Oxfordshire
Clinical Commissioning Group

Oxfordshire Transformation Programme

OXFORDSHIRE PRIMARY CARE FRAMEWORK

Primary Care Workstream

v15

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1 Author: with contributions from Locality Clinical Directors, Federations, Patient representatives, Providers and Public Health

2 Editor: Julie Dandridge, Deputy Director, Head of Primary Care and Localities, Oxfordshire Clinical Commissioning Group

3 Lead: Joe McManners, Clinical Chair, Oxfordshire Clinical Commissioning Group

FOREWORD

"There is arguably no more important job in modern Britain than that of the family doctor.

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-orientated primary care is central to any country's health system. As a recent British Medical Journal headline put it – "if general practice fails, the whole NHS fails".

So if anyone ten years ago had said: "Here's what the NHS should now do - cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs", they'd have been laughed out of court. But looking back over a decade, that's exactly what's happened. Which is why it's no great surprise that a recent international survey revealed British GPs are under far greater pressure than their counterparts, with rising workload matched by growing patient concerns about convenient access.

Simon Stevens, GP Forward View, April 2016

EXECUTIVE SUMMARY

Good primary care is the bedrock of a high-quality and cost-effective health system, and the NHS has traditionally prioritised primary care compared to many other health systems worldwide, which is generally accepted as key to its success and pre-eminence internationally in **effective, safe, coordinated, patient-centred care** and in **efficiency**.

However, it is recognised that primary care, and particularly general practice in the UK is stretched as never before, with increasing workload from patient demand and complexity, with many GPs working increasingly long hours and looking to leave the profession, and the numbers of trainees entering the system seeking to work as GPs or practice nurses steadily declining.

Ensuring the sustainability of General Practice, and supporting it to be the lynchpin of our newly transformed health and care service will require new thinking and new models of care and delivery. The new model of primary and community care in Oxfordshire will be based on a number of operational principles:

- Delivering appropriate services at scale
- Organised around geographical population-based need
- Delivering care closer to home
- A collaborative, proactive system of care
- Delivered by a multidisciplinary neighbourhood team
- Supported by a modernised infrastructure

1. Purpose of the Framework

The Primary Care transformation plan has to describe the direction of Primary Care over the next 5 years. The main needs of any transformation are to stabilise general

practice, remove financial risk upon practices and encourage the work force to remain within Primary Care. This needs to be done alongside maintaining the tradition role of Primary Care to act as the main entry point into the health care system and delivering timely access and quality care. General practice will also support the care closer to home strategy and link into wider work on neighbourhoods and localities.

This Primary Care Framework **seeks to describe a framework for GPs and their teams, working with their patients, to further describe how this model and the specific actions can work for their own local populations.**

This together with the GP Forward View (GPFV) and local implementation plan will ensure Primary Care remains the cornerstone of the NHS going forward. Many of the changes in developing new models of primary care will require additional resources with much of the funding released as a result of moving activity from hospitals into the community.

2. Oxfordshire Vision for Primary Care

The starting point of this framework is the vision for Primary Care in Oxfordshire:

Oxfordshire's vision for Primary and Community Care is:

> ***To provide a 21st century modernised model of care that works with patients across neighbourhoods and locality populations 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.***

Primary Care is defined as the entire team employed and deployed by general practices which will include GPs, practice and community nurses, health care assistants, phlebotomist, allied health professionals, paramedics, psychological therapists, physicians' assistants, care navigators, as well as community pharmacists, dentists and opticians.

3. The Current State of General Practice in Oxfordshire

It is well recognised that Primary Care in Oxfordshire, with the rest of the country, is in difficulty, and practices will need to adapt and transform in order to have a sustainable Primary Care fit for the future. To provide a clear strategic roadmap for implementation of this vision in Oxfordshire, the following sections outline the baseline or starting point of the transformation that is needed. They set out the patient profile, current strengths and challenges of the current system to give a holistic view of why change is needed, and an overview of what strengths Primary Care currently possesses as a foundation on which to build, enable and facilitate further sustainable improvement of Primary Care in Oxfordshire.

3.1. The Oxfordshire Patient Profile

Whilst it recognised that the patient population is different for each practice taking into account geographical and population demographics, according to the current figures for Oxfordshire:

- about 75% of the population are usually well (those with one long-term condition such as diabetes or asthma) and as a result the population needs are general health improvement measures, simple care, and episodic health support;
- about 20% have two or more long-term conditions and require at least a background level of proactive and coordinated care;
- about 4% have complex needs, frailty, or instability requiring a significant level of proactive and coordinated care;
- 1% is experiencing a current health crisis, requiring acute assessment and treatment, and possibly admission. See below for further modelling of this.

3.2. The Challenges Facing General Practice in Oxfordshire

Between April 2016, when the CCG received delegated powers for the commissioning of primary medical services, to October 2016, out of 72 practices, one practice has closed and over a dozen others have declared themselves vulnerable. The most common cause of general practice stress and vulnerability is workforce, partly because Oxfordshire has the lowest ratio of average income to house price in the UK, but also the declining state of GP premises, the decline in GP funding, and the escalating challenge of providing good quality care to an ageing and more demanding population are also cited as significant factors.

The general practice system in Oxfordshire faces challenges common to practices elsewhere in the UK:

- The **shortage in workforce and difficulty in recruiting staff** contributes to problems of access for patients;
- **Increasing demand as a result of patients requesting same-day access for urgent care**, who are generally 'low-intensity patients' or 'low complexity patients';
- **Increasing pressure in managing complex, frail, or elderly patients** who require continuity and co-ordination of care, who are generally 'high-intensity patients' or 'high-complexity patients';
- The **need to update premises** and other infrastructure;
- The **increasing administrative burden** in general practice, as practice teams (including GPs and other clinicians) are required to spend more time on bureaucratic tasks and supporting patients to navigate the NHS;
- An **increase in the number of potentially avoidable non-clinical consultations** (up to 27% of all consultations for GPs and other clinicians)[1];
- A **lack of integrated working** and co-ordination in communication and common health records across multiple caregiver organisations;
- A lack of investment to allow General practice to thrive

[1] Making time in general practice. Primary Care Foundation and NHS Alliance report 2015

3.3. The Strengths of General Practice in Oxfordshire

Despite its many challenges, general practice in Oxfordshire has traditionally been a high-quality and consistent service by national standards, and attractive to new GPs entering the system. Its main strengths as a service and as part of the whole health and social care system are:

