Place Director, Integrated Care Board and the Corporate Director, Adults & Health would be meeting on the afternoon of 29th February 2024 to discuss future investment. The Corporate Director noted the pressure on all budgets and stressed that dementia care would be a priority for investment.
- Much work had been done in the last 6 months to ensure that memory screening and post diagnostic support were consistent across all Primary Care Networks. There was some variance, but many PCNs were committed and had conducted good quality annual patient reviews. Two training courses had been provided for social prescribers and other staff.

- In care homes, the Diagnosing Advanced Dementia Mandate (DiADeM) initiative had supported diagnoses. Around 70% of care home patients had dementia and it was important that they were correctly supported. The DiADeM project was a pilot carried out in Buckinghamshire and would end in May 2024. Anecdotal evidence showed that it had been effective and well received. It was hoped that the project would continue in the future. This would be dependent on a business case being made. The Chairman hoped that there would be clarity around funding for Dementia Support Services at the 12-month review, due in September 2024.
- The work for patients with early onset dementia was praised but there were concerns raised that most of the estimated 240 people affected in Buckinghamshire were not being properly supported. The problem stemmed from the historical emphasis on the over-65 cohort. There was not a standardised infrastructure to support patients with early onset dementia across the country. People with early onset dementia needed to be identified so that they could receive the support needed. The Oxfordshire model, where an early onset dementia specialist was available at the John Radcliffe hospital was mentioned. There would be a cost implication if Buckinghamshire introduced similar provision.
- There was a general discussion on the role of Dementia Friends and Dementia Champions. As many residents as possible were encouraged to be Dementia Friends. Dementia Champions (DC) tend to be professional health workers. There was a DC in every social worker team who could support their colleagues. Most PCNs had a DC, often a social prescriber. Care homes had a key member of staff who could support colleagues. Adrian Timon acknowledged that the precise number of DCs was not known and agreed to find out if the DCs in adult social care had received training in Alzheimer's disease (to be reported at the 12 month review).
- A Member suggested that everyone prominent in the local community, such as shop and business owners, should be aware of who the DCs were so that they could pass on any concerns. Adrian Timon explained that the visibility of DCs would be shared in the next dementia strategy group

Action: Adrian Timon

- 30 PCN staff had attended training on how to conduct dementia annual reviews. The staff were from a variety of roles and it was intended to run training sessions every 6 months to ensure that all new staff received training. The training was promoted by Dr Roberts and Adrian Timon in conjunction with the social prescribing team.
- A Member suggested that the Dementia Strategy Group link with the Community Boards as some were keen to set up dementia-friendly cafes. The Member went on to report the usefulness of the dementia bus but noted that there was a charge to hire the bus. It was noted that there should be information on what the dementia bus was for and who it could benefit.
- A Member noted that there had been an undertaking to set aside an area for dementia patients in the emergency department of Stoke Mandeville Hospital but was not aware that this had happened.
- A Member asked whether full use was being made of technology to support patients living with dementia, such as slippers containing GPS trackers and balance detectors to monitor falls. Dr Roberts explained that a team in the social care was actively looking at telematics such as alarms and sensor mats. These enabled patients with dementia to stay in their own home for longer. The Corporate Director, Adults & Health about explained that thousands of patients across the county were being supported. Technology was always progressing, but ethical issues had to be considered. He agreed to provide more detailed information at the 12-month update.

Action: Corporate Director, Adults & Health

- The Place Director, Integrated Care Board explained that she would be discussing funding

priorities with the Corporate Director, Adults & Health after the meeting. She pointed out that planning for 2024 to 2025 had been delayed as the NHS planning guidance had been issued late. The plans would make the best possible use of funding for the population.

- Dementia Action Week runs from 13th to 19th May 2024. A Member noted that there was little activity to promote this in 2023 and hoped that activities would take place across the county with the involvement of Community Boards. Dr Roberts offered to use the partnership to promote the action week.

Action: Dr Roberts

- The Cabinet Member for Health and Wellbeing offered to talk to the Communications team about promoting the event.

Action: Cabinet Member for Health & Wellbeing

- A Member was concerned that dementia diagnosis rates in Buckinghamshire were lower than the national average. They were also lower than neighbouring authorities. Diagnosis was the key to early treatment and support. This was the only quantitative figure available and the member requested an update before the 12-month review. Dr Roberts agreed that data was key and there were plans to develop a local information dashboard. Dr Roberts received monthly figures from NHS England which could be shared.

The Chairman thanked all the presenters and explained that the requests for information to be included in the 12-month Dementia review would be provided in advance of it coming before the Committee.

10 WORK PROGRAMME

Members agreed the following items for the next meeting, to be held on 11th April.

- Dentistry
- Development of Primary Care Networks Annual Report

11 DATE OF NEXT MEETING

11th April 2024 at 10.00am

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Dr Rachael De Caux
Deputy Chief Executive/Chief Medical Officer
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

cc. Dr Abid Irfan, Director of Primary Care
Louise Smith, Deputy Director of Primary Care
Sim Scavazza, ICB Acting Chair
Dr Nick Broughton, ICB Chief Executive Officer (Interim)
Catherine Mountford, ICB Director of Governance
Hannah Iqbal, Chief Strategy and Partnerships Officer
Sarah Adair, Director of Communications and Engagement

5th March 2024

Dear Rachael,

On behalf of the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee (JHOSC), I am writing to thank you and your colleagues for attending the recent BOB JHOSC meeting to discuss the Integrated Care Board's (ICB) draft primary care strategy.

We would like to start by acknowledging the enormity of the task in bringing together a primary care strategy for the BOB Integrated Care System, with a population of nearly 2 million, 156 GP practices, 51 Primary Care Networks, 253 pharmacies and 203 dental practices.

This letter brings together some of the discussion from the JHOSC meeting on 24th January and subsequent comments, reflections, and feedback from JHOSC Members.

General comments

For many people, primary care means access to their doctor and the services provided at their surgery. We suggest that a clear explanation of all the services across primary care is made at the beginning of the strategy to provide clarity for all readers, particularly members of the public.

An overall comment on the strategy would be that we feel some of the language will not immediately resonate with people, for example, "pillars" and "enablers". It would help to replace these words with more everyday phrases.

The strategy document has been written for those working within the health sector. 55 pages of densely worded slides does not make it an easy read for those that are not health experts. We appreciate an executive summary has been produced to sit alongside the main strategy document, but it is written in the same style and is still 17 pages.

We feel there could be a correlation between the low response rates and the complexity of the strategy. The cover report provided to the JHOSC states that just 345 people have shared their views and experiences as part of the "Primary Care conversation". With a BOB population of nearly 2 million, this is an incredibly low response rate and represents a tiny proportion of the population affected. Patient buy-in will be crucial to the delivery of any proposed changes so it is vital that far more accessible comms and feedback collection processes are developed as a priority.

We understand that there was a requirement to pre-register to complete the survey which we feel creates unnecessary barriers. The two-stage authorisation for the survey also felt like an unnecessary burden for respondents and we heard that for some people it took almost an hour to complete the survey.

Comms and engagement remain a key area of concern for the JHOSC as ongoing discussions do not appear to be generating improvements in response rates to engagement exercises.

JHOSC Members feel that the strategy document would have benefitted from a level of pre-engagement work with independent groups, such as Patient Participation Groups, voluntary groups, and Citizen's panels. We feel confident these groups would have commented on language, complexity, and length of the strategy document, which could have been addressed before launching the strategy for wider engagement.

Based on our comments above, we feel there needs to be a shorter, easy to read and simplified version to encourage greater public engagement. We suggest the following needs to be addressed in this simplified document, which could sit alongside the main strategy.

- We feel the strategy needs to be put into context at the outset - national direction and the Fuller report states primary care should streamline access, provide continuity of care, and focus on prevention. These are terms which the public can understand and relate to.
- Be clear about what is meant by primary care – general practice, pharmacy, optometry, and dentistry.
- Then an explanation of the challenges facing primary care and why change needs to happen in the way services are delivered, including increase in demand for services and more complex health needs linked with an ageing population, population and housing growth, addressing health inequalities, funding pressures and workforce pressures. Again, terms which people can understand and relate to.
- Bring in what the key priorities will be for primary care over the next 3 years and link to the Fuller report. For example, introduce non-complex same-day care to improve and streamline access to services, develop integrated neighbourhood teams to provide continuity of care and focus on prevention, particularly around cardio-vascular disease, a major cause of death within the BOB population.

- Finally, explain how these priorities will be delivered using workforce, digital and data, estates, and resources.
- By keeping it simple, it is easier to see the thread between challenges, priorities and deliverables which is what you are asking the public to feedback on. At the end of each section, you could pose the question you are asking people to feedback on – for example, after describing the challenges, ask "do these reflect your understanding and/or experience of primary care?". At the moment, questions are posed on page 2 of a 55-page strategy and are not repeated so these key questions are lost.
- If people want to see the detail, they can refer to the main strategy document.
- It was good to see patient stories and health professional stories in the strategy to help understand how the changes will affect patients and the ambitions around a more integrated health and care service. It would be useful to also include a patient story around optometry as there is little mention of this service in the strategy and it is hard to see how this service will be part of the integrated neighbourhood team.
- We felt that the strategy would benefit from some additional insights into how the ICB will make commitments to learn from best practice elsewhere in other systems, particularly around the increases in demand for primary care as well as the rise in housing developments.

As JHOSC Members, we have sight of other ICB strategies which will underpin delivery of the primary care strategy, particularly the digital and data strategy which will support delivery of shared records and better access to digital and data solutions. We understand that the BOB workforce strategy is in development and the ambitions around integrated neighbourhood teams, highlights the need for an estates strategy at place to drive their delivery.

The primary care strategy does not refer to these strategies, so we feel there is a risk that these key strategies are not aligned and would like reassurance that the Board is monitoring the golden thread through all ICB strategies to ensure joined-up delivery.

Priorities

Streamlining access to provide non-complex same day care.

- From our experiences as Members, name changes to health services and signposting to services has led, on occasion, to confusion by those trying to access services. The introduction of non-complex same-day care needs to be very clear to the patient as to what is meant by non-complex care. We would also urge health providers to be very clear about how the out-of-hours service integrates with same day care.

Developing Integrated Neighbourhood Teams to deliver continuity of care.

- The introduction of integrated neighbourhood teams raises questions around how Primary Care Networks align with these teams. Communications around this need to be strong and very clear about how the teams work together for patients within their communities.

Focus on prevention, particularly Cardio-vascular disease (CVD).

- At the JHOSC meeting, concerns were raised as to why CVD had been chosen as the main prevention focus over other diseases, such as dementia, dental prevention,

mental health prevention measures or obesity. We understand that prevention work will continue in these areas but the focus across primary care will be on reducing cardio-vascular disease. We feel this point should be made clear in the strategy.

Whilst we appreciate that the strategy must focus on some key priorities and cannot focus on all matters of concern, we are concerned at the growing number of additional issues that do not fall into any of the priority categories. For example, inadequate NHS dentistry provision, busy pharmacies, demand for GP appointments, GP estates issues, population growth, an ageing population, health inequalities, staff changes and reallocations that will affect continuity of care, patient issues with receptionist triage, lack of awareness of optometry provision, social isolation and greater numbers of residents with multiple long-term conditions.

The BOB ICB has put the four pillars of Primary Care - General Practice, Community Pharmacy, Optometry and Dentistry – at the "heart of transformation to deliver a shared ambition and vision for a new model of care and a more integrated way of working across the system." We assume that these four key pillars will vary according to place-based provision. Will the ICB or the place-based teams now accept responsibility for mapping the current service provision, identifying gaps and planning for future growth and need in each region?

We note that mental health does not constitute one of the key pillars, yet mental health issues have dramatically increased in scope and complexity, and either underpin or exacerbate physical health issues.

Enablers

Workforce

- We are aware of the recently published NHS Long Term Workforce Plan.

- We read with interest the BOB staff passport but recognise the challenges in introducing this across the geographical footprint and the potential increased risk to staff wellbeing associated with changes in working arrangements.

- Within our local health scrutiny committees, we have looked at Primary Care Networks and reviewed how these are developing. It has been challenging recruiting to some of the additional roles created by Primary Care Networks and we are acutely aware of workforce pressures across the whole health and care system. We feel the plans around workforce need to be developed soon to support delivery of the primary care strategy and will need to be under constant review. Whilst the strategy states concern around numbers of workforce leaving the sector it does not contain any tangible recovery plan.

- As the strategy develops, we would like to see clarity around how the additional roles within the PCNs, including social prescribers, Physician Associates and Care Co-ordinators will take pressure off the GPs and the impact their roles are having on transforming primary care.

- We are concerned about workforce capacity across the wider system to support the integrated care teams based on the PCN experiences and would like to see evidence from partner organisations, such as the police, social care, and mental health providers, that they can support the development of these teams.

