



## Locality Place Based Primary Care Plan: Oxford City Locality

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## Foreword

Oxford City locality is undergoing a period of immense change. This is set against a backdrop of:

- Severe difficulty in General Practice staff recruitment
- Increases in demand for services
- Significant reductions in primary care funding as a percentage of the rest of the NHS
- Challenges in the provision of social care; and
- Greater fragmentation of provision.

Even in these circumstances General Practice in Oxford City continues to deliver a high quality service, with close to 900,000 patient contacts each year including an estimated 420,000 face to face appointments with a GP and 26,000 home visits over the year.



Locality Clinical Director: David Chapman

To face this challenge over the next 5 years, there will be a need for practices to work at scale and where necessary integrate with existing community services and social services to support vulnerable patients as close to their home as possible with high quality medical care. It will also be necessary to build patient's own resources to care for themselves and prevent illnesses so that the need to impact on formal services will be reduced, as well as supporting informal carers in their hugely valuable role in supporting their friends and relatives to remain at home.

Practices have been forced to close in Oxford City and we need to stabilise and support General Practice to sustain the geographically located services they deliver. However, due to the ageing population and the complexity of their health needs, patients are most likely to see a range of clinical staff best qualified to meet their needs and GPs will be focussing more on the most complex patients.

Services also need to be mapped more to the needs of the populations, and there are clear health inequalities in the City which correspond to areas of deprivation. These areas will need special focussed support and services to reduce these inequalities, including those in Mental Health.

This plan sets out a framework to deliver the sustainability of primary care into the future and a comprehensive range of services closer to patients' homes. At its inception, it has had some patient review and a lot of enthusiastic clinical input but needs further scrutiny and definition from the wider community of Oxford, including patients and carers, to make sure it represents the structures and outcomes they desire, if it is to be successful.

A handwritten signature in black ink that reads "D. E. Chapman". The signature is written in a cursive style and is positioned above a short horizontal line.

## City Locality Executive Summary

### Locality Overview:

The current population of Oxford city is 223,232 (Jan 2018). The population has a younger demographic than the county average. Oxford city also has 7m tourists a year with nearly 0.5m from overseas and has approaching 34,000 students. Compared to the other parts of Oxfordshire, Oxford City is becoming younger with more families and young people, in poorer quality (rented) housing, with greater levels of child poverty. There are also areas of additional population growth due to new housing developments.



### What is working well:

- Delivering in the order of 300,000 routine face to face GP appointments and 120,000 same day face to face GP appointments each year
- Well established federation that supports delivery of extended access back office functions and also delivers a frail elderly social prescription
- Innovative approaches to care navigation and social prescribing



### Key locality challenges:

- High deprivation areas with inadequate funding
- Lack of ambulatory/integrated care for patients with high healthcare needs that could keep them out of secondary care
- Increase in number of patients seeing their GP means it is increasingly difficult to manage home visits and emergencies among housebound patients
- High use of ED from patients that could be directed elsewhere more appropriately
- High cost of housing which makes recruitment difficult combined with lack of GPs and nurses



## Key priorities for the City of Oxford locality:

We have identified four key priorities and 19 workstreams which will enable us to deliver these.

#	Workstreams	Priorities			
		Frailty and vulnerability	Deprivation and health inequalities	Sustaining primary care	Neighbourhood community practice
A.	Primary Care Visiting Service (PCVS)				
B.	Virtual Ward – City & Neighbourhood Teams				
C.	Ambulatory assessment and diagnostics for frail / complex patients				
D.	Social prescribing and care navigation				
E.	Barton Healthy New Town Project				
F.	City Health and Wellbeing Network				
G.	Practice and workforce sustainability				
H.	Focussed Weekend General Practice Care				
I.	City Care Home Service				
J.	Additional funding for practices treating deprived populations				
K.	Enhanced practice care for learning disability or severe mental illness or autism				
L.	Extension of minor ailments pharmacy scheme				
M.	Extending services at Luther Street medical				
N.	City student health service delivered from a city centre hub				
O.	Enhanced practice care for children and young people				
P.	Enhanced practice care for people with mental health conditions				
Q.	Enhanced practice care for people with long term conditions - diabetes				
R.	Enhanced practice care for people with long term conditions - breathlessness				
S.	Enhanced practice care for people with long term conditions - COPD/asthma				

## Part A: Introduction: Approach to developing the plan for the City of Oxford

Part A describes how the City plan was developed. It provides the reasoning behind the creation of the plan, the methodology behind the plan's design and the sources for the data which have been used as an evidence base.



### 1. The purpose of this locality place based plan

The aims of the Oxford City plan are to deliver the Oxfordshire Primary Care Framework, develop the Closer to Home strategy in this locality and to try to reduce health inequalities as highlighted in the Health Inequalities Commission Report<sup>1</sup>. The Framework highlighted the importance of investing in the sustainability of General Practice and supporting it to be the lynchpin in our health and care services. Transformation of these services will require new thinking and new models of care and delivery. In particular our aim is to:

- 1) Improve access to high quality primary care for people who need it, when they need it. This includes making sure that appropriate primary care services are available throughout the week, tailored to the needs of the local population.
- 2) Build on the strengths of GPs and their teams to continue to care for the majority of people close to home, leveraging their generalist skills, expertise and ability to hold risk, while acting as a gateway to further care when necessary.
- 3) Facilitate the development of a thriving and expanded primary care workforce with greater resilience, capacity, resources and enhanced skill mix
- 4) Implement services that reduce health inequalities and improve health outcomes for the diverse population in Oxford City
- 5) Support the development of the city federation, OxFed, as a local healthcare organisation to enhance collaborative working, foster innovation and provide support for practices
- 6) Improve the integration and effectiveness of services that enable people requiring care to receive this in an appropriate home or community setting, reducing hospital admissions and supporting their return to the community if they have had to enter secondary care

All of the proposals within this plan are considered against the following sustainability and transformation criteria:

- Closing the health gap (inequalities)
- Closing the care gap (quality of care)
- Closing the money gap (achieving system savings)

The plans will remain iterative: as the population changes and the way we deliver healthcare evolves, we will continue to work with patients and clinicians to ensure that primary care remains responsive, accessible and of high quality.

<sup>1</sup> <http://www.oxfordshireccg.nhs.uk/key-occg-publications/oxfordshire-health-inequalities-commission-report/32180>

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## 2. Who helped to inform our plan

This document draws on the knowledge and experience of Oxfordshire's clinical community and patients to both describe and develop an Oxford City locality place based plan for the delivery of sustainable primary care and support for the model of moving care closer to home. It aims to develop the Oxfordshire CCG Primary Care Framework and opportunities outlined in the GP Forward View to achieve this aim. This process included:

### 2.1 Clinician input:

- Extensive discussion with member practices at the City's main Locality meetings from April to October 2017
- Patient voices and clinicians from Oxford Health NHS Foundation Trust from the Locality Community Services Group
- Detailed discussions with the local GP federation for Oxford City, OxFed.

### 2.2 Patient participation input:

- The inclusion of patient voices is important to the Locality, and the Primary Care Framework has been shared with the Oxford City PPG Forum Core Development Group, and was a main workshop item at the Forum's public event held 5.7.17, to enable wider discussion.
- Patient participation in commenting on the Primary Care Framework
- Patient participation on regular Locality Community Service group looking at developing Neighbourhood integrated services
- Each of the GP practices within the Locality has a Patient Participation Group (PPG), which either meets face to face, or communicates virtually. A patient Lead from each of these PPG groups is invited to provide a representative on the PPG Forum, which has a deputy Chair and core development group.
- In addition, Oxfordshire CCG held an event in Oxford in November 2017. The workshop gave local people the opportunity to share their views on how GP and primary care services in their localities could be organised. The workshop and an online survey (for anyone unable to attend the workshops) follow and expand the work involving the CCG, local GP practices and patient representatives, who have been discussing plans for the future of primary care services in Oxfordshire for the past six months.
- This feedback has helped to shape and inform the locality plans, in particular:
  - Funding implications of delivering the plans
  - Considerations around contract review of the Luther street homeless service so that it is accessible for patients at the right time

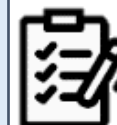
- Additional information on improved skillmix to support access, in particular using mental health link workers and other community agencies.
- A full summary of feedback from the Patient Forum, from the workshop in Oxford and subsequent patient feedback on the draft plan published in November 2017 are highlighted in Appendix 1.
- If any proposals require significant changes that could adversely impact patients a more formal consultation will be undertaken for the specific service area.

### **2.3 Gap analysis and prioritisation:**

- The plans have been tested against the priorities set out in the Oxfordshire CCG Primary Care Framework, the opportunities outlined in the GP Forward View and local transformation programmes. Proposals with funding consequences have been further assessed according to need across Oxfordshire. A sustainable model of primary is dependent on releasing funding from secondary care to invest into primary care.

#### **Key messages:**

The City locality based primary care plan builds on the principles identified by the Oxfordshire Primary care framework to create a 5 year strategy for the region. The plan has received input from locality forum meetings as well as patient participation input to ensure that the knowledge and experience of City's clinical community is adequately captured. Patient input has been welcome.



## Part B: The demographics of the City population



Part B outlines the current population need in City, Oxfordshire and how this will change over time. This section also lays out the current primary care provision in and the workforce mix required to sustain primary care for the future.

### 1. Summary

#### 1.1 Population

The current population of patients registered with Oxford city practices is 223,232 as at 1 January 2018<sup>2</sup>. Oxford city also has 7 million tourists a year with nearly 0.5 million from overseas and has approaching 34,000 students who reside for at least 6 months of the year in the city attending its 2 major universities Oxford University and Oxford Brookes.

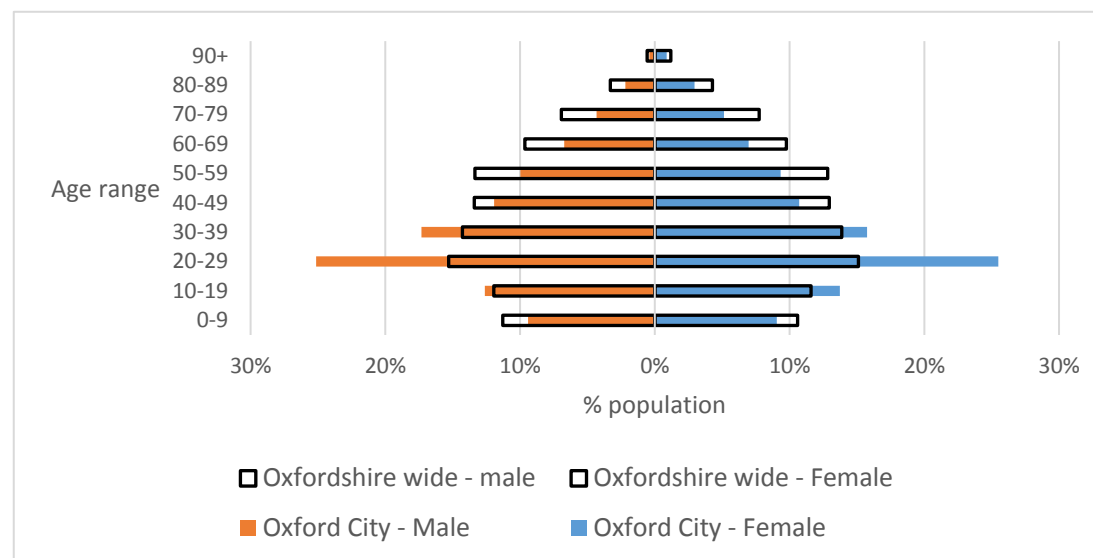
#### 1.2 Age

The population has a younger demographic than the county average. However, parts of the city, in particular the South and West, have an older than average population. The proportion of older people in Oxford is increasing and is expected to increase further, which will have implications on service demand.

The population aged 85 and over is expected to increase by 50% to 4,200 by 2030<sup>3</sup>.

#### 1.3 Ethnicity

Oxford's population is more ethnically diverse than the county and England average, with 36.4% of the population not identifying as White British (16.4% in Oxfordshire and 20.2% nationally<sup>4</sup>). All of Oxford's black or minority ethnic (BME) communities have grown since the 2001 census.



**Figure 1: % Age distribution of population registered in Oxford City Locality practices and all Oxfordshire practices (NHS Digital Jan 2017)**

<sup>2</sup> Practice list size data published by NHS Digital (Jan 2018) at: <http://content.digital.nhs.uk/gppatientsregistered>

<sup>3</sup> Source: ONS 2014-based population projections

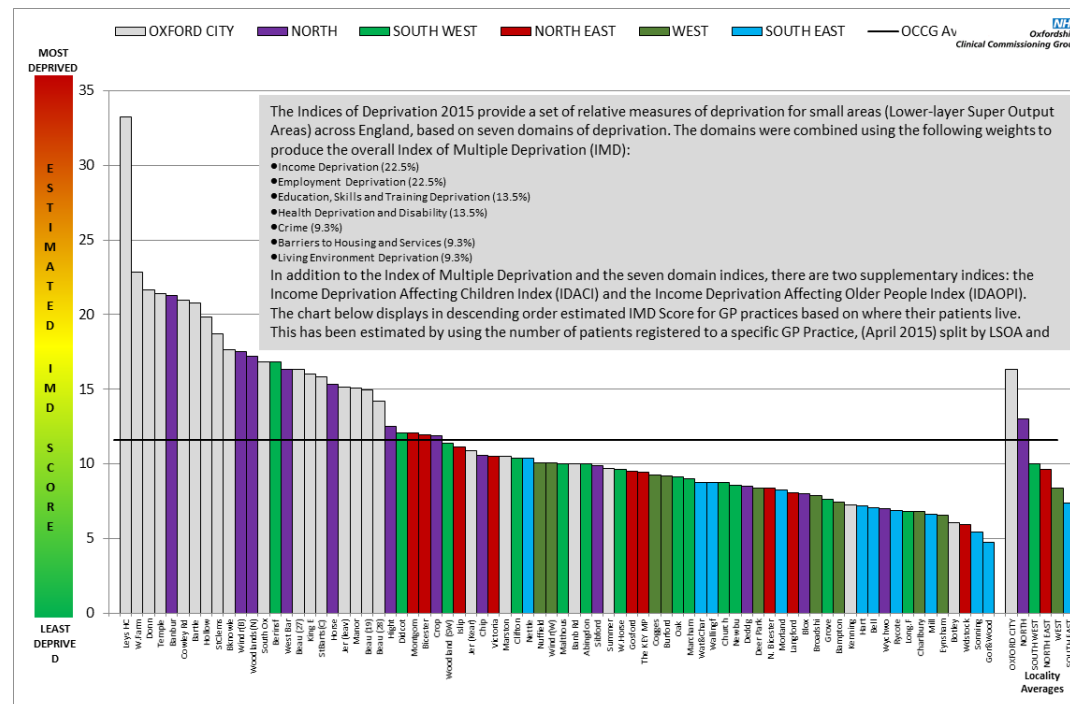
<sup>4</sup> Source: ONS Census 2011

## 1.4 Deprivation

Oxford is a diverse city with both prosperous and deprived areas. Two areas in Oxfordshire are in the worst 10% of 'lower-layer super output' (LSOA) areas nationally for health deprivation and disability (both in the city - in parts of Northfield Brook and Carfax wards). Twelve areas in the county are in the 20% most health deprived areas nationally (most of these are also in the city - in parts of Northfield Brook, Rose Hill and Iffley, Barton and Sandhills, Churchill, Carfax, St Mary's, and St Clement's wards)<sup>5</sup>. Deprivation in some areas is quite extensive and, with the exception of areas in Banbury, this is very different from the rest of the county. According to the supplementary indices to the IMD 2015, 5,125 children in Oxford were affected by income deprivation and 3,270 older people in Oxford were affected by income deprivation. The life expectancy gap for men due to deprivation is 9.7 years and for women 3.3 years.

Between December 2015 and December 2016 the number of claimants of Job Seeker Allowance and Universal Credit in Oxford increased from 920 to 985 (+7%)<sup>6</sup>. In December 2016, Northfield Brook and Blackbird Leys were 2 of the 3 wards in Oxfordshire with the highest number of claimants. In line with deprivation there are increased numbers of children on Child Protection Plans, Children In need and Looked After Children which requires a great deal of primary care and social worker input as well as domestic violence (figures 3 and 4).

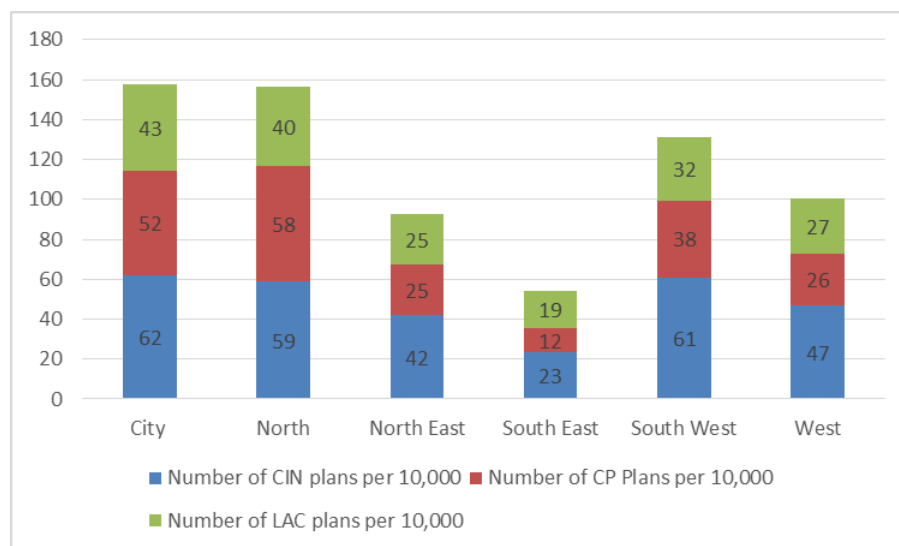
**Figure 2: Deprivation levels for different Oxfordshire practices and the Oxfordshire average (city practices are shaded grey) – Indices of Deprivation, ONS 2015**



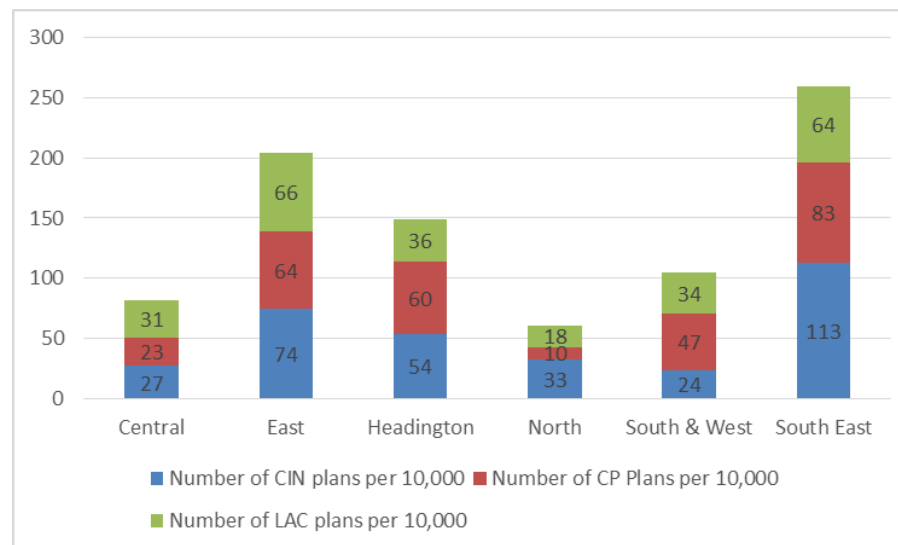
<sup>5</sup> Source: [https://www.oxford.gov.uk/info/20131/population/459/oxfords\\_population](https://www.oxford.gov.uk/info/20131/population/459/oxfords_population)

<sup>6</sup> Department for Communities and Local Government

**Figure 3: Numbers of children on Child Protection Plans, Children In need and Looked After Children by locality (all Oxfordshire localities)**



**Figure 4: Numbers of children on Child Protection Plans, Children In need and Looked After Children by neighbourhood (Oxford City)**



## 1.5 Carers and Care Homes

There are 29 care homes in the city with 1,011 beds<sup>7</sup> and at the fringes of the city more care homes are being built which will have an impact on the provision of primary care. Cumnor has by some way the highest number of care home beds (205).