- **General practice is comprehensive**. It offers a wide range of services, defined both nationally and locally, but also by the ethos of the practices themselves and the needs of their specific populations and communities. Over the last ten to twenty years, general practice has taken over the majority of long-term condition care and preventative care in the UK. With the onset of clinical commissioning in 2012, Oxfordshire GPs have led on whole system leadership, improving care, reducing waste and variability, and planning for future change.
- **General practice is holistic**. Since GPs hold the majority of the health record for their patients, and have seen those who need continuity of care most often for up to several decades, they are naturally placed to co-ordinate holistic care for their patients, coordinating other services, ensuring that all caregivers who are involved with that patient are informed and updated about their current care, and developing a mutually agreed care plan with the patient, their relatives, and other caregivers. This is a challenge to which Oxfordshire GPs have risen particularly well; a good example is the digital proactive care plan (dPCP) project, which has ensured that proactive care plans written by GPs for their most frail patients are shared with other organisations, and is one of the most advanced and comprehensive projects of its kind in the UK.
- **General practice is the visible and local NHS**. The local practice and the family doctor have been traditionally the first port of call for patients seeking healthcare in Oxfordshire who are not experiencing an emergency condition. The practice has always been part of the community in which it is set, and has generally known the patient and their family for many years, making them well placed not only to treat them for illnesses but also to advise on social and family issues.
- **General practice is responsive and adaptable**. Each practice's population is different, and Oxfordshire itself is a quite heterogeneous county, with high variation between areas in deprivation, rurality, disease prevalence, and ethnic mix. As the population changes and so do the challenges delivering healthcare to their patients, each practice has been able to respond flexibly to developing demand and patient needs.

4. Key features of a new model of Primary Care

The following section sets out some key features of the new model of Primary Care that will act as aspirations for quality general practice to aim for in the action plan to implement the new model.

4.1. General practice will continue to be population based:

- All residents will be able to register with a practice of their choice which will usually have a geographical relationship, but may have a historical or quality

relationship (e.g. expertise in a particular area). In return, residents will commit to using the services responsibly and with courtesy. Those residents who are unable to behave in a reasonable manner will have an allocated practice to look after them which may have expertise in behavioural management;

- The registered practice will provide continuity of care to all their patients except where geographical considerations would not allow home visits, and be the main foundation for their care over their lifetimes;
- Services needed to support patients who need more intensive care which the practice cannot deliver on its own will work with the practice in a holistic manner, not separately from it, to provide high quality care;
- Following our Care Closer to Home model, services will work at several levels - practice, neighbourhood, locality, and hospital – but will be integrated together;
- All people will have equality and equity of access to primary care services, but people will need to show equal responsibility to their care providers.

4.2. The general practice patient record will be a central comprehensive record for medical information relating to the patient:

- All people will have the opportunity to remotely access their own medical record, and be able to use online services via their record, such as ordering prescriptions or booking appointments;
- All clinicians (health and social care professionals) involved in direct care of the patient will, with the patient's consent, be able to access the GP record, including proactive care plans for high-intensity patients, for the purpose of providing coordinated and better care for that patient.
- General practice will be responsible for maintaining a high quality record appropriately formatted and coded to allow it use across the whole health system

4.3. General practice will continue to support public health initiatives for the prevention of disease in their population

- This will include immunisations, especially where GP practices are best placed to deliver them (not schools);
- Health checks strategies on obesity, drugs and alcohol;
- Cervical screening and promoting other screening programmes;
- Promote good mental health and improved patient's wellbeing.

4.4. General practice will practice high quality medicine including:

- Following current evidence based medicine including following NICE guidelines and other national guidance noting that additional funding may be required;
- Following local CCG and Trust guidance around patient care;
- Supporting good patient safety;
- GPs will be aware of a holistic model of patient care;
- Working to move to 15 minute face to face appointments with complex patients, where appropriate (maximum 13 per session).

4.5. General practice will be attentive to health inequalities and strive to promote schemes which reduce variation across the whole of Oxfordshire

- Improve physical health for those with Learning Disabilities (LD), Autism and severe mental illness;
- Support families and children especially those on with a child protection plan, looked after children and asylum seekers/refugees;
- Improve access for those from deprived and chaotic backgrounds and those where there are cultural or language barriers.

4.6. Decisions around planning of general practice to improve patient care will happen at scale:

- Support for patients will be, wherever possible, at practice level as long as it is appropriately funded, but may require more support due to lack of resources or skills. If more help is needed, GP surgeries may then be supported at neighbourhood or locality level;
- General practices will be encouraged build up relationships and to work in the neighbourhood of around 30,000-50,000 patients to plan improvements to care and services;
- Challenges to neighbourhood working, such as those related to rurality and county geography, will be addressed by developing new models of working in different settings from the ground up. Top-down one-size-fits-all approaches will be discouraged;
- OCCG will work closely with GP federations/groupings to deliver neighbourhood -level working.

4.7. All patients will have access to a same day urgent appointment if clinically appropriate:

- All patients requesting an urgent appointment will be seen or clinically triaged by a high skilled health care professional (not a protocol based system) and seen the same day if urgent need is thought to be appropriate. Patients will not have an automatic right either to same day appointments or home visits;
- Same day urgent appointments will not necessarily be at the patient's own general practice or by the patient's own GP and the patient will see an appropriate member of the Primary Care Health care team.
- Patients will see the most appropriate health professional first time as defined by the expert triage.

4.8. All patients requesting a routine appointment will be able to book one within one week if clinically appropriate:

- This appointment may not need to be face to face, but if the patient would prefer this then all efforts must be made to provide this.
- The appointment will be with the most appropriate health care professional.

4.9. High-intensity patients will have a named accountable GP who will be responsible for making sure that their care is appropriately co-ordinated for 24 hours a day, 7 days a week

- High-intensity patients include frail elderly patients, those receiving end of life care, and other patients needing coordinated continuous complex care;
- The GP will co-ordinate the development of an appropriate care plan which is freely available 24 hours a day across all caring systems to enable the patients to remain at home as long as possible to allow 24hour care;
- Proactive care plans and other essential information on high-intensity patients will be accessible to any clinician who is or becomes directly involved in their care, with the patient's consent;
- High-intensity patients will also have access to telephone support from primary care clinicians with full access to their clinical record, 24 hours a day, seven days a week.

4.10. All patients diagnosed with a long-term condition will be offered sufficient support to manage their condition

- All practices will be offering best practice care to all their patients with long-term conditions. Practices will be responsible to make sure that their workforce is adequately skilled to provide for the needs of these patients. Training and education will be available at neighbourhood and locality level;
- Practices will work at neighbourhood level to develop the skills needed to look after these patients and deliver the patient defined outcomes;
- Patients (with the support of their carers, formal and informal) will be encouraged to take ownership of their own care, by accessing their own patient record and receiving support and training in managing their own condition in their day-to-day lives. Development of resilience and learning for patients will be enhanced.

4.11. General practice will maintain the vast majority of prescribing

- For each patient a comprehensive list of medication will be maintained at practice level with known allergies and adverse reactions;
- Primary Care will be the gateway for non-urgent secondary care prescribing according to appropriate limitations through community formularies, traffic light systems and shared care protocols;
- Each practice will be aware of cost and restrictions and be cost effective in their prescribing as well as engaging with the OCCG prescribing team.