- We recognise that the funding formula for future workforce recruitment, training and retention are unclear. What specific impact will the same day role training have, and will this role impact the provision of 111 services and staffing levels?

- The strategy leans heavily towards improving GP capacity and new pathways for treating patients. However, there is little detail on dentistry and pharmacy provision and how these services will be supported, and capacity expanded.

Digital and Data

- The strategy refers to Population Health Management (PHM). The ICB's digital and data strategy states that funding for PHM activities has yet to be identified. We are concerned that some parts of BOB have access to tools to help support PHM, yet others do not, leading to greater inequalities. How will this be addressed and what support is available to those areas which require more support with PHM?
- We are unclear on how funding will be assessed and allocated as place-by-place comparisons will be problematic, i.e. Oxfordshire has a greater capacity need with a higher population count but Buckinghamshire and Berkshire West have greater deprivation issues. The emerging digital and data strategy places the level of investment needed at £147 million. How will that be shared proportionately at place? Will there be a single system-wide commissioning / procurement strategy, or will equipment and software needs be met by the place-based teams?
- A key priority for delivery of continuity of care relies on robust data sharing arrangements, including shared patient records. The data and digital strategy states that over the next 12 months (unclear what the timeframe is) the development of clear priorities to support digitisation of Pharmacy, Optometry and Dentistry services will be established. Investment in, and delivery of, a robust digital and data solution across BOB is fundamental to the successful delivery of the primary care strategy. As mentioned above, how well aligned are these strategies as it is not clear in the strategy document?
- How much consideration has been given to the growing concerns around digital exclusion, the scale of the issue and the impact a move to virtual consultations will have on the population? How will the shortcomings realised by digital exclusion be identified and addressed? In addition, how will a perceived lack of public trust in data sharing be overcome?

Estates

- The strategy details estates pressures and states that in Bucks, approximately 570,000 patients are served by a primary care estate of approximately 24,121m$_2$.

This needs some context as we assume this is not a good statistic but how does this figure compare to other parts of BOB?

- We recognise the need for an extensive review of estates, and we do not under-estimate the challenges around this, however, the primary care strategy is light on details around how the ICB will be addressing some of the findings in the Fuller report.
- The Fuller report acknowledges that much of the general practice and wider primary care estate across the country is not up to scratch and goes on to state that there needs to be a detailed review of the space available at each system, service by service, to inform the ICS estates infrastructure strategies. The report also says that there is a need to build estates models that align with clinical, digital and workforce. Will this detailed work be completed by the ICB or by each of the place-based teams?
- The work detailed in the Fuller report around estates needs to be undertaken as a priority otherwise the ambitions around Integrated Neighbourhood Teams will not be realised. Careful consideration of wider concerns that the plan could exacerbate existing estate issues need to be addressed, i.e. will PCNs find they have to relinquish space to accommodate Neighbourhood Teams when they are already struggling to accommodate extra staff employed under the ARRS.

- With estates playing such a key role in successfully delivering the primary care strategy, we seek assurance that there are clear timeframes for reviewing estates at Place and the necessary future planning of primary care estates to meet the ambitions described in the strategy. We cannot emphasise enough the importance of strong communications between the ICB and the local authorities planning departments.

- Will the ambitions to deliver same day care include the provision of physical sites? If so, locations will need to be well planned and allow good access to and via public transport. A strong balance of rural and urban locations will be needed to ensure ease of access and delivery to ensure strong uptake.

Resources

- A key concern with the ICB strategies produced so far is around capacity and resource to deliver such ambitious plans, within relatively short timeframes.

- As mentioned earlier, the success of this strategy relies heavily on positive buy-in from all primary care providers. Without this buy-in, it could lead to greater disparity in terms of access to services across BOB and mean that some residents could be more disadvantaged through decisions made locally. Before the strategy is approved by the Board, we would like to see strong evidence, provided by primary care providers, which brings together their concerns and a clear response as to how these concerns will be addressed.

Please accept this letter as the BOB JHOSC's formal response to the BOB ICB's draft primary care strategy, as part of the key stakeholder engagement process. As discussed at the JHOSC meeting, we would like to invite you and your colleagues to future JHOSC meetings to update Members on the progress in delivering this key strategy across BOB. We would also welcome far greater clarity in the future of the role that stakeholder consultation and JHOSC scrutiny will have within your regular evaluations of how this crucial roadmap evolves.

Yours sincerely

Cllr Jane MacBean
Chairman, Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview & Scrutiny Committee

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Dr Rachael De Caux
Deputy Chief Executive/Chief Medical Officer
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

cc. Dr Abid Irfan, Director of Primary Care
Louise Smith, Deputy Director of Primary Care
Sim Scavazza, ICB Acting Chair
Dr Nick Broughton, ICB Chief Executive Officer (Interim)
Catherine Mountford, ICB Director of Governance
Hannah Iqbal, Chief Strategy and Partnerships Officer
Sarah Adair, Director of Communications and Engagement

29th February 2024

Dear Rachael,

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board's (BOB ICB) draft primary care strategy

As Chairman of the Buckinghamshire Health and Adult Social Care Select Committee, I am writing to provide a formal response to the ICB's draft primary care strategy, on behalf of Committee Members. Whilst Members have not considered the draft strategy within a formal meeting, they have reviewed it and provided feedback. This letter brings together their comments and observations on the strategy.

For ease, I have grouped the feedback under the headings used within the strategy document – Pillars of Primary Care, Priorities and Enablers, as well as more general, overall comments.

General comments

- Having a plan for primary care has been acknowledged as a positive step for the BOB Integrated Care System but Members are concerned about the ambitions detailed in the strategy. The strategy is high level, covering a large geographical area with significant differences in how people access primary care services across the wider system. We feel the challenges in bringing health and social care partners on this transformation journey are significant and the risks in being unable to deliver the priorities are a key concern for Members.

- From a local scrutiny point of view, the local delivery plans will provide a more useful basis upon which to evaluate the success in delivering improvements in primary care for residents. We would like to understand who will be leading on developing these delivery plans locally and the timescales for doing so. More about capacity concerns later.
- Whilst recognising that the strategy is in draft format and feedback from key stakeholders may lead to refinement and revisions, we feel that the draft strategy stops short on the next steps. We would welcome a draft timescale for developing the delivery plans for each priority and a summary of the key pieces of work which need to be undertaken in each priority area.
- We would like to see robust comms and engagement programmes as an integral part of each delivery plan to ensure everyone is part of this ambitious transformation programme and has an opportunity to help shape the plans as they are developed.

Pillars of Primary Care

- We are aware of the existing challenges within the pharmacy sector, with the draft strategy stating that many pharmacists are leaving the sector. The strategy does not provide any detail on a recovery plan or a plan to address their challenges.
- Through a recent HASC Select Committee inquiry, we heard about the statutory Pharmaceutical Needs Assessments and would like to encourage close working between the ICB, local pharmacy committees and Public Health to ensure the challenges around pharmacy can be discussed and addressed through this process. Our inquiry also recommended closer working with the council's planning team to ensure current and future housing growth is given due consideration when looking at the local pharmacy needs.
- In terms of GP capacity, we would like to understand the impact that GPs working in the integrated neighbourhood teams will have on GP capacity within local surgeries. We are aware of the shortages in recruiting GPs so would be interested to hear how this will work in practice.
- The strategy provides details on improvements to address capacity within general practice, including new ways of treating patients. However, there is very little specific detail on dentistry and pharmacy and the plans to improve access to these services. Both are an important element of primary care so it feels as though more detailed work needs to be undertaken in both areas within the strategy and subsequent delivery plans.

Priorities

As a local scrutiny committee, we undertook an inquiry into the development of Primary Care Networks (PCNs) in Buckinghamshire. During this inquiry, it became clear that PCNs are developing at different rates due to their success in recruiting and retaining to the additional roles specified as part of the Additional Roles Reimbursement Scheme. Patient Participation Groups were highlighted as being instrumental in being the conduit between the practice and its patients and helping to shape and inform service delivery. We hope that this strategy has been co-designed with local PPGs and their feedback will continue to be sought as the strategy and delivery plans are progressed. We would be interested to know how pharmacy, optometry and dentistry operate, in terms of gathering patient experience information to help shape services.

Streamlining access to provide non-complex same-day care

- It is not clear in the strategy whether the same-day care will be provided using physical sites. If so, the location of any physical building needs to be well thought out and allow for consistent access to public transport links, particularly for our elderly residents.

Developing Integrated Neighbourhood Teams to deliver continuity of care

- We are concerned about the introduction of Integrated Neighbourhood Teams as a new concept and feel that more explanation needs to be provided in the strategy around how this team will work with PCNs, as the geographical footprints are not aligned.
- We feel that the communications around this need to be strong and very clear about how the teams work together for patients within their communities.

Focus on prevention, particularly Cardio-vascular disease (CVD)

- We are not clear where the funding will come from for the schemes highlighted in the strategy. We are aware that some of the proposed interventions, such as Health checks, already have a below target take-up rate so we feel that more variety and successful interventions in the community will be needed to deliver this priority.
- In Buckinghamshire, the Director of Public Health Annual report focussed on CVD last year and we are aware of several recommendations aimed at the health and social care system to help tackle CVD. We will be evaluating this at a future Select Committee meeting and we hope this work will be the starting point for developing this priority area.

Enablers

Workforce

- We read with interest the BOB staff passport but recognise the challenges in introducing this across the geographical footprint and the potential increased risk to staff wellbeing associated with changes in working arrangements.
- As mentioned earlier, we have reviewed the development of Primary Care Networks and one of the key findings was the challenge in recruiting to some of the additional roles. We are acutely aware of workforce pressures across the whole health and care system. We feel the plans around workforce need to be developed soon to support delivery of the primary care strategy.
- Workforce capacity across the wider system to support the integrated neighbourhood teams remains a concern and we would like to see evidence from partner organisations, such as the police, adult social care, community health providers and mental health providers, that they have the capacity to support the development of these teams.

Digital and Data

- Through the recent inquiry into future planning for primary healthcare, the issues with consistent data collection and the challenges around data sharing were highlighted. We remain concerned about this, particularly at a local level and feel

that pace needs to be given to delivering better digital and data solutions to those working in primary care.

- The aspirations around continuity of care will not be realised unless solutions can be implemented around robust data collection to inform population health management and digital solutions to aid delivery of a joined-up health and social care system. The ICB's digital and data strategy does not currently outline funding for some of the activities associated with Population Health Management so we remain concerned about delivery in this area and the impact this will have on the overall delivery of the primary care strategy.

Estates

- One of the biggest challenges in Buckinghamshire (and we suspect the other parts of BOB), is the current state of primary care estates and the lack of agreed plans for future provision. Having just undertaken a review into planning for future primary healthcare, we recognise the complexities around estates ownership within primary care. The draft strategy does not offer any solutions and we are concerned that demand for estates could be exacerbated by the additional roles within PCNs requiring physical space and the development of local action teams and integrated neighbourhood teams.
- We feel that the Place-based Partnership needs to focus on improving estates first to allow for the local action team and integrated neighbourhood team to succeed with their priorities. Extensive buy-in and engagement with GPs will be crucial and we feel the strategy needs to be strengthened around how the ICB will support and work with GPs.
- The strategy states that in Bucks, approximately 570,000 patients are served by a primary care estate of approximately 24,121m2. This needs some context as we assume this is not a good statistic and it would help to know how this figure compares to other parts of BOB.
- We recognise the need for an extensive review of primary care estates and we do not under-estimate the challenges associated with this. However, the primary care strategy is light on details about how the ICB will be supporting and addressing some of the key findings in the Fuller Stocktake report.
- The work detailed in the Fuller report around estates needs to be undertaken as a priority otherwise the ambitions around delivering new models of primary care will not be realised.
- We seek assurances that there are clear timeframes for reviewing estates at Place and developing a local estates plan to meet the ambitions described in the strategy.

Resources

- We have major concerns around capacity and resource to deliver such an ambitious strategy. We are not clear about the level of resource within the ICB to help support delivery of this strategy at Place. Without the right level of dedicated resource to drive this significant change programme, it will not deliver. With the known challenges and pressures on the ICB, and the system as a whole, we would like assurance that there is significant resource allocated within primary care and the ICB to deliver the strategy across BOB.

- Linked to the point above, the success of this strategy relies heavily on positive buy-in from all primary care providers, social care, mental health providers, the police and community health providers. Without this buy-in, it could lead to greater disparity in terms of access to services across BOB and mean that some residents could be more disadvantaged through decisions made locally. Before the strategy is approved by the Board, we would like to see strong evidence, provided by all these key providers in the system, which brings together their concerns and a clear response as to how these concerns will be addressed.

