Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 29 November 2016	**Paper No: 16/78**

Title of Presentation: General Practice in Oxfordshire

Is this paper for	**Discussion**		**Decision**		**Information**	✓

Purpose and Executive Summary (if paper longer than 3 pages):
This report highlights the high performance of General Practice in Oxfordshire whilst recognising the pressures that they face. It details some of the actions taken by the CCG, looks at the background and vision and the programme of work, and outlines the development of a new model for sustainable primary care.

Financial Implications of Paper: None

Action Required: To note the paper and work programme

NHS Outcomes Framework Domains Supported (please delete tick as appropriate)	
✓	Preventing People from Dying Prematurely
✓	Enhancing Quality of Life for People with Long Term Conditions
✓	Helping People to Recover from Episodes of Ill Health or Following Injury
✓	Ensuring that People have a Positive Experience of Care
✓	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed *(*please delete tick and attach as appropriate)	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

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A report for Oxfordshire Clinical Commissioning Group Board
General Practice in Oxfordshire

1. Background

The GP Forward View published by NHS England in April 2016 reiterated the importance of general practice at the heart of the NHS. It emphasised that, with a growing and aging population with complex and multiple health conditions, a personal and population-orientated primary care is central to any country's health system. Oxfordshire CCG took on delegated responsibility for the commissioning of general medical services from NHS England on 1st April 2016. However other primary care services still commissioned by NHS England are also key to the delivery of primary care to the population of Oxfordshire. They include[1] 118 pharmacies, 81 high street dental practices and 67 high street opticians.

2. The Challenge

Primary care is central in a high functioning health system. The areas identified as care and quality gaps in primary care are mainly ones of sustainability and skills development across a wider workforce. Attracting and retaining sufficient GPs and practice nurses is a challenge.

The shortage in workforce results in problems of access for patients. Access is really important for some of our more vulnerable population such as our frail population with multiple conditions, those with mental health conditions and learning disabilities with and without autism.

To deliver the proposed changes for the population primary care will need to develop a wider skill mix and allow GPs and other practitioners to operate 'at the top of their licence' with simpler or more routine tasks being picked up by others. Use of technology such as Skype or FaceTime for tele-consultations and to support a secondary care interface will play a key role.

A new model for primary and community care

GPs are by far the largest branch of British medicine. A growing and ageing population with complex multiple health conditions, means that personal and population oriented primary care need to be central to Oxfordshire's health and care system.

Oxfordshire currently has around 600 GPs and 300 other clinical staff working in 72 general practices, with a total of around 720 000 patients on their collective lists. Practices are grouped into six localities (City, North, Northeast, Southeast, Southwest, and West).

[1] NHS E data Oct 2016

General Practice in Oxfordshire faces challenges common to general practices across the UK, including:

- Increasing demand as a result of patients requesting same-day access for urgent care, who are generally low-intensity patients
- Increasing pressure in managing complex, frail, or elderly patients who require continuity and co-ordination of care, who are generally high-intensity patients
- Fragility in practice sustainability due to funding, running in some cases a small but highly complex business model, difficulty in recruiting and/or retaining staff, the need to update premises and other infrastructure, and retirement of older GPs with a lack of new GPs who want to practice in th partnership model
- A plethora of patient contacts and multiple patient records across various organisations (general practice, hospital, mental health services, community health services, social care) leading to delays and gaps in communication creating difficulty in co-ordinating how care is delivered to patients.

To take this forward we are developing a Vision for Primary care and a programme of work to support this. The following section of this paper lays out some areas on which we will engage Practices and Patients to strengthen sustainability and proactive primary care. Whilst Oxfordshire Primary Care, in line with the national picture, is facing a challenging time, it is worth reflecting on how well our practices are performing compared to national averages. Appendix 2 gives some of the recent performances achievements.

3. Oxfordshire's vision for primary care is:

To provide a 21st century modernised model of primary care that works across neighbourhoods and localities to provide enhanced primary care, extended primary care teams, and more specialised care closer to home delivered in partnership with community, acute and social care colleagues.