5. Proposed Future Operating Model

5.1. A Transformative Shift to Prevention

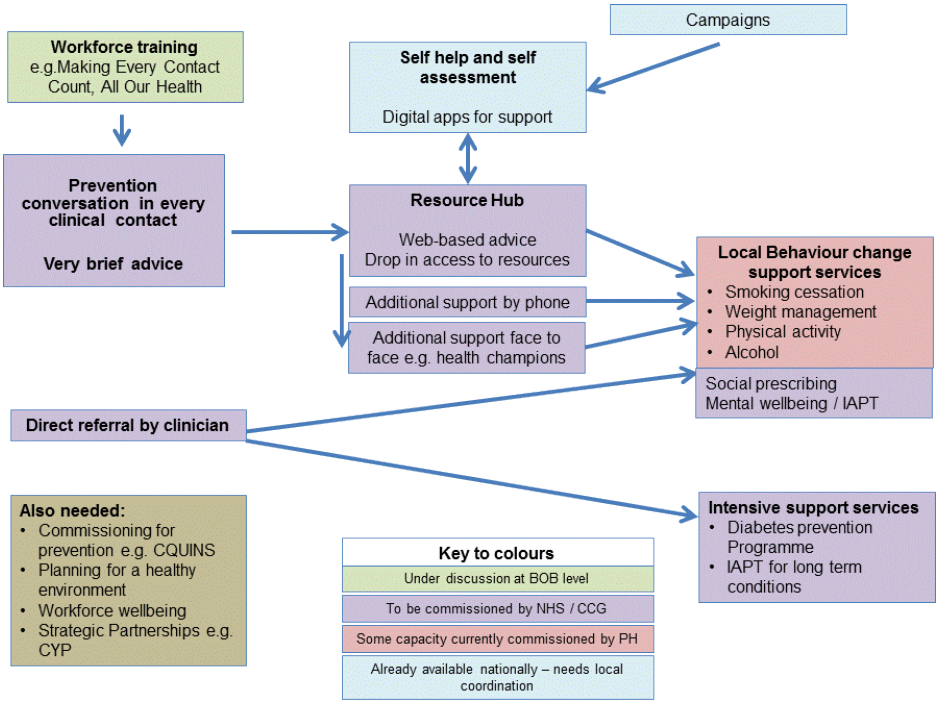
It is proposed to increase the scale of prevention work as set out in the diagram below. This will include:

- More comprehensive delivery of very brief advice by clinicians in all settings, underpinned by training in Making Every Contact Count (which is currently

being scoped by the Sustainability and Transformation Plan Prevention Group);

- Developing at least one "resource hub" to which clinicians can refer people directly. The hubs could provide face to face, telephone and web-based support to individuals and facilitate referral to behaviour change services. More intensive support by phone or in person will be available to mitigate the risk of widening health inequalities. An example of face to face work of this type is currently provided by the Here for Health Centre at the Oxford University Hospitals Foundation Trust[2];
- Increase the capacity of those behaviour change services where needed;
- Ensure that people can access web-based support for self-help easily and reliably;
- Build on national campaigns and coordinate locally across the system;
- Addition of specialist prevention services including psychosocial support for people with long term conditions and participation in phase 2 of the national Diabetes Prevention Programme.

The Prevention Pathway

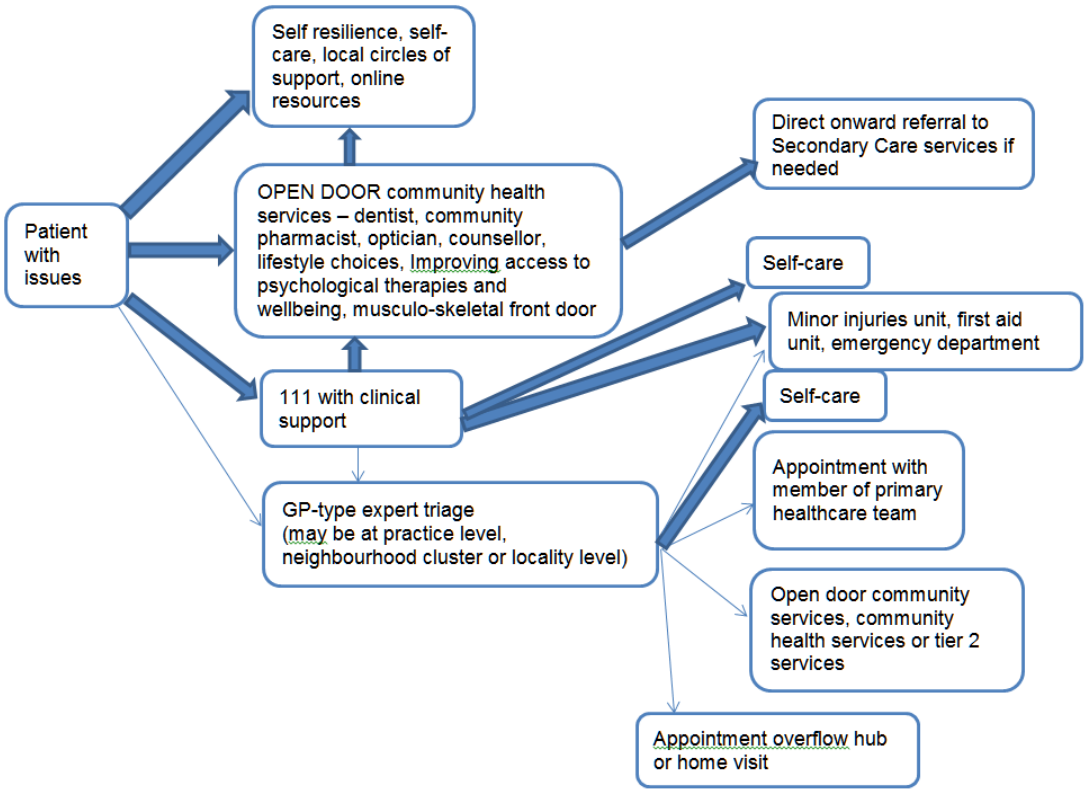


5.2. Patient to see most appropriate person

By ensuring expert triage both at the level of 111 and also when thinking of accessing Primary Care services the population can be seen by the most appropriate person. This may mean that patients will NOT necessarily see a GP but an appropriately trained person within the Primary Care team.

