Draft notes on the Bob ICB Primary Care Strategy V

These are comments being sent to the Bob ICB primary care strategy consultation as a result of Katherine's request. Estates are taken as the first item. This consultation closes on the 29th next Thursday so my apologies for the lack of time for comments:

https://yourvoicebob-icb.uk.engagementhq.com/primary-care-strategy

This shows the recent Zoom-based discussion of this strategy:

Recordings of public & patient meetings | Primary Care Strategy | http://yourvoicebob-icb.uk.engagementhq.com

**Bob ICB Primary Care Strategy draft comments**

These comments are provided for the Wallingford Medical Practice Patient Participation Group Committee. It is important for patient representatives to comment on the strategy, in a field which has the potential to deliver substantial improvement in a time of growing challenge to capacity for delivery. The slide references are to the 55 page version.

The particular circumstances in Wallingford mean we make a comment on the primary care estate as our first priority. The substantial growth in population and housing here mean that the adequate supply for the future of primary care estate has a key place to play in strategy, which has implications for adequate funding as the population grows. We welcome it having its own treatment as a key enabler in a section of the strategy p30.

P1 of the four primary care elements: general practice, community, pharmacy, optometry, and dentistry - general practice and community pharmacy seem to have the most obvious potential for development in an integrated local form. It is not clear from this document how this strategy would help dentistry. Dentistry does have many parallel issues to GP of free NHS funded local delivery, urgent care and hospital backup. Optometry is mostly already a locally delivered service, and of a far smaller scale.

There are many other locally delivered community health elements too. They are listed p25 for Integrated Neighbourhood Teams in the context of complex needs, but it would be useful to have this whole potential field of locally delivered elements listed early in the strategy. There may be other element missing such as hearing and non-hospital first-aid.

P14. The strategy provides a very useful table of the growing mismatch between demand and capacity; the document as a whole should provide a much larger evidential base, which can be seen to guide choices in the strategy and provide justification. There is a useful scorecard provided on p53. But potentially key elements of the crisis identified of inputs and outputs seem to be missing.

As part of the evidence base it is very useful to see the slide page 17 provided that looks at the transformation of the Israeli Clalit funding. It sounds most interesting, with apparently a

clear transformation occurring according to the graph. But there isn't enough to be sure as outsiders why this is happening; for example the potential for competition between and from the four providers of which Clalit is one is not mentioned. Hospital provision is mentioned here explicitly rather than being implicit.

The four enablers of: workforce; resource; digital and data; estates; p29, are appropriate and the strategy is open in describing how change might be made with very limited funding. We would add communication and persuasion here and have already referenced the importance of a stronger reference base of evidence and analysis. For example South Oxfordshire and Vale District Councils have recently conducted very effective roadshows on their joint Local Plan in each local community, and something similar could be considered here in order to allow patients, representatives and service providers of all sorts, to understand and approach the large body of slides, and also communicate with the authors directly.

The 3 delivery priorities of: non-complex and same day care; CVD prevention; integrated neighbourhood teams; look well chosen and are themselves useful in illustrating the advantages of the primary care approach. Non-complex and same day care, and CVD prevention are good places to start, and we welcome the more detailed treatment in evidence and scorecards p38-50. (Obesity may be a key factor in the crisis of demand and care, not just CVD but is not referenced.) The third priority of integrated neighbourhood teams is a different character from the others.

The glossary of terms p54 is useful. It could go further for example to provide a read across from terms continuing to be used in the patient population to terms you wish to use as specialists. For example, pharmacy for chemist; optician or eye health for optometry, if that is what is intended.

The slides need numbering as well as the pages, as then they can be referenced in a more stable way. It would be helpful to provide reference to other key documents, for example:

> Briefing for ICS strategies: Primary Care, August 2022, Healthwatch
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> https://network.healthwatch.co.uk/guidance/2022-08-19/influencing-integrated-care-systems-briefings
>
> The Fuller Stocktake, Next Steps for Integrating Primary Care; May 2022, Dr Claire Fuller

Trevor Bedeman
Chair Wallingford Medical Practice PPG
07785970963