To ensure the sustainability of primary care and to support it to be the lynchpin of our newly transformed health and care services, new thinking is required and new models of care. The key design principles for a new model of primary care in Oxfordshire are based on *care closer to home*:

Figure 1.3 – **The key design principles for a new model of primary care**

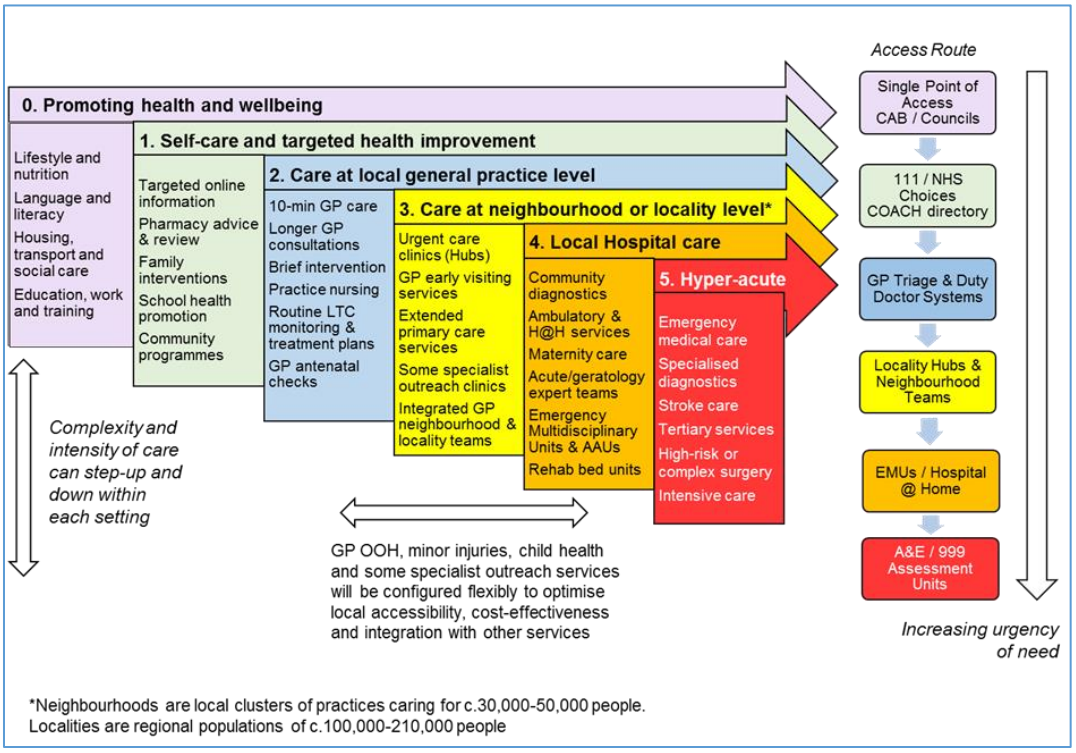

Figure 1.4 – **The underlying model for the Transformation Programme**

In essence, the new model will transform primary care from a predominantly reactive health system, which responds to people when they become ill, to a proactive system which enables and supports people to improve their health and remain well. This change will be essential for the sustainability of primary care and the wider health service.

The new model of delivery will support and build on the strengths of local general practice care and move to a new model of Primary Care at scale. The model will detail how care can be organised around populations to provide economies of scale, facilitate practices to work to share resources and workload in order to provide a better service and manage demand.

To offer patients the best outcomes we need to move care and resources away from secondary care, wherever appropriate, to primary and community care settings, supported by greater levels of prevention and self-care. This recognises that 'the best bed is your own bed'. These principles underline not only the primary care model, but all of the other new models developed as part of the Transformation Programme. The model below (the 'onion' diagram) shows how care can be organised around populations to provide economies of scale, facilitate practices to work together through federations to share resources and share the workload to provide a better service and manage demand.