[2] http://www.ouh.nhs.uk/patient-guide/here-for-health/default.aspx

Patient Flows into Health Services or Self-Care



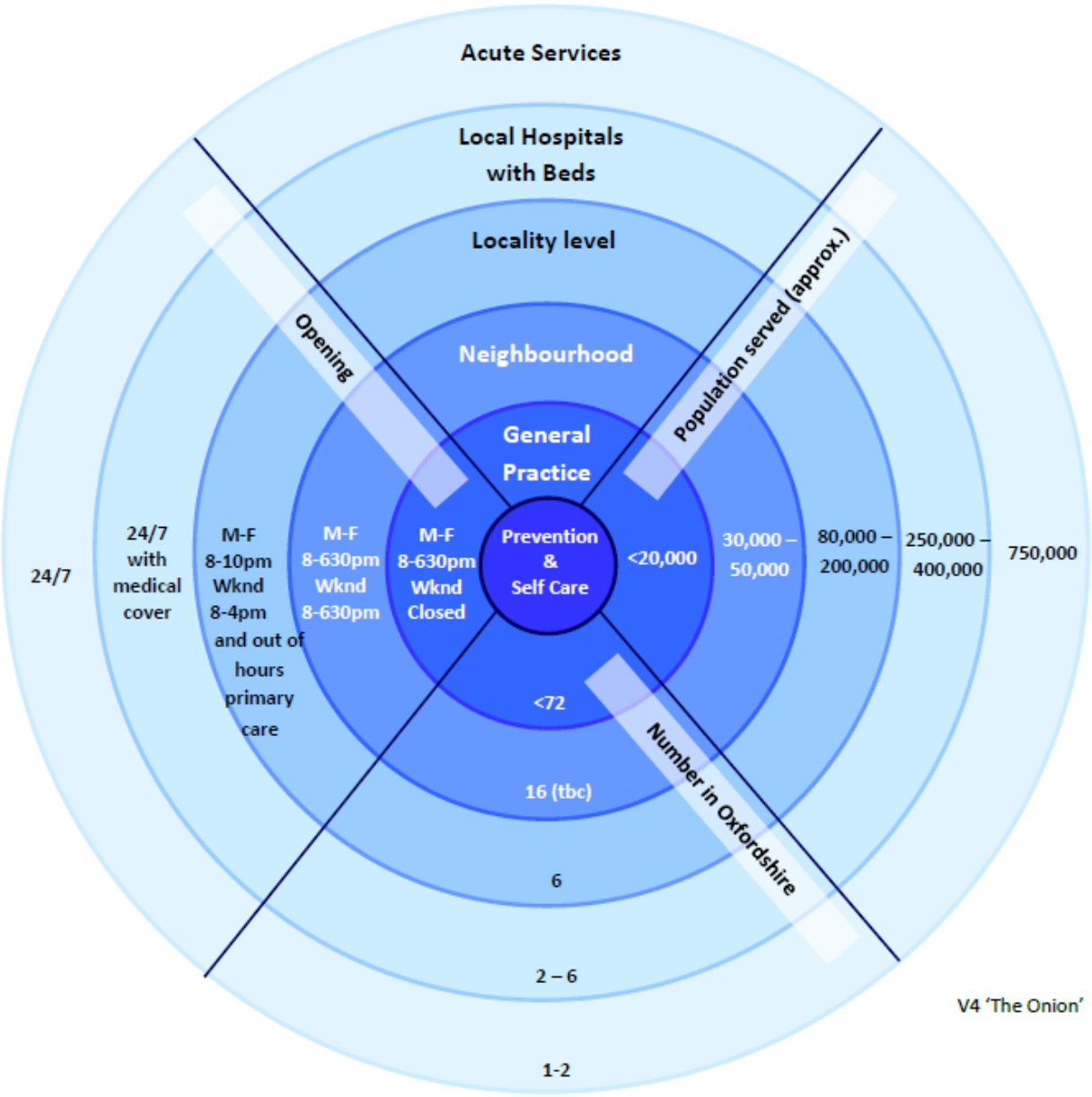
5.3. Delivering appropriate services at scale

We 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 below 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.

Examples of what can be provided at each level can be found in Appendix 1.

The key to this is a shared IT system across the levels of care that is usable for all the teams.

Mode - levels of delivery



5.4. Organised Around Geographical Population Based Need

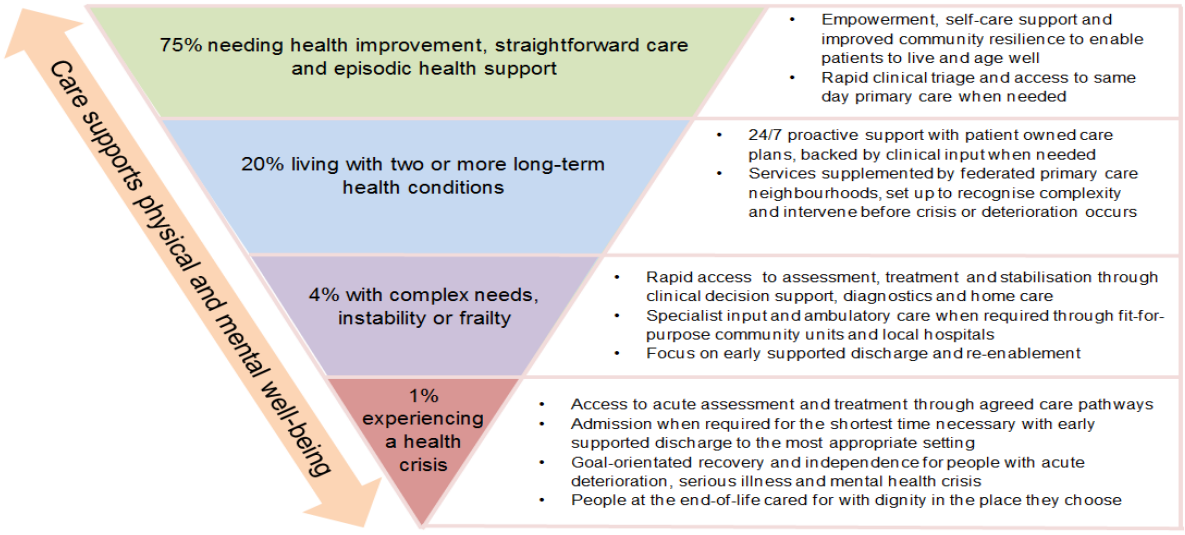
Segmenting the population according to need, as shown in the figure below, provides the basis for the new service model. This is further refined using an estimate of the scale of population that makes delivery of care viable at different tiers from individual GP practice through to neighbourhoods, to localities to local hospital level.

Putting this into context within a Primary Care neighbourhood with an all age population of 40,000:

- 30,000 people would be generally healthy or living with a single long-term health condition;
- 7,500 people would be living with two or more long-term conditions;

- 1,600 people would be managing at home with frailty or complex healthcare needs;
- 400 people would be nearing the end of life or experiencing an acute deterioration or health crisis.

This then defines the scale of the population needing more extensive support in the community and therefore determines the models to support them, and the level of care best to do this.