Oxford has above the regional South East average of working age carers aged 35 to 49<sup>8</sup>. Many of those providing care are more likely to be in poor health than those not providing care. Carers can often suffer social deprivation, isolation and ill health. They may have fewer opportunities to do the things other people may take for granted, such as having access to paid employment or education, or having time to themselves or with friends. For young carers, it can often mean life chances are severely limited. In 2011 Oxford had double the national average of young

<sup>7</sup> Source: Care Quality Commission data

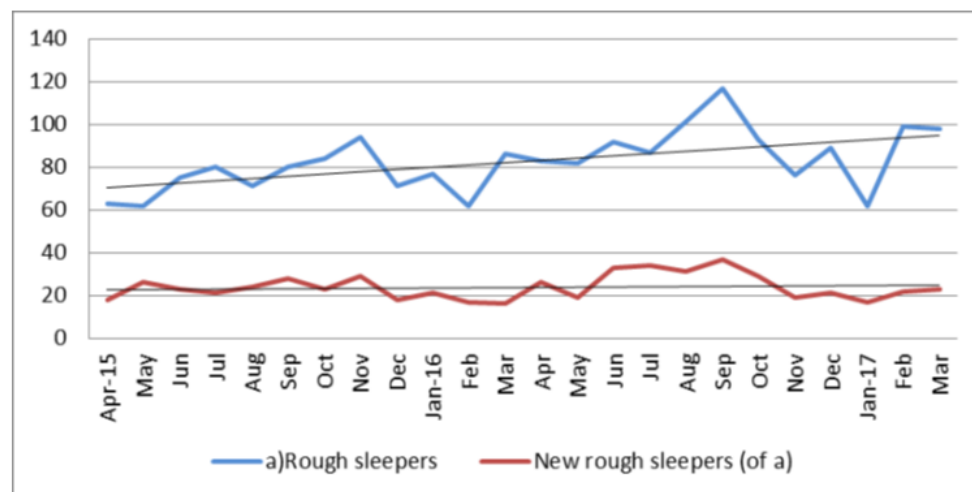
<sup>8</sup> Source: ONS Census 2011

carers (aged under 16). The number of carers in this age group in Oxford was 90, of which half (45) were residents in the wards of Cowley Marsh, Northfield Brook, Lye Valley and Blackbird Leys.

### 1.6 Housing and homelessness

The Centre for Cities report 2017<sup>9</sup> ranks Oxford as the least affordable UK city for housing. The analysis uses average house prices and average earnings and found that:

- In 2016, the average house price in Britain was 9.8 times the average annual salary
- Oxford, London and Cambridge were the top 3 least affordable cities
- In Oxford, the least affordable city, house prices were 16.7 times annual salaries
- In Oxford in 2015, average social rents were 18% above the national average
- There were 190 households in temporary accommodation in Oxfordshire at the end of the financial year 2015-16
- Since the closure of hostels for the homeless in Oxford City there has been an increase in homeless in Oxford City, from 433 in 2015/16 to 518 in 2016/2017 of which rough sleepers are the most vulnerable. Although figures vary slightly month by month, it's fairly safe to say that more than two-thirds of those sleeping rough have mental health problems, and more than half have mental health problems and clinical addiction.



**Figure 5: Number of people seen sleeping rough by month in Oxford City (April 2015 – March 2017), Centre of Cities report**

<sup>9</sup> Centre for Cities report: [www.centreforcities.org/publication/cities-outlook-2017](http://www.centreforcities.org/publication/cities-outlook-2017)

## 1.7 Change in population

Oxford is estimated to grow significantly in population. A new local plan for Oxford 2036 is at an early stage of development with the consultation on draft options completed in August 2017<sup>10</sup>. Wards within the city with the greatest number of new homes expected from 2017-18 to 2021-22 are Wolvercote (Northern Gateway), Barton and Sandhills (Barton Park) and Littlemore. There are also plans for growth in Botley, Kennington and Cumnor in the Vale of White Horse district council area. Over the next 10 years this breaks down according to the different neighbourhood clusters in the city as below:

**Table 1: Housing growth in Oxford city to 2026/27<sup>11</sup>**

	Housing growth						Population growth	Housing growth						Population growth
	2017/18	2018/19	2019/20	2020/21	2021/22	5 Year Total	5yr Total	2022/23	2023/24	2024/25	2025/26	2026/27	10 Year Total	10 year total
<b>Central Oxford Cluster</b>	27	82	105	156	109	479	1,150	60	76	60	60	60	795	1,908
<b>East Oxford Cluster</b>	24	46	25	10	10	115	276	45	45	52	40	55	352	845
<b>Headington Cluster</b>	200	189	138	110	205	842	2,021	185	221	120	147	10	1,525	3,660
<b>North Oxford Cluster</b>	16	50	167	160	150	543	1,303	178	178	145	90	60	1,194	2,866
<b>South and West Oxford Cluster</b>	54	134	335	274	255	1,051	2,522	227	148	107	107	107	1,747	4,192
<b>South East Cluster</b>	27	214	369	241	294	1,145	2,748	247	165	125	173	60	1,915	4,596
<b>Oxford City total</b>	<b>348</b>	<b>715</b>	<b>1,139</b>	<b>951</b>	<b>1,023</b>	<b>4,175</b>	<b>10,019</b>	<b>942</b>	<b>833</b>	<b>609</b>	<b>617</b>	<b>352</b>	<b>7,528</b>	<b>18,066</b>

<sup>10</sup> [https://www.oxford.gov.uk/info/20067/planning\\_policy/743/the\\_local\\_plan](https://www.oxford.gov.uk/info/20067/planning_policy/743/the_local_plan)

<sup>11</sup> Data provided by OXIS - Oxfordshire County Council 2017-2035; population growth assumes average 2.4 people per dwelling

## 2. Health Assessment of Oxford city population

### 1.1. Morbidity and Mental Health<sup>12</sup>

#### Life expectancy and overall health outcomes:

- There is life expectancy gap of 9.7 years for men and 3.3 years for women that are most deprived compared to the least in the Oxfordshire<sup>13</sup>.
- There is also increased use of emergency department attendance and reduced uptake of screening programmes. The influx of ethnic groups with high incidence of diabetes means more complex patients where cultural influences will affect outcome. There is also a high incidence of smoking and smoking related illnesses such as COPD.
- QOF data shows significant numbers of long term conditions including diabetes, centred around practices with high populations of diabetes prone people. Cancer, severe mental health, obesity, COPD and high smoking rates are often clustered around deprived communities especially in the South East neighbourhood. (see table 2).

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<sup>12</sup> Source: Public Health England Public Outcomes Framework unless otherwise specified

<sup>13</sup> Source: ONS 2016; Figures are based on the number of deaths registered and mid-year population estimates

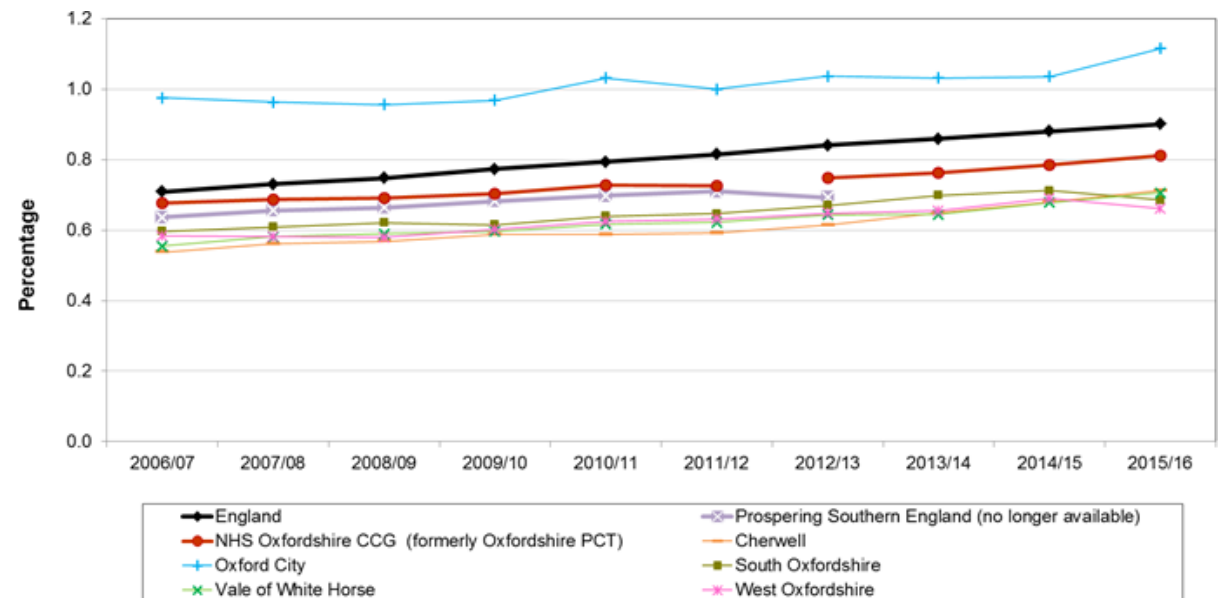
Table 2: 2015/16 Disease prevalence in Oxford city localities – QOF 2015/16

Disease Prevalence Neighbourhood	COPD	Hypertension	Smoking	Cardiovascular disease	Cancer	Dementia	Obesity	Severe Mental Health	Learning Disability	Stroke/TIA	Peripheral arterial disease	Diabetes	Chronic Kidney
Central	0.71%	5.42%	14.87%	1.04%	1.57%	0.30%	2.68%	1.16%	0.17%	0.82%	0.22%	1.93%	1.28%
East	0.67%	6.51%	17.97%	1.25%	1.19%	0.36%	4.04%	1.20%	0.30%	0.79%	0.26%	3.15%	0.96%
Headington	1.30%	10.46%	15.27%	2.05%	1.78%	0.53%	4.36%	0.89%	0.37%	1.23%	0.50%	3.60%	1.80%
North	0.79%	7.75%	10.55%	1.42%	2.10%	0.34%	3.73%	0.89%	0.17%	1.08%	0.39%	2.29%	1.97%
South & West	1.42%	13.14%	10.66%	2.85%	3.11%	0.75%	5.25%	0.80%	0.22%	1.89%	0.53%	3.76%	3.39%
South East	1.86%	12.29%	19.68%	2.49%	2.17%	0.83%	7.50%	1.27%	0.57%	1.64%	0.62%	5.12%	2.93%
City Total	1.11%	9.04%	15.45%	1.79%	1.90%	0.51%	4.64%	1.06%	0.32%	1.20%	0.42%	3.33%	1.97%
OCCG Total	1.28%	11.49%	13.22%	2.32%	2.53%	0.68%	5.72%	0.87%	0.35%	1.56%	0.49%	3.84%	2.59%

### Mental Health:

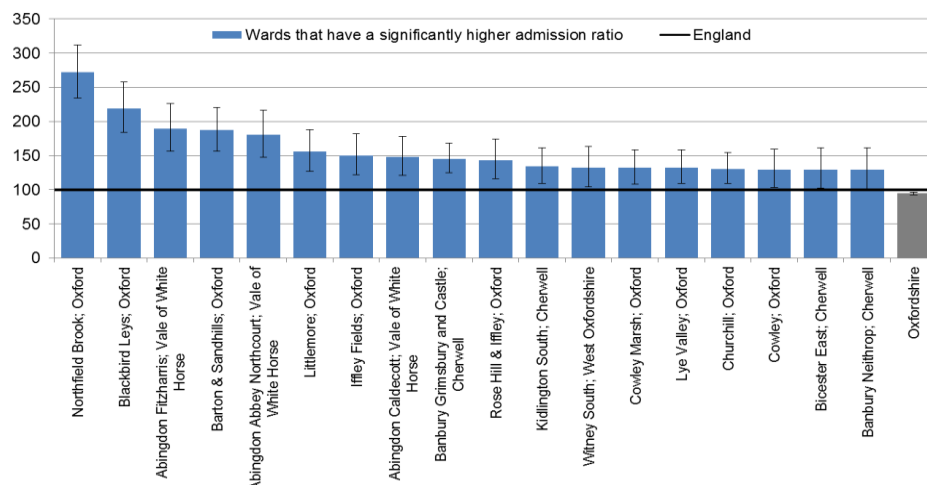
- Trend data for Oxfordshire districts shows an increase in the percentage of patients with a recorded diagnosis of a severe and enduring mental health problem in the GP-registered population in Oxford city compared to Oxfordshire with some neighbourhoods having double the prevalence of other neighbourhoods.
- Depression is common and there is a separate payment in the core contract through the QOF to provide a level of care for these patients. However, this is not the case for other mental health disorders such as post traumatic stress disorder (PTSD) and anxiety disorder, which are also commonplace, or personality disorder (PD).
- Personality-disorder (PD) requires significant resource to manage at primary care level (without which there would be an even greater burden on secondary care).
- There were 18 wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (2010-11 to 2014-15), these included 10 in Oxford, 4 in Cherwell, 3 in Vale of White Horse and 1 in West Oxfordshire<sup>14</sup>.
- Of the 18 wards in Oxfordshire with a significantly higher admission rate for intentional self-harm than England (2010/11 to 2014/15), 10 were in Oxford City.

**Figure 6: Percentage of patients with a recorded diagnosis of a severe and enduring mental health problem in the GP registered population (JSNA 2006-07 to 2015-16)**



<sup>14</sup> Source: Hospital Episode Statistics (HES), NHS Digital. Self harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at ED within the year.

**Figure 7: Wards in Oxfordshire with a significantly higher admission ratio for intentional self-harm than England (JSNA 2010-11 to 2014-15)**



### Cancer:

- Between 2013 and 2015, age standardised mortality rates for cancer in Oxfordshire remained at a broadly similar level. The cancer mortality rate for females in Oxford increased to just above the national average.
- There were 5 wards in Oxfordshire with a significantly higher mortality ratio for cancers than England (2010-14) including 3 in Oxford: Headington Hill & Northway, Blackbird Leys and Cowley.

### Coronary Heart Disease:

- There were 2 wards in Oxfordshire with significantly higher rates of emergency hospital admissions for coronary heart disease than England (2010-11 to 2014-15): Banbury Ruscote in Cherwell and Northfield Brook in Oxford.

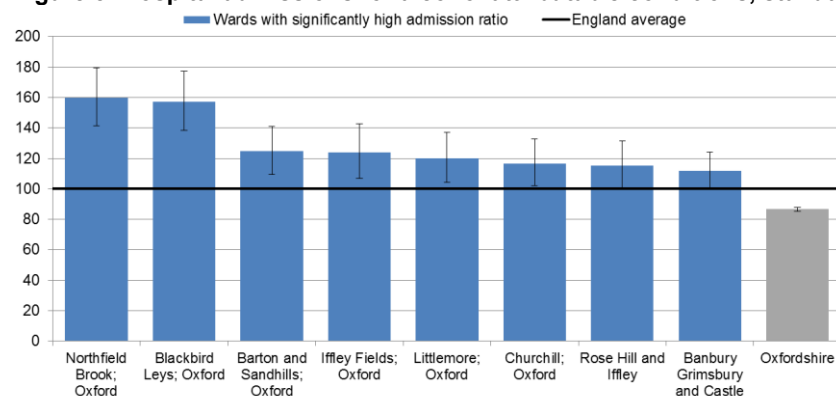
### Stroke:

- There were 7 wards in Oxfordshire with a significantly higher mortality ratio from stroke than England (2010-14) including Cowley in Oxford.

### Drug and alcohol misuse:

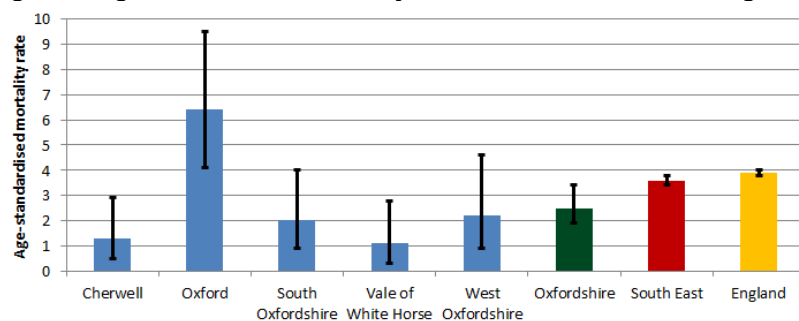
- Admission episodes for alcohol-related conditions in Oxford increased between 2013-14 and 2014-15, remaining significantly above the national and regional averages. 8 wards in Oxfordshire had a significantly higher rate of hospital admissions linked to alcohol, 7 of which are in Oxford.

**Figure 8: Hospital admissions for alcohol attributable conditions, standardised admission ratio, 2010-11 to 2014-15 (Source: NHS Digital 2014-15)**



- The rate of deaths from drug misuse (not including alcohol and tobacco) was statistically above the national average in Oxford.

**Figure 9: Age-standardised mortality rate for deaths related to drug misuse, persons (ONS 2013-15)**



## Part C: How our population in Oxford City accesses services

### 1. Urgent and Emergency access

ED attendances in City are above the county average and the second highest of the Oxfordshire localities. Leys HC is particularly high with over 250 attendances per 1,000 patients.

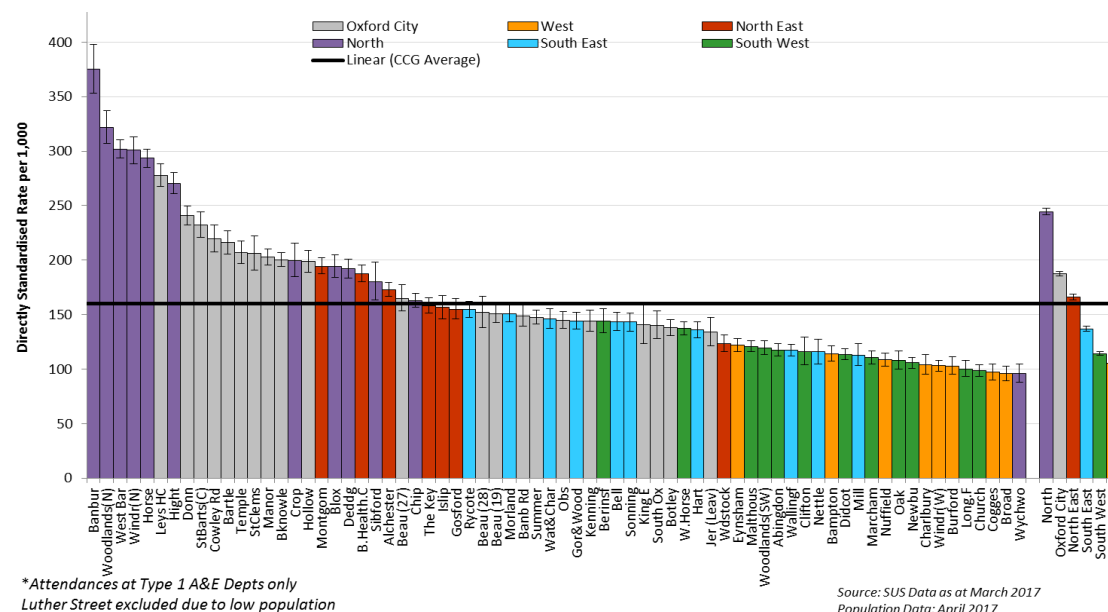
ED admission rates also seem to be influenced both by geographical closeness to the OUHT but also deprivation. Oxford city also has 7m tourists a year and 34,000 students. A Healthwatch study in 2013 indicated that 14% of students had used ED during their time in Oxford and it is likely tourists seeking medical attention will attend ED.