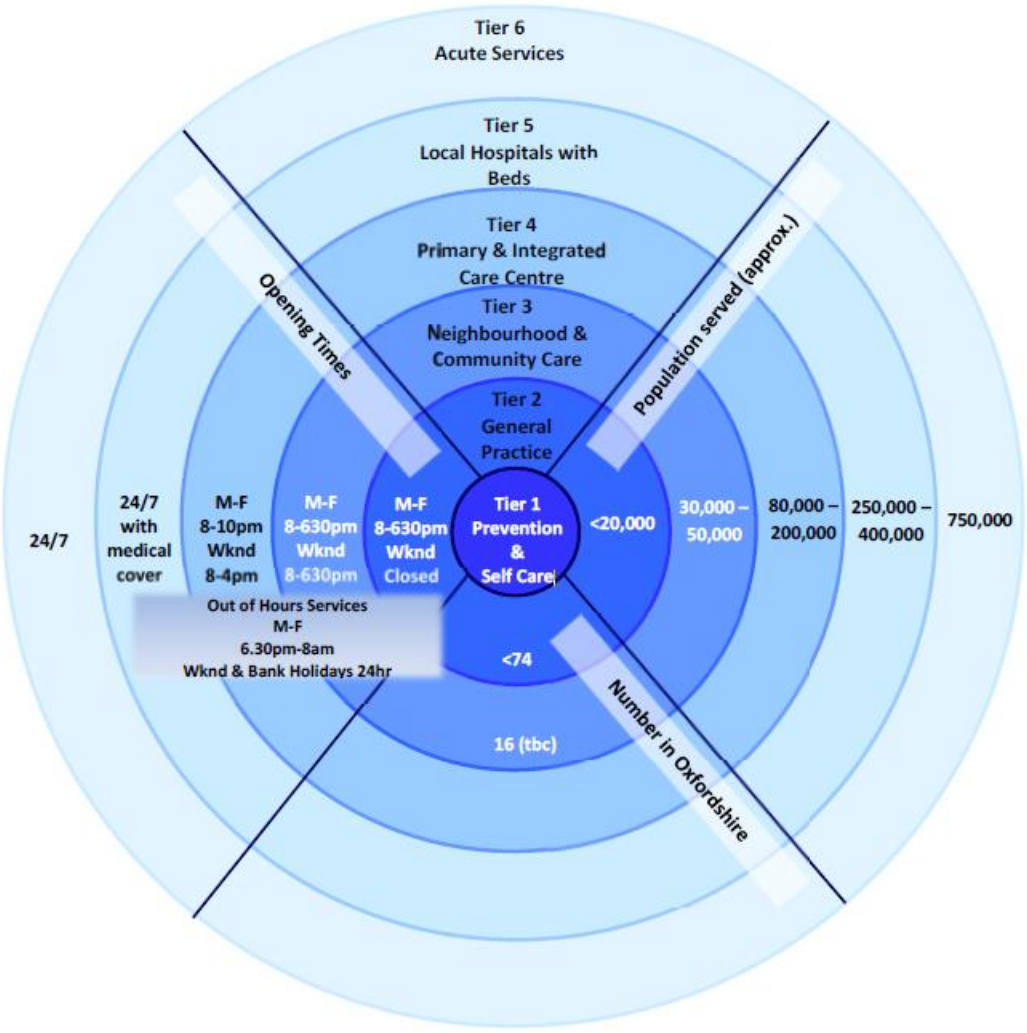

Figure 1.5 – **The Population Based Approach**

Scaling services in this way means:

- More specialist care to be provided in the community, better aligned to other health, community, social care and voluntary organisations;
- Better use of skill mix and shared practice resources, including infrastructure;
- New primary care neighbourhoods as resilient, sustainable and scalable networks with the capability and resources to deliver a coordinated suite of health services for their population;
- Improved access to same day urgent appointments.

The new model of care for primary care ensures that the patient is receiving care at the correct place, first time, by the most appropriate person. We will develop sustainable local practices and larger, more integrated primary care services.

Segmentation of the population according to need supports planning of services at scale.