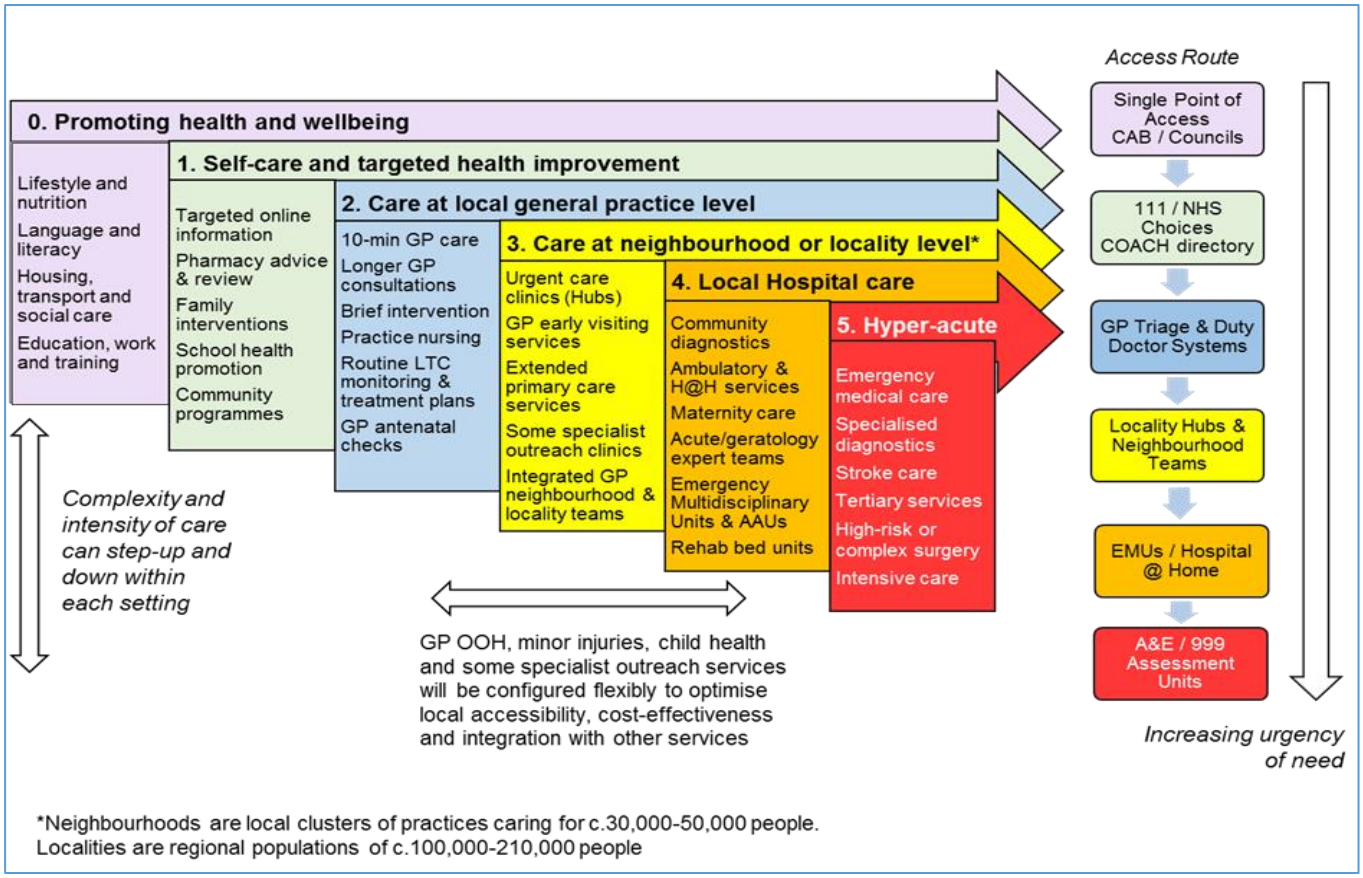


For some cohorts of patients hospital outreach will be important with consultant advice and clinics in the community. Shared care will be an important feature of the model especially in diabetes. This could be supported by interface medics and primary and secondary care IT integration (see section 5.8.2)

5.5. Delivering Care Closer to Home

The *Care Closer to Home* model aims to move care away from secondary care, wherever appropriate, to Primary and Community Care settings supported by greater levels of prevention and self-care. It sees care move from Secondary Care to Primary Care; from Primary Care to Community Care and from Community Care to self-care; and recognises that most of the time '*the best bed is your own bed*'.

The 'Care Closer to Home' model can be best described as below:



5.6. A Collaborative, Proactive System of Care

The new model would 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.

5.6.1. Patient Partnerships and Self Care

To help support the sustainability of Primary Care and general practice in particular, it is important to help the population to self-care, take up opportunities provided by screening, be aware of all the resources they can access (the 'choose well' campaign is useful – see NHS Choices website) and also understanding what Primary Care and in particular general practice can provide and what it cannot.

We need to find ways to help the population of Oxfordshire to respond to these changes by taking responsibility for using the services appropriately, taking responsibility for their own health and being conscious of ways to prevent ill health. We will work with patients and the public on this.

Co-production is key, the patients and the professionals should have a shared agenda to keep them in the best health longer term. This means to do this most successfully we develop a genuine partnership between patient/carer and professionals.

- Support the population to self-care including managing their own long term conditions;
- Support the population to understand what is appropriate to bring to the Primary Care services and understand clearly what can be delivered;
- Support patients accessing the 'open door services' which exist and will be developed such as community pharmacists, dentists, optometrists (including for minor eye conditions), direct access psychological services (through Improving Access Psychological Therapy – IAPT), direct access physiotherapy, etc.

The NHS constitution has this section on 'your responsibilities':

- *You should recognise that you can make a significant contribution to your own and your family's good health and well-being and take some personal responsibility for it*
- *You should register with a GP - the main point of access for NHS care*
- *You should treat NHS staff and other patients with respect and recognise that causing a nuisance or disturbance on NHS premises could result in a prosecution*
- *You should provide accurate information about your health, condition and status*
- *You should keep appointments or cancel within reasonable time. Receiving treatment within a maximum waiting time may be compromised unless you do*
- *You should follow the course of treatment which you have agreed and talk to your clinician if you find this difficult*
- *You should participate in important public health programmes such as vaccination*
- *You should ensure that those closest to you are aware of your wishes about organ donation*
- *You should give feedback - both positive and negative - about the treatment and care you have received including any adverse reactions you may have had*[3]

The CCG also has two demonstrator sites for Healthy New Towns which will show how the built environment will assist with health creation. The CCG looks forward to learning more about this as it progresses.