Please accept this letter as Buckinghamshire's Health & Adult Social Care Select Committee's formal response to the Buckinghamshire, Oxfordshire and Berkshire West's Integrated Care Board's draft primary care strategy. We will be inviting ICB colleagues to future HASC Select Committee meetings as the key elements of the strategy start to be developed and delivered.

Yours sincerely

Cllr Jane MacBean
Chairman, Health & Adult Social Care Select Committee (Buckinghamshire)

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Victoria Otley-Groom
Chief Digital and Information Officer
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

cc. Sim Scavazza, ICB Acting Chair
Dr Nick Broughton, ICB Chief Executive Officer (Interim)
Catherine Mountford, ICB Director of Governance

13th March 2024

Dear Victoria,

On behalf of the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee (JHOSC), I am writing to provide feedback on the BOB ICB's Digital and Data strategy. The JHOSC set-up a working group of Members to review the strategy approved by the ICB Board in May 2023 and the update paper which was discussed at the Board meeting in November 2023.

We would like to start by saying that we fully support the need for this strategy and, as Members of the JHOSC, we welcome it. For ease, I have grouped the comments made by the working group under headings, similar to those detailed in the update paper – system governance, stakeholder engagement, delivery and finances. The working group also has some overall comments and observations on the strategy, as detailed below.

General Comments

From a lay person's perspective, there are references throughout the strategy about what good looks like and the aspirations around delivering the strategy, but as a resident, what will be different at the end of the digital and data transformation? A clear, user-friendly explanation of what a truly integrated digital health and care system looks like, where we currently are on this transformation journey and how it benefits residents when it is fully implemented would help to put the strategy into context.

The timeframes for delivering this strategy are not clear and need to be confirmed. The strategy document states that it is a three-year strategy, which was approved by the ICB in May 2023, yet page 29 indicates that the strategy is for 2022-2025. The cyber security strategy funding was going to be locally funded but now appears to be delayed until 2024. We have concerns about delivering this ambitious strategy, particularly as funding has not been agreed against some of the key projects. There are already signs of slippage, which we

feel will be further exacerbated by a lack of clarity around how and when funding will be forthcoming.

The strategy states that one of its commitments is to contribute toward reducing health inequalities. However, there is little identification of how technology can be utilised, harnessed, and maximised to this effect. There appears to be a disconnect between the commitment to using technology for reducing inequalities on the one hand, and the ways in which there are plans to use technology to achieve such outcomes for the population. We would like to see some clarity around this.

From our understanding of strategy development, best practice indicates that the document should identify the starting point to build the future strategy from – the "as-is" situation. The strategy infers that the "as-is" situation is not the ideal situation. It states - "***To deliver our Strategy successfully, we will need to change our ways of working to realise the benefits of being unified as a system***". We feel that the as-is situation is not clearly laid out in simple terms or diagrams which can be understood by the lay reader.

System Governance

We were pleased to see a detailed description and understanding of the governance arrangements around how the strategy will operate. However, as a joint health scrutiny committee, one of our key roles is to independently review and challenge the development of strategies being developed by health and social care partners and to drive improved outcomes for all our residents. We do not feel that scrutiny has been given due consideration as part of the governance process and would like to see this strengthened as the activities within the strategy start to be delivered.

Stakeholder Engagement

The strategy relies heavily on partnership working across health and social care. As the strategy is delivered, we would like to see evidence of close collaboration with adult social care, mental health providers, Hospital Trusts and providers across primary care.

We feel that ongoing engagement with residents across the BOB footprint for the purposes of understanding how they currently use technology, and how they feel it could be utilised for their benefit, is a key part of developing this strategy. An action for 2023 was to produce an ICS Digital Patient Engagement strategy. Can the JHOSC have sight of this strategy to help evaluate the strength of patient engagement?

Given that the strategy also encompasses patient data, lived experience and co-production needs must be evidenced as the strategy is delivered. There is specific inclusion of a Data Charter, although it is not clear what this is. Co-production of a Charter, including reasonable expectations of the public regarding Digital, would be helpful in building public understanding and trust.

We also felt that the strategy was light in terms of Primary Care, particularly for general practice and Primary Care Networks. We would like reassurance that GPs are receiving

digital and data support to help them deliver robust population health management and meet the health needs of local communities within their PCN.

Implementation & Delivery Against Timeframes

The strategy states that 8 actions will be prioritised and delivered in 2023. From the update paper in November, there appears to have been some delay in delivering some of the actions. Could we have a written update on each of the 8 actions so we can understand what progress has been made, the impact any delays have had on other deliverables in the strategy and the revised timeframes.

In terms of digital and data maturity, there is clear disparity across the BOB Hospital Trusts, with some parts of the system requiring significant investment to move forward on their maturity journey. We would like to see the specific action plans at Place, to include costs and timeframes.

Similarly, there is mention of re-procuring GP principle clinical systems. However, there doesn't appear to be a plan for deployment of systems to GP surgeries, which is probably one of the key considerations. How will the ICB strategy work with surgeries that are independent, often with dramatically varied levels of hardware and software adoption? Part of this might be overcome by the move to establish an ICS Cloud Strategy. However, we note that the Cloud Strategy has not been defined and there does not appear to be an implementation and deployment plan.

The strategy mentions that a Cyber Security Strategy will be drafted in 2024. The strategy does not refer to lessons learnt from Oxford Health's cyber-attack in 2022, particularly around building resilience within the organisation and with partners to prevent further attacks. Could the cyber security strategy be shared with JHOSC Members so we can be reassured that these issues have been addressed.

A digital strategy implementation plan is mentioned and needs to be developed. No timescale has been given for this work, but we feel that this should be a priority to allow for improvements in the way the health and care system deals with data going forward.

Monitoring & Accountability

We would like to see clear Key Performance Indicators against each activity so they can be measured effectively. This will allow not only a higher degree of transparency for the public and stakeholders regarding the effectiveness of delivery but will also enable the ICB and providers to self-assess the degree to which technology is having an impact on services and improving patient experience.

Finances

We have several concerns around funding, particularly those projects which do not currently have a funding stream allocated to them and have some questions which are set out below.

- We understand that out of 13 roadmap activities, 4 have funding agreed, one is a national initiative but what about the other activities which do not have any identified funding? What is the process for applying for funding and how is it then allocated across BOB?
- What reassurance can the ICB provide around the fact that only 4 activities have funding agreed, 3 activities are pending approval and 5 activities have not had funding identified. How are the risks being managed if funding is not granted through the bidding process?
- Page 29 details the costed portfolio summary and shows matched funding of £640,000 which has been agreed to digitise adult social care. How has this figure been worked out and who is providing the match funding?
- Page 8 of the strategy states that one of the key design principles is population Health-led which "will be led by population health data in evaluating our investments to further the outcomes of our population". Page 29 shows that Population Health Management does not have an identified funding stream – it has been costed at £894,954. If this is one of the fundamental principles, why hasn't funding already been agreed and what are the risks around not being able to fund this activity? How has this figure been put together and what does this deliver across BOB?
- Page 15 states that – "*Over the next 12 months the development of clear priorities to support digitisation of Pharmacy, Optometry and Dentistry will be established".* We would like to see these priorities and the plans to help support digital transformation of POD services, both financially and additional capacity.
- The strategy states that the projected total cost to implement the strategy is £143.9million. With the financial challenges facing the health and social care sector, what contingencies are in place if funding is not available and how does this cost compare to other ICBs of a similar size to BOB?

<u>Leadership, Transparency & Capacity</u>

We are concerned about capacity across BOB to deliver the actions outlined in the strategy. With significant workforce challenges and budget pressures facing the system, we would like to understand the current levels of resource allocated to the digital transformation team, both within the ICB and key partner organisations who are responsible for delivering the key elements of the strategy – Hospital Trusts, Oxford Health, Adult Social Care and Primary Care. Has additional funding been made available to strengthen the digital teams to help deliver the strategy?

The strategy relies heavily on engagement and buy-in from health and social care partners. We feel there needs to be strong leadership and ownership of the activities outlined in the strategy to ensure successful delivery. We would like to see evidence of this leadership with named individuals against the key deliverables.

In addition, there does not appear to be any detail around the ICB team that are leading this work. The governance structure on page 23 jumps from a singular ICB CIO straight to Provider Leads / ICS Analytics / ICS Infrastructure / ICS Cyber Security but it remains unclear how these roles and/or teams relate to one another and report into the ICB CIO. Best practice, policies, standards, Cloud infrastructure, Cloud Deployment, etc, should be created

and monitored centrally. Having a virtual team with no formal structure and control feels insufficient for a programme of this scale.

Please accept this letter as the BOB JHOSC's formal feedback to the BOB ICB Digital and Data Strategy and we look forward to receiving a response on the specific points and questions raised above. We would also like to invite you to a future JHOSC meeting to present to JHOSC Members on the progress in delivering this strategy across BOB.

Yours sincerely

Cllr Jane MacBean
Chairman, Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview & Scrutiny Committee

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Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

NHS Dental services in Buckinghamshire, Oxfordshire and Berkshire West

Report to:

Reading Adult Social Care, Children's and Education (ACE) Committee meeting 20th March 2024

Buckinghamshire Health and Adult Social Care Select Committee meeting, 11th April 2024

Oxfordshire Health Overview and Scrutiny Committee, 18th April 2024

The West Berkshire and Wokingham Health and Well-Being Boards

Hugh O'Keeffe, Senior Programme Manager - Pharmacy, Optometry and Dental

March 2024

Contents

	Page
1. Introduction	3
2. Dental Services in Buckinghamshire	4
3. Access to services	6
4. Contract Delivery	8
5. Access challenges	10
6. Actions to address challenges	13
6.1 Temporary UDAs	13
6.2 Payment for contract overperformance	14
6.3 Additional Access sessions	14
6.4 Flexible Commissioning	15
6.5 Replacing the lost activity	17
6.6 Changes to the NHS Dental contract 2024	18
7. Summary	19

1. Introduction

On 1st July 2022 the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board took on delegated responsibility for Dentistry, alongside Pharmacy and Optometry. Integrated Care Boards (ICBs) have an explicit purpose to improve health outcomes for their whole population and the delegation will allow the ICB to integrate services to enable decisions to be taken as close as possible to their residents. The ICB is working to ensure their residents can experience joined up care, with an increased focus on prevention, addressing inequalities and achieve better access to dental care and advice.

The ICB discharges its responsibility for dental commissioning in partnership with NHS Frimley who host a Commissioning hub for Pharmacy, Optometry and Dental Services, providing operational leadership within ICB governance structures.

Clinical engagement is achieved via a Local Dental Network (LDN) covering the Thames Valley area (Buckinghamshire, Oxfordshire, Berkshire West and Berkshire East). This is a clinically led group involving Dentists, Dental Public Consultants, representatives from Health Education England and the Local Dental Committees and service commissioners. Reporting to the LDN are specialist led Managed Clinical Networks for Oral Surgery, Orthodontics, Restorative Dentistry and Special Care and Paediatrics.

Patients are not registered with a dentist in the same way as they are with a GP. A dental practice is only responsible for a patient's care while in treatment, although many will maintain a list of regular patients so may only have the capacity to take on new patients when patients do not return for scheduled check-ups or advise they are moving away from the area.

Dental practices deliver services via cash limited contracts with the NHS in which they are required to deliver agreed levels of activity each year.

Since the onset of the pandemic dental services have faced major challenges. Enhanced infection control procedures, necessitated by the types of procedures carried out in dental surgeries, led to reduced dental capacity. Their capacity has been gradually increased as infection rates have dropped, under strict guidance aimed at keeping patients and staff safe. Since July 2022 that practices have returned to full capacity.

Although the gradual increase has improved access to dental care there remains backlog of care from earlier in the pandemic that will take some considerable time to address. The rate of recovery is being impacted by the greater oral health needs of patients due to gaps in their attendance with

treatment plans taking longer to complete and some practices have decided to cease NHS provision. This has impacted primary care dental services and referral services including hospital and a range of community-based services.

This paper provides update position in terms of access to primary care dental services and the actions being taken to address challenges.

2. Dental services in Buckinghamshire

Primary and community dental services are commissioned via contracts which fall within the NHS (General/Personal) Dental Services Regulations 2005. Some of these services provide direct patient access and others are accessed via professional referral. Secondary care (hospital) providers deliver services on referral under NHS standard contracts.

NHS Patient Charge Regulations apply to the contracts falling within the 2005 Regulations, but not to services provided under NHS standard contracts for service delivered in acute hospital settings. The patient charges relate to the bands of treatment delivered in primary care. Services are delivered under treatment Bands 1, 2 and 3. The link below provides more details:

https://www.nhs.uk/nhs-services/dentists/dental-costs/how-much-will-i-pay-for-nhs-dental-treatment/

Providers of NHS primary care services are independent contractors in receipt of cash limited financial allocations from the NHS. All practices also deliver private dental care. Some provide NHS services to all groups of patients, but some are for children and charge exempt patients only. The providers are required to deliver pre agreed planned levels of activity each year, known as Units of Dental Activity (UDAs). The UDAs relate to the treatment bands delivered by the practices.

