

This plan was developed by local GPs, practice managers, patient representatives and district council officers. The plans were discussed with local people at meetings and through a survey. Their views were used to help develop the plan further.

MY LOCALITY



222,468* patients across 20 GP practices grouped in six neighbourhood clusters:

CENTRAL OXFORD

33,134 registered patients at:

- 19, 27 and 28 Beaumont Street practices
- King Edward Street

NORTH OXFORD

44,958 registered at:

- Summertown Medical Practice
- Banbury Road
- Jericho Health Centre
- Observatory Medical Practice

SOUTH EAST OXFORD

40,572 registered at:

- Donnington Medical Practice
- Hollow Way Medical Centre
- Temple Cowley Medical Centre
- The Leys Medical Centre

SOUTH AND WEST OXFORD

20,169 registered at:

- Botley Medical Centre
- South Oxford Health Centre

EAST OXFORD

42,235 registered at:

- Bartlemas Surgery
- Cowley Road Medical Practice
- St Bartholomew's Medical Centre
- St Clements Surgery

HEADINGTON

41,400 registered at:

- Hedena Health
- Manor Surgery

WHAT WILL CHANGE?

1. Improving care for frail and vulnerable patients:



- A city-wide GP-led assessment team.
- Access to rapid diagnostics.
- Support for these patients at home.

2. Tackling deprivation and health inequalities:



- Improve the health of homeless, mental health, and vulnerable children and adult services (including learning disability).
- Pilot of social prescribing for mental health – accessing self-help, community and voluntary support.
- Support practices in deprived areas to help their local populations.

3. Ensuring sustainable primary care:



- Progress work with OxFed (GP federation) to support GP practice workforce issues.
- Improved integration and streamlining between city practices.
- Review care for patients with long term conditions to find improvements.
- Developing teams with appropriate skills across practice and neighbourhoods.

4. Neighbourhood community practice:



- Rapid assessment and services for patients at risk of deterioration.
- Deliver prevention services through the wider primary care community team.
- Social prescribing: signposting and advising on other support with positive impact on health.
- Continued joint working with Oxford City Council.

HOW WILL WE MAKE IT HAPPEN

- More very unwell patients to be rapidly assessed at home and less likely to be admitted to hospital.
- Set up a 'virtual ward' of high risk patients across neighbourhoods to match patient needs to resources.
- Care home support team – proactive reviews and care planning, including skills development of care home staff.

- Support for existing staff, and recruiting and training multi-skilled teams.
- Clinicians with specialist skills to work across locality.
- New posts for mental health link workers and clinical pharmacists in practice.
- More and better information easily available.
- Learn from the Barton and Bicester Healthy New Town pilots on what makes a healthy population.

- Support staff with increased capacity, resources, and enhanced skill mix, including use of care navigators to link patients and carers to a range of services and pharmacists.
- Improve communication between NHS partners and social care.
- Focus on improved care for diabetes, breathlessness and COPD/asthma.

- Provide local services for frail patients in their own homes, including those who need palliative care.
- People better able to care for their own conditions, reduced loneliness and improved prevention.
- Signpost people to get the right help, including community activities. GP surgeries/practices to work with local organisations and councils.

WHAT WILL HAPPEN THIS YEAR?



ACTIVITY	WHAT	HOW	WHEN
Primary care visiting service (PCVS)	More rapid home visits for frail patients.	Develop practice visiting service with OxFed.	From April 2018
Frailty pathway (part of PCVS and neighbourhood working)	Temporary support to stay at home during an acute deterioration.	Work to develop integrated frailty pathway with Oxfed, OH and OUHT.	Have an agreed plan by March 2019
Clinical pharmacists	Consider how virtual wards might work locally.	Employed by OxFed to work within practices and also look at Care home support.	Employed by June 2018
Access hubs	Develop GP, nurse and physio appointments through extended hours.	Develop 7 Day access scheme with OxFed.	From April 2018
Extend diabetes model	Joined up care provided to people with diabetes and extend to other conditions.	Introduce a diabetes 'at a glance' progress report to improve care. Review learning, do the same for other respiratory conditions. Develop Year of Care model. Developed MDT meetings in practices.	Diabetes – April 2018
Urgent Treatment Centre	Join up care provided to people with diabetes and extend to other conditions.	Countywide review.	Others – April 2019
COUNTYWIDE INITIATIVES THAT AFFECT ALL LOCALITIES			
Social prescribing, self-care and wellbeing	Scheme linking patients to other non-medical local support available.	Work with local partners on services available, including voluntary sector, schools and others.	Ongoing for Barton Healthy New Town. Introduce Mental health workers (MIND) and extend current practice care navigator model (OxFed).
Workforce	Staff retirements, and recruitment issues will require more capacity planning and improved skills and new roles.	Develop strategy with partner organisations.	Implement Summer 2018
Developing buildings	Consider future development sites in Oxford and work with council on funding infrastructure for health.	Estates review undertaken. Computerise paper records, with safe storage and back up.	May 2018 for early option appraisal. Moving patient records starts spring 2018
Digital and information technology	Shared access to patient records for those providing care to patients.	Implement countywide approach.	To be confirmed

The full Oxford City Locality Plan is available on the OCCG website. This summary explains what will be changing in the year ahead and will be updated in April 2019 as the plan develops. Information about how to get involved is available on the OCCG website.