5.6.2. Professional Partnership and Collaboration is Key

Some services, such as local hospitals with beds, may provide services for more than one locality, and will operate at 'sub-county' level:

- Formal links across organisations with a named GP lead for each locality/federation;
- Collaboration with member practices and other providers to ensure best use of human resources to meet patients' needs, agree goals

[3] (http://www.ncuh.nhs.uk/patients-and-visitors/nhs-constitution/rights-and-responsibilities.aspx)

and maximise opportunities for improving patient care including developing IT/remote monitoring;

- Management – devolved to Locality Joint Management Teams at both operational and clinical level – comprising GP lead, organisational leads, nursing lead and operational management. Joint responsibility for outcomes, joint planning and joint clinical operating are key.

5.6.3. Interdependencies with other Transformation Programmes

Planned Care

- There will be outcome based contracts for patients with long term conditions initially starting with diabetes but latterly including Chronic Obstructive Pulmonary Disease (COPD), Asthma, heart failure / breathlessness. It will be expected that Acute/Community/Primary Care work together to deliver the best outcomes for the patient and funds and risks will be shared across the system;
- Complex elderly patients will be supported to stay in their home via a neighbourhood team consisting of district nurses, specialist nurses and GPs, care navigators and social care. They will be proactively managed to prevent / predict and actively manage unstable health;
- Diagnostics will be available in Urgent Care centres and will be directly bookable by GPs/Advanced Nurse Practitioners (ANPs); to include echocardiography, ultrasound, x-ray, etc.

Urgent Care

- Support to complex patients in care homes will be commissioned, possibly at a county level relying on technology where necessary;
- Development of the 111 integrated urgent care model and the clinical hub. A core element of this model is the commissioning of a functionally integrated urgent care access, treatment and clinical advice service. Out of hospital services and a range of expert clinical and non clinical professionals will form a multidisciplinary hub with the aim of managing as many calls within that hub as possible and when that is not possible making sure the caller gets to the service they need first time e.g. pharmacy, dental, mental health, care homes support, palliative care
- Support for GPs delivering care to the frail elderly will be provided through a central care co-ordination service with access to consultants etc.;
- There will be a home visiting service provided to those that cannot make it to the practice. In some cases this will be provided by Emergency Care Practitioners. This will be delivered at locality or neighbourhood level;
- 7 day access to general practice will be provided through GP Access fund appointments. There will be increased provision in the evening and at weekends. Each locality will have pre-bookable Saturday appointments. Sunday appointments will be provided in key locations, but available to the whole population of Oxfordshire. The out of hours service will continue to provide access to GPs for urgent issues in the out of hour period. These appointments will be for both planned and urgent care

Maternity Care in Primary Care

- Pending the outcome of the Oxfordshire Transformation Programme consultation, it is proposed that GPs will be involved in pre-conceptual care;
- GPs will undertake a maternal risk assessment of all women at first presentation (usually at around 6-8 weeks) to determine the level of care required and that all routine antenatal care will be undertaken by midwives or specialists, as appropriate.
- The GP will continue to manage any other general physical or mental health conditions in pregnant women as they arise. The GP or the midwife will assess women with any obstetric emergencies (including seeking advice or referring if appropriate);
- The GP will continue to have postnatal involvement, including the routine maternal and neonatal 6-8 week check.

Children

- Children with Urgent Care needs will access GP face to face direct in hours and through same day access clinics with GPs having direct access to the Paediatric Consultant on call and rapid access clinics for next day assessment.

Mental Health, Dementia, Learning Disabilities and Autism

- Primary Care will develop champions in practices to support better outcomes for people living with mental illness, dementia, learning disabilities and autism, whether as a patient or a carer;
- Practices will support the improvement of physical health and wellbeing amongst people with learning disability and autism. We will ensure that 90% of people with learning disabilities have had an annual health and wellbeing check in Primary Care by 2019, and that we have developed an assessment of the physical health of people with autism to inform future commissioning;
- We need to improve post diagnostic dementia care, particularly in relation to avoiding unnecessary admissions to hospital. Primary Care and the integrated locality teams will need to be able to provide this support for people still living at home and those in care homes;
- We will develop a Primary Care-based response to the the needs of people with emotional distress or behavioural challenges and medically unexplained symptoms. These people may not meet the thresholds for secondary mental health services and/or may not engage with them;
- Practices and Primary Care services need to be able to recognise and support the needs of people with comorbid mental and physical health problems, especially in relation to long term conditions and psychological therapies. This care needs to be integrated into diagnostic pathways in Primary Care.

5.6.4. Other elements of a collaborative system

A number of Primary Care services are commissioned by NHS E and are not considered in detail here but include:

- Community Pharmacy

- Optometry
- Dentistry

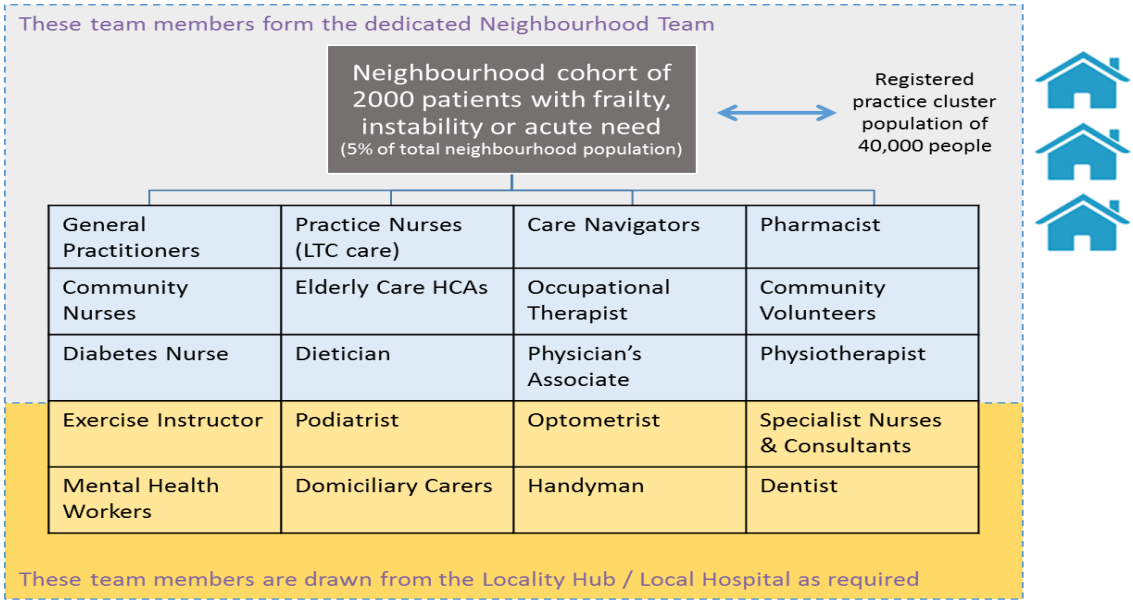
However, all are fundamental in the delivery of Primary Care and it will be essential that we continue to work with NHS England to ensure that we have a collaborative cross-Primary Care service.