Patients are not registered with practices but are encouraged to attend at regular intervals with the regularity of attendance based upon their assessed oral health needs. In the Thames Valley area (Buckinghamshire, Oxfordshire, Berkshire East* and Berkshire West) prior to the pandemic, about 1.1m people (52% of the population) attended an NHS Dentist on a regular basis (attendance within a 2-year period).

**Since July 2022 Berkshire East has been part of the NHS Frimley ICB*

The % of the population attending NHS dental services in Buckinghamshire prior to the pandemic was below the overall average for the Thames Valley area with 43.7% of patients (adults and children) attending an NHS Dental practice

over a 2 year period. The table below provides more detail of the numbers attending in October 2018:

Table 1 Number of patients attending NHS Dental practices in Buckinghamshire in 2018

Local Authority	Population (children)	Number attending	% attendance	Population (adults)	Number attending	% attendance	Number attending (total)	% attendance (total)
Aylesbury Vale	44,423	24,655	55.5%	148,286	59,166	39.9%	192,709	43.5%
Chiltern	22,080	10,996	49.8%	73,082	22,290	30.5%	95,162	35.0%
South Bucks	15,138	10,551	69.7%	54,671	33,732	61.7%	68,809	64.4%
Wycombe	40,747	21,148	51.9%	134,694	49,702	36.9%	175,441	40.4%
Bucks	**122,388**	**67,350**	**55.07%**	**410,733**	**164,890**	**40.14%**	**532,131**	**43.7%**

Details of practices providing NHS dental care can be found on: https://www.nhs.uk/service-search/find-a-dentist

In addition to the services delivered in primary care there are other NHS dental services. They are:

- Unscheduled Dental Care (UDC) – most 'urgent' treatment needs are met by the local dental practices. In addition to this there are services that provide back-up in the day and on evenings, weekends and bank holidays. Urgent dental care can be accessed via the practice normally attended by a patient or via NHS 111
- Orthodontics - these services are based in 'primary care' but are specialist in nature and provide treatment on referral for children for the fitting of braces.
- Special Care Dentistry and Paediatrics (also known as Community Dental Services) – services for patients who have additional needs which makes treatment in a primary care setting difficult. This includes treatment both in clinic and in hospital for extractions carried out under General Anaesthetic. This service also provides some of the unscheduled dental care.
- Hospital services – for more specialist treatment needs delivering Oral and Maxillofacial Surgery and Orthodontic services.
- Tier 2 Oral Surgery (more complex extractions) and Restorative (Root canal, treatment of gum disease and dentures) – provide more complex community-based treatments than in primary care but do not require treatment in hospital.

The tables below detail NHS Dental services available in Buckinghamshire

Table 2 NHS Dental services in Buckinghamshire

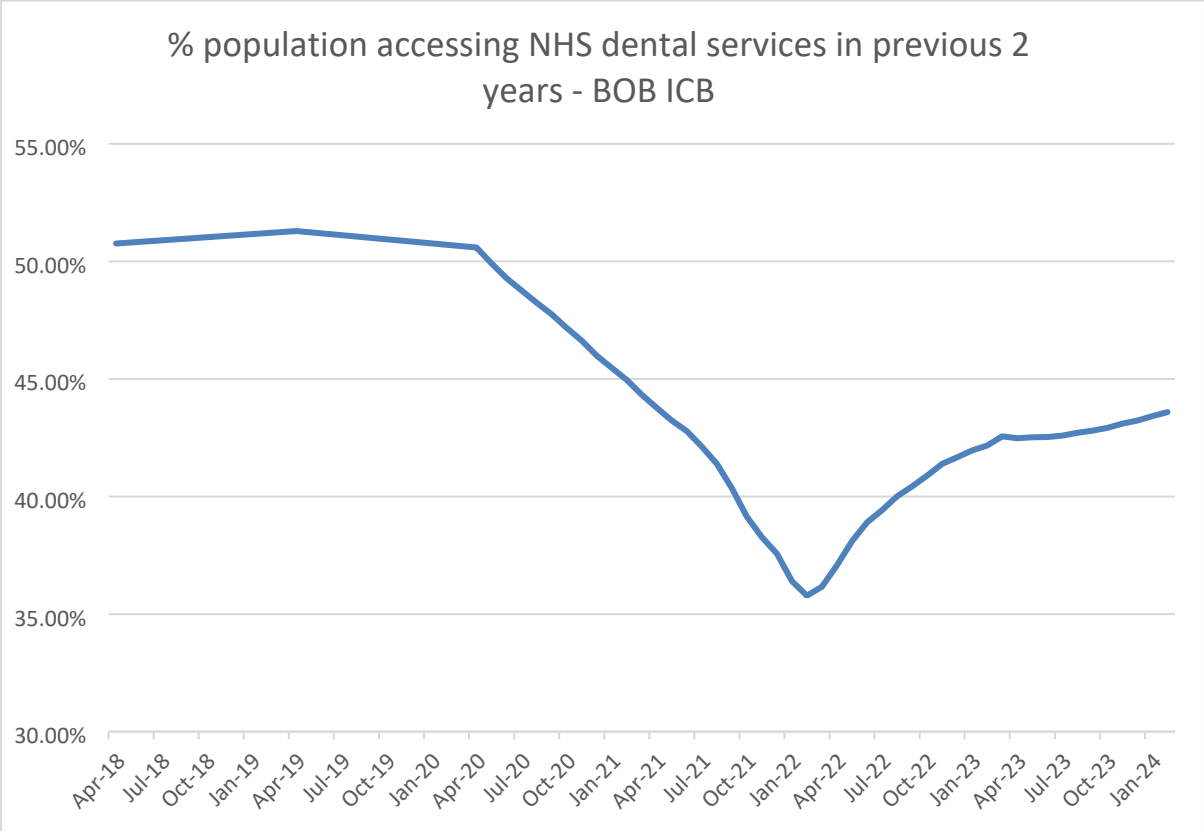
Service	Number of providers	Units of Activity	Contract value
Primary Care	71	608,255	£18,571k
Orthodontics			
Community Dental Service	1	7,259	£2,293k
Tier 2 Oral Surgery	1	7,539	£664.6k
Tier 2 Restorative	1	2,235	£268.3k
Secondary Dental	1	-	£4,000k

3. Access to services

This report focusses on access to primary care dental services as most of the concerns about access since the pandemic have related to primary care. Access to primary care dental services is measured on the basis of the number of unique patients attending over a 2 year period. The introduction of the current dental contract in 2006 was accompanied by a programme of ringfenced financial investment under the Dental Access Programme designed to recover NHS dental access which had fallen significantly following the introduction of the 1992 contract. Access to NHS Dentistry in the Thames Valley (BOB plus Berkshire East) increased from about 43% of the population in 2008 to about 51% in 2019 (an increase of about 250,000 people; 25%).

The impact of the pandemic was such that by early 2022, the number of patients attending BOB ICB dental practices in the previous 2 years fell below 36%. Since then, there has been a recovery in access. In February 2024, 43.59% of the BOB ICB population (751,324 people, an increase of 134,716 compared to February 2022) had attended an NHS dental practice in the previous 2 years. This is the second highest percentage in the South-East Region.

Table 3 Access to NHS Dental services in BOB 2018 – 2024

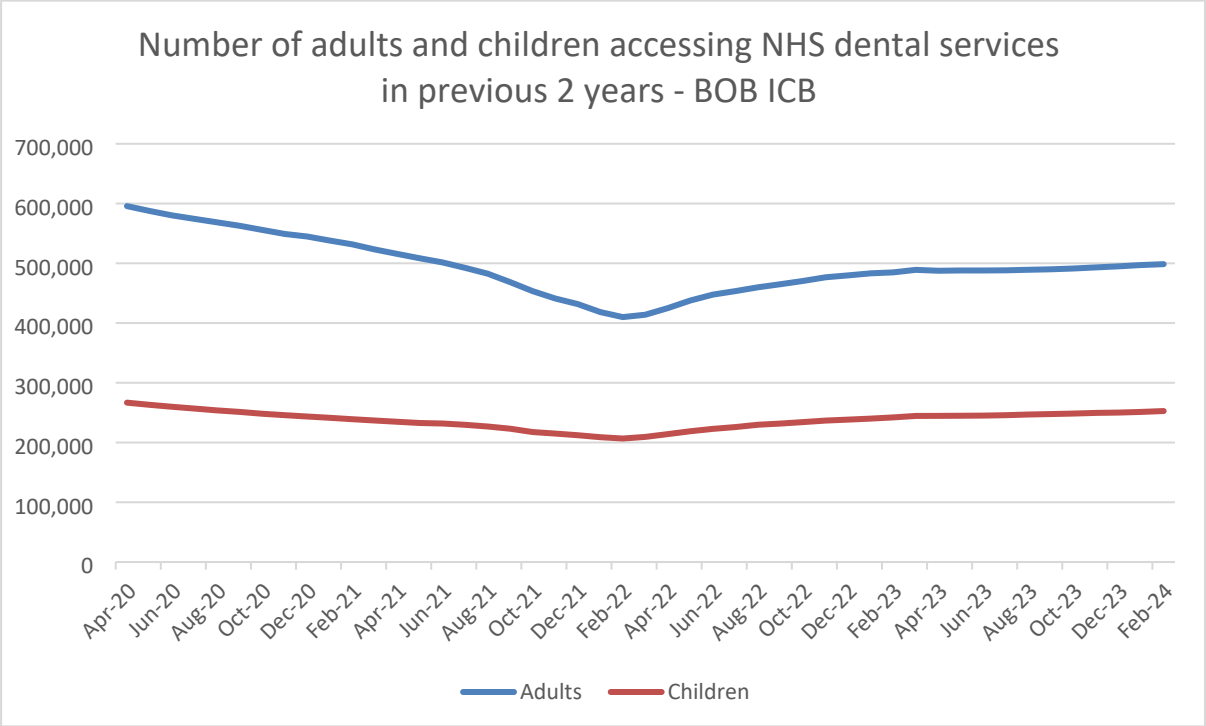


The rate of increased access has been similar for adults and children. The table and chart below detail the numbers of adults and children in BOB accessing NHS dental services in this period:

Table 4 Number of people accessing NHS Dental services in BOB February 2022 and January 2024

Patient group	Number attending Feb '22	Number attending Feb '24	Increase	% increase
Adults	409,943	498,539	88,596	21.6%
Children	206,665	252,695	46,030	22.3%
Total	**616,608**	**751,324**	**134,716**	**21.8%**

Table 5 Number of adults and children accessing NHS Dental services 2020 - 2024



However, the number attending is still some way below the pre-pandemic figures of 51.29% attending pre-pandemic.

As capacity has been increased practices have been able to deliver more of their contracted activity. Practices are required to deliver an agreed number of Units of Dental Activity (UDAs) each year. The UDA payment bands relate to the patient treatment bands under the NHS Patient Charges Regulations 2005.

https://www.nhs.uk/nhs-services/dentists/dental-costs/how-much-will-i-pay-for-nhs-dental-treatment/

4. Contract Delivery

Practices are paid on the basis of delivery of an agreed level of activity each year. In BOB, in April 2022 the ICB commissioned about 1.26 UDAs per head with Oxfordshire the highest at 1.41; Berkshire West 1.20 and Buckinghamshire 1.12. There is also variation between each local authorities, varying from 0.94 in Bucks East to 1.85 in Oxford.

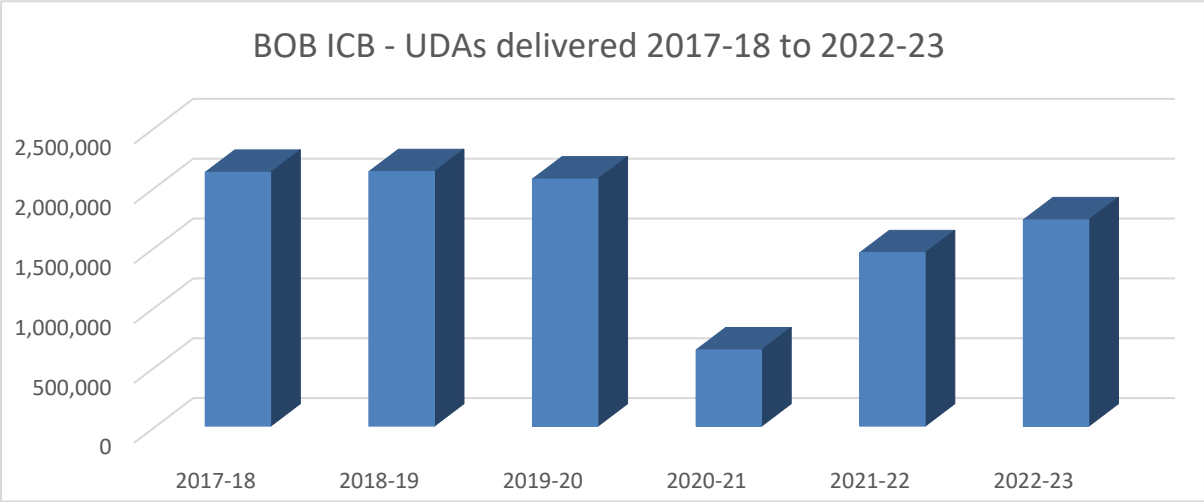
These levels are based on levels of activity commissioned at the point the current dental contract took effect in 2006 and any additional activity commissioned by the PCT or NHS England since then.