Between April 2016 and March 2017, Oxford City has had levels of outpatient referral in line with the countywide average although there is still room for improvement. There is some evidence that increasing usage of email advice services can lead to a reduction in referrals. Since 2015/2016 the number of outpatient referrals for dermatology has decreased, whilst Oxford City's usage of dermatology advice has increased to the highest locality in the county (see figures 11 - 14). Despite the fact that Oxford City's usage of email advice services is above the county average there is, nevertheless, significant variation in usage across practices.

As a result, increasing usage of the email advice service continues to be an aim for Oxford City.

Part C sets out how current services are used by the population in City, Oxfordshire. This includes ED and MIU attendances, current workforce and primary care provision as well an overview of urgent and community care.

**Figure 10: Urgent Care – ED Attendances 2016/17**  
Source: SUS data March 2017



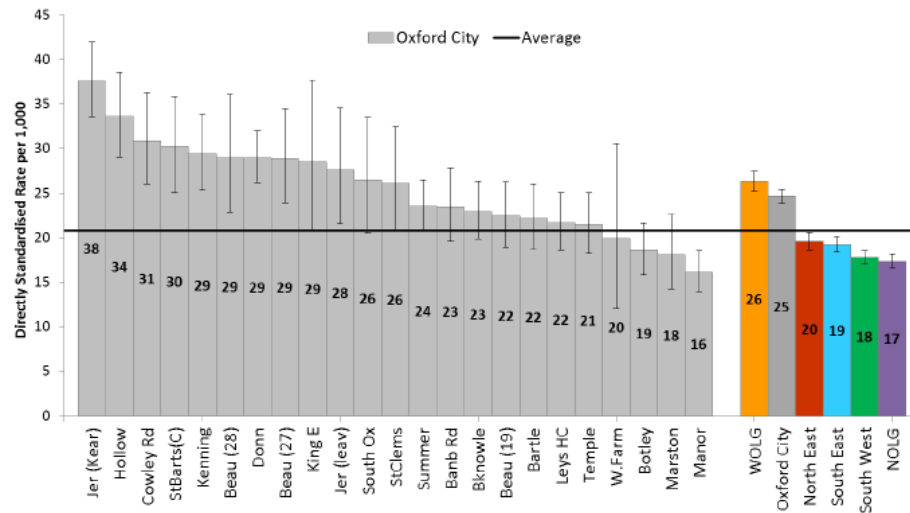


Figure 11: Dermatology outpatient GP referrals per 1,000 population in 2015/16 (SUS)

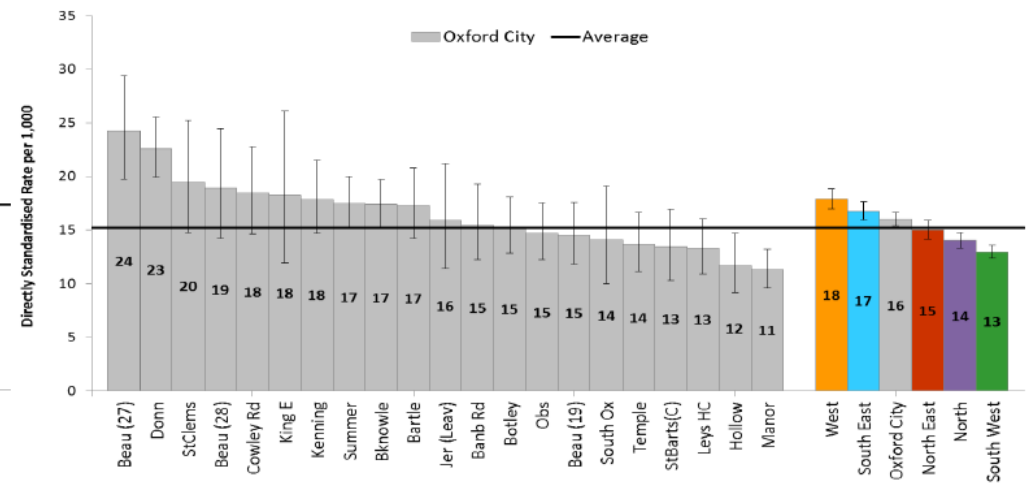


Figure 12: Dermatology outpatient GP referrals per 1,000 population in 2016/17 (SUS)

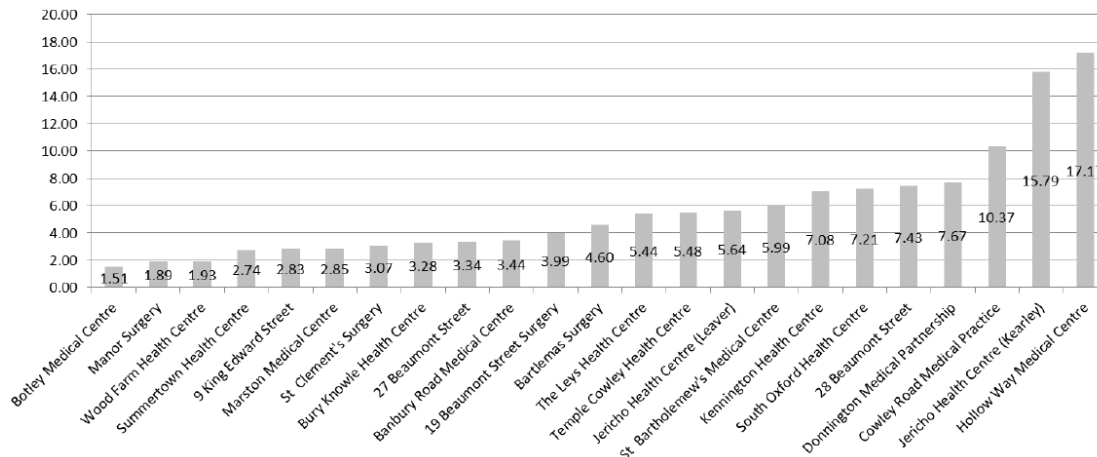


Figure 13: Dermatology email advice per 1,000 population in 2015/16

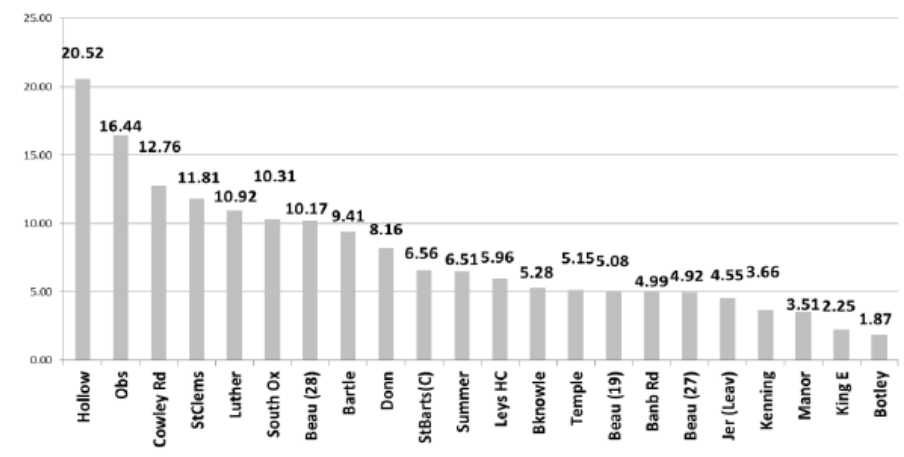


Figure 14: Dermatology email advice per 1,000 population in 2016/17

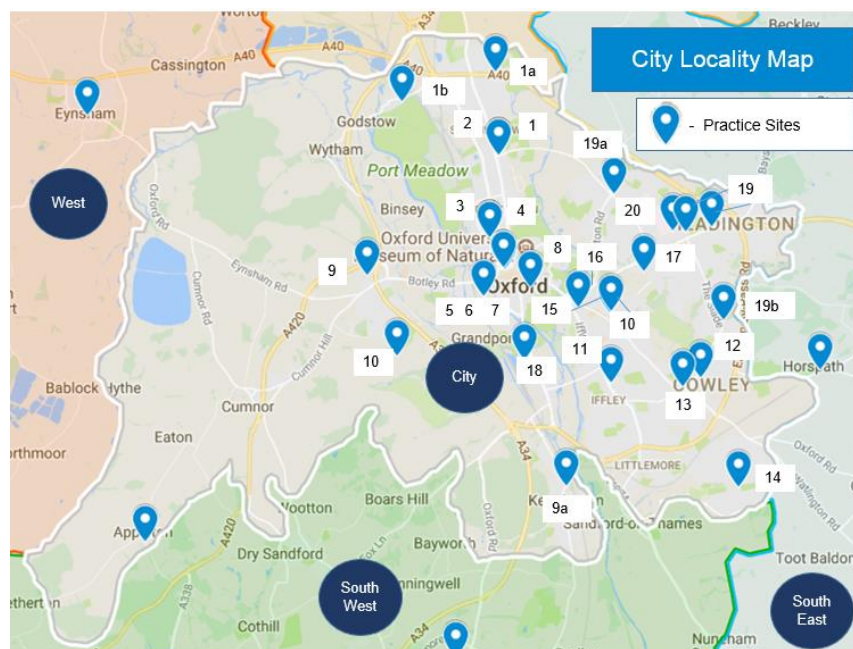
## 2. Overview of Current Locality Primary Care

### 2.1 Summary of practice provision

The City Locality, working in collaboration with OxFed (the Oxford Federation for GPs & Primary Care), have defined the 20 practices across the City into 6 neighbourhoods to align staff, and work at scale. These neighbourhoods, with registered populations of 20,000-45,000, are defined as follows:

Oxford City is also the location of Luther Street run by OHFT which is commissioned to provide primary care services to the street homeless and those on the edge of homelessness in singles hostels during core practice operating hours.

**Figure 15: Map of practices and branch surgeries in Oxford City locality**



Neighbourhood /Practice	#	List Size (Jan 18)
<b>North Oxford</b>		<b>45,259</b>
Summertown – including Cutteslowe and Wolvercote	1 1a 1b	16,928
Banbury Road Medical Centre	2	8,508
Jericho Leaver	3	8,688
Observatory Medical Practice	4	11,135
<b>Total</b>		
<b>Central Oxford</b>		<b>33,419</b>
19 Beaumont St	5	15,428
27 Beaumont St	6	7,212
28 Beaumont St	7	5,471
King Edward St	8	5,308
<b>South and West Oxford</b>		<b>20,155</b>
Botley Medical Centre – including Kennington	9 9a	15,819
South Oxford Health Centre	10	4,336
<b>South East Oxford</b>		<b>40,544</b>
Donnington Medical Partnership	11	13,348
Hollow Way Medical Centre	12	8,806
Temple Cowley Medical Group	13	8,088
The Leys Medical Centre	14	10,302
<b>East Oxford</b>		<b>42,413</b>
Bartlemas Surgery	15	8,916
Cowley Road Medical Practice	16	8,915
St Bartholomew's Medical Centre	17	19,669
St Clements Surgery	18	4,913
<b>Headington</b>		<b>40,961</b>
Hedena Health (previously known as Bury Knowle – includes Marston and Wood Farm)	19 19a 19b	25,025
Manor Surgery	20	15,936
<b>Sub-total Oxford City Locality Total (excluding Luther St)</b>		<b>223,232</b>
<b>TOTAL</b>		<b>(481) 222,751</b>

OxFed, the federation of Oxford City General Practices formed to deliver services at scale on behalf of practices, has started to develop its five year plan which will dovetail with the work the Locality is doing for the City plan. OxFed have continued to gather input from shareholders, stakeholders and staff as they develop the plan supplemented by the OxFed AGM in November 2017. Further details on the OxFed plan are set out in Appendix 2.

## **2.2 Access to Primary Care**

Currently General Practice is open through core hours 8.00 to 18.30 Monday to Friday. Some practices have also signed up to the extended hours DES to deliver service beyond these core hours to their populations. This can involve early morning surgeries or beyond 18.30 and in some cases pre-bookable surgeries on Saturday morning. A detailed study in 4 practices covering 46,000 patients looked at the number of appointments utilised in the last year. If this was scaled up to Oxford City it suggests the order of 300,000 face to face (F2F) routine GP appointments were offered over the year by 20 practices with approximately 120,000 same day GP F2F appointments. There were approximately 26,000 home visits delivered and nearly 300,000 phone calls by clinicians. There were similarly 230,000 Nurse/HCA F2F appointments and 91,000 phlebotomy appointments and at least 23,000 flu vaccinations. A more detailed study is underway to look at these numbers more closely.

Since mid-April 2017, OxFed has established extra bookable appointments funded through the 7 Day Access Fund (7DAF) run from St Bartholomew's surgery for the whole of Oxford City and these services are being scaled up. Appointments will additionally be available to all of Oxford City in Botley and Summertown. This extends pre bookable appointments to a broader range of times especially at weekends and addresses the problems of ambulant patients. To provide a greater range of support for practices and patients, appointments are now available with a range of primary care practitioners, including GPs, practice nurses, HCAs, phlebotomists and physiotherapists.

An Out of Hours service runs from the East Oxford health centre, Manzil way. Out of Hours Urgent services are GP lead but represent a reactive service and therefore high risk patients cannot be seen proactively especially at weekends. There is no First Aid Unit, or Minor Injuries Unit, as the main provision is via the ED department at the John Radcliffe Hospital site. There is also no EMU but the Ambulatory Assessment Unit runs from the John Radcliffe hospital.

## **1.3 Impact of changes to urgent care on primary care**

A number of nationally driven changes will have an impact on the provision of primary care in the city:

1. **GP streaming in Emergency Departments (ED) from 1/10/2017.** A streaming nurse will direct attenders at ED who appear on broad criteria not to require ED to a GP run service running from 08.00 to 23.00 7 days a week. At the GP service they will receive a

GP-lite service dealing with immediate issues but redirecting to their own GP in hours. This will require anything from 6-9 full time equivalent GPs to run the service.

2. **Standardise access to 'Urgent Treatment Centres' by March 2019.** These facilities will have an increasingly standardised offer - open 12 hours a day and staffed by clinicians, with access to simple diagnostics. Currently, there are no UTCs in the city of Oxford to which patients can be diverted.
3. **A consistent access through NHS 111** with high level clinical triage, more clinical advice to ensure correct support is offered to patients and the ability to book directly into further appointments out of hours. OOH primary care urgent services will need to be more accessible including taking more booked patients to try and steer those who walk in to ED to attend a primary care service.

Clearly this will mean a fundamental change in delivery of urgent treatment across Oxfordshire and a need to link in with the **frailty pathway and the community services required to keep subacute patients at or near to their home**. For Oxford City, equity of access to UTCs will be fundamental for transformation.

#### 1.4 Impact of Planned Care initiatives on primary care

There are currently a number of Planned Care projects which impact on primary care in Oxford City. A bowel and bladder service has been commissioned across the county, allowing single point of access triage and self-referral to ensure patients are quickly streamlined into the appropriate treatment pathway. Similarly the MSK hub and Minor Eye Condition service also allows for self-referral, diverting demand away from primary care and encouraging self-care and increased focus on prevention.

Oxford City is recommending three planned care initiatives to improve long term conditions care for patients with diabetes, breathlessness and COPD/Asthma. These will ensure that patients receive an improved service in these areas whilst also aiming to reduce ED admissions and attendance.

#### 2.5 Other health services

The two main provider Trusts for the City are Oxford University Hospitals Foundation Trust, incorporating the Churchill Hospital, the Nuffield Orthopaedic Hospital, and the main John Radcliffe Hospital sites providing secondary and tertiary care.

Oxford Health Foundation Trust provide the community services, and mental health services, from a variety of sites across the City, including the Littlemore Hospital site, and with mental health predominantly housed at the Warneford Hospital site.

There is a local community hospital for Oxford City situated at the Fulbrook on the Churchill hospital site hospital – which is staffed by Oxford Health, with 25 beds. However, this does not function like other community hospitals in the county as GPs have no direct admitting rights.

Furthermore this facility is used to move patients from the OUHFT acute hospital into the community and often Oxford City patients have to go to distant community hospitals in the county for rehabilitation.

Drugs and alcohol services are delivered both in general practice and also in hubs supported by Turning Point. The main hub for delivery is based in Rectory Road, Oxford and also through the Drugs and alcohol Shared care LES in practices using drugs workers supplied by Turning Point supported by suitably qualified GPs in the practice.

**Table 3: Breakdown of opiate users between Turning Point (TP) and GP shared care: April 2016 to March 2017 (OTIS OCC database)**

OST Care	Opiate users
TP OST Care	367
GP Shared Care	266
<b>Grand Total</b>	<b>636</b>

**Table 4: Counts of the number of episodes recorded throughout the year under TP and GP shared care April 2016 to March 2017**

Oxford	Number of Episodes
Alcohol and non-opiate	82
Alcohol only	208
Opiate	684
<b>Grand Total</b>	<b>974</b>

### 3. Primary care workforce

OxFed undertook a workforce survey in March 2017. This survey confirmed the high level of vacancies across GPs and other practice staff. The results of the survey demonstrate the need to develop solutions to tackle these workforce challenges. In collaboration with the Oxfordshire training network, Oxford is developing a series of projects that will help to tackle these workforce challenges and improve workforce sustainability. (These are set out in more detail in Part D.)

The locality undertook a subsequent workforce survey in October 2017 to assess current capacity in practices. This showed that 2 of the practices are at capacity, and there is the capacity for up to 14,900 additional patients, as long as recruitment / GP sessions remained stable. Oxford City is still some way below the capacity required to meet the expected housing growth. Table 4 indicates the number of sessions currently delivered and the future number of sessions and GPs required to deliver general practice in the same way as currently.

Future numbers of GPs is likely to be impacted by:

- Intentions across Oxfordshire to move to longer 15 minute appointments for patients with greater needs
- Potential changes in skill-mix and a greater role for signposting and community champions to support patients manage their long term conditions.
- The number of GPs expected to retire, which is expected to be 30% every 5 years.

General Practice is now seen as a less popular area of medicine to pursue<sup>15</sup> hence the flow of GPs to replenish the workforce is inadequate to match the flow out and the demand. This indicates a clear need to develop a different approach to workforce in primary care to ensure that it is resilient and able to meet the future needs of the population.