Further information can be found in Appendix 2

5.7. Delivered by an Enhanced Multi-disciplinary, Fit for Purpose Neighbourhood Team

There is a gap in the detailed understanding of the numbers and skills of practice members and this becomes more important as in the future using the wider Primary Care team to take on roles traditionally done by the GP will be important (e.g. navigating care, minor illness, medicines management etc.).

An example of a neighbourhood team with possible staffing is described below. This will change depending on the needs of the population serviced by the neighbourhood. Community Mental Health therapists may also be part of the team as described in the GP Forward View.



5.8. Supported by a Modernised Infrastructure and Workforce

5.8.1. Transport - A more innovative approach to travel would need to be established so that those where travel under their own control would be difficult then transport would need to be provided. This could be a locality-based volunteer service, or a formal patient Primary Care transport service, but could include commercial taxis with the ability to carry wheelchairs. For those where travel would be impossible, care would need to be delivered at home.

The CCG will need to work with practices where patients face barriers to accessing services in Primary Care settings because of the lack of appropriate transport and associated support. There would be a need to support patients who are elderly/frail or children who have mobility issues or other health problems which restrict their ability to access their own or public transport. Older people often require additional support to navigate leaving their homes and accessing health services. It is these people who often have the greatest health needs and would benefit the most from services such as a Primary Care patient transport.

The CCG will also need to work with District and County Councils to ensure that public transport to Primary Care facilities is considered where appropriate.

5.8.2. IT infrastructure - The aim would be to use EMIS Web to its fullest extent within the county as all but two practices in Oxfordshire use this system. EMIS Web allows healthcare professionals to record, share and use vital information, so they can provide better, more efficient care. The ambition will be to develop clinically useful interoperability with other systems with the right amount of readability and write ability so that all providers can access one record.

The digital revolution has yet to fully be embraced by the health service. The possibilities we would want to explore and accelerate include:

- Full use of patient electronic record by patients, so patients can manage own appointments, medication, results, and interact better with health care professionals. This has the potential to reduce workload on professionals and empower patients to help manage their own health better;
- Improving digital integration of records to avoid duplication and reduce time spent with communication failures;
- Exploring the potential of using technology to help patients get to the right person and help 'co-produce' the assessment;
- Better functionality of care plans, so they become more patient-focused and help as a tool for patients to manage their ongoing care with input from professionals;
- Better use of patient self-testing and monitoring, using insulin in diabetes as an excellent example of what can be done;
- Better use of patient-held mobile technology;
- Alternative ways of seeking advice from Primary Care can be developed utilising technology advancements such as via email or remote technologies such as Skype. Learning from areas where this has been successfully implemented will be key;
- Technology should help teams work better together, with a reduced requirement for physical co-location, more remote monitoring and a more coordinated flow of information through the healthcare system.

The development of the Digital Proactive Care Plan (dPCP) acts as a good model for the personalised approach which will be needed for many of these patients and further development of this will produce a transportable plan which

can be accessed widely. All levels of the organisation will have a range of templates they can complete containing the types of data which will need to be collected on each patient both for management purposes but to transmit to other care organisations to the benefit of patients. Patients will provide their consent for their data to be shared.

5.8.3. Data collected across the system at practice, neighbourhood and locality levels will be essential for evaluating the quality and safety of the new services and to inform future service and workforce planning decisions. This will require adoption of new systems to aid coding, collation, reporting and analysis. It will be important to ensure that any workload as a result of this is kept to a minimum and technological advances will be vital.

5.8.4. Physical infrastructure. The current Primary Care estate needs considerable investment to make it fit for the future. There are opportunities to co-locate more services with community health and local authorities, but a lot of practices will need capital investment. This will only partially be available through NHS sources; local plans will need to consider what other sources are available (e.g. local authority bonds, developer contributions). This area needs further work as this framework develops.

There are also large areas of housing growth expected across Oxfordshire and the infrastructure will need to be improved in order to deal with the population increase. In some cases this will mean extending existing premises or in areas of large housing growth might mean working with local practices and the District Councils to ensure that there is new estate planned.

5.8.5. Workforce

There is therefore need for a fourfold plan:

- To increase capacity in primary care;
- To upskill existing staff;
- To bring in and expand new roles;
- To reduce the bureaucracy of reporting and streamline payment systems where possible.

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 license’ 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 in releasing GP time.

An essential part of a sustainable general practice is to reduce current workload. An audit done by the Primary Care Foundation of 5,128 appointments found that 27% of them were potentially avoidable GP consultations. It is essential that other services are put in place so that GPs only see those patients that require their skills.

Working at scale within multidisciplinary teams alongside outreach community and acute clinicians and social care staff requires a coordinated workforce plan that addresses Oxfordshire's key challenges in recruiting and retaining people at all levels of care delivery.

Oxfordshire's transformation workforce plan also details work required to develop new roles in Primary Care. There are a wide range of functions currently undertaken by general practice that could be done by other healthcare professionals or at other community locations. The workforce plan will reflect the needs identified in the Prime Minister's Challenge Fund pilot projects, including same day urgent neighbourhood 'hubs', early visiting nursing and care navigators. The workforce plan considers skill mix and pilots to evaluate the role and value of roles such as physicians' assistants and new and novel ways of attracting staff to work in Oxfordshire, such as GP Fellow schemes/joint roles with other providers.

There are very clear needs for having the ability to train the workforce which is needed to deliver the locality, neighbourhood and primary care workforce. This will be picked up through the Community Education Providers Network (CEPN). This means that to reduce the demands on GP workforce we would upskill the other members of the team. The workforce which will need to be skilled up includes receptionist and practice manager, health care assistant (health checks, phlebotomy, ECGs etc), practice nurse, advanced nurse practitioner (ANP) and community nurse (band 4-6); extended GP; psychological therapist and complex medicine practitioner; skilling community pharmacists to promote self-care and deal with minor illnesses. The Community Education Provider Networks (CEPN) commissioned by Health Education England can assist practices in ensuring that staff are appropriately trained.

In terms of safety and quality of GP practice including dealing with more complex patients it has been argued most recently by the British Medical Association (BMA) and Royal College General Practitioners (RCGP) that GPs should be moving to 15 minute appointments. At current GP numbers this would give a significant shortfall. OCCG agrees, however, that the aim we should be targeting is the default appointment being 10 minutes. Realistically to achieve this aim we will need to do more about reducing (or at least levelling) the number of patients who need to see a GP and not delegating new tasks to Primary Care unless appropriate resources are available. This means that better clinical triage, combined with making the most of other health care professionals, and recruiting new ones, needs to be looked at.