Table 6 UDAs commissioned per head April 2022

Local Authority	**UDAs commissioned per head April '22**
Bucks Central and North (formerly Aylesbury Vale)	1.02
Bucks East (formerly Chiltern)	0.94
Bucks South (formerly South Bucks)	1.70
Bucks West (formerly Wycombe)	1.13
Bucks	**1.12**
Cherwell	1.70
Oxford	1.85
South Oxon	1.04
Vale of the White Horse	0.96
West Oxon	1.36
Oxon	**1.41**
Reading	1.46
West Berks	1.08
Wokingham	1.07
Berks West	**1.20**
BOB	**1.26**

Practices are contractually required to deliver a minimum of 96% of contracted activity each year to avoid financial recoveries. If they fall below this threshold financial recovery will be made. Prior to the pandemic the average annual delivery in the BOB area was about 95%. Contract delivery requirements were relaxed during the pandemic as the practices operated at below 100% capacity between 2020 -22. Since the peak of the pandemic contract delivery has been increasing and this has supported increased access. In 2022-23, about 80% of contracted activity was delivered in BOB.

Table 7 BOB ICB – UDAs delivered 2017-18 to 2022-23



Whilst this is significant increase on the peak pandemic year of 2020-21 (28% of UDAs delivered) it is still some way below pre-pandemic levels.

There is also significant variation within the ICB. In Buckinghamshire and Berkshire West in 2022-23, about 85% of contracted activity was delivered; in Oxfordshire it was about 74%.

5. Access challenges

There are a number of challenges that continue to impact access to NHS services. Many of the patients who have attended dental practices since the pandemic have increased treatment needs due to increased gaps in attendance. This means their treatment plans are taking longer to complete. For some patients who had previously attended local practices prior to the pandemic it has been difficult to access care and that challenge has been even greater for people who have not attended a local service for a number of years or who have relocated to the area.

The commissioner has received high numbers of queries, concerns, complaints, and MP letters as a result.

For some Dentists this has had an impact on whether they wish to continue providing NHS services. To seek to retain Dentists, many practices have increased pay to their staff but, if many patients have increased treatment needs this may impact on the practices' ability to achieve contracted activity targets. The annual financial uplifts applied to dental contracts are set nationally, but many practices have advised that these increases fall below the additional costs being incurred. This combination of factors has two main effects. It can make practices reluctant to take on new patients (due to likely

additional treatment need and costs of treatment) and their NHS business may become less profitable. This has meant that some practices have decided to either hand back their contracts or reduce their NHS commitment. When they leave the NHS, they provide dentistry on a private basis. Patients are then invited to join them on that basis and the practice will also advise about other NHS practices in the area, with the effect of increasing pressure on those practices.

Since 2021, 17 practices in BOB have handed back their contracts and 8 have reduced their NHS commitment. A total of 108,872 UDAs have been lost as a result of this, which is about 4.9% of the total capacity. The table below details the contract handbacks:

Table 8 Contract handbacks and reductions

County	Local Authority	Practice name	Dare of contract expiry	Number of UDAs handed back	% UDAs lost to area
Buckinghamshire	Aylesbury Vale (now Bucks North and Central)	Mr C J Morris	19.07.2022	1,443	
		Miss E H Nichols	31.03.2023	500	
		Long Crendon Dental Practice	31.08.2023	2,164	
		Dr Balaji	31.03.2024	360	
	Aylesbury Vale Total			**4,467**	**2.20%**
	South Bucks (now Bucks South)	Mr P C Brash	30.06.2022	760	0.64%
	Chiltern (Bucks East)	Mr M A Ladak	Reduction 2023-24	3,306	3.67%
	Wycombe (now Bucks West)	No handbacks			
Bucks total				**8,533**	**1.40%**
Oxfordshire	Cherwell	Market Square Dental Practice, Bicester	28.02.2023	8,424	
		Bicester Dental Care	Reduction 2023-24	6,194	
	Cherwell total			**14,618**	**5.73%**
	Oxford	Mr AK Murgai	30.09.2022	200	

		Mr D Duggan	Reduction 2021-22	2,784	
	Oxford total			**2,984**	**1.06%**
	South Oxfordshire	Mr S Patel, Henley	31.10.2022	190	
		Portman Healthcare, Henley	31.07.2022	1,308	
	South Oxon total			**1,498**	**0.97%**
	Vale of the White Horse	Nicholas Harrison and Caitlin Devlin, Abingdon	31.05.2023	10,982	
		Portman Dental, Gloucester House, Faringdon	30.09.2023	19,387	
	Vale of the White Horse total			**30,369**	**23.20%**
	West Oxfordshire	Broadshires Dental Practice, Carterton	Reduction 2021-22 and handback 28.02.2023	5,111 6,000	
		Ratti GDS Partnership Witney	Reduction 2023-24	12,367	
		Charlbury Dental Practice	Reduction 2023-24	588	
		Oxford Therapy Ltd, Carteron	Reduction 2022-23	2,000	
		Mr MD Jackson	Reduction 2022-23	300	
		Tafft and Patel (Partnership)	Reduction 2023-24	926	
	West Oxon total			**27,292**	**17.25%**
Oxfordshire total				**76,761**	**7.88%**
Berkshire West	Reading	Greystone Dental Practice	31.10.2021	963	
		Alexandra Dental Practice	31.10.2021	675	

		Castle Hill Dental Practice	31.03.2023	8,250	
	Reading total			**9,888**	**4.03%**
	West Berkshire	No handbacks			
	Wokingham	Mr Z R Anwar	30.04.2023	9,276	5.08%
		The Gallery Dental Practice	31.01.2024	4,414	
	Wokingham total			**13,690**	**7.50%**
Berkshire West total				**23,578**	**3.90%**
BOB TOTAL				**108,872**	**4.90%**

6. Actions to address the challenges

6.1 Temporary UDAs

When contracts are handed back, local practices are approached about replacing the lost activity on a temporary basis. A total of 18,100 UDAs have been commissioned until 31st March 2024, detailed below:

Table 9 Temporary UDAs commissioned to 31st March 2024

Location	**Number of temporary UDAs to 31st March 2024**
Bucks Central	2,500
Buckinghamshire total	**2,500**
South Oxfordshire	1,000
West Oxfordshire	1,100
Oxfordshire total	**2,100**
Reading	3,500
Wokingham	10,000
Berkshire West total	**13,500**
BOB total	**18,100**

6.2 Payment for contract overperformance

National changes were made to the dental contract in late 2022 with practices able to deliver higher levels of activity each year; receive higher payments for more complex treatments and use greater skill mix in delivering services. A minimum UDA price of £23 was introduced; practices were reminded of the need to follow national guidance on recall intervals; they were required to update information about patient acceptance status on https://www.nhs.uk/service-search/find-a-dentist and ICBs could unilaterally rebase contracts for persistent underperformance from 2024-25 onwards.

One of the key changes was to allow practices to be paid to deliver up to 110% of their contracted activity in 2023-24 (up from 102%). In October 2023, the ICB wrote to the dental practices to say that it would pay for contract performance of up to 110% for the year. Twenty-six practices replied to say they planned to deliver up to 110% of contracted activity, breaking down as follows:

Table 10 Impact of 110% contract performance 2023-24

County	Number of additional UDAs 2023-24
Buckinghamshire	6,285
Oxfordshire	2,184
Berkshire West	19,909
BOB	**28,378**

Due to the activity caps placed on dental contracts, some practices have to slow down their activity as they get towards the end of the financial year. This allows increased provision in the final few months of the year if the practices have the capacity to provide it.

6.3 Additional Access sessions

During the coronavirus pandemic, NHS South-East commissioned Urgent Dental Centres where a small number of practices could provide treatment for patients with an urgent treatment need. In early 2021, a few months after practices began to re-open, these arrangements were changed to Additional Access sessions for patients who struggle to access care and need urgent dental treatment. There are 2 practices currently involved in the scheme in BOB; one in Reading and the other in Buckinghamshire. In the period April to October 2023, they provided 276 (3.5 hour) sessions with 1,022 patient attendances. The take-up of this scheme has been low mainly due to the

requirement to provide additional sessions when many practices are facing capacity constraints.

6.4 Flexible Commissioning

The ICB has also commissioned a Flexible Commissioning scheme for patients who have faced challenges access dental care. The allows dental practices to convert up to 10% of their contract value (national guidance issued in October 2023 increased this to up to 20%) from delivering activity targets to providing access sessions for patients who have struggled to access dental care. This allows more time for practices to treat patients with more complex needs

The following patient groups have been identified in priority groups for the scheme:

- Patients who have not attended a local dental practice for more than 2 years
- Patients relocating to the area
- Looked After Children
- Asylum seekers and refugees
- Families of Armed Forces personnel
- Other groups as identified by the practice

This is a pilot scheme for the period 1st June 2023 to 31st March 2024. 33 practices in BOB are taking part with plans to deliver just over 3,000 access (3.5 hour) sessions across the year.

The table below provides a breakdown of practices taking part in the scheme by Local Authority:

Table 11 Flexible Commissioning practices

Local Authority	Number of practices in FC scheme	Number of sessions June 2023 to March 2024
Bucks Central	2	221
Bucks East	0	0
Bucks North	1	95
Bucks South	0	0
Bucks West	5	326
Buckinghamshire	**8**	**642**
Cherwell	6	658
Oxford	6	834
South Oxfordshire	3	297

Vale of the White Horse	2	178
West Oxfordshire	3	203
Oxfordshire	**20**	**2,170**
Reading	1	23
West Berkshire	1	50
Wokingham	3	209
Berkshire West	**5**	**282**
BOB	**33**	**3,094**

The table below details the number of sessions provided and the type of patients seen.

Table 12 Flexible Commissioning activity June 2023 to February 2024

County	Number of practices	Planned sessions to March '24	Sessions delivered to Feb '24	No seen for 2 years	Relocating to area	Looked After Child	Family of Armed Forces	Asylum Seeker	Other*	New patients	Total attendances	Did Not Attend
Bucks	8	642	530	1,134	375	24	11	56	265	1,865	2,540	311
Oxon	20	2,170	1,883	4,834	699	69	105	205	340	6,252	8,721	778
Berks West	5	282	237	480	304	15	3	2	10	814	986	79
BOB	**33**	**3,094**	**2,600**	**6,448**	**1,378**	**108**	**119**	**263**	**615**	**8,931**	**12,247**	**1,168**

*includes urgent, vulnerable patients, maternity, clinical need

There was a higher take-up of the scheme in Oxfordshire where more practices have struggled to deliver their activity targets and patient access has been more difficult. The practices have seen an average of about 4.6 patients per session. Of the new patients seen about 87.5% were those who had not attended a dentist for 2 years or were relocating to the area.

The table below details the proportion of patients treated within each of the NHS treatment bands in the period up to the end of January 2024:

Table 13 Treatment bands under Flexible Commissioning

County	**Band 1**	**Band 2a**	**Band 2b**	**Band 2c**	**Band 3**	**Band 1a (urgent)**
Bucks	60%	17.1%	5.3%	0.3%	1.0%	16.3%
Oxon	46.9%	23.2%	8.6%	0.5%	1.2%	19.6%
Berks West	54.3%	20.3%	10.9%	0%	0%	14.5%
BOB	**50.2%**	**21.7%**	**8.0%**	**0.3%**	**1.1%**	**18.7%**

About half of the patients received check-ups, about 20% less complex Band 2 treatment and just under 20% were treated for an urgent need. Just under 10% of the patients received treatment for complex needs.

The scheme has been evaluated in terms of patient and provider feedback with positive responses received from both.

The ICB has agreed that the service should continue for a further year from 1st April 2024. Thirty-five practices have signed up to take part in the scheme, breaking down as follows:

- Buckinghamshire 9
- Oxfordshire 21
- Berkshire West 5

6.5 Replacing the lost activity

Arrangements for the commissioning of temporary UDAs end on 31st March 2024. The ICB has been working as part of an NHS South-East programme to replace UDAs that have been lost due to contract handbacks and reductions, with the aim of commencing implementation from April 2024. This has been pursued as a two-stage process. The first has been to approach local practices to apply to provide additional activity to replace what has been lost in their area. If this falls short of the activity sought the ICB will go out to procurement to seek new provision into the area.