**Table 5: GP workforce in Oxford City locality**

Cluster	Current workforce				Future workforce	
	Current number of sessions delivered*	Number of sessions if no vacancies*	Number of GPs (wte**) if no vacancies	Number of patients per GP (wte)***	Additional GPs required (FTE) – does not account for vacancies or retirements	
					5 years****	10 years****
North	157	168	23.3	1,843	0.6	1.1
Central	127	127	17.6	1,786	0.1	0.4
South West	93	97	13.5	1,491	1.3	2.4
South East	176	176	24.4	1,675	0.7	1.6
East	143	148	20.6	2,017	1.7	2.8
Headington	182	182	25.3	1,534	1.6	2.7
<b>Oxford City locality</b>	<b>878</b>	<b>898</b>	<b>124.7</b>	<b>1,730</b>	<b>6.1</b>	<b>11.0</b>

\* Data from workforce survey  
 \*\* wte assumes 8 sessions per week 45 weeks per year  
 \*\*\* List size October 2017  
 \*\*\*\*Data calculated from housing projections

Practices are already considering the broader skill mix required to deliver primary care in the future (Table 6). The locality approach to delivering this is set out in more detail in under Part E (workforce).

<sup>15</sup> National Recruitment Office for GP Training publish the number of GP training vacancies not filled each year <https://gprecruitment.hee.nhs.uk/Recruitment>

**Table 6: Future intentions to recruit other clinical staff (from workforce survey)**

Are you considering recruiting any of the staff groups below in the next year?	Advanced Nurse Practitioner					Emergency Care Practitioner					Assistant Practitioner					Physician's Associate				
	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share
City Locality	3	6	9	5	1	0	10	7	1	2	0	12	6	0	1	0	12	7	0	2

Are you considering recruiting any of the staff groups below in the next year?	Pharmacist					Physiotherapist					Phlebotomist					Mental health practitioner				
	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share
City Locality	5	7	3	5	4	1	11	5	2	3	3	9	3	4	1	2	12	4	0	4

## Vision for primary care in Oxford city

The plan for Oxford City will be to deliver the primary care framework. This will sustain practices in Oxford city as much as possible in their geographical positions whilst encouraging more skill mix at practice level to deliver the appropriate care to practice populations. More access and support will be given to practices servicing the deprived populations with Oxford city to address health inequalities. Practices will be encouraged to work at scale especially to deliver increased access to out of hours services and to help maintain the frail vulnerable population in their homes as much as is possible. This will be supported by a thriving federation of GP practices (OxFed). Neighbourhoods of practices working together will form the core of the community service required to support patients in their home. Integration of health and social care at locality and neighbourhood level will lead to efficiencies across the system and remove unnecessary barriers to good health and well being. Working at scale also opens up opportunities to provide prompt access to diagnostic activity closer to home including spirometry and ECG tests. In addition, improved services around LTCs, especially Diabetes and COPD as well as a more useful mental health support in primary care, will link in with functional social prescribing.

**Key messages:**

Oxford City is served by 20 GP practices grouped into 6 neighbourhoods. There is an Out-of-Hours service which runs from the East Oxford Health centre which is GP led. There is no MIU or EMU, however, although there is an Ambulatory Assessment Unit which runs from the John Radcliffe. There is a growing shortage of GPs in Oxford City, which is likely to be further impacted by changes to urgent and emergency care and the growing demands of the population. Therefore, a change in skillmix will be required to meet the future needs of the population in Oxford.



## Part D: How we will meet the needs of our community

Part D outlines the highest priority areas for primary care in City, describing both the current challenges and objectives for improvement. This section also outlines our proposed initiatives that will support us to deliver our key priorities. These form the key recommendations for developing primary care in the locality.



### Priority 1 – Improving care for frail and vulnerable patients

#### Background

There is a population of frail and elderly patients with complex health needs, defined here as high input patients (HIPs), in the City locality that requires primary care to be delivered in an integrated fashion. The general aim is to keep frail, patients who often have several long term conditions at home if at all possible when there is an acute deterioration as this enables patients to recover better and prevent loss of long-term independence. These patients are often already known to GPs and community services. To do this, it is necessary to be able to mobilise clinicians, carers and health care workers to support patients for a temporary period until the situation is stabilised. The outcome may be that more services will be required to help support the patient in the longer term (usually social input) and possibly a move to a more sheltered supported living environment (such as a care home).

#### Objectives

The locality needs to provide:

- Appropriate services that are rapidly available to assess patients if they deteriorate at home;
- Access to rapid diagnostics in an appropriate place to reduce admission;
- Support for the frail and vulnerable at home for transient exacerbations/illnesses;

If patients must be admitted, then the aim is for it to be for as short a time as possible (increase discharge to assess with appropriate support for as long as is necessary). If patients cannot get back to home without further rehabilitation or require a new form of housing but do not need acute services then rapid movement to a bed based rehabilitation service.

A new frailty pathway will:

1. Link together primary care and community services (including the community bed base) to provide a robust and responsive out-of-hospital alternative for patients with subacute deterioration
2. Establish a 'Virtual Ward' system to proactively monitor and improve the health of a risk-stratified population of elderly, frail and multi-morbid people living in the local community, with the bulk of care delivered through integrated neighbourhood teams
3. Identify, respond rapidly to and 'hold' those patients experiencing episodes of sub-acute health instability or deterioration
4. Establish a High Input Primary Care Assessment Team (HIPCAT) for each locality to provide 7/7 rapid medical assessment of patients with acute deterioration and provide the immediate medical and nursing input required to re-stabilise these patients in their homes
5. Dovetail effectively with ambulatory and acute services in secondary care, drawing on diagnostic, geratology and other specialist input as required.

The proposed new frailty pathway will operate as one integrated service, 7 days a week. It will be delivered by four integrated teams:

**Primary Care Visiting Team – will provide:**

- Rapid response to acutely ill housebound patients 7/7
- ECP assessment (with GP supervision)
- Referral of acutely ill elderly/frail patients into Virtual Ward.

**Neighbourhood Team – will provide:**

- True integration of primary and community care for identified cohorts of elderly/frail people, within a local practice-based population of 30,000-50,000 people
- A GP-led, multi-professional team delivering the routine care and proactive monitoring and review of patients in the Virtual Ward (Silver, Bronze, Iron)
- The ability to draw in specialist expertise and additional resources from locality level teams as needed
- Targeted, proactive weekend reviews of identified at-risk patients ('Focussed Weekend GP Care')

### High Input Primary Care Assessment Team (HIPCAT) – will provide:

- 24/7 rapid response, stepped-up assessment and acute care for unwell/high need patients in the Virtual Ward (Gold)
- Provides medical and nursing input, supporting Neighbourhood Teams when intensive home care is required
- Offers an extended H@H capability with more risk-holding capacity (adding medical and diagnostic input to the existing nursing skill mix)
- Links with local specialist advice (e.g. geratology), ambulatory care and care home support

### Care Home Support Team – will provide:

- Regular proactive reviews, care navigation and care planning for care home residents
- 24/7 phone support for care home staff, with GP and geratology liaison
- Training and skills development programmes for Care Home staff

This frailty pathway will bring a range of benefits to patients, the service and the workforce:

### Patient benefits

- Increased quality and experience of care for the frail and their carers
- Enhanced independence, wellbeing and slow deterioration
- A person-centred alternative to hospital admission

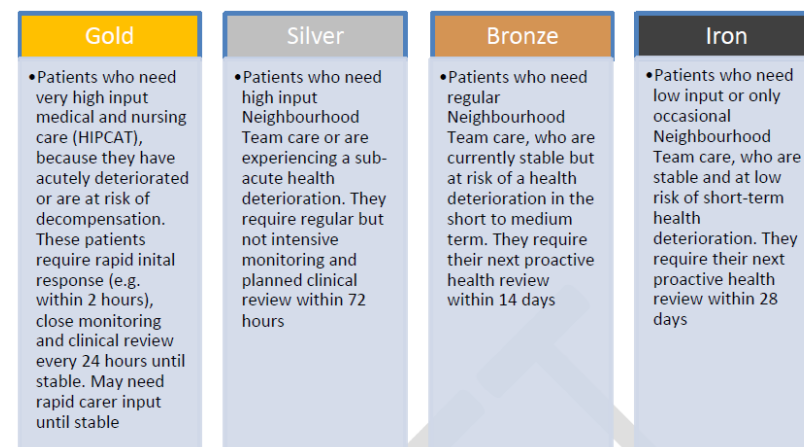
### Service benefits

- Reduced unnecessary hospital admissions
- Reduced DTOCs
- Improved system financial sustainability
- Opportunities for funding to be diverted to develop and stabilise GP and community services

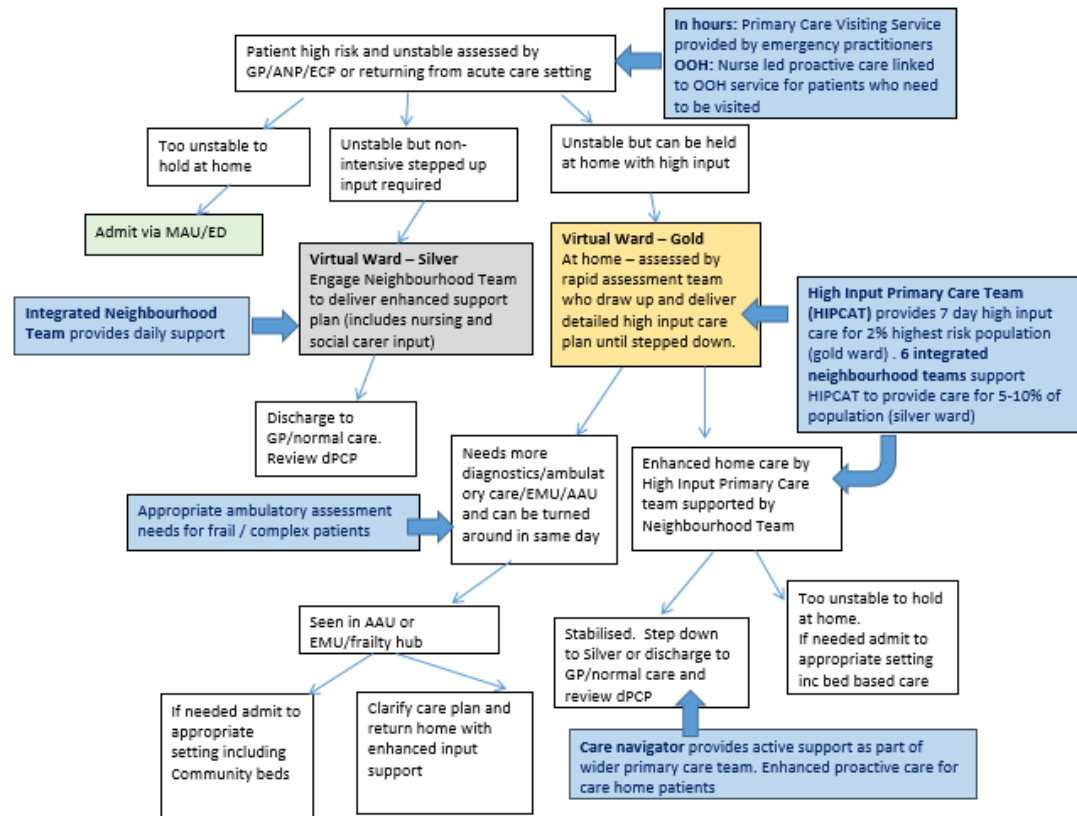
### Workforce benefits

- An integrated team with increased skill-mix
- Reduced stress on over-worked and under-resourced teams
- Enhanced recruitment and retention and increased professional satisfaction

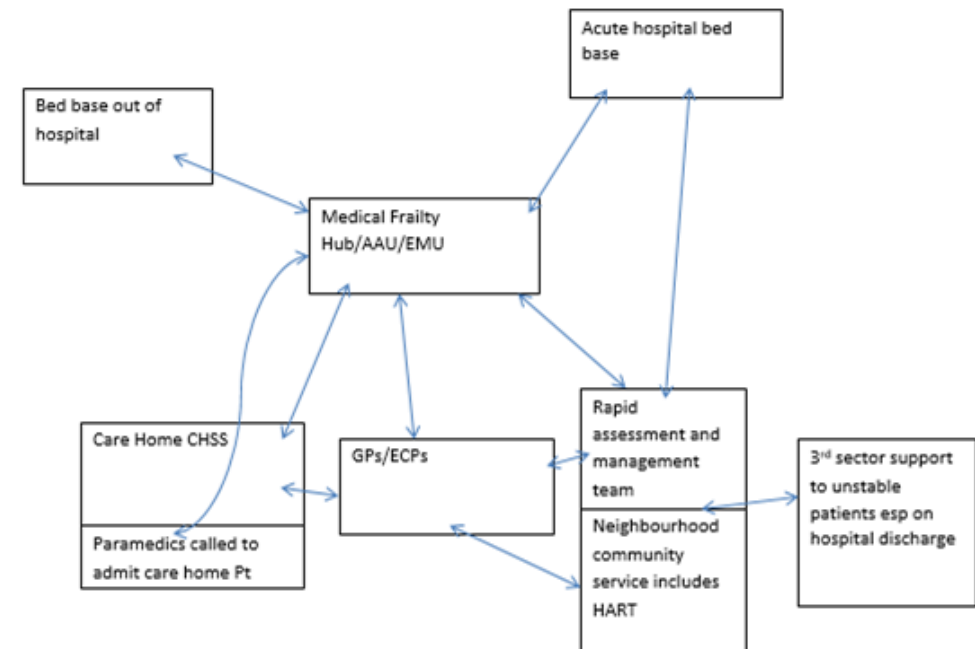
**Figure 16: Proposed virtual wards**



**Figure 17: New frailty pathway for Oxford City patients (new services highlighted)**



**Figure 18: Relationships between medical teams**



## Priority 2 – Addressing deprivation and health inequalities

### Background

The locality contains a patch-work of relatively prosperous and much more deprived local populations; for example, there is a high amount of deprivation among the people residing in the East Oxford Corridor up the Cowley and Iffley roads to Blackbird Leys and Rose Hill. There is also a very health deprived adult population residing in the city centre. This extent of deprivation has contributed to a number of health inequalities that affect the mortality and morbidity of the population of Oxford City locality.

Deprivation and health inequalities manifest themselves in: income deprivation, child protection plans and domestic abuse, self-harm, cancer levels, stroke prevalence, drug and alcohol misuse, and increased smoking and obesity as well as homelessness which is associated with drug and alcohol misuse and abuse, poor mental health and reduced life expectancy. Deprivation leads to premature morbidity reduced life expectancy in some areas of up to 8 years. Mental health issues are also more prevalent in such areas.

### Objectives

- Address the health inequalities faced by the deprived population in Oxford city locality by improving services that focus on particularly affected population groups; homeless, mental health patients and vulnerable children and adults. These services will aim to improve the health outcomes of these identified groups and seek to close the mortality gap in the locality.
- Pilot use of mental health wellbeing link workers related to neighbourhoods and practices along a social prescription model to improve MH wellbeing of those identified with anguish in part related to mental health issues but who are not engaging with formal services.
- There is a wealth of international evidence showing that the provision of locally accessible, high quality primary care is one of the most effective ways of reducing health inequalities, so initiatives must be designed to sustain this core service. To support these service changes there is a need to divert funding to primary care services specifically for treating the deprived population in Oxford city locality.
- Integrate the current and future built environment to support healthy lifestyles, positive health outcomes, community cohesion, and successful ageing as part of the Barton Healthy New Town Project, so that residents in Barton can enjoy the same life expectancy and health outcomes as their Oxford neighbours. This includes walkways, cycle routes, green spaces and other policies that support a healthy environment. These principles will also apply to the new community of Barton Park and learning from this will be shared more broadly across similar populations.

## Priority 3 – Ensuring sustainable primary care

### Background

The General Practice Forward View (GPFV) published by NHS England April 2016 sets out a plan to help sustain Primary care over the next 5 years. Many of the points made in the GPFV align to the challenges faced in the Oxford City locality.

There are gaps in the current out of hours services which are resulting in unnecessary ED or even primary care attendance. There is a need to better steer acutely ill patients either through 111 or streaming patients when they arrive at ED, so that they are appropriately triaged by an experienced GP where they can be redirected to self-care, pharmacies, or GP led in-hours or out of hours services. Oxford City population is estimated to grow significantly in population, further exacerbating this problem. Oxford city also has 7m tourists a year with nearly 0.5m from overseas and has approaching 34,000 students who reside in Oxford City for at least 6 months of the year, these patients have been identified as high ED users. The student population also has a significantly higher than average consultation rate and a high prevalence of mental health conditions and eating disorders, according to local data.

Practices are struggling to cope with demand for urgent same day appointments during certain high demand periods. As a result practices are unable to sufficiently limit the number of patients seen in a routine session as a point of quality and safety in order to offer 15 minute appointments for patients with more complex problems.

Currently it is difficult to provide prompt access to patients that are housebound or in care homes for urgent issues without disturbing the service being delivered to the vast majority of mobile patients. The inability to react quickly and effectively can result in unnecessary ED admissions.

Mental health issues have an increasing impact on patients attending primary care. Some of this is due to recognition that physical illness is one aspect of a biopsychosocial dimension and many frequent attenders at primary care, ED and outpatients would be better addressed if the psychosocial issues are also addressed. Even when services are available, some patients do not feel able to engage with these services but turn up repeatedly at GP surgeries. Also some patients with complex mental health issues do not feel able to access the services dedicated to these issues and bounce around GP surgeries, ED, and other parts of the health and social care system without any long term engagement.

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Children and young people, especially those aged less than 5, use general practice at high levels, in particular when parents seek urgent reassurance. More complex issues around childhood development and management of LTCs as well as mental health issues and behavioural management have an impact on primary care but expertise is placed remotely in secondary care. There is also intense workload due to child protection issues and domestic violence which impacts on primary care.

Other vulnerable patient groups are being identified with needs beyond the usual model of primary care, but where extension or adaption of General Practice would lead to better access for these patients and better care. Attention is drawn to those with learning disabilities (LD), severe mental illness (SMI) and those with autism – groups where there is poor access and engagement and poor health outcomes.

There is a shortfall of qualified workers including nurses, health care assistants, social workers, carers and GPs in Oxford City, partly due to under-investment in training and also driven by the high cost of housing. A workforce survey conducted by OxFed (which takes into account vacancies and planned retirements) has indicated shortfalls in all practice staff e.g. there will be a need for 13-14 full time equivalent GPs to cover the existing General Practice structure (see table 5).

## Objectives

- Progress the 2016-17 scoping projects for practice sustainability completed by OxFed into delivery and implementation phases and provide support on workforce sustainability. More details on these is provided in Appendix 2.
- Improved integration and streamlining between city practices and other urgent care providers (111, SCAS, ED, OOH, Community Services, Social Care, etc.)
- Cost-effective assessment and treatment for people with acute illness
- Improved access to high quality primary care for people who need it, when they need it. This includes making sure that appropriate primary care services are available throughout the week, tailored to the needs of the local population.
- Build on the strengths of GPs and their teams to continue to care for the majority of people close to home, leveraging their generalist skills, expertise and ability to hold risk, while acting as a gateway to further care when necessary.
- Development of care for children and young people and also management of LTCs
- Broaden access to MH support in primary care and also address extended needs of vulnerable groups identified
- Facilitate the development of a thriving and expanded primary care workforce with greater capacity, resources and enhanced skill mix.
- Increase the contribution from non-clinical staff in primary care, including care navigators to link patients and carers with the full range of services required to maintain care outside hospital, and training in signposting for receptionist to support patients in sensitively exploring options for patients to see the right clinician.