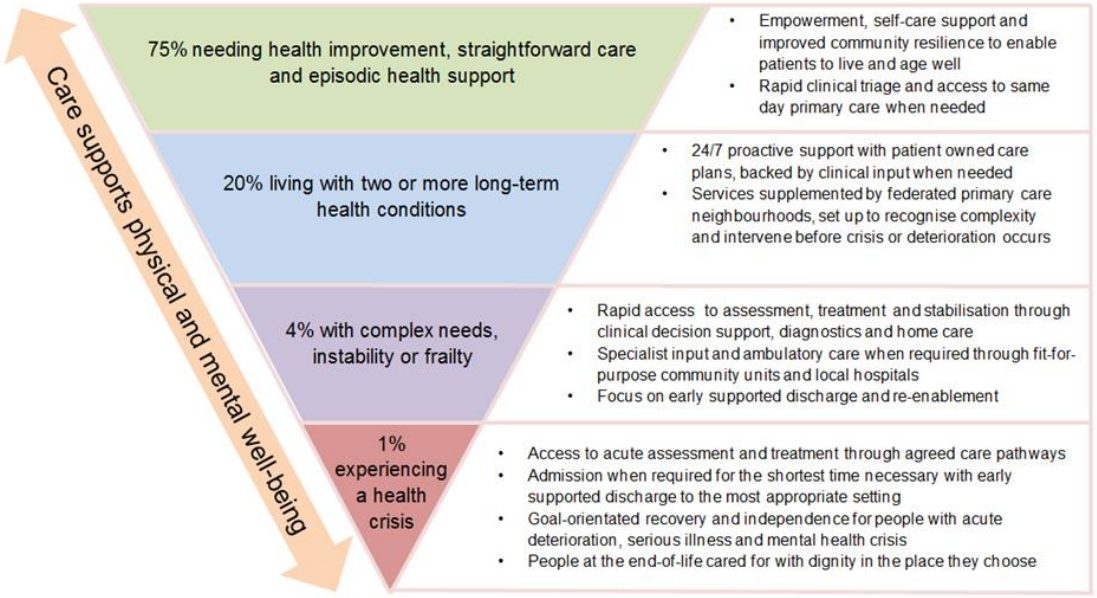

Figure 1.6 – **Segmentation of the population to support planning as scale**

Working at scale within multidisciplinary teams alongside outreach community and acute clinicians and social care staff requires a co-ordinated workforce plan that addresses Oxfordshire's key challenges in recruiting and retaining people. A wide range of functions currently undertaken by general practice could be better done by other healthcare professionals or at other community locations. We will evaluate new roles such as physicians' assistants and new and novel ways of attracting staff to work in Oxfordshire, such as GP Fellow schemes. Self-care with the support of the local community pharmacist will enable and empower patients to better self-care. GP workload will be reduced as many tasks are taken up by another professional or in another way.

Technology will be central to ensuring general practice is sustainable in the future. This will include shared records systems, or technology to monitor conditions, doses or treatment. The use of new technology will make it easier to access health advice, to book an appointment, to order repeat prescriptions. It will also support different types of interaction between patient and professional and will help make sure information systems are interoperable between organisations. Patients will be empowered by records access. Technology will help teams work better together, more remote monitoring and a more coordinated flow of information.

In summary, the features of the new model are:

1. General practice will continue to be population based;
2. General Practice will support public health initiatives for the prevention of disease in their population;
3. The general practice patient record will be a central comprehensive record for medical information relating to the patient;

4. Decisions around planning of general practice to improve patient care will happen at scale;
5. All patients will have access to a same day urgent appointment if clinically appropriate;
6. All patients requesting a routine appointment will be able to book one within seven days if clinically appropriate;
7. High-intensity patients will have a named accountable GP who will be responsible for making sure that their care is appropriately provided for 24 hrs a day seven days a week;
8. All patients diagnosed with a long-term condition will be offered individualised support to manage their condition;
9. General practice will maintain the vast majority of prescribing;
10. General practice will be mindful of health inequalities and strive to promote schemes which reduce variation across the whole of Oxfordshire.

These features will mean that primary care will remain sustainable, patient access and satisfaction will improve, self-care will be supported, skill mix will be optimised, and more care will be undertaken in non-hospital settings.

To implement the new model requires effective workforce planning, good collaboration between health care professionals, and realigning care delivery around the scaled and stratified populations described above.