The first stage of the process has been completed and practice applications for additional activity have been approved from 1st April 2024 on the following basis:

Table 14 Number and locations of approved applications for additional activity

Local Authority	**Additional UDAs to be commissioned from April 2024**	**Location(s)**
Bucks Central	7,356	Haddenham and Aylesbury
Bucks South	117	Chalfont St Peter
Bucks West	12,082	High Wycombe, Wooburn Green and Loudwater
Buckinghamshire total	**19,555**	
Cherwell	3,995	Bloxham and Banbury
Oxford	7,800	Cowley and Headington

South Oxfordshire	4,500	Thame and Henley
West Oxfordshire	2,601	Witney
Oxfordshire	**18,896**	
Reading	13,250	Reading and Tilehurst
West Berkshire	4,800	Newbury and Thatcham
Wokingham	14,047	Woodley, Wokingham and Twyford
Berkshire West	**32,097**	
BOB	**70,548**	

No applications were received for Bucks East, Bucks North or Vale of the White Horse.

Formal offers have been made to these practices during March 2024. If the offers are accepted as above then the re-commissioning of the activity lost in both Buckinghamshire and Berkshire West will have been restored. It was likely that take up in Buckinghamshire and Berkshire West would be higher than in Oxfordshire as less capacity has been lost and therefore practices are more likely to have capacity to provide additional activity. Whilst the first phase of re-commissioning will increase capacity in Oxfordshire by nearly 20,000 UDAs significant gaps remain in the county. The next phase of the programme will focus particularly on increasing provision in Cherwell, the Vale of the White Horse and West Oxfordshire.

6.6 Changes to the NHS Dental contract in 2024

At the end of 2022, the government introduced changes to the NHS Dental contract which were implemented in 2023. Further changes were announced in February 2024. These are:

- The payment of a new patient premium for the period March 2024 to March 2025; ranging from £15 - £50, depending on treatment need.
- Support the Dentists to treat around one million new patients and launch a new public health campaign to raise awareness about how to find a Dentist.
- Increasing the minimum UDA price to £28 (current minimum is £25.33).
- A ‘Golden Hello’ payment for Dentists to work in areas of need, starting with a cohort of 240 Dentists later in 2024.
- Actions to increase the dental and dental therapy workforce.
- Legislation to support to development of skill mix.

- Making it easier for overseas dentists to work in the NHS, including legislation for the introduction of provisional registration status.
- Ringfence on NHS Dentistry budgets for 2024 to 2025 so ICBs can seek to improve dental access within this budget.
- Commence work in 2024 to ensure that the funding provided to ICBs better reflects changing population demographics.
- Reform the contract to make NHS work more attractive with options for consultation with dental profession with any changes phased in from 2025 onwards.
- The deployment of dental vans in under-served areas while longer term solutions are established.
- Support oral health improvement in Family Hubs and other settings that provide Start for Life services.
- Improve oral health of children by providing oral health advice to parents and a ‘Smile for Life’ programme into early years settings.
- Deploy dental teams to schools in areas of the oral country where oral health and NHS access is worst.
- A national programme of water fluoridation with new legislation to make it easier to start programmes to systematically bring water fluoridation to more of the country.

More details are to follow, but the ICB is reviewing the implications for implementation in BOB. Arrangements are now being put in place for the new patient premium and the minimum UDA price of £28; the latter of which impacts 25% of practices in BOB.

7. Summary

There have been significant improvements in access to and delivery of dental services since the peak of the coronavirus pandemic. Dental services only returned to full capacity in July 2022 and the levels of provision are now moving back towards pre-pandemic levels, particularly in Buckinghamshire and Berkshire West.

Local actions such as allowing practices to deliver more activity; additional access sessions; the Flexible Commissioning scheme and replacing activity lost due to contract handbacks/reductions has helped to ease the reductions. Many practices have actively engaged with the ICB in responding to these challenges.

Changes have been made to the national dental contract with the aim of increasing support to the profession and improving access for patients. One of the key features of the national changes is the increased focus on prevention through the 'Smile for Life' programme. This is likely to increase opportunities for joint working between local authorities and the ICBs to address the causes of demand for dental services.

Significant challenges remain. Practices are still working through backlogs of patients built up as a result of the pandemic which is impacting the rate of growth in access. For patients who have not attended local services access is still a challenge. Workforce issues remain with contract handbacks and reductions continuing.

The recent announcement of changes to the national contract are designed to help further address the access and workforce challenges, but they also start to outline plans to improve oral health.

The ICB is working with a range of local stakeholders to develop a primary care strategy, which includes dental services, with the aim of commissioning services to meet local needs in ways that are sustainable. The ICB is also working in partnership with other ICBs across the South-East Region to re-commission referral services.

It will be important to continue work collaboratively and innovatively to maintain progress.

April 2024 Bucks HASC report – addendum to the Primary Care Annual Report

	Section
1	23/24 PCN review
2	24/25 GP contract and DES arrangements
3	Additional Roles Reimbursement Scheme (ARRS) overview
4	Patient Participation Group (PPG) updates
5	Priorities for next 12 months
6	IT developments

Section 1: 23/24 Primary Care Network (PCN) review

I. Investments in Primary Care Networks (PCNs)
   a. Network Contract Directed Enhanced Service (DES) Specification in 23/24
   b. Enhanced Access
   c. Capacity and Access Improvement Payments
   d. Impact and Investment Funding
II. Improved collaboration between GP practices within PCNs
III. General Practice collaboration with system partners
IV. Other ways of working at-scale in primary care
V. Support provided for general practice

There has been continued national investment for the development of PCNs through several mechanisms.

I. Investments in Primary Care Networks (PCNs)

A) Network Contract DES Specification in 2023/24

The Network Contract DES is the primary contract for primary care networks (PCNs) and is updated annually alongside the core general practice contract. Buckinghamshire PCNs have delivered to the requirements of the Network Contract DES funding which equates to a total investment budget of £10.4 million in Buckinghamshire in 23/24. Deliverables in year included the design and delivery of plans and interventions for Tackling Neighbourhood Health Inequalities and Personalised Care. Commitments to supporting improvements in Early Cancer Diagnosis, deliver better Enhanced Health in Care Homes supplemented by Buckinghamshire Care Home SNS deliverables, CVD Prevention and Diagnosis, Medicines optimisation and of Enhanced Access were also areas of focus in the DES.

B) Enhanced Access

Under the Network Contract DES, PCNs are required to provide additional hours of access to patients in the evenings during the week and some weekend hours. 530 additional hours were delivered by General Practice in Buckinghamshire in 23/24 representing another £4.1 million of DES contract investment.

C) National Capacity and Access Improvement Payments (CAIP)

In 2023/24 there was a reduction in the number of investment and impact fund (IIF) indicators from 36 to 5 with the associated funding (£246m) being used to support the new Capacity and Access Payment designed to focus PCNs on improving access for patients. The plan covers the three areas of:

- patient experience of contact
- ease of access and demand management
- accuracy of recording in appointment books

Funding for this element of the DES was made available in two parts. PCNs received 70% of the funding (£172.2m nationally) unconditionally, based on their adjusted population, in 12 equal payments over the 2023/24 financial year. The remaining 30% of the funding (£73.8m nationally) will be paid to PCNs based on delivery of their agreed access improvement plans. Full delivery against the plan for an average PCN is worth approximately £60k. All Bucks PCNs have had their initial plans approved and they are currently being reviewed against progress. It is anticipated that all Buckinghamshire's PCNs will receive their remaining payment.

D) Impact and Investment Fund (IIF)

The Impact and Investment Fund (IIF) is an additional funding stream made available to PCNs through the Network Contract DES to support PCNs with the time, funding and flexibility to ensure patients can access good and timely care. The budget in 23/24 for Buckinghamshire sat at £573,000 based on PCN achievement over 5 investment and impact fund (IIF) indicators. PCN IIF achievements of note in year include:

- 75.89% of clinically at-risk patients 18–65-year-olds received a flu vaccine
- 75% of 2- and 3-year-olds received a flu vaccine
- 86.5% of appointment bookings where time from booking to appointment were 2 weeks or less

II. Improved collaboration and closer working across GP surgeries within a PCN

There are notable examples of GP surgeries working more closely within a PCN over the course of 23/24 and supported through the Network Contract DES mechanisms.

- Cygnet PCN - developed a 6-week support programme to empower young mothers living in an area with high level of deprivation.
- ARC PCN – developed a Dementia Carers Support Group to offer proactive social prescribing to carers supporting those living with dementia along with partner organizations.
- Dashwood PCN –delivery of childhood immunisations across a section of children at highest risk of deprivation and health inequality, from a high-risk inclusion group such as the BAME or traveller community and receiving social services input.

III. General practice collaboration with system partners

In Buckinghamshire, there are examples of PCNs working more closely with system partners and place-wide partnership between general practice and other system providers.

Examples of PCNs working with system partners include:

- Arc PCN hosts multidisciplinary team meetings (MDTs) for the Beaconsfield and Marlow areas, attended by various professionals including PCN ARRS staff, GPs, and adult social care. These meetings primarily focus on elderly and frail individuals, with housing concerns often raised by SPLW teams. Patients are brought to MDTs when uncertainty arises about their care, coordinated by a Care Coordinator and led by SPLW teams, with patient consent always sought.

- North Bucks PCN and The Swan Network - The Befriending service is a partnership between the social prescribers in the North Bucks PCN, The Swan Network and The Winslow Big Society with over 50 volunteers supporting our patients with friendly regular calls to reduce social isolation.
- Aylesbury Central PCN were awarded funding to focus on Liver Cancer Case Finding, one of just 10 providers in England to be awarded and the only PCN to receive the funding to deliver the pilot. The pilot aims to increase early detection of liver cancer to help achieve the Long-Term Plan ambition for 75% of all cancers to be diagnosed at an early stage by 2028. Aylesbury Central PCN are working with Health Share, Buckinghamshire Healthcare Trust and One Recovery Bucks.

Examples of place-wide partnership working include the Buckinghamshire Interface group was established during the Covid-19 pandemic to facilitate the closer working of primary, community and acute care. Membership includes senior leaders from BHT as well as general practice. Three priorities identified for 2024/25 include:

- Call/recall system for hospital and community settings.
- Proactive prevention for people at risks of falls.
- Improving quality and safety through shared learning events.

The group also recognised some specific challenges to improve its effectiveness including enhancing communication with on the ground clinicians, better integration with Bucks Executive Partnership and better incorporation of the Community Team into the work of interface. As a first step towards this the Interface Meetings now provide a Highlight Report which is shared across formal communications channels and social media and any individual queries regarding secondary care requests of general practice notified to the trust.

Finally, there were historical issues surrounding the Discharge to Assess (D2A) model in Buckinghamshire, highlighted in early 2023, including who held clinical responsibility and therefore subsequent increased risk to patient safety, as well as a lack of central coordination of these patients. This lack of coordination created several potential risks: challenges in workload management, discharge medication inaccuracies, poor information transfer and rapid readmissions. Through a task and finish group, an agreement was reached that the future discharge model should provide high-quality care and appropriate support for those involved in patient care. An interim solution was agreed upon which involved a small number of GP practices and block beds to facilitate discharge from secondary care while ensuring geographical coverage in Buckinghamshire. An MOU was developed to commission a total of 40 block beds in Care Homes to support hospital discharge, backed by a multidisciplinary team (MDT), with the ambition for a cross-system MDT. The discharge hub model will continue in Bucks under the existing MOU from April 2024 with reduced bed numbers, which will be extended for a further 12 months.

IV. Other ways of working at-scale in general practice

PCNs are one method of working at scale in general practice. Buckinghamshire has notable other examples of this at-scale working.

One example of this at-scale working is with the GP Provider Alliance (GPPA). Against a backdrop of criticism for disinvestment in Primary Care, the BOB ICB are pioneering this approach to General Practice Leadership and investing in mechanisms to support and provide resilience to General Practice and its Primary care Networks and GP Federation.

The General Practice Provider Alliance (GPPA) provides the united front for General Practice in Buckinghamshire by directly working at System and Place with the ICS and local providers. It supports Buckinghamshire General Practice resilience through the principle of the maintenance of choice and autonomy of its constituent members whilst being able to provide a consensus opinion to System and External Partners regarding opportunities to improve and develop services for Buckinghamshire residents.

Some key highlights have included:

- Close working to design a new model of Care Home Hub, supported by GP-led multi-disciplinary Teams;
- Work to address commissioning gaps in Buckinghamshire, for example around the provision of ECGs, and their support to develop both a short and long term solution;
- Engagement around our Health Inequalities projects, including the development of proposals for a Deep End Network, for GPs working in the ten wards in Buckinghamshire that have the highest levels of social deprivation.