- Support all interactions with a strategy for “Making Every Contact Count”. This is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. This will be rolled out across all health and social care services in Oxfordshire.

## **Priority 4 – Neighbourhood community practice**

### **Background**

The OCCG primary care framework sets out the development of neighbourhood teams built around clusters of practices as a key strategic approach to deliver joined-up, sustainable services for patients with complex needs and frailty. This is based around populations totalling 20,000-50,000 patients. The aim of the neighbourhoods is to deliver integrated and responsive primary and community services supporting the subacute frail population to enable them to be supported at home as long as possible and avoid unnecessary hospital admissions.

There needs to be a functioning frailty service to support those subacutely unwell to be stabilised and maintained as much as possible in their home. This must include a needs assessment of the frail population with stratification to different risks of deterioration held in a virtual ward system and, derived from this, a single integrated service to support frail/vulnerable patients to remain at home. This needs to be wrapped around General Practices in geographically convenient locations which provide the first community level of medical support and often identify those who are at risk. The variety of workforce needed in the services are clear but the numbers required for any neighbourhood are not so clear. Also the neighbourhood community services will need supra-neighbourhood/locality services which will include an equivalent of hospital at home, workforce planning alongside virtual wards which assess the level of need among frail patients across the locality with the support of the more expert medical team.

Modelling work conducted by OCCG suggests that there is a gap in Oxford City locality of 20 WTE clinicians, primarily in Care navigator / coordinator, specialist nurses / AHPs, GP and mental health worker roles. These additional staff will provide the additional clinical and medical input required to deliver a city-wide service with the capacity and skill mix to keep elderly and frail patients effectively out of hospital.

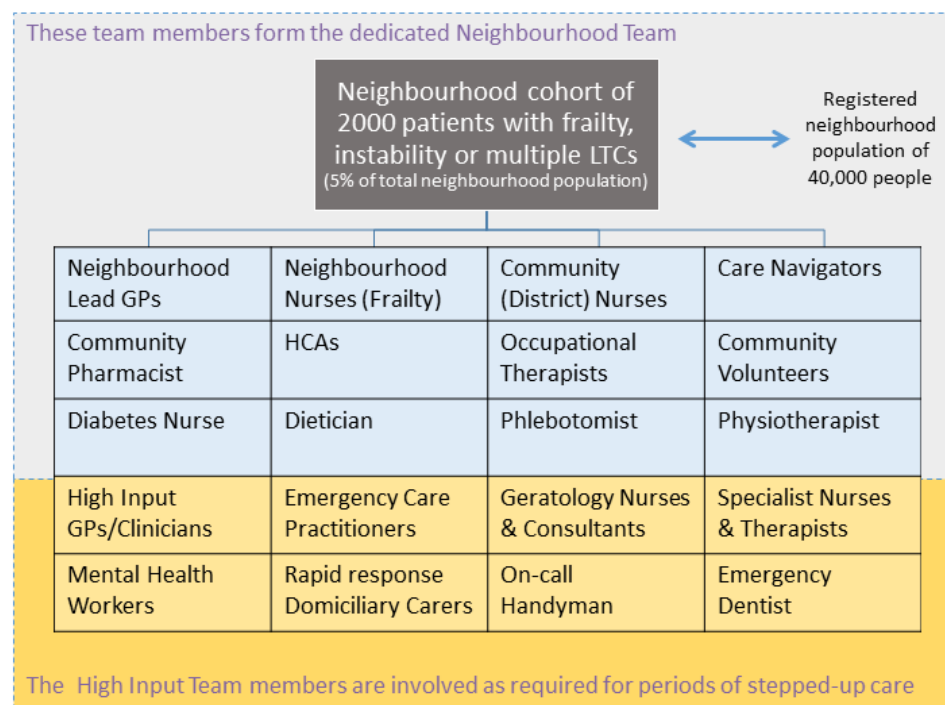
## Objectives

- The neighbourhood community service will link in with the whole frailty pathway (see priority 1 above). The new model will build on the workforce already in the community service to form an integrated team in the cluster wrapped around the neighbourhood practices whose aim is to deliver the support of the frail at home.
- It will be able to deal with preventing those at high risk of decompensating as well as supporting those with subacute acuity requiring increased support. A city-wide (supra-neighbourhood) rapid assessment team known as the High Input Primary Care Assessment Team (HIPCAT) will manage the acute assessment and treatment of those who are decompensating. Critically, this team will have a strong clinically-led ethos with dedicated 7-day GP and other clinical input, providing a more robust clinical decision-making and risk-holding capability than the current H@H, which this new service will supersede. This will add extra clinical support to the neighbourhood teams to enable the patients to be treated more effectively, reliably and safely in the community and to interface more effectively with gerontology services.
- Neighbourhoods will also be a focus to deliver integrated LTC such as Diabetes, Breathlessness services (including COPD), paediatric services based out of hospital, and support of particular vulnerable groups where more specialised services might need to be concentrated eg around Learning Disability, autism, complex mental health patients.

**Figure 19: Example of an integrated Neighbourhood Team (in blue) providing primary and community care to an identified, risk-stratified population.**

Each Neighbourhood Team is able to draw on a rapid response High Input Primary Care Assessment Team at locality level (in yellow) as required (e.g. for periods of stepped-up care, to prevent admission).

The integrated neighbourhood teams will also be well placed to provide palliative care in the community where it is needed.



## Planning for the future

In response to the key objectives outlined in each of the 4 priority areas, we have recommended the following workstreams. Each workstream responds to the challenges of at least one priority. The chart below indicates how each initiative aligns to the different priorities.

### Alignment of workstreams to priorities:

#	Workstreams	Priorities			
		Frailty and vulnerability	Deprivation and health inequalities	Sustaining primary care	Neighbourhood community practice
A.	Primary Care Visiting Service (PCVS)				
B.	Virtual Ward – City & Neighbourhood Teams				
C.	Ambulatory assessment and diagnostics for frail / complex patients				
D.	Social prescribing and care navigation				
E.	Barton Healthy New Town Project				
F.	City Health and Wellbeing Network				
G.	Practice and workforce sustainability				
H.	Focussed Weekend General Practice Care				
I.	City Care Home Service				
J.	Additional funding for practices treating deprived populations				
K.	Enhanced practice care for learning disability or severe mental illness or autism				
L.	Extension of minor ailments pharmacy scheme				
M.	Extending services at Luther Street medical				
N.	City student health service delivered from a city centre hub				
O.	Enhanced practice care for children and young people				
P.	Enhanced practice care for people with mental health conditions				
Q.	Enhanced practice care for people with long term conditions - diabetes				
R.	Enhanced practice care for people with long term conditions - breathlessness				
S.	Enhanced practice care for people with long term conditions - COPD/asthma				

## Workstreams

The table below provides additional detail for each workstream. Each row documents how each workstream would be implemented and what it will do and provides an approximate costing and list of benefits to the locality. The workstreams are grouped into at-scale services, to be provided at locality/federation level, and practice neighbourhood / local practice services.

In keeping with OCCG's *Care closer to home* strategy, the following at-scale primary care services will be provided at the locality/ federation level:

Proposed solutions	Service scope	Benefits	Implementation steps	CCG support	Duration
<b>A. Primary Care Visiting Service (PCVS)</b>	<p>A city-wide, GP-led home visiting service that provides initial assessment and treatment to patients in their homes or in care home settings.</p> <p>This will be an in-hours visiting service staffed by ECPs with GP supervision, providing:</p> <ul style="list-style-type: none"> <li>Urgent assessment of acutely ill people (mainly elderly and frail)</li> <li>More responsive end of life care</li> <li>Access to point-of-care-testing diagnostics</li> <li>Coordination with ambulatory care and hospital-at-home services</li> </ul>	<p>Prompt access to care for acutely ill frail, elderly or housebound patients or those at risk of deterioration, thereby reducing unplanned admissions.</p> <p>Supports best use of GP time to see as many patients as possible and free up practice team capacity.</p> <p>Care Navigator support to link patients and carers with the full range of services required to maintain care at home, working with Community Services.</p> <p>Integrates with the Virtual Ward (see below)</p>	<ol style="list-style-type: none"> <li>1. Implement delivery model based on successful models in other localities</li> <li>2. Set up a single call centre to coordinate calls and dispatch (linked to the virtual ward)</li> <li>3. Provide visiting clinicians with full access to EMIS GP records, using federation IT</li> <li>4. Integrate with neighbourhood and locality teams</li> <li>5. Utilise traffic and route analysis technology to minimise travel time</li> </ol> <p>Through the federation, this service will share workforce and infrastructure with other services (reducing costs though shared overheads)</p>	Solicited through proposal and business case	Recurrent

<p><b>B. Virtual Ward – City and Neighbourhood Teams providing integrated care to a risk-stratified population</b></p>	<p>Patients with frailty and multiple long-term conditions will be identified and monitored in a 'virtual ward'. This will enable them to receive an enhanced level of targeted care from a two-tier integrated team, depending on the patient's intensity of need (based on pilots in other city populations, e.g. Manchester and London):</p> <p><b>High Input Primary Care Team (HIPCAT)</b> - a 7-day high impact GP-led team of primary care clinicians, community nurses, therapists and other practitioners who will provide enhanced, targeted medical care to c.2% of the city population (4,300 people) at high risk of emergency hospital admission (including people with multiple LTCs, frailty and 'complex lifestyles'). These people will be identified in the virtual ward as 'Gold Ward' patients.</p> <p><b>Neighbourhood Teams</b> - Supporting the HIPCAT team, six integrated neighbourhood teams will deliver care to and monitor the 5-10% of the population with the next highest level of risk of health deterioration (virtual ward 'Silver Ward' patients). These teams will bring together a range of existing primary and community care services, built around local clusters of GP practices, enabling local GP clinical leadership and facilitating close working relationships between professionals.</p> <p>People will step up or down between the virtual ward levels following regular holistic assessments.</p>	<p>Silver Ward patients will receive:</p> <ul style="list-style-type: none"> <li>- Nursing and therapy services from an integrated primary and community team</li> <li>- Reablement and homecare</li> <li>- Timely and inclusive care reviews</li> <li>- Local named GP</li> <li>- Care navigation and social prescribing</li> <li>- Enhanced, pro-active monitoring</li> <li>- Health improvement support and interventions</li> </ul> <p>Gold Ward patients will receive the above, plus:</p> <ul style="list-style-type: none"> <li>- Enhanced medical input to support their hospital-at-home, stepped-up care, community or shared care interventions</li> <li>- Longer, bespoke appointments (depending on patient need)</li> <li>- Proactive GP-led care with regular planned contacts and reviews</li> <li>- Regular multi-disciplinary input with access to shared record</li> <li>- Streamlined access to specialist advice, opinion and diagnostics</li> <li>- Rapid response stepped-up personal care</li> </ul>	<ol style="list-style-type: none"> <li>1. Clinical and corporate governance arrangements put in place (e.g. through Joint Enterprise)</li> <li>2. Risk stratification undertaken for target populations</li> <li>3. Formation of the HIPCAT</li> <li>4. Implementation of new virtual ward monitoring and response systems</li> <li>5. Roll-out of neighbourhood teams built around clusters of GP practices as the main delivery vehicle of community services</li> </ol> <p>This service will share workforce and infrastructure across primary and community services (reducing costs though shared overheads)</p>	<p>OCCG strategy to develop integrated N'hoods</p> <p>Business case in development</p>	<p>Recurrent</p>
<p><b>C. Ambulatory assessment and diagnostics for frail / complex patients</b></p>	<p>An Emergency Multi-Disciplinary / Urgent Care Centre function in Oxford city will be established as an alternative to ED for frail / complex patients which includes, where appropriate, a medical assessment by a clinician and appropriate diagnostics; rapid response and support from therapies; social care and psychological assessment.</p> <p>This will provide clinical, diagnostic and assessment support for the PCVS and virtual</p>	<ul style="list-style-type: none"> <li>- Improved care for high input patients.</li> <li>- Integrated with the frail patient pathway to reduce duplication</li> <li>- Closer working relationships between gerontologists and interface physician, and act as a vehicle to unify other services being delivered at scale in the locality, e.g. whole frailty pathway and virtual ward</li> <li>- Reduce burden on ED for services especially out of hours</li> </ul>	<p>Business and implementation plans will be modelled based on other ambulatory services in the county, to be developed in partnership with the Joint Enterprise and OUH</p>	<p>Solicited through proposal and business case</p>	<p>Est. 26-94 weeks</p>

	<p>ward patients requiring short periods of assessment or ambulatory care.</p> <p>This provision may be met through reconfiguration of the current AAU although primary/community access will need to be improved and appropriate location(s) considered in line with expected patient flow and broader strategic estate plans.</p>				
<b>D. Social prescribing and care navigation</b>	<p>Building on the successful care navigator service for elderly and frail housebound patients, this development will provide a social prescription model to a wide range and greater number of patients with deprivation and unmet health and wellbeing needs.</p> <p>Clinics will be provided in practices and other community settings for ambulatory patients.</p> <p>Clinicians will be able to refer for non-medical issues such as isolation, benefits / financial advice and wider wellbeing needs.</p>	<ul style="list-style-type: none"> <li>- Improved coverage of social prescribing across the locality, addressing health inequalities</li> <li>- Increased access to the wide range of self-help, community-based and third sector services available to patients including mental health wellbeing</li> <li>- Improved wellbeing and empowerment, leading to increased independence and health resilience, with a reduction in ED attendances, outpatient attendances, and hospital admissions</li> <li>- Increased health literacy and lifestyle awareness</li> </ul>	<ol style="list-style-type: none"> <li>1. Review and evaluate current social prescribing pilots to inform service development</li> <li>2. Train existing team of care navigators in new services and expand team for additional capacity</li> <li>3. Roll-out to all neighbourhoods</li> <li>4. Provide additional provision in areas of greater deprivation</li> </ol>	Business case	Recurrent
<b>E. Barton Healthy New Town Project</b>	<p>One of 10 healthy new town sites in England supported by NHS England and Public Health England that aim to create a physical and built environment that supports health and wellbeing. The Barton project focuses on providing an equal opportunity to good physical and mental health and to good health outcomes.</p> <p>Phase 2 of the project is on health and wellbeing projects related to falls prevention, diabetes, MSK services, COPD and improved mental health.</p>	<ul style="list-style-type: none"> <li>- Improved health and wellbeing outcomes for Barton residents -</li> <li>- Reduce health inequalities</li> <li>- Foster community cohesion</li> </ul>	<p>Town and Country Association Developers Wellbeing Project</p> <p>Learning event with Bicester Healthy New Town</p> <p>Dementia-friendly action planning and wayfinding</p> <p>Targeted interventions for patients to attend activities</p> <p>Evaluation</p> <p>Extend social prescribing support to all practices in Barton</p>	As currently	

<b>F. City Health and Wellbeing Network</b>	<p>Complementing the above service for people with an existing poorly controlled LTC, this hub-and-spoke health improvement model will support the general population with a focus on evidence-based approaches to reduce pre-disease risk factors, including:</p> <ul style="list-style-type: none"> <li>- Smoking cessation</li> <li>- Weight management</li> <li>- Exercise classes</li> <li>- Screening and immunisation</li> <li>- Social prescribing and care navigation</li> <li>- Mental health wellbeing and IAPT services</li> </ul> <p>The 'spokes' will be located in appropriate settings for health deprived or at-risk patients (i.e. focussed on areas with deprived populations, e.g. OX4).</p> <p>The service will also support the provision of more effective health promotion activities in practice and federation services (e.g. through shared staff training, advice and development of resources).</p>	<ul style="list-style-type: none"> <li>- More effective disease prevention and health improvement offerings in the city, particularly for deprived population groups, leading to greater take-up and engagement</li> <li>- Improved health outcomes leading to reduced costs to other services</li> </ul>	<ol style="list-style-type: none"> <li>1. Design and agree service spec. and locations of centres with locality stakeholders</li> <li>2. Fully cost new service proposals in a business case and submit to the CCG</li> <li>3. Secure funding</li> <li>4. Pilot services</li> <li>5. Full roll out of services</li> </ol>	Joint support with council to secure funding and confirm site	recurrent
<b>L. Extension of minor ailments pharmacy scheme</b>	<ul style="list-style-type: none"> <li>- Expand the current minor ailment scheme to all pharmacies in Oxford City; this will deliver consultations for minor ailments and focus on areas of higher deprivation.</li> </ul>	<ul style="list-style-type: none"> <li>- Improved access for patients who do not need to see GP and promote signposting people to self-care.</li> <li>- Free up GP capacity.</li> </ul>	As for previous scheme	To confirm	Est. 12-18 weeks
<b>M. Extending services at Luther Street medical centre</b>	<ul style="list-style-type: none"> <li>- Provide extended primary care services to the street homeless population and those on the edge of homelessness living in hostels in Oxford city, overlapping with drugs and alcohol services for this population and mental health.</li> <li>- Advice service to other practices. Liaison service with hospital</li> <li>- Review service to ensure that it is available to homeless patients at the times when it is most likely to be accessed.</li> </ul>	<ul style="list-style-type: none"> <li>- Improved health outcomes for the homeless population that has increased (2014/15 estimate – 90) and is now above the Health and Well-Being Board's target (68).</li> </ul>	n/a	As currently	Recurrent

<b>G. Practice and workforce sustainability</b>	<p>Following the successful phase 1 scoping projects in 17-18, the OxFed phase 2 projects will deliver a range of initiatives to support primary care and practice sustainability, including:</p> <ul style="list-style-type: none"> <li>- Clinical Pharmacists in Practice</li> <li>- EMIS Enterprise Search and Reporting</li> <li>- Federation Staffing Pool</li> <li>- Education and Workforce Development</li> <li>- Digital Integration and IT</li> <li>- Volunteering in General Practice</li> <li>- Patient Transport</li> <li>- Sustainability and System Integration</li> </ul> <p>In addition, OxFed will take forward work with OCCG, the other Federations and NHS Trusts in Oxfordshire, to implement integrated services and innovative models of care, in the interests of patient care and practice sustainability.</p>	<ul style="list-style-type: none"> <li>- OxFed has secured NHSE funding to deploy clinical pharmacists in practices. The working model will be developed with practices</li> <li>- OxFed will implement Search and Reporting to improve data collation and support practice teams</li> <li>- OxFed will pilot a physiotherapist staff pool. Other shares staffing options will be developed</li> <li>- Variety of courses for practice nurses and HCAs will be available through the OxFed website</li> <li>- A detailed training needs analysis will be completed, focusing on practice nurses, ANPs and HCAs as well as pharmacists working in general practice. This will identify gaps in training to enable local tailoring of courses and input for the City workforce plan</li> <li>- A Minor Illness Course took place in June 2017 with over half of the City practices benefitting. OxFed will run similar courses in 18-19</li> <li>- Courses for Receptionist Triage and Signposting training will be provided</li> <li>- The Digital Transformation Project will identify ways to use IT to support core aspects of practice clinical and administration workload</li> <li>- OxFed will evaluate and roll-out the practice-based volunteer roles developed in 16-17, enabling practices to offer quality volunteer opportunities safely, legally and with minimal workload.</li> <li>- A simple (digital) tool to direct patients to existing transport services will be developed. OxFed will also develop solutions for groups who are not supported with patient transport</li> </ul>	Details to be provided in separate OxFed implementation plans		
<b>H. Focussed Weekend</b>	A focussed, GP-led provision that will proactively review patients identified to be at high risk of deterioration or admission over the weekend, including care home residents and	<ul style="list-style-type: none"> <li>- Proactive review will support self-care and encourage and improve the resilience of both patients and carers, in order to reduce unplanned admissions</li> </ul>	To procure	Solicited through proposal and business case	Recurrent