4. Current Pressures in General Practice

4.1. Practice Changes

Whilst we develop the overall vision, the pressures in primary care are well recognised and were reported to the Board in July 16. Since receiving delegation for the commissioning of primary medical services the CCG has overseen a series of changes as laid out below:

	No.	Practices	Date effective
Practice Mergers	2	Marston Medical centre and Bury Knowle Health Centre Victoria House Surgery and Langford Medical Practice	1 July 2016 1 October 2016
Resignation of Contract	2	North Bicester Health centre Kennington Health Centre	1 October 2016 1 April 2017
Expiry of APMS contract	1	Deer Park Medical Centre	3 November 2016 but extended to 31 March 2107
Boundary Change*	2	Oak Tree Health Centre The Leys Health centre	September 2016 November 2016
Branch Surgery Closure	2	Richards Medical Centre branch of Donning ton Medical partnership Middleton Cheney branch of Horsefair Surgery	2 September 2016 Consultation currently underway

* this does not affect existing patients

4.2. Investment for a Sustainable and Transformational Primary Care

In 2016/17 the CCG allocated an additional £4M to support a sustainable primary care The CCG six localities were asked to submit proposals for spend against the £4million allocation to support a sustainable and transformational primary care. Following a review of the financial recovery plan by the extra ordinary CCG Board held on 25 August 2016, the following investment in primary care for 2016/17 was agreed in line with the business case presented to the Oxfordshire Primary Care Commissioning committee (OPCCC) in August 2016. Full year funding will be available for 2017/18.

Scheme	Locality	Budget for October 16 – March 17
Home visiting service	North, North East, South West, West	£407,403
Care Navigator and Social prescribers	Oxford City	£145,763
Practice Sustainability and working at scale scheme	Oxford City	£472,193
Guaranteed access to routine appointments	South East	£182,000
Enhanced long term conditions management	South West	£36,000
Improving GP access	South West	£125,702
Increase in appointments from hubs	North, North East, West	£354,844
	Total	£1,723,905

4.3. General Practice Access Fund (GPAF)

As a result of a successful application to the Prime Ministers Challenge Fund in March 2015, the CCG has been invited to be an early participant in the Access Fund. The GP Access Fund will fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.

The new national requirements include

- weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and
- appointments can be provided on a hub basis with practices working at scale.
- a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population.

The CCG is working with practices and Federations to ensure delivery of extended access for the population. There will be mixed delivery models across the CCG with some additional appointments provided at locality level possibly through an access hub or out of hours service and some will be provided through practices although not necessarily the patient's own practice. Patients will not necessarily see their own doctor but will have access to more appointments. The patient's own practice will book the extended hour appointment at the practice/hub offering the service. Some services are currently being scaled up with full service delivery by 31 January 2017.

4.4. Vulnerable Practices

Quality and primary care team leads are working closely with 11 practices currently assessed as vulnerable either due to recruitment difficulties, CQC inspection at requires improvement or quality issues. Funding from the national team has been provided for 'expert' practice management support, away days for the practice to explore new ways of working, training sessions with staff and facilitation costs. From 1 November 2016 the vulnerable practice scheme is being replaced by the General Practice Resilience Programme and a further 11 practices and a group of practices have been identified for support.

5. Next steps

In order to drive through the agenda a high level programme plan has been created which can be found in Appendix 1. This together with an agreed Primary care framework and implementation as part of the Transformation agenda will lead to a more sustainable primary care service that is at the heart of the health system.

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21 November 2016 V6

Appendix 1

Primary Care Programme

	Outcome	Milestone	Time frame	Lead
1.	**A sustainable primary care that can be the lynchpin of the new health system**	GPFV plan produced as part of operational plan	December 2016	JD
		Commission services to support sustainability from the £4M investment identified by the CCG for primary care	March 2017	JG
		Implement the GP resilience programme for 16/17	March 2017	JG
		Develop a framework for practice mergers to offer support	January 2017	JG
		Develop an agreed solution for Banbury primary care	December 2016	JD
		Commission support for vulnerable and pre-vulnerable practices to undertake a diagnostic and provide subsequent support	December 2016	LB
		Review Ten High impact actions for releasing capacity in General Practice	April 17	SW
2	**Improved access to primary care**	Implement GP Access Fund to provide additional appointment capacity both in hour and in the evening and at weekends	January 2017	JG
3	**Patients will be empowered to self care**	Digital support for self care for patients with long term conditions	December 2017	SB
		National Diabetes Prevention programme (NDPP) implemented	By March 2017	SB
4	**Patients will be seen and cared for closer to home**	Implement estates funding to ensure practice premise is fit for purpose	March 2019	JD
		Agree Primary care framework	January 2017	JMCM
		Implement Primary care transformation plan	From September 2017	JD
		Implement national Urgent medicines supply by community pharmacy scheme	April 2018	JD/SW
5	**Improved skill mix to ensure correct person sees the patient at the correct time**	Develop and implement model for receptionist training	March 2017	JG
		Develop CCG web page to encourage health care	February 2017	Comms