Another example of at-scale work with general practice has been through the GP federation in Buckinghamshire, Fedbucks. In February 2023, practices highlighted commissioning gaps, specifically:

- ECGs
- Vaginal pessaries
- IUS/Mirena for menorrhagia or HRT
- Denosumab injections

The GPPA surveyed Buckinghamshire practices to understand the scale of the commissioning gaps. Based on these responses we estimate that nearly 12,000 hours of work without a commissioned service are undertaken in these four areas every year.

Over the past 12 months, general practices, PCNs and FedBucks have been represented by the LMC and the GPPA to review and discuss these services with the ICB and produced a Locally Commissioned Service for ECGs in collaboration with the ICB. This has meant that over 1,000 ECGs per month have been delivered across 37 GP practices, with the remaining 10 practices able to refer patients to a service run on their behalf by FedBucks.

A final example of at-scale working has been around tackling health inequalities. Practices and PCNs in the most deprived wards in Bucks receive the lowest capitation funding due to nationally set funding formulas, and tend to have the lowest approval ratings from patients and the starkest inequalities in outcomes. This year the GPPA and ICB are focusing on enabling these PCNs and practices to be better supported. This includes the ICB developing an Inequalities Service to support practices in delivery of outcomes for their patients. The GPPA are also establishing a general practice ‘Deep End network’ to provide a preventative approach to health inequalities, providing dedicated forums for knowledge-sharing, learning and problem-solving to general practice teams to supporting people experiencing inequality. To ensure this is not only accessible to those with a very strong interest, but is tailored to the communities in need, we will target funding to ensure attendance and backfill for the practices whose patients experience inequalities.

V. Support provided for general practice

Buckinghamshire general practice have a series of networks and meetings to ensure collaboration and sharing of best practice and challenges. These include:

- Monthly PCN Leadership Meetings, attended by PCN Clinical Directors and those with management responsibility for the PCN. In our most recent meeting 2 PCNs shared their operating models and talked about their structures and work.
- Monthly Peer to peer meeting for PCN Management, a meeting to troubleshoot strategic and operational issues.
- LMC Monthly Practice Manager Drop-ins to support Practice managers in their challenging day to day roles.
- ICB Facilitated Managers Forum for Managers across Practices and PCNs.
- Assemblies – The GPPA hosts twice a year assemblies for general practice.
- Protected Learning Time – this is a combination of protected time for practices to work as a team, addressing their learning needs, or supporting training, as well as a virtual program curated by the GPPA drawing on expertise forum system partners to share with Practice and PCN teams.
- Other forums include; Social Prescribing Forum, Digital Forum, digital Innovation Group, CVD Champions network, Workforce Support Leads Network.

Section 2: 24/25 GP contract and DES arrangements

An initial letter providing an overview of the 24/25 GP contract was released at the end of February, with the contract specification recently released.

Highlights of the 24/25 GP contract and what we know today, including the Network Contract DES for PCNs, includes the following:

- 1.9% pay growth for the core GP contract, including for contractor GPs, salaried GPs, other practice staff.
- Cut bureaucracy for practices by reducing and income protecting 32 out of the 76 Quality and Outcomes Framework (QOF) indicators. Similarly, the Impact and Investment Fund (IIF) indicators are reducing from 5 to 2.
- Help with cash flow and financial flexibilities by raising the QOF aspiration from 70% to 80%, and the CAIP payments will now be paid at any point in the year once the criteria have been met.
- More PCN staffing flexibility by including enhanced nurses in the ARRS and removing caps on all other direct patient care roles.
- Simplified DES requirements, including replacing 8 of the current PCN service specifications with one overarching specification. Enhanced Access will remain as a separate specification.

The GP contract for 24/25 was imposed and has faced controversy. On the 28th March, the results of the BMA referendum on the contract were shared, with 99% of 19,000 GPs and GP registrars voting ‘no’ to accepting the Department of Health and Social Care and NHS England 24/25 GP contract changes, which accounts for about 70% of qualified GPs. This is primarily due to the contract baseline funding uplift of 1.9%, which is below inflationary pressures in recent years, as well as not including GPs in existing funding of the ARRS budget, and new funding that can only be used to hire non-GP staff which the BMA says will make it harder to hire more doctors in general practice.

The GP contract negotiations are led nationally, rather than by the ICB. While the ICB cannot control the outcome of the national negotiations, it can seek to identify ways of bolstering primary care through other mechanisms, such as investment in locally

commissioned services to support the work of general practice outside of the core GMS contract.

Section 3: Additional Roles Reimbursement Scheme (ARRS) overview

Additional Roles Reimbursement Scheme (ARRS) funding in 2023/24 continued to cover actual salary plus employer on-costs (National Insurance and pension) to the maximum per whole time equivalent amounts as outlined in the Network Contract DES Specification. The DES has reinforced the investment in local leadership as well as removing the caps on a couple of ARRS roles encouraging further recruitment of ARRS staff during 2023/24. Changes have included the following:

- adding Advanced Clinical Practitioner Nurses to the reimbursable roles
- increasing the cap on Advanced Practitioners to three per PCN
- removing the caps on Mental Health Practitioners.

ARRS staff continue to be recruited to PCNs maximum allocated budgets to provide the additional appointments, improve patient access to general practice, and provide personalised, proactive, care for the populations that they serve. PCNs have been supported to take advantage of virtual options to support services where applicable and to widely advertise for recruitment in national job boards and specialist professional publications to assist with recruitment to roles where they have been challenging. ARRS workforce data continues to be regularly monitored to ensure that all PCNs are adding to the appropriate capacity which will match their patient needs (see Table 1 below).

Table 1: Illustrates the range of funded PCN ARRS roles & FTE recruited across Buckinghamshire PCNs in 2023/24 and 2022/23.

DES funded ARRS ROLES	Buckinghamshire WTEs **22/23** (as of March 23)	Buckinghamshire WTEs **23/24** (as of Feb 24)	Change
Social Prescriber	35.6	32.84	-2.76
Clinical pharmacist	49.1	58.69	+9.59
Physiotherapist	8.4	12.38	+3.98
Physician Associate	7.5	15.77	+8.27
Health and Wellbeing Coach	14.2	11.95	-2.25
Care Coordinator	46.7	69.20	+22.5
Pharmacy Technician	15.3	15.35	+0.05
Trainee Nurse Associate	2.5	3.51	+1.01
Nursing Associate	1.7	6.01	+4.31
Paramedic	16.5	16.29	-0.21
Mental Health Practitioner (8a)	7.8	3.00	--
Mental Health Practitioner (7)		5.80	--
Mental Health Practitioner (6)		0.00	--
Mental Health Practitioner (5)		0.00	--
Mental Health Practitioner (4)		0.91	--
Advanced Clinical Practitioner - Nurse		5.92	--
Advanced Practitioner - Pharmacist		8.23	--

Advanced Practitioner - Paramedic	4.3	1.99	--
Advanced Practitioner - Physiotherapist		0.80	--
Dietician	0.00	0.00	--
Digital and Transformation Lead	5.2	8.34	+3.14
General Practice Assistant	6.2	9.08	+2.88
Apprentice Physician Associate		0.00	--
Chiropodist/Podiatrist (including Advanced Practitioners)	0.00	0.00	--
Occupational Therapists (including Advanced Practitioners)	0.00	0.00	--
Bucks ARRS Workforce (Total FTEs)	**221**	**286.06**	**+65.06**

Source: *Data NHSE ARRS Portal

Note: the status of ARRS roles in PCNs is always a snapshot in time. There can be flux in number of WTEs due to circumstances such as staff leaving and ongoing recruitment of those roles, changes in staffing plans.

PCN Clinical Directors and Network Managers also are encouraged to take up leadership and training through national initiatives like the General Practice Improvement Programme (GPIP) and Workforce Development Managers lead roles intended to support the development of PCN ARRS staff along with other leadership & development courses and opportunities.

Section 4: Patient Participation Groups (PPGs)

All GP practices are required by their contract to have and engage with a Patient Participation Group. BOB ICB have had assurance through annual e-Declaration from 43/47 Buckinghamshire practices that they have met this requirement. The ICB is following up with the remaining 4 practices.

Additionally, the ICB and GPPA are continuing to support practices making the most of working with their PPGs by planning learning sessions for summer 2024 to have high performing GPs and their PPGs share best practices on how they work together.

Finally, Healthwatch in Buckinghamshire has been actively working with PPGs to start identifying ways of supporting. The Patient and Public Experience Manager started full-time for Healthwatch in January 2024, and the group has worked with Healthwatch Oxfordshire and the ICB to develop a baseline survey for PPGs exploring how they would like to be supporting moving forward. The online survey ran from 25 January to 9 February, and it was sent to all PPG leads and Practice Manager contacts and was promoted in a Healthwatch Bucks / ICB Primary Care webinar. They received 31 responses and heard from 25 PPGs (over half the practices in Buckinghamshire). They carried out follow up in person interviews with 12 people covering 8 PPGs to get a more in-depth perspective, with the last interview taking place on the 23rd February. They are in the process of finalising the report and the recommendations. The recommendations will focus on enhancing the support and communications that PPGs receive both from the ICB and from Healthwatch Bucks.

Section 5: Priorities for PCNs for the next 12 months

The ICB has been developing a Primary Care Strategy over the past year to provide a vision for a more resilient, integrated primary care in BOB. The strategy focuses on the following three priorities:

- Access: ensure people get to the right support the first time to meet their needs
- Integrated Neighbourhood Teams (INTs): provide personalised, proactive care to people with complex needs, supported by INTs.
- Prevention: design targeted support for everyone to stay well by understanding our population by a review of the information, starting with cardiovascular disease.

Additionally, there will be further clarity around resourcing and capacity to drive improvements through the 24/25 GP contract, covered in earlier sections. The LMC will also be supporting access in primary care by improving workflow and handoffs via the interface, through such actions as developing an educational video for trusts to articulate how primary care operates in BOB and Buckinghamshire. Trusts | Berks, Bucks & Oxon LMCs (bbolmc.co.uk)

For Buckinghamshire, primary care will also be oriented around the priorities identified through the Buckinghamshire Executive Partnership (BEP), which is currently planning priorities for 24/25. A primary delivery mechanism for the BEP for 24/25 will be through developing INTs. Customising the strategy to fit Buckinghamshire is paramount, so for example same day access will look to the clinical assessment service (CAS) to determine if that should be expanded.

Estates continues to be a priority, which has been covered in more detail in the Future of Primary Care Planning report with the council.

Finally, there are several structural elements in place to support these transformation initiatives. Along with the GPPA, the ICB has a team within the Primary Care Directorate devoted to supporting PCNs and their transformation initiatives.

Section 6: IT developments

- **GP websites** NHS England (NHSE) has published guidance Creating a highly usable and accessible GP website for patients. Implementation of this is encouraged in the Delivery plan for recovering access to primary care (May 2023). BOB ICB intends to provide recommendations to practices by the end of June 2024 about steps to improve the accessibility and usability of their websites by their patients.
- **Telephony** All Buckinghamshire practices now have digital telephony systems in advance of the national analogue switch-off. The Delivery plan for recovering access to primary care sets out steps for practices to implement key features to support patient access. These are now largely in place, but there are a small number of practices without a call-back facility i.e. patients have the option to be called back when they are higher in the queue. BOB ICB is working with these practices to address this as soon as possible.
- **Online consultation overview** – All GP practices have been required to offer online consultation since April 2020. BOB ICB offers a choice of 3 fully funded systems to GP practices (AskFirst, eConsult and Footfall). Alternatively, practices can choose other part-funded or unfunded systems. On-line consultation is an important access route for patients into general practice alongside improved telephony and any other local access arrangements.
- There are now more than 8 **Digital and Transformation Leads** at PCNs in Buckinghamshire, which support the management infrastructure in PCNs and adopting digital tools to support primary care. The Leads and Network Managers regularly come together in a digital innovation forum held by the ICB.