<b>General Practice Care</b>	<p>others not already under the 7/7 care of the HIPCAT.</p> <p>Patients requiring additional medical review will be assessed in 7DAS or practice clinics.</p> <p>Visiting of housebound patients will be delivered through the OOH or other services as appropriate.</p> <p>[Subject to funding, a clinical pharmacist with access to GP records could be provided to resolve medication issues]</p>	<ul style="list-style-type: none"> <li>- Patients and carers will have more confidence to manage symptoms over the weekend, when their local practice is closed</li> <li>- Avoidance of ED attendance for patients identified to be high users of ED at weekends who have been identified as needing additional support but are unlikely to be suitable for the virtual ward due to their low background risk, including: <ul style="list-style-type: none"> <li>- Students</li> <li>- People experiencing mental health crises or emotional distress</li> <li>- Acutely ill children and adults</li> <li>- Women and infants in the post-natal period</li> </ul> </li> </ul>			
<b>I. City Care Home Service</b>	<p>A proactive and responsive 7/7 care home service, providing:</p> <ul style="list-style-type: none"> <li>- Rapid-access primary care clinical support to care home teams</li> <li>- Education and training interventions to develop the skills and capabilities of care home staff</li> <li>- Integration with the Virtual Ward and Primary Care Visiting Service</li> </ul>	<ul style="list-style-type: none"> <li>- Improved quality of care and responsiveness for patients in care homes</li> <li>- Reduced demand on practice teams, releasing capacity in core primary care</li> <li>- 7/7 support for care home staff to enable accurate assessment of patient need, earlier intervention and reduction in avoidable admissions</li> </ul>	<ol style="list-style-type: none"> <li>1.Utilise PCVS and 7DAS infrastructure where appropriate</li> <li>2.Fully cost new service proposals in a business case and submit to the CCG</li> <li>3.Agree service spec. with locality stakeholders</li> <li>4.Secure funding</li> <li>5.Pilot new services</li> <li>6.Full roll out of services</li> </ol>	TBD with locality	Recurrent
<b>N. City student health service delivered from a city centre hub</b>	<ul style="list-style-type: none"> <li>- Multi-professional care will be provided for high ED users (students and tourists) at weekends.</li> <li>- Minor illness, musculoskeletal injuries and low level emotional disturbances/ mental health crisis will be treated, with links to student welfare services.</li> <li>- Services will be provided through e-consultations, telephone, face to face appointments. Promotion of self-care.</li> </ul>	<ul style="list-style-type: none"> <li>- Reduce burden on ED for services especially out of hours.</li> <li>- Cost-effective care for the city's students and tourists.</li> </ul>	<ol style="list-style-type: none"> <li>1. Design and agree service spec. with locality stakeholders</li> <li>2. Fully cost new service proposals in a business case and submit to the CCG</li> <li>3. Submit estates business case to NHSE</li> <li>3. Secure funding</li> <li>4. Pilot new services</li> </ol>	Solicited through proposal and business case	Recurrent

	Nursing led - with back up provided by 7DAF GPs. The service will be delivered from an existing GP access hub.		7.5. Full roll out of services		
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In keeping with OCCG's *Care closer to home* strategy, the following primary care services will be provided at the practice neighbourhood/local practice level:

Proposed solutions	Service scope	Benefits	Implementation steps	CCG support	Duration
<b>J. Additional funding for practices treating deprived populations</b>	Current deprivation funding considers use of language line for populations where ESOL, and also number of children on child protection plans. Plan to extend to Lowest 30% IMD populations according to practices in Oxfordshire 2018/2019	- Improved access and range of services provided for deprived population groups.	1. Develop detailed proposals for funding alterations and test feasibility 2. Write proposal to the CCG/ NHSE for changes 3. Achieve sign off 4. Implement funding changes	As currently	April 2019
<b>K. Enhanced practice care for people with learning disability or severe mental illness or autism</b>	Define the patient needs, the best evidence based interventions and how we support practices and Neighbourhood services to support this.  Health checks for LDs and improved identification for patients with SMI and autism and improved health outcomes including wider health and wellbeing reviews	Improved identification of patients with SMI and LD and autism	1. Define patient healthcare needs and identify best practice solutions to meet those needs as part of an improved service 2. Fully cost new service proposals in a business case and submit to the CCG 3. Secure funding 4. Pilot services 5. Full roll out of services	tbc	tbc
<b>O. Enhanced practice care for children</b>	Working in partnership with OUH FT paediatricians, practice neighbourhoods will pilot child health outreach clinics in primary care settings.	These joint GP-paediatrician clinics have been successfully evaluated in a number of urban areas and provide reciprocal learning opportunities for both clinicians,	1. Design and agree service spec. with locality stakeholders 2. Agree funding streams	Solicited through proposal and business case	Pilot

<b>and young people</b>	In these clinics, a consultant or ST7+ paediatrician delivers a monthly primary care clinic alongside a GP. Together, they see patients who would otherwise have been referred to a hospital based general paediatric clinic. Each clinic is preceded or followed by a lunchtime teaching session with the wider primary care team. This provides an opportunity for discussion of specific patients' management, avoiding the need for referral.	as paediatricians develop an increased appreciation of the challenges faced in primary care. The clinical and patient feedback from pilot evaluations elsewhere is overwhelmingly positive, with substantial reductions in general paediatric outpatient referrals, in the order of 40%	3. Pilot services 4. Evaluation of pilot		
<b>P. Enhanced practice care for people with mental health conditions</b>	<ul style="list-style-type: none"> <li>- A multidisciplinary community liaison psychiatry service working in partnership with neighbourhoods of local practices to support practice care of people with mental health problems.</li> </ul> <p>Pilot use of MH wellbeing link workers related to neighbourhoods and practices along a social prescription model to improve MH wellbeing of those identified with anguish in part related to MH issues but who are not engaging with formal services.</p> <ul style="list-style-type: none"> <li>- Named mental health consultants and other team members work proactively with clusters of GPs to address identified needs and provide mental health support including screening, out reach, assessment of needs, advice, signposting, access to therapies and support of primary care workforce.</li> </ul>	<ul style="list-style-type: none"> <li>- A multi-disciplinary team will improve the health and wellbeing of the local population and more effectively deal with common problems.</li> <li>- Improved support for family members and the wider support network.</li> <li>- Improved treatment of complex patients who have mental health needs and have drug and alcohol issues</li> </ul>	<ol style="list-style-type: none"> <li>1. Design and agree service spec. with locality stakeholders including linking current work around social prescription and redesign of complex MH patient/PD pathway with MH providers</li> <li>2. Fully cost new service proposals in a business case and submit to the CCG</li> <li>3. Secure funding</li> <li>4. Pilot services</li> <li>5. Full roll out of services</li> </ol>	Solicited through proposal and business case	Recurrent
<b>Q. Enhanced practice care for people with long term conditions - diabetes</b>	<ul style="list-style-type: none"> <li>- Delivery of a new model of planned care for diabetes patients built around neighbourhoods (being developed as part of the planned care workstream):</li> </ul> <ol style="list-style-type: none"> <li>1. A named consultant and specialist nurse for each practice / neighbourhood cluster.</li> <li>2. Improve skillset of the whole workforce.</li> <li>3. Develop an Oxford city model with OCDEM which addresses the needs of our multi-ethnic population and ensures services reach patients from deprived or culturally separated communities.</li> </ol>	<ul style="list-style-type: none"> <li>- Improved service for patients</li> <li>- Reduce ED attendance and admissions</li> </ul>	<ol style="list-style-type: none"> <li>1. Roll out pilot sites</li> <li>2. Fully cost locality wide service in a business case and submit to the CCG</li> <li>3. Secure funding</li> <li>4. Full roll out of services</li> </ol>	As currently	Recurrent

<b>R. Enhanced practice care for people with long term conditions - breathlessness</b>	- A one-stop shop (including ECHO, Spirometry and exercise testing with saturation monitoring as well as MH input) to support practices in diagnosing and caring for people with breathlessness.	- Improved service for patients - Reduce ED attendance and admissions	1. Design and agree service spec. with locality stakeholders 2. Fully cost new service proposals in a business case and submit to the CCG 3. Secure funding 4. Pilot services 5. Full roll out of services	As currently	Recurrent
<b>S. Enhanced practice care for people with long term conditions - COPD/asthma</b>	- A practice support service with connections to neighbourhood teams, with respiratory nurses supported by a respiratory physician, as has worked in other parts of the country.	- Improved service for patients - Reduce ED attendance and admissions		As currently	Recurrent

#### Key messages:

Oxford City's key priorities are focussed on:

- Frailty and vulnerability
- Deprivation and health inequalities
- Sustaining primary care
- Neighbourhood community practices

In response to these priorities the locality have designed 17 workstreams to which act as the central recommendations for this plan and a strategy for the future of primary care within the locality.



## Part E: Making a success of our plan

Part E describes what is required from different parts of the system in order to deliver the work streams proposed. It also lays out where CCG support is needed to achieve these desired outcomes.



Delivery of this plan represents a significant ambition for service improvement and requires strong collaboration from all parts of the NHS, local authorities, Health Education Thames Valley, the Oxford Health Science Network and the voluntary sector. This section sets out the support the CCG will provide, working with partners, across all localities and how they will apply in the City of Oxford. A key aim across all enablers is to strengthen practice sustainability. We will work in particular with OxFed to support practice sustainability.

### 1. Workforce:

A workforce of appropriate number, skills and roles is essential for delivery of the plans in the context of significant housing growth across Oxfordshire and an ageing population. In line with the Oxfordshire Primary Care Framework, the CCG is developing a workforce plan across the staff groups with the aim of:

- increasing capacity in primary care;
- upskilling existing staff; and
- bringing in and expanding new roles.

This includes concrete working with partners to:

- Make Oxfordshire an attractive place to work, in particular areas that have had historical difficulties in recruiting
- Facilitate a flexible career path through developing specialist roles and encouraging professional integration
- Increase training capacity and encourage GPs to remain in the area where they have trained
- Consider implementing a local bursary or training and refresher scheme
- Recruit internationally
- Develop a career development framework for staff working in primary care
- Implement mentoring schemes for all staff groups with the support of experienced professionals
- Continue to support the introduction of new general practice support staff to take workload off GPs, such as physician associates, medical assistants, clinical pharmacists and advanced practitioners, building on the success of pharmacist and mental health workers in general practice

- Develop a standardised approach to the development and training of healthcare assistants
- Increase community-based academic activity.

Current GP and primary care staff training and career development opportunities in Oxfordshire have historically been patchy and provided by many different organisations. There has been a lack of a coordinated approach and current provision does not meet the demands of the changing nature of General Practice.

To address this, the Oxfordshire Training Network (OTN), a new Community Education Provider Network, has recently been established in Oxfordshire with funding from Health Education England Thames Valley. The OTN is hosted by OxFed and contains a range of key partner organisations (currently OxFed, Oxfordshire CCG, PML, Abingdon, SEOx (South East Oxfordshire Federation), Oxford Brookes University, HEE Thames Valley, Oxfordshire Deanery, Oxford Health NHS Trust, Public Health England and BOB STP). The OTN's function is to develop a network of education and training providers that will accelerate the development of a sustainable and highly skilled health and care workforce in Oxfordshire. By working together with its members and partners, it is developing the infrastructure and the stakeholder relationships necessary to effectively identify workforce needs and secure the investment and innovative approaches required to address these.

The core aims of the OTN are:

- a) Workforce planning and development to respond to local needs that enable the redesign of services within primary care and the community to better support general practice;
- b) Improved education capability and capacity in primary and community settings through the development of multi-professional educators and through the creation of additional learner placements;
- c) Improving education quality and governance, acting as a local coordinator of education and training for primary and community care.

OCCG has recently appointed a primary care nurse lead for the city who is working closely with the OTN, to provide strategic direction and clinical leadership for practice nursing education and development.

Federations also have an important role in ensuring resilience in primary care and enabling practices to work at scale, for example offering employment models that enable practices to use resources flexibly across clusters and neighbourhoods.

An effective workforce planning requires:

- a detailed understanding of the health and wellbeing needs of the population
- opportunities to develop and design roles that are fit for the demand and needs of the population.

The CCG will provide support at locality level for practices to model and plan the workforce appropriate for populations of 30-50,000. This may include sharing staff across practices or providing support for mergers, including through OxFed and where requested by practices, to provide a greater level of sustainability.

In Oxford City specifically, there is a shortfall of qualified workers including nurses, health care assistants, social workers, carers and GPs, partly due to under-investment in training and also driven by the high cost of housing. A workforce survey conducted by OxFed has indicated shortfalls in all practice staff e.g. there will be a need for 13-14 full time equivalent GPs to cover the existing General Practice structure.

In Oxford City the federation will have a key role in supporting future workforce development, through its roles as a provider of at-scale service delivery, practice sustainability support and the host organisations for the new Oxfordshire Training Network. Since it was formed, OxFed has developed its strategy, set up its office, obtained CQC registration, and is now delivering the 7DAF services, back-office functions and also delivering a frail elderly social prescription and care navigation service. To achieve a more robust and secure federation able to deliver services at scale will take several years and the federation is seeking at least another 3-4 years of direct support to be able to survive and thrive.

Current actions for the OxFed education and workforce development team include (in tandem with the OTN's county-wide work):

- By June 2017, scope and develop the infrastructure and capability to deliver high quality Primary Care training at scale in Oxford city that meets practice needs and draws on existing best practice and modules from around the country
- By the end of 2018, scope and develop opportunities for healthcare staff, including Advanced Nurse Practitioners, Receptionists, HCAs, PAs, clinical pharmacists and care navigators/social prescribers
- By the end of March 2018, deliver high quality training for Receptionists across City Practices to enable safe and consistent signposting and patient streaming to appropriate services
- By the end of March 2018, deliver high quality training for Advanced Nurse Practitioners across City Practices to enhance the role and career path for primary care nursing staff in the City and expanding capacity to safely take on more GP tasks, such as minor illness, home visiting and duty-doctor work.

In addition, OxFed will focus on the following areas which will support sustainability of practices.

Efficiencies:

- Realising both the resource and cost-saving benefits of working together at scale. These opportunities will range from day to day savings for all practices to consolidated research and negotiation for large scale switches (e.g. the recent Confidential and Sanitary Waste project).

- Working in partnership with other Oxfordshire healthcare providers. This includes working together with other parts of the system and focusing limited resources on the development of options appraisals, business cases that deliver opportunities for closer, more efficient working that enables improved efficiency.

Services:

- Streamlining communications, sharing tools and best practice and testing new ways of engaging with our patients to help influence their behaviour. The single OxFed point of contact will be in place to facilitate sharing (reducing duplication across practices), develop new tools and improve communications with both practices and patients, working with Healthwatch
- Ad hoc opportunities to support practices to work at scale will arise over the course of the year.

## 2. Estates

The Primary Care estate across Oxfordshire needs considerable investment to make it fit for the future: some practices require capital investment now and large areas of housing growth will mean that infrastructure will need to be improved in order to deal with the population increase. As set out in the Oxfordshire Primary Care Framework, capital investment will only be partially through NHS sources and we will need to consider other sources (e.g. local authority bonds, developer contributions).

The CCG will need to prioritise schemes for estates developments in line with the overall resourcing available. Some practices need to improve or extend their premises so that they can continue to deliver mainstream primary care more sustainably and to a larger number of patients. Other practices have larger-scale ambitions to deliver services over and above what is generally provided in general practice, often in collaboration with other practices and in partnership with other NHS organisations, local authority and voluntary sector agencies. Both types of scheme will need to demonstrate innovation and maximise opportunities to work collaboratively, but for the larger-scale schemes, which are likely to come at a higher cost, a more comprehensive range of criteria will be used for prioritisation that are in line with the CCG's estates strategy and plans for primary care.

The CCG will additionally provide support for appraisal of estates solutions together with community health and local authorities, where relevant. This includes solutions that respond to developments in new models of care, or which have the potential to deliver direct financial efficiencies, for example through digitisation of notes or merged partnerships.

In Oxford City itself, many primary care settings are inappropriate to deliver the services required and new premises need to be developed. However, building space in the city is limited. NHS Property Services provides advice on the indicative square meterage calculations historically

used to determine the core GMS space required for a practice<sup>16</sup>. This ranges from 12 patients per m<sup>2</sup> for smaller practices (4,000 list size) to 17 patients per m<sup>2</sup> for larger practices (approx. 20,000 and above) which are able to gain from economies of scale. In Oxford city the average number of patients per m<sup>2</sup> is 26.1 with almost all practices far above NHS Property Services advice (table 6). This is particularly acute in Central Oxford.

**Table 7: GP estate in Oxford city locality:  
Number of patients per m<sup>2</sup> of estate measured for valuation purposes**

Neighbourhood	Average number of patients per m <sup>2</sup>
Central	39.3
East	24.9
Headington	26.3
North	25.9
South & East	15.7
South & West	22.9

Currently, a critical need for premises development has been identified in two practices in the City locality:

- Summertown development (affecting 2 practices)
- City centre development (affecting 3-4 practices currently located in and around Beaumont Street).

Bids were put in for capital funding for these projects. In the last funding round, NHSE awarded a project development grant to support the first stage development of the city centre proposal, for which a potential development site has been identified, but capital funding has not yet been secured for either of these projects – Conversations are taking place with Oxfordshire County and Oxford City Councils to ensure a strategic fit with their plans especially around population growth, for which ongoing rental reimbursements will be required to allow developments to go ahead. There may be opportunities to collocate future services in these new developments, in particular any services that support urgent access for students who are particularly high users of ED and the high number of tourists in the city, as well as ambulatory services for frail / complex patients that can avoid attendance in ED and subsequent admission.

<sup>16</sup> Health Building Note 11-01: Facilities for primary and community care services:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/148509/HBN\\_11-01\\_Final.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/148509/HBN_11-01_Final.pdf)

**Transport** - remains a problem and patients can be classed as housebound but with suitable accessible transport they might be carried to health settings. The development of community transport possibly supplied by the voluntary sector supported by Oxford City Council transport budget needs to be explored at an affordable cost to allow patients to be carried to primary and community settings. Contact has been made with Aspire a voluntary organisation to further this work.

### 3. Digital and IT infrastructure

'Digital' has a significant role to play in sustainability and transformation, including delivering primary care at scale, securing seven day services, enabling new care models and transforming care in line with key clinical priorities. In line with Oxfordshire's Local Digital Roadmap, the CCG's focus will be to support:

1. Records sharing for cross-organisational care, in particular CareNotes which are used by community and mental health services and are currently not interoperable with any other health records used by general practice (EMIS web) or secondary care (Cerner Millennium)
2. Citizen facing technology, including aligning portal plans and auditing apps that empower patient self management
3. Risk stratification and modelling to support care co-ordination, clinical decision support and referral management tools
4. Infrastructure and network connectivity, including shared network access and access to records by care home staff
5. Information Governance, developing confidence in primary care over how data is accessed.

Oxford City has identified as key priorities:

EMIS web:

- Both Hospital Urgent care teams, community services and Adult Mental Health Teams have both stated that there would be great benefit in using EMIS Web clinically as there are difficulties recording important clinical activities directly into a unified clinical record to the detriment of integrated patient care. All Oxford city practices are established on EMIS Web.
- Ongoing access to the EMIS record by OOH clinicians – OxFed has facilitated the installation by EMIS of a secure system in the OOH centres called EMIS EPR viewer. This allows OOH clinicians to view the EMIS GP record remotely during an OOH consultation if the patient they are consulting with consents to this at the time.
- EMIS Web - Oxford City Locality will ask all providers of services to its patients especially in the community to have as much interoperability with EMIS Web with at least an EMIS Web EPR viewer function but preferably an ability to write in the notes. All

communication systems must be robust and rapid. If there is development of Neighbourhood/cluster working in the community, then the bulk of clinical recording should be through Emis web. OxFed also uses Emis Clinical services in their 7DAF hubs so that they can book appointments from any practice in Oxford City and also enter notes directly in the practice EMIS record to record clinical engagement

- OxFed and the CSU now have access to EMIS search and reporting and this will be suitable to look at needs across the locality and also plan services. An expert data analyst will support the development, implementation and rollout of new tools and processes that enable better, more efficient data capture and reporting as well as expert insight that can support service design, ongoing improvement and streamlining of requirements. Over time it is expected that this will support the identification of new opportunities as well as reduce duplication and minimise the cross-practice administrative burden of some tasks through remote data collection.

#### Telephony:

- Practices with growing populations are struggling to cope with telephone access. As GP computer systems are put on a single domain, this improves the ability to have computer based telephony using the internet rather than line rental. This in turn allows for centralisation of practice intranets with security protocols in place. With the latest technological advances in telephony (VOIP systems), there are solutions available which can not only provide a reduction in overall spend but also add significant value to practices and their patients. These benefits can include the ability to increase call handling capacity, monitor activity, integrate with electronic patient record systems and could enable centralisation of telephony services should practices wish to explore this in the future.
- OxFed has undertaken a scoping exercise to map current Telephony systems and identify whether there are opportunities to upgrade and modernise the systems being used by our member practices.

#### Telehealth and digital solutions to triage and online consultations:

- The Locality is keen to reduce the need for visits to both practices and secondary care through the use of telehealth and with high student populations this may be a target area. Pilots have shown whilst telephone consultations save travel time, they don't save GP time overall, and they are not so suitable for non-English speakers, children and in some instances older people. However, this could be tested on a more focused student population, to check that this is the case overall. This may be a part of developing an Out of Hours (OOH) hub for students operating at the weekends in the city centre in association with OxFed.
- The locality will engage with plans to look at digital triage and online consultations as soon as funding is available as long as it does not undermine the stability of current General Practice.

## 4. Funding

Implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. The vast majority of investment in primary care is determined through a nationally agreed formula. However, some additional funding that was secured through the Prime Minister's Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. Remaining funding will be allocated to the plans according to agreed criteria for prioritisation, including:

- Patient outcomes and experience
- Primary care sustainability
- Health inequalities and deprivation
- Alignment with national and regional strategies and other transformation programmes
- Whether they are able to be delivered successfully within the required timeframes, and
- Population coverage.

In addition, the CCG aims to improve practice resilience by reducing the bureaucracy of reporting and streamlining payment systems where possible.

Oxfordshire CCG has responsibility for the review, planning and procurement of primary care services in Oxfordshire, under delegated authority from NHS England. The Oxfordshire Primary Care Commissioning Committee (OPCCC) carries out these functions and is chaired by a lay member<sup>17</sup>. Funding recommended by OPCCC for delivery of the plans across Oxfordshire in addition to current funding in the initial years is set out in table 8 below. This covers part of a longer term investment over the period of the plans and does not include investment in estates or future demographic growth, which is determined nationally.

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<sup>17</sup> The papers and minutes of the OPCCC are available at: [http://www.oxfordshireccg.nhs.uk/oxfordshire-primary-care-commissioning-committee-\(opccc\)-meetings](http://www.oxfordshireccg.nhs.uk/oxfordshire-primary-care-commissioning-committee-(opccc)-meetings)

**Table 8: Funding approved for initial delivery of the locality plans across Oxfordshire**

		Examples of schemes to be funded and relevant localities	Benefits for patients	Recurrent (full year) (£000)	Non-recurrent (£000)
Priority areas	Sustainable primary care	New posts for mental health workers and clinical pharmacists in practice (all localities)	Improved outcomes for patients with mental health conditions and support for family members; Proactive reviews for patients with asthma, diabetes and other conditions, better treatment coordination.		£850
	Caring for the frail / elderly	Expansion or introduction of Primary Care Visiting service (N, NE, W, City, SW) Additional proactive support in care homes (all localities)	More patients at point of crisis assessed in their homes and less likely to be admitted to hospital	£531	
	Access to the right care at the right time for a growing population	Additional overflow appointments (NE, W)	Additional same-day appointments to ensure that patients who need to can be seen on the same day.	£189	£25
	Prevention, self-care and health and wellbeing	Social prescribing initiatives (City, N, NE, W, SE) Health and wellbeing hub (City)	Patients better able to care for their own conditions, reduced social isolation, improved prevention	£337	£55
	Reduction in deprivation and inequalities	Expansion of services to address deprivation (all localities) Expansion of minor ailments scheme (City)	Improved access for patients who do not need to see a GP through pharmacy consultations; Improved outcomes for patients in most deprived parts of the county	£100	£36
Enablers	Workforce redesign	Headroom to design new teams (all localities)	Workforce more responsive and better designed around patient needs		£300
	Physical infrastructure	Digitisation of notes (all localities) Efficient use of space through different work patterns (SW)	Better use of estates for delivery of front line services		£410
<b>Total</b>				<b>£1,157</b>	<b>£1,676</b>

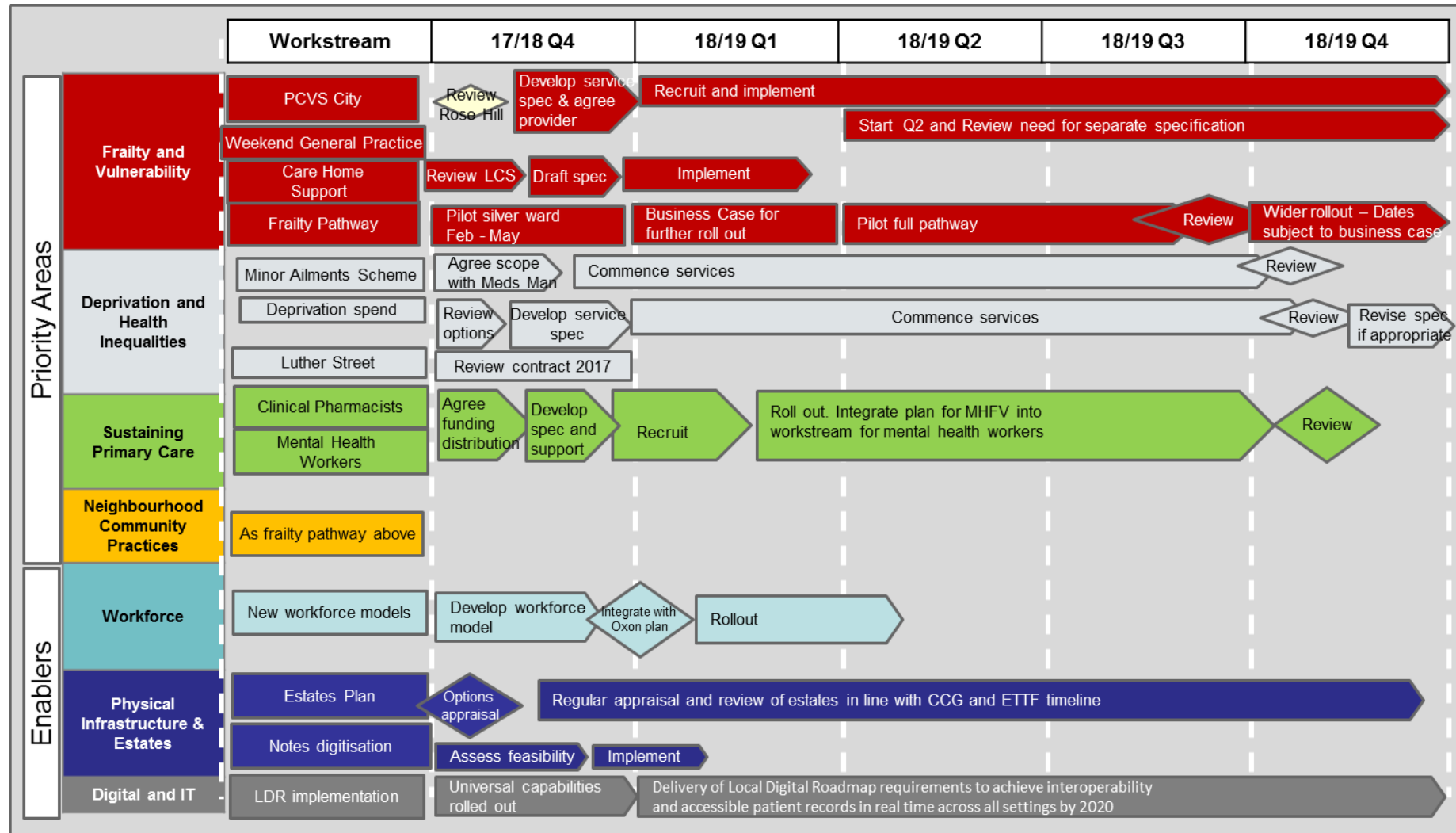
**Key messages:**

In order to deliver this plan, there are 4 key enablers that must be considered:

- **Workforce** – focus on retention and recruitment as well as utilising different staffing skill-mixes to meet community demand
- **Estates** - ensuring that services are delivered from appropriate venues in terms of geographical location, size and upkeep
- **Digital** – utilise digital technology to improve access and help deliver patient centric care through increased technological capability and improved interoperability
- **Funding** – understanding where funding can be allocated most efficiently to meet the needs of the community outlined in this plan



## 5. High Level Mobilisation plan



## Appendix 1 - Patient and Public engagement and involvement

### Patient Participation Forum

Each of the GP practices within the Locality has a Patient Participation Group (PPG), which either meets face to face, or communicates virtually. A patient Lead from each of these PPG groups is invited to provide a representative on the PPG Forum, which has a deputy Chair and core development group.

The Forum holds 4-6 meetings per annum, plus two meetings in public. Recent meetings have covered topics such as the planned council cuts, supply chain finance, and evidence based medicine. A Forum meeting covering patient access to records, and NHS IT systems is planned in July 2017, where the Primary Care Framework, and Place Based Plan intentions will be discussed in a workshop.

The Forum group raise issues on behalf of patients to the OCCG at a number of meetings, and a representative attends the monthly main Locality commissioning meetings. Each of these GP main locality meetings have had focused discussions on the place based plans since April 2017.

City Locality practices are keen to have a strong patient voice in all of their service planning, and supports the development of the forum across the city.

A summary of meetings held is as follows:

#### **16.6.17 – PPG Forum Core Development Group meeting**

The Locality Co-ordinator presented the Primary Care Framework and explained that Place Based Plans would be put in place to baseline primary care services. OCCG sought patient input into these documents, and public engagement and later public consultation would follow. The group requested early involvement and a meaningful approach to engagement.

#### **5.7.17 – PPG Forum and public event held on Developing your Patient Participation Group**

This included Workshop 1 – What next for primary Care? PPG involvement in developing place based plans, and the importance of patient voices in planning, led by Dr David Chapman – City Locality Clinical Director + Dr Karen Kearley, Deputy LCD.

From this and other events, feedback included:

- ☐ High attendance at ED by patients who could be redirected to self-care, pharmacies, or GP led in-hours or out of hours services.
- ☐ Emergencies in the housebound frail patients – it can be difficult to react without disturbing the service being delivered to the vast majority of mobile patients. Often ambulances will be called to try and fill this gap and this leads to unnecessary admissions

- ☐ Out of hours is reactive and many frail patients require proactive care outside core hours to keep them out of hospital
- ☐ It is not always easy for different providers to access each other's notes – important for a prescription out of hours
- ☐ Support in care homes could be more proactive
- ☐ Prevention and public health initiatives are required in areas of greatest health need.
- ☐ Across Oxford city there is an 9.2 year difference in mortality for men between the wards with the highest lowest areas of deprivation

#### **18.10.17 – meeting of the City Core Development Group**

The group considered the presentation on the Place Based Plans by the Locality Co-ordinator in detail, and requested that for it to be used out in City PPGs a reduction in detail and slides would be beneficial. The questions being asked of PPGs in terms of involvement with the 4 priority work-streams were also considered, and adjusted to reflect what City reps would be more useful for the engagement events:

- ☐ OCCG is seeking patient involvement in the formation and delivery of the projects; some are already gathering pace, some not yet started.
- ☐ We would like PPG involvement.
- ☐ Please do let your PPG Chair know if you are interested in being part of this work, or would like to share any comments.

#### **Key themes from the patient engagement: November – December 2017**

A period of engagement was undertaken between 3 November 2017 and 3 December 2017 for each of the locality plans. The plans were presented and discussed at a series of public workshops around Oxfordshire, and discussed at various stakeholder meetings including in Oxford on 23 November 2017. An online/paper survey was available on OCCG's engagement website - Talking Health. People also had the opportunity to give direct feedback via email, letter, phone, or freepost. Following this period of engagement the draft plans were published and were available for further comment until 17 December 2017. 46 people in the Oxford city locality registered and followed this engagement activity on Talking Health. Of these 46 people, 21 people then responded to the survey.

There was a general acceptance from respondents that services are good but overstretched. For those that responded they receive a good service currently with continuity of care, and there was concern that some of the proposals may lose this. People felt that more could be done to raise awareness of services, either through better practice websites or with better direct communication with patients. Funding was again a key theme in this locality, with concerns about how these plans will be delivered. The key themes were:

- Staffing, recruitment and retention
- Access, parking is an issue
- Integration of health and social care

- Promotion of services.

This feedback, together with the feedback from the stakeholder events has been incorporated into this updated plan. A summary of the responses is set out below:

Key Themes	Summary of issues	CCG response
Readability	<ul style="list-style-type: none"> <li>• The plans are long</li> <li>• How do we know how to navigate the plans?</li> </ul>	<p>Alongside the locality plans, OCCG will also publish short summaries for each of the localities, in addition to an Oxfordshire-wide document, which draws out the key priorities in each locality and our approach to delivering the plans in a coherent and planned way.</p> <p>The CCG will consider other comments relating to readability in the next iteration of the plans.</p>
Relationship between the plans and BOB STP and Accountable Care Systems	<ul style="list-style-type: none"> <li>• Are the aims of the plans consistent with the BOB STP objectives?</li> <li>• Do the plans aim to contribute to the BOB STP objectives</li> <li>• Are the plans part of a process to turn Oxfordshire into an ACS</li> </ul>	<p>The Oxfordshire-wide plan sets out how the plans integrate with the wider OCCG strategy and documents such as the BOB STP and the Oxfordshire Primary Care Framework. Of the 8 STP objectives the plans contribute to achieving 6 of them directly. The Oxfordshire Summary document also highlights how the plans have been developed from both a population based, locality driven perspective as well as a 'top down' county wide perspective. In this way the plans provide a holistic strategy for primary care in the county.</p> <p>The CCG will support future investment in workstreams that are intended to deliver savings elsewhere in the system subject to a robust business case. This will provide a significant step forward in delivering accountable care, in which resources are allocated according to the needs of the population of Oxfordshire and in which partners in the health and social care system share financial and clinical accountability to deliver better outcomes.</p>
Funding Implications	<ul style="list-style-type: none"> <li>• Is there enough funding for the recommendations in the plans to be implemented?</li> <li>• To what extent is the feasibility of the plans unknown / unlikely?</li> </ul>	<p>Not all aspects of the plans require long term investment. Some elements include, for example, different ways of working or delivering efficiencies that reduce bureaucracies.</p> <p>However, full implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. The vast majority of investment in primary care is determined through a nationally agreed formula. However, some additional funding that was secured through the Prime Minister's Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. In the longer term, the sustainability of health and social care in Oxfordshire will be dependent on releasing funds from secondary care and investing this into primary and community care.</p>

Phase two STP transformation programme	<ul style="list-style-type: none"> <li>Why are you producing the plans now when the consultation on phase 2 of the STP transformation programme has not yet started?</li> </ul>	<p>The plans aim to set out how primary care can best meet the needs of the local population and remain resilient and fit for the future, building on the national GP Forward View and Oxfordshire Primary Care Framework. They also aim to provide a locality plan for health services drawing out key components from other work streams in Phase 2 of the Transformation Programme. This is an iterative process, as the plans will both inform the work to develop options for services within the scope of phase 2 and respond to the outcomes of the consultation process related to the transformation programme. We will provide a clear narrative of this in future versions of the plans.</p>
Support areas of deprivation	<ul style="list-style-type: none"> <li>Will resource allocation follow deprivation, therefore innovations in health teams. Can work to local need.</li> <li>Allocate resources - based on deprivation so people can see.</li> <li>Deprivation pockets - if tell them to go elsewhere they can be setting up additional problems - must be careful. If from deprived community may be an education issue.</li> </ul>	<p>Most investment in primary care is determined through a nationally agreed formula. However, some additional funding that was secured through the Prime Minister's Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. Health inequalities and deprivation is a key factor in determining how this funding is allocated.</p> <p>In addition, a number of specific projects aim to tackle deprivation and unmet health and wellbeing needs, including the introduction of a social prescription model in practices and other community settings.</p> <p>Examples also include the Barton healthy new town initiative and the expansion of the deprivation locally commissioned services which currently includes safeguarding and use of language line (our interpreting service).</p> <p>We have used the Joint Strategic Needs Assessment (JSNA) to identify needs in plans and will continue to look at how deprivation is affecting health.</p>
Funding concerns	<ul style="list-style-type: none"> <li>Why are public health budgets slashed?</li> <li>Fund them properly (and in line with need not geography)</li> <li>Inequality of funding</li> <li>Place based funding in Oxfordshire (nationally underfunded)</li> <li>How can we shift from specialist care budgets which are over-funded</li> </ul>	<p>Public Health budgets reside at the local authority. We recognise however that more needs to be done on prevention.</p> <p>Implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. This requires a step change in the model of primary care and services that are better joined up to keep people out of secondary care. Shifting funds from acute (and specialist) to community care is difficult due to the nature of national funding flows. We are redesigning pathways to get patients the support from the right person. Social prescribing is a good example of this.</p>