Acknowledging this, it is clear that we need to deliver skill mix across Primary Care and the community to plug the workforce gap, including developing advanced nurse practitioners (ANPS), clinical pharmacists working within Primary Care, skilled community nurses and practice nurses with the skills to support a variety of needs including minor

illnesses and long term conditions (and we should acknowledge that this has been happening variably across primary care already).

6. The benefits of the new model of care

A range of benefits would be delivered by implementing and utilising a new modernised Primary Care service and this would include:

- A sustainable Primary Care that can be the lynchpin of the new health system;
- Improved access to Primary Care – all patients should be able to access a same day appointment with a health care professional where appropriate;
- People will be empowered to self-care so that they can take control of their health so reducing demand on Primary Care;
- Patients will be seen and cared for closer to their own home where appropriate;
- Patients will receive holistic care;
- Improved skill mix to ensure the correct person sees the patient at the correct time so ensuring that GPs see only those patients that they need to;
- Patients with a long term condition will be offered individual support to manage their condition;
- Improved patient satisfaction and experience;
- Delivers high quality access to urgent and routine care across the whole county;
- Supports Primary Care to manage populations so reducing the need for hospital based care particularly providing more time to manage complex care and patients with long term conditions;
- Be integrated into the health system to prevent poor health and reduce health inequalities.

7. How Do We Get There?

This transformation requires Primary Care, including each practice, to work differently. This means more collaboration between practices and between other organisations. Some practices are already well on the way to significant changed skill mix in teams and we will need to learn from those on what works well. We will also need to better understand the input by optometrists, dentists and pharmacists and how they can help transform the Primary Care model of care.

Some of this change relies on patients being empowered to self-care. Different modes of delivery will need to be developed to ensure that all patient cohorts are reached and that each person is able to self-care to their own level.

However most fundamental to a sustainable Primary Care is a sustainable workforce with appropriate skill mix. Without this Primary Care is not sustainable and will not remain the cornerstone of the NHS.

7.1. Initiatives already in place

Whilst recognising that further support is needed the CCG has:

- Provided expert practice manager support to 4 practices that deemed themselves vulnerable;
- Provided consultancy support to two practices to prepare for Care Quality Commission inspection and also support before re-inspection for those practise requiring improvement;
- Placed an Oxfordshire-wide advert in the British Medical Journal (BMJ) to coincide with the GP Careers Fair. 12 candidates contacted the CCG and were matched with one of the 22 practice vacancies that the CCG were aware of;
- Provided an agreement for Banbury practices to discourage inter practice transfers as a way of reducing work load and preventing practices closing their lists to new patients;
- Continued to commission the same day access 'hubs' following the end of the Prime Minister's Challenge Fund to improve capacity in General Practice;
- Tailored support to practices who are receiving large numbers of patients following list dispersal or merger;.
- Increase in the remuneration of warfarin monitoring to recognise the cost of providing the service;
- Agreed core offering from District Nursing;
- Provided recurrent investment of up to £4m a year to support the sustainability and transformation of Primary Care. Each locality has prioritised this investment to better support the needs of local patients and practices. For example, some localities have commissioned more GP hub appointments and a home visiting service to build on the successes recognised from the Prime Minister's Challenge Fund. One locality has invested in peripatetic staff to help provide additional capacity within primary care;
- Commissioned GP Access Fund outcomes for the whole population of Oxfordshire so providing additional appointments in hours and at both the weekend and in the evenings;
- Piloted a clinical pharmacist in two practices to identify the benefits to the practice and system and identify what workload could shift to a Clinical pharmacist.

7.2. Short to medium term measures to help sustainability

The following measures could be implemented reasonably quickly locally:

- Reduce bureaucracy in commissioning locally commissioned services so that as many as possible services are combined (in discussion with Local Medical Committee), with reduced monitoring requirements;
- Doing data collection at scale, rather than individual practices;
- Commission comprehensive community nursing teams integrated with general practices;
- Developing improved access (based on the Oxfordshire 'GP Access Fund outcomes' developed) in and out of hours to support the work load on GPs with possibly up to 20% of appointments being moved/directed to these 'hubs' – which will be manned by a workforce supported by GPs but the main work force will be non-GPs;

- Urgent community visits (needed within 2 hours) supported by a service which works together with GP practices and allows timely visits throughout the day. GPs will still be responsible for less-urgent and planned visits including end of life. (This service has been tested in Oxfordshire with the 'Early Visiting Service' pilots and has had good feedback);
- Work with hospital providers and commissioners to:
    - Develop and enforce specification for internal hospital referrals;
    - Ensure hospital-initiated investigations are followed up by hospital clinicians;
    - Work to develop direct from hospital e-prescribing and full treatment prescriptions for short term courses;
    - Ensure timely communication of patient contacts (admissions, appointments) is available electronically;
    - Enable and ensure patients discharged have the recommended follow up tests directly booked and followed up;
    - Ensure home support is arranged before discharge.

7.3. Medium term measures to help sustainability:

Local discussions with general practices through the Localities and Local Medical Committee (LMC) as well as recognising other models been developed in the country through the Prime Minister's Challenge Fund, Vanguard projects, and the GP Forward View, have suggested a number of areas where services might benefit from a neighbourhood model.

These include the following:

1) Investing in practice (or neighbourhood based) clinical pharmacists to improve patient care, reduce GP workload;
2) Working to move GPs to 15 minute appointments where appropriate. This realistically will need some expansion in GP numbers, but also ensuring we use clinical triage, telephone consultations and a wider range of primary care team members, including practice nurses, Advanced Nurse Practitioners (ANPs), pharmacists, physiotherapists etc.;
3) GPs through neighbourhoods, community teams and federations to support proactively the frail high risk patients to remain at home providing planned visits at the weekend for those patients who have been identified as clinically unstable previously;
4) Developing neighbourhood level older people's multi-disciplinary teams who can work with acute hospital outreach services to focus on the group of patients who are unstable but in their own beds. These teams would need to include increased GP capacity and time to make them work well;
5) Care homes would be supported by a more comprehensive service including doctors, nurses, pharmacist, Occupational Therapists/Physiotherapists, mental health services which work with GPs, building on the Care Homes Enhanced Service (provided by GPs), the Care Home Support Service (provided by Oxford Health) and the hospital based 'outreach hub' .There is

increasing demand for a more integrated service to reduce unnecessary admissions to hospital;

6) GPs would have access to better and responsive more locally based diagnostics and 'point of care testing', which will improve the speed at which diagnoses can be made. These may be based more locally in diagnostic hubs. GPs would have easy access to named consultants for Long Term Conditions and other areas (such as dermatology) using functional technology;
7) Effective use of electronic records based on EMIS Web which should be used by neighbourhood teams, with full interoperability with hospital based electronic patient records, will be essential with full interactivity with other clinical and social care systems;
8) The neighbourhood may offer routine services if not done at GP practice level, or may benefit from economies of scale. This may include sexual health services, minor operations and joint injections, insulin conversion