Appendix

I. **Additional examples of good practice in PCNs**
II. **Structure of the GPPA and perspectives on working with the GPPA**

I. Additional examples of good practice in PCNs:

- The Digital Cafés initiative, spearheaded by Arc Bucks PCN in collaboration with various organisations including BOB ICB Digital Team, Buckinghamshire Libraries, and The Good Things Foundation, aims to address the challenges faced by individuals in adopting digital technologies. These cafés offer informal and friendly IT support to help people overcome barriers hindering their use of technology, such as difficulty in sending emails or accessing online health resources. Research by NHS Digital highlights multiple barriers to digital connectivity, and the initiative recognizes that individuals may face several of these simultaneously. To tackle this, the PCN secured support from The Good Things Foundation, obtaining SIM cards with free data to assist those lacking internet access due to financial constraints. The Digital Cafés have already made a tangible impact, providing assistance with various tasks including navigating the NHS App, basic smartphone operations, accessing trusted online health information, and organizing digital photo galleries. Testimonials from participants underscore the importance of such initiatives in catering to the needs of older individuals, who often lack accessible avenues for tech-related inquiries. As one grateful patient expressed, ***"Thank you so much, there is nowhere an 80-year-old can go to ask these questions, I'm so pleased that you are here to advise."***
- The Swan Network responded to the urgent healthcare needs of asylum seekers in their local community with a compassionate and innovative approach. Collaborating with the local authority and third sector organisations, they established primary care services in a temporary healthcare facility within a nearby hotel. Led by their Clinical Services Manager, their dedicated team of healthcare professionals ensured a welcoming and culturally sensitive environment for asylum seekers. By setting up the clinic in the hotel, they eliminated barriers to healthcare access and provided timely and comprehensive medical attention. Services offered encompassed general health screenings, vaccinations, treatment for common illnesses, mental health support, specialist referrals, and collaboration with community wider community services. This initiative exemplified The Swan Network's not only provided essential medical care but also demonstrated the importance of solidarity and compassion in the face of challenging circumstances.

24

Big turnout for Community Event

Practice Manager ***Sue Hazell*** *reports from Southmead Surgery*

On Thursday 13 July Dr Tilly Siva held a well-attended Community Event in the Village Hall, organised by our social prescribers, Jane Quince & Emily Freeman.

Earlier in the year Dr Siva had attended a Leadership Course with GPs across Bucks, Oxfordshire & Berkshire. While there, he was inspired by hearing about community events that had proved successful in other parts of the country.

As Farnham Common is a community, he felt that this would be a good initiative to bring and share with the village.

Tea, cakes and talk

Everyone was invited to join us for tea and cakes and talk about what was happening in the village and find out what people would like to see.

Our friends and patients were able to meet local organisations such as Carers Bucks, the Village Hall, Sing & Sign, the Cinema Club, Short Mat Bowls, the Library, Rotary Club, Prevention Matters, Tai Chi with Simon Jennings, Signature Care Home, Tracey Trust, Women's Institute, Yoga with Lindi, and Parenting Special Children. A wonderful turnout!

A big thank you to everyone who came, it was a fun afternoon!

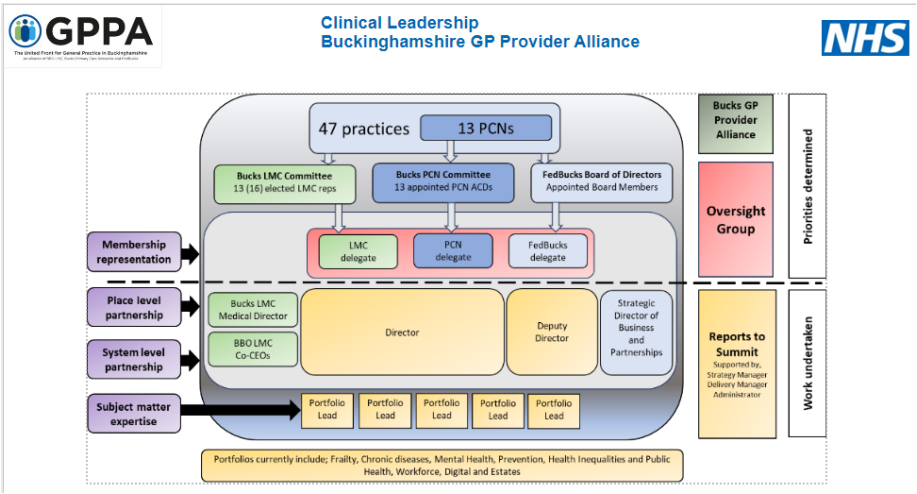
We hope to build on this event & hold another towards the end of the year.

In September Emily will be setting up a local walking group.
If you are interested in joining, please email her emily.freeman5@nhs.net
or leave her a message with Reception.

III. Structure of the GPPA:

The purposes and remits of the GPPA are to:

1. Collaborate on issues that affect general practice
2. Gain consensus wherever possible to represent a united front
3. Operate as the 'system partner' for the benefit of General Practice in the BOB ICS
4. Work with other ICB system partners to agree on ICS priorities for General Practice in the BOB ICS
5. Be recognised as subject matter experts in General Practice service delivery and how those ICS priorities should be delivered within General Practice



Perspectives on working with the GPPA:

"The GPPA are integral to partnership working in Buckinghamshire. Whether sitting on our Buckinghamshire Executive Partnership, working through the operational challenges of the day, or helping us shape the future of primary care through the BOB Primary Care Strategy; their knowledge, experience and influence has helped ensure the voice of primary care is more closely embedded in our decision-making architecture.

Philippa Baker, Buckinghamshire Place Director

"As a large council serving over half a million people it is critically important that we develop a positive relationship with primary care so that we can work collectively to improve the health and wellbeing of our residents. The formation of Bucks GPPA has undoubtedly enhanced communication and collaboration between general practice and Buckinghamshire Council and allowed us to develop a partnership which enables a stronger contribution from General Practice in thinking and decision-making processes.

I am confident that the integration of Bucks GPPA into initiatives like Opportunity Bucks (with the establishment of a Deep End Network of practices) will result in even greater benefits for our communities and we are delighted to be able to work productively with the GPPA on a range of issues."

Rachael Shimmin

Chief Executive, Buckinghamshire Council

"General Practice is complicated and communicating directly with GPs to get a consensus view has historically been challenging. The GPPA has simplified communication channels to enhance the GP contribution to collaborative work. Bucks GPPA are now a core member of the Bucks Exec Partnership and have become an essential system partner in the design and delivery of local priorities.

As well as their contribution to the BEP, the GPPA has allowed BHT to begin collaborative work with General Practice providers to develop new Community Services for our patients as we look to define and implement Integrated Neighbourhood Teams in Bucks."

Neil Macdonald
Chief Executive

Buckinghamshire Healthcare NHS Trust

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Healthwatch Bucks update report

March 2024

This report includes the results of a snapshot survey we recently undertook on access to NHS dentistry in Buckinghamshire, alongside a breakdown of feedback on dentistry that we heard from Buckinghamshire residents over the past two years.

Snapshot survey: Access to NHS Dentistry in Buckinghamshire

Aim of survey

To get an understanding of how many dental practices, with existing NHS contracts, were able to see 'new' NHS patients.

What we did

Between 16th and 20th March 2024 we contacted 63 dental practices in Bucks by phone. We asked the following questions:

- Were they able to see any children (17 or under) as a new NHS patient
- Were they able to see any adult as a new NHS patient
- Were they able to see any new NHS patients with an exemption certificate
- Were they able to see any new NHS patient who had a referral

What we found

We spoke with 54 out of the 63 dental practices we called. We attempted to contact all practices a maximum of 3 times.

Of the 53 dental practices we did speak with:

- 31 answered 'Yes' to one or more of the four questions
- 23 practices were unable to see any new NHS patients and answered 'No' to all questions.

Of the 31 practices that said they could see a new NHS patient we found the following:

- 27 could see a child *
- 12 could see an adult
- 18 could see someone entitled to free dental care ('exempt')
- 11 could take a medical referral.

**It varies between practices as to the age they would see a child. One practice said it would see children until they were 16 whilst others expressed that they would see them under their NHS contract until they were 18, so long as they were in full time education.*

A couple of practices would only take on new children as NHS patients if their parents were a private patient within that practice.

- Nine practices answered 'Yes' to all our questions. A further three said 'Yes' they could see children and adults, but were unsure about exempt or referral patients.
- Three practices were only able to see those with an exemption certificate.

Practices that said 'No' to one or more questions were asked if they had a waiting list that people could be put on to get an NHS appointment. 10 practices said they did have a waiting list. Waiting list times varied from 3 months to 4 years.

Comparing what we found to the NHS "find a dentist" website

We looked at all 63 practices on the "find a dentist" website on 20th March 2024. https://www.nhs.uk/service-search/find-a-dentist

We found that against 22 practices the following message could be seen:

> "This dentist surgery has not given a recent update on whether they're taking new NHS patients. You can contact them directly to ask."

We compared the 54 practices answers we heard with the messaging that was on the NHS find a dentist website.

- 16 practices that we spoke to did have the same information on the NHS website as we heard.
- 38 practices gave us different information, or had out of date information on the NHS for the website.

Geographical differences

The table below shows, by area, the number of practices we spoke to who are taking on new NHS patients.

Region	Town	Children	Adults	Exempts	Referrals
North	Aylesbury	3	0	6	2
	Buckingham	0	0	0	0
	Princes Risborough	1	0	0	0
Central	Amersham	6	2	3	2
	Beaconsfield	1	1	1	0
	Chesham	2	0	0	0
	Great Missenden	0	0	0	0
	High Wycombe	7	5	4	4
South	Burnham	1	1	1	1
	Denham & Farnham Common	3	2	2	2
	Iver	1	0	0	0
	Gerrards Cross & Chalfonts	1	1	1	1
	Marlow	0	0	0	0

Voices Summary

Dentistry

From 05/01/2022 to 27/01/2024

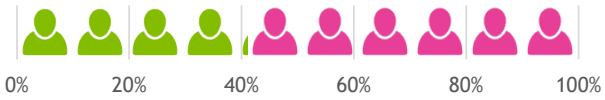
Voices Heard

100

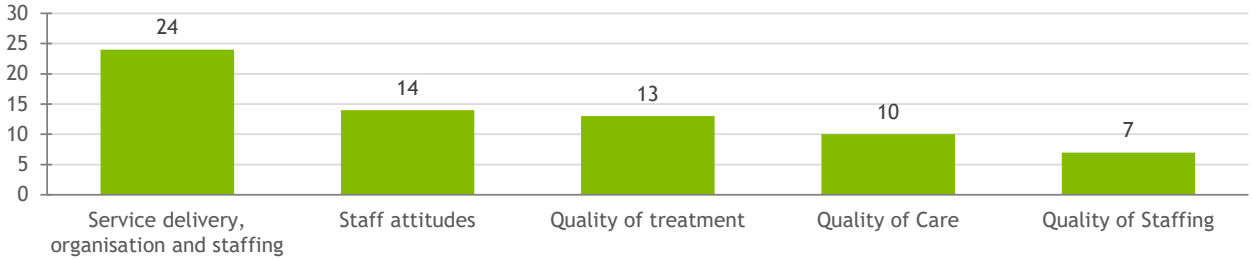
Feedback elements

198

Positive vs Negative

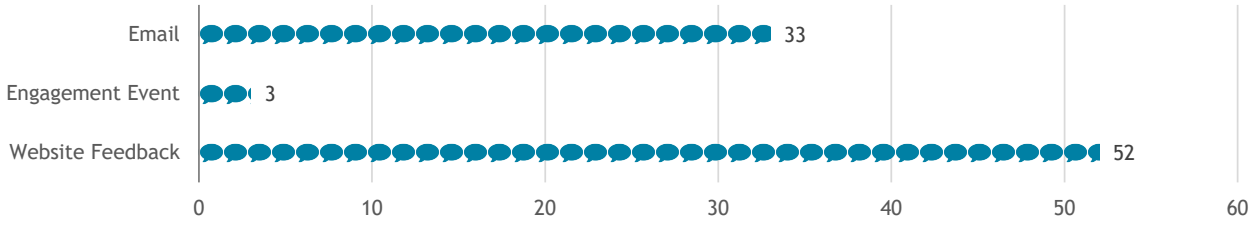


Top 5 Positive Themes

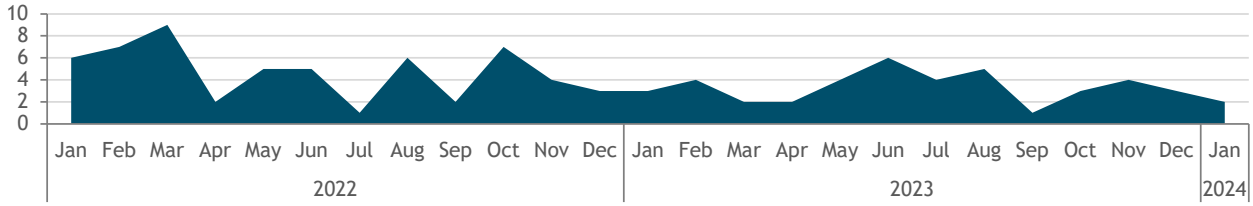


Top 5 Negative Themes

Source



Comments per month



As the chart illustrates we hear feedback from Buckinghamshire residents via a range of sources, including online, by phone, email and face to face.

People tell us;

- They struggle to find an NHS dentist. This includes long term residents and people new to the area. People who are able to find a practice accepting NHS patients say they are, in some cases, having to travel long distances to access one.
- That the information on the NHS 'find a dentist' website is not always consistent with what they hear from dental practices.
- That there is confusion about whether there is a 'right to register' with a dentist.

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