Recruitment	<ul style="list-style-type: none"> <li>• Young medical students are being put off becoming GPs</li> <li>• Scope for different models of employment - flexible employment - Oxford weighting</li> <li>• 111 don't have staff either and tell patients to call back</li> <li>• Increase attractiveness of GP/community work</li> </ul>	<p>The CCG agrees that there is increasing pressure on the GP workforce through changes in working patterns and an ageing workforce. NHS England is working with partners to increase medical school places, recruit from overseas and offer incentives for returning GPs. The CCG is also developing a countywide workforce plan with the aim of</p> <ul style="list-style-type: none"> <li>• increasing capacity in primary care;</li> <li>• upskilling existing staff; and</li> <li>• bringing in and expanding new roles.</li> </ul>
Work differently	<ul style="list-style-type: none"> <li>• Neighbourhood teams and practices working together</li> <li>• Pharmacy nurses who can prescribe - extended hours (surgery just started doing)</li> <li>• More social prescribing - CAB/MIND</li> <li>• Use other staff eg nurse practitioners can advise on the smaller health problems</li> <li>• Changing patient expectations/nurses are not second best</li> <li>• Social care experts - not in a bed - direct elsewhere</li> </ul>	<p>Future sustainability of primary care will be dependent on increasing the contributions from a wider range of staff than the traditional model of GPs and practice nurses. Some practices are already seeing the benefits of employing, for example clinical pharmacists and social prescribers. We will aim to increase effective contributions from:</p> <ul style="list-style-type: none"> <li>• Extended trained health care assistants</li> <li>• Advanced Nurse Practitioners</li> <li>• Clinical pharmacists</li> <li>• Paramedics</li> <li>• Practice based Mental Health workers</li> <li>• Social prescribers and other staff appropriate to the demographics of the practice.</li> </ul>
Prevention	<ul style="list-style-type: none"> <li>• School health nurses very important for prevention and to ensure mental health and other issues addressed early</li> <li>• Health education - schools should be starting to educate children, education and money are main drivers for prevention</li> <li>• GP practices to include things like pilates/prevention</li> </ul>	<p>School nursing is commissioned via the Local Authority. As we join our plans better with Local Authority planning we intend to place greater integration and focus on prevention. This needs further development in future plans as our vision for integration develops through the Health and Wellbeing Board.</p> <p>There are some excellent examples from across the county of working with schools to promote healthy lifestyles and increase health literacy, which we will aim to build on. In addition, the social prescription model will enable clinicians to refer for non-medical issues such as isolation and financial advice that can have an impact on people's wider health and wellbeing needs.</p>

Concerns for vulnerable patients	<ul style="list-style-type: none"> <li>• Frailty - essential that local services are available for people who are frail regardless of age.</li> <li>• Have someone linked to the practice who links to the area looking after elderly people</li> <li>• Continuity of care for elderly is an issue particularly for ongoing illness, repeating prescriptions is an issue</li> <li>• Specialists - more for vulnerable children and safeguarding</li> </ul>	As a result of the planning process, the CCG is working with partners to develop a frailty pathway that provides appropriate services available to assess patients at home, access to rapid diagnostics in an appropriate place to reduce admission and support for the frail and vulnerable at home for transient illnesses. The aim is to keep patients out of hospital or, if they must be admitted, to ensure that they are discharged appropriately and with support for as long as is necessary.
Services for mental health	<ul style="list-style-type: none"> <li>• Appointments for mental health - need to be seen then, not wait.</li> <li>• Possible hub for wellbeing - for people to go to and talk about it. Mental health is such a wide range - severe to minor/access to mental health - develop support network</li> <li>• Support for mental health across age range in the hubs</li> <li>• Waiting times for mental health support/quicker - people go back to GPs - not necessarily right place to go</li> </ul>	Mental health services is a key priority for the City locality plan with a high prevalence of patients with severe and enduring mental illness, depression and other common complex mental health problems. As part of the plan, the CCG is developing a programme of enhanced care for people with mental health conditions, staffed with multidisciplinary teams working in partnership with neighbourhoods of local practices to address identified needs and provide mental health support. This may include screening, outreach, and assessment of needs, advice, signposting and access to therapies and support of primary care workforce. We need to consider how we enhance this support across the county but for this need a long term funding source. This is under consideration.
Access and transport issues	<ul style="list-style-type: none"> <li>• Transport and access is a huge issue- bus services are a main issue as parking is horrid.</li> <li>• Ensure transport is available for patients to travel e.g. local people who can help transport</li> </ul>	<p>This level of detail has not been possible in the first plans – however it is acknowledged as being a very important consideration. We will need future plans to evidence close working with Districts and City Councils to understand how patients can easily access services.</p> <p>The CCG will consider transport and infrastructure in deciding future primary care estates and in bringing services out of the hospital closer to people's home, working with local councils. The process for agreeing this will be clarified in the next draft of the plans.</p>
Luther Street primary care services for homeless patients	<ul style="list-style-type: none"> <li>• The service should be available more at weekends and evenings, potentially through outreach.</li> </ul>	The CCG agrees on the importance of accessibility for this vital service in the city for street sleepers and other homeless patients. We will engage with patients and other relevant organisations to assess this as part of a review of the service.

## Appendix 2 - OxFed delivered services and developments

### Federation Development

During June OxFed started to develop its five year plan which will dovetail with the work the Locality is doing for the City plan. OxFed will continue to gather input from shareholders, stakeholders and staff as OxFed develop the plan between now and the OxFed AGM in November.

### Health and Care Services

#### **Seven Day Access Fund:**

- The new Seven Day Access Service launched and appointment numbers are growing slowly and steadily. OxFed have extended recruitment to include nurses and phlebotomists and are offering appointments for these clinics from July.
- Clinics remain fully booked and OxFed continue to work with practices across the City to increase uptake of appointments as OxFed offer more slots.
- OxFed continue to work in partnership with Oxford Health to explore the potential to share resources and minimise the risk of destabilising the OOH service.

#### **Clinical Pharmacists in General Practice Pilot Bid:**

- OxFed successfully placed a bid for national money to develop pharmacist roles in practices on behalf of a number of practices and have been informed that they have been successful in the bid. The working model will be developed with practices.

#### **Practice Care Navigator Service:**

- The PCN team continues to operate at full strength.
- OxFed have begun work to explore social prescribing starting with a social prescribing template currently under development to help guide PCNs through conversations with patients.
- In parallel OxFed are in discussion with Hedena Health to explore ways to extend their social prescribing model into different patient groups in different parts of the city (covered in social prescribing workstream).

#### **EMIS Enterprise Search and Reporting:**

- OxFed are reporting using EMIS Search and Reporting and are ironing out early challenges.
- OxFed are in the process of exploring the range of ways Search and Reporting can help both practices and OxFed and will provide a more detailed update shortly.

**Oxford College Nurse Service:**

- OxFed are in discussion with some existing and new colleges variously to discuss options to fill vacancies with an OxFed employed nurse or to introduce a new nursing service.

**Practice Sustainability**

Practice Manager steering groups have now been set up and kick-off meetings have taken place for each of the work streams.

Federation Staff Pool:

Work continues on the Federation Staff Pool. Following work with Oxford Health, OxFed have offered practices to pilot a physiotherapist staff pool in the Autumn.

**Education and Workforce Development:**

**Oxfordshire Training Network (OTN):**

- The OTN continues to grow and there are a variety of courses for practice nurses and HCAs available through the OxFed website. OxFed are actively looking to grow the OxFed website resource.

**Training needs analysis:**

- The Oxfordshire Training Network has undertaken a detailed training needs analysis pilot across Oxfordshire focusing on practice nurses, ANPs and HCAs as well as pharmacists working in general practice. OxFed have completed information gathering and are reporting. This will help us identify areas where there are gaps in training need to enable better planning and local tailoring of courses as well as being a key input into the City workforce plan. The aim is to enable all practices to participate later in the year and, subject to further funding, extend the analysis to other roles.

**Minor Illness course for nurses:**

The Minor Illness Course took place at the end of June with over half of the City practices benefitting both from the course and the >50% discount. OxFed is evaluating the training.

OxFed are running the course again in the Autumn for practices who were unable to send a delegate this time and the discount will apply for those who are not able to participate last month.

- Receptionist Triage Training:

OxFed continue to work on developing proposals for Receptionist Triage Training and are awaiting CCG feedback on wider receptionist training initiatives to ensure OxFed are maximising resources and delivering in the most efficient way possible, bearing in mind the impact on practices of taking people out for training

#### Digital Integration and IT:

##### **There are two core facets to this work:**

- The results of the Telephony survey provide a range of opportunities to explore. OxFed are in conversation with other Oxfordshire health providers to learn from their experience and will evaluate the best approach to realise short and medium term savings for practices.
- The wider Digital Transformation Project has commenced. OxFed are engaging with a wide range of practice colleagues over the next few weeks.

In addition OxFed have identified an opportunity to support core aspects of practice administration workload and are investigating options for this year to see if OxFed can deliver this project in addition to wider commitments and dependent on funding options.

#### In General Practice:

Three projects are underway to enable OxFed practices (and ultimately patients) to benefit from harnessing the time, skills and passion of local people through volunteering:

##### **Volunteering in General Practice:**

- The RSA motivate (public) event in June provided key insight into opportunities in General Practice. OxFed are pooling those ideas with feedback from practices. OxFed have also engaged with the PPG leads for the City.

##### **Team Oxford:**

- Team Oxford is a cross-city initiative which will grow the number of people volunteering while streamlining operations for organisations working with volunteers. This will directly benefit OxFed practices when OxFed scale up the 4 test roles (likely to be in October 2017) by enabling them to offer quality volunteer opportunities safely, legally and with minimal workload. Team Oxford launched during Volunteers week (1-7 June), <http://www.team-oxford.co.uk/> and OxFed encourage individuals or practices to sign up for updates and opportunities to get involved.

### **Patient Transport:**

- Of the three projects, this is newest and it is therefore at an earlier phase of development. The majority of the mapping exercise has been completed this month and considered marketing, eligibility, capacity, availability, geography and price as possible factors behind current gaps in patient transport. Our main finding is that there is a lack of awareness as to current patient transport services and associated support for getting to/from appointments. Therefore our first priority as a partnership is to create a simple (digital) tool to help direct patients to existing services that they are already eligible for. This will include open access services and self-care services. In parallel, OxFed will continue to understand and explore groups who are not being supported with patient transport so OxFed can either support an existing service to scale up to meet this need or design a new service.

### **Sustainability and System Integration: OxFed continue to work with the CCG, the other Federations in Oxfordshire, Oxford Health and Oxford University Hospitals to explore ways to better work together in the interests of patients:**

- Joint working with the whole system and the plans underway to manage the current financial risk. This month sees the start of increased focus on ways of working among the group as well as support for the new focus on RTT targets.
- Joint working with Oxford Health and the other Federations to explore new approaches and options for working together. OxFed have now developed specific proposals and a draft timeline and have begun to explore potential legal forms. OxFed anticipate bringing more detailed proposals to practices for consultation later in the summer.

## Appendix 3 – References

1. Oxfordshire CCG Primary Care Framework, Oxfordshire CCG, March 2017
2. GP Forward View, NHS England, April 2016
3. Health Inequalities Commission Report, Oxfordshire Health Inequalities Commission, October 2016
4. Berkshire, Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Plan, October 2016
5. Patients registered at GP practices by age and gender, NHS Digital, updated quarterly
6. Centre for Cities report 2017, January 2017
7. Oxfordshire Joint Strategic Needs Assessment, March 2017
8. Oxfordshire Growth Board, including the Oxfordshire Infrastructure Strategy (OxIS) and the Oxfordshire Strategic Housing Market Assessment

## Appendix 4 – Glossary of Abbreviations

<b>7DAF</b>	<b>7 day access fund, GP Access Fund, Prime Minister’s Challenge Fund</b> In 2015/16, Oxfordshire received national funding as a second wave pilot to extend appointment access outside core hours, in order to provide a further 15,600 consultations on weekdays and at weekends (7:30am to 8:00pm), strengthening the support available for those with the most complex needs and introducing new ways of accessing services.
<b>A&amp;E</b>	<b>Accident and emergency department in hospital that deals with life threatening emergencies.</b> In Oxfordshire, these are sited at the John Radcliffe in Oxford city, the Horton General Hospital in Banbury. Patients in Oxfordshire also attend the Royal Berkshire Hospital in Reading and the Great Western Hospital in Swindon.
<b>AAU</b>	<b>Ambulatory Assessment Unit</b> A multidisciplinary unit at the John Radcliffe hospital in Oxford dedicated to urgent ambulatory and day case management of complex patients. The Unit has open visiting.
<b>AHPs</b>	<b>Allied Healthcare Professional</b> Includes dental hygienists, diagnostic medical sonographers, dietitians, medical technologists, occupational therapists, physical therapists, radiographers, respiratory therapists, and speech language pathologists.
<b>BME</b>	<b>Black and minority ethnic</b> used to refer to members of non-white communities in the UK.
<b>BOB STP</b>	<b>The Sustainability and Transformation Partnership for Buckinghamshire, Oxfordshire and Berkshire West</b> NHS and local councils have formed partnerships in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations.
<b>CCG</b>	<b>Clinical Commissioning Group</b> Clinical Commissioning Groups commission most of the hospital and community NHS services in the local areas for which they are responsible. Oxfordshire CCG also has delegated responsibility from NHS England for commissioning primary care services.
<b>COPD</b>	<b>Chronic Obstructive Pulmonary Disease</b>
<b>CPN</b>	<b>Community Psychiatric Nurse</b>
<b>CQC</b>	<b>Care Quality Commission</b> The independent regulator of all health and social care services in England.
<b>DES</b>	<b>Directed Enhanced Service</b> A national service commissioned from GP practices by NHS England that involves an enhanced level of provision above what is required under core contracts.
<b>DM</b>	<b>Diabetes Mellitus</b>
<b>ECHO</b>	<b>Echocardiogram</b>

<b>ECP</b>	<b>Emergency Care Practitioner</b>
<b>ED</b>	<b>Emergency department</b> The emergency department assesses and treats people with serious injuries and those in need of emergency treatment. In Oxfordshire, these are sited at the John Radcliffe in Oxford city, the Horton General Hospital in Banbury. Patients in Oxfordshire also attend the Royal Berkshire Hospital in Reading and the Great Western Hospital in Swindon.
<b>EMU</b>	<b>Emergency medical unit</b> EMUs are developed to offer an alternative to ED attendance for patients who are frail and vulnerable to acute admission. Patients may access the service in response to acute illness or because they require a multi-disciplinary assessment to prevent further deterioration of their condition. In Oxfordshire, there are EMUs currently in place in Witney and Abingdon.
<b>ESOL</b>	<b>English for Speakers of Other Languages</b>
<b>GP</b>	<b>General Practitioner</b>
<b>GPFV</b>	<b>General Practice Forward View</b> The GP Forward View was published in April 2016 and sets out NHS England's commitment to improving patient care and access, and investing in new ways of providing primary care.
<b>H@H</b>	<b>Hospital at home</b> Service provided by Oxford Health for patients as an alternative to hospital admission support earlier discharges from hospital for people who are well enough to return home. The plan proposes neighbourhood community teams in place of H@H, providing a more robust clinical decision-making and risk-holding capability.
<b>HCA</b>	<b>Health Care Assistant</b> A healthcare assistant works under the guidance of a qualified healthcare professional. In a GP surgery an HCA typically takes blood samples or does health promotion or health education work.
<b>HEE</b>	<b>Health Education England</b> HEE is a Non-Departmental Public Body that works with partners to ensure the healthcare workforce has the right numbers, skills, values and behaviours, at the right time and in the right place.
<b>HIP</b>	<b>High input patients</b> Frail or elderly patients who require the most resource intensive care, typically 5% of a practice's registered list.
<b>HIPCAT</b>	<b>High Input Primary Care Team</b> Proposal in the plan for a new team that provides 7 day high input care for 2% highest risk population (gold ward).
<b>IAPT</b>	<b>Improving access to psychological therapies</b> Services provided by Oxfordshire Health NHS Foundation Trust to support people suffering from depression and anxiety disorders.
<b>IMD</b>	<b>Index of Multiple Deprivation</b> A qualitative study of deprived areas in English local councils. Areas are ranked into quintiles of deprivation.

<b>JE</b>	<b>Joint Enterprise</b> Primary Medical Care Ltd, which is the GP Federation for North, West and parts of South Oxfordshire, is in advanced talks with OxFed (the Oxford city federation) and Oxford Health NHS Foundation Trust to create a joint enterprise. The aims of this alliance would be to bring the best of both primary and community care together and to achieve resilient Primary Care and Community Services, integrated care where it benefits patients / carers and more care closer to home.
<b>LD</b>	<b>Learning disabilities</b>
<b>LCS</b>	<b>Locally Commissioned Service</b> A service commissioned by Oxfordshire CCG from general practice to provide services that involve an enhanced level of provision above what is required under core contracts.
<b>LIP</b>	<b>Low input patients</b>
<b>LIS</b>	<b>Local improvement scheme</b> Local use of CCG resources to pay for improvements in services provided under their GP contract or to support activities such as clinical audit or peer review.
<b>LSOA</b>	<b>Lower Layer Super Output Area</b> A geographic hierarchy covering approximately 1,500 people in one area.
<b>LTC</b>	<b>Long term condition</b>
<b>MH</b>	<b>Mental Health</b>
<b>MSK</b>	<b>Musculoskeletal</b>
<b>OCCG</b>	<b>Oxfordshire CCG</b>
<b>OHFT</b>	<b>Oxford Health Foundation Trust</b> provides mental health and community services in Oxfordshire. OHFT also holds the contract for the Luther Street homeless service in Oxford.
<b>OOH</b>	<b>Out of hours services</b>
<b>OTN</b>	<b>Oxfordshire Training Network</b>
<b>OUHT</b>	<b>Oxford University Hospitals Foundation Trust</b> , includes the John Radcliffe Hospital and the Churchill Hospital in the City and the Horton General Hospital in Banbury
<b>OxFed</b>	<b>GP practice federation for Oxford city</b>
<b>PA</b>	<b>Physician Associate</b> A physician's associate is a new healthcare professional who supports doctors in the diagnosis and management of patients.
<b>PCVS</b>	<b>Primary Care Visiting Service</b> A service run by emergency care practitioners to provide emergency assessment and treatment of patients in the working day in addition to home visits.

<b>PD</b>	<b>Personality Disorder</b>
<b>PML</b>	<b>Primary Medical Ltd</b> – GP practice federation covering North, West and parts of South Oxfordshire and Northamptonshire
<b>PMS</b>	<b>Personal Medical Services</b> A type of GP practice contract. Following a review of contracts some funding from PMS contracts has been released to support local delivery of primary for all practices regardless of the type of contract.
<b>POCT</b>	<b>Point of Care Testing</b> Medical diagnostic testing at or near the point of care including at a patient's home.
<b>PPG</b>	<b>Patient Participation Group</b> All practices have, or are setting up, a PPG. Their role is to advise practices on the patient perspective and providing insight into the responsiveness and quality of services. They may also encourage patients to take greater responsibility for their own and their family's health, support communications with patients and undertake research on behalf of the practice.
<b>QOF</b>	<b>Quality and Outcomes Framework</b> An annual reward and incentive programme for practices, the QOF also provides registers for practices and the public of numbers of patients with specific conditions to support better management of these patients.
<b>SCAS</b>	<b>South Central Ambulance Service</b>
<b>SMI</b>	<b>Severe Mental Illness</b>
<b>SUS</b>	<b>Service Uses Service</b> The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services
<b>UTC</b>	<b>Urgent Treatment Centre</b> Under NHS England plans, urgent treatment centres will be GP-led, open 12 hours a day, every day, and be equipped to diagnose and deal with many of the most common ailments people attend ED for. By December 2019 all services designated as urgent treatment centres will meet the guidelines issued by NHS England.
<b>WTE</b>	<b>Whole Time Equivalent / Full Time Equivalent</b>