		professionals to come to work in Oxfordshire		
		Roll out – retainer scheme, indemnity support and return to practice	November 2016	JG
		Apply for new wave of clinical pharmacist in practice funding	Summer 17	JD
		Deploy and review use of GP Fellow	Summer 17	JD

Appendix 2

GP Access survey

The GP Patient Survey (GPPS) is an England-wide survey, providing practice-level data about patients' experiences of their GP practices[2]. The most recent data collection is based on the July 2016 GPPS publication. This combines two waves of fieldwork, from July to September 2015 and January to March 2016, providing practice-level data. In Oxfordshire CCG, 20,571 questionnaires were sent out, and 8,718 were returned completed. Feedback was positive from patients with Oxfordshire CCGs results being better than the national average in all but one of the domains.

Survey questions	% who answered	CCG result	National result
Overall, How would you describe your experience of your GP surgery?	very good / fairly good	90%	85%
Generally how easy is it to get through to someone at your GP surgery by phone?	very easy / fairly easy	79%	70%
How helpful was the receptionist?	very helpful / fairly helpful	88%	87%
Last time you wanted to see or speak to a GP or nurse from your GP surgery, were you able to get an appointment to see or speak to someone?	yes / yes, but I had to call back closer to or on the day	89%	85%
How convenient was the appointment you were able to get?	very convenient / fairly convenient	93%	92%
How would you describe your experience of making an appointment	very good / fairly good	80%	73%
How do you feel about how long you normally have to wait to be seen?	they didn't wait too long	57%	58%
Did you have confidence and trust in the GP you saw or spoke to?	Yes definitely / Yes, to some extent	97%	95%
Did you have confidence and trust in the nurse you saw or spoke to?	Yes definitely / Yes, to some extent	98%	97%
How satisfied are you with the hours that your GP is open?	very satisfied / fairly satisfied	77%	76%

Quality and outcome framework (QOF)

The QOF was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. The objective of the QOF is to improve the quality of care patients are given by rewarding practices for the quality of care they provide to their patients. The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding

[2] Ipsos MORI administers the survey on behalf of NHS England and more information can be found at https://gp-patient.co.uk/

good practice. This Quality and Outcomes Framework (QOF) publication[3] provides data for the reporting year 1 April 2015 to 31 March 2016.

Oxfordshire GP practices achieve better quality for their patients compare to the national average.

	Oxfordshire CCG average	England average
Total achievement	97.5%	95.3%
Clinical domains totals	97.7%	95.2%
Public Health domains totals	98.2%	98.3%

Compliance with Care Quality Commission (CQC) Standards

Registration with the CQC means that a GP practice is making a legal declaration that they meet all the CQC standards of quality and safety. Once a practice is registered, the CQC has a duty to monitor and inspect the service to make sure the practice is compliant with these standards. Where a practice is non-compliant the CQC has a range of sanctions, including withdrawing registration. The role of the CQC is to ensure that practices in England provide people with safe, effective and high-quality care, and to encourage them to make improvements. The CCG works closely with the local CQC representative to share intelligence and promote best practice.

The table below compares England performance with Oxfordshire performance. (Up to 30 October 2016)

Rating	England		Oxfordshire CCG		% difference
	No of practices*	%	No of practices*	%	
Outstanding	201 / 5194	4%	3 / 57	5%	+1%
Good	4345 / 5194	84%	47 / 57	82.5%	-1.5%
Requires Improvement	524 / 5194	10%	7 / 57	12.5%	+2.5%
Inadequate	124 / 5194	2%	0 / 57	0%	-2%

*No of practices with rating over the number of practices inspected

[3] http://content.digital.nhs.uk/catalogue/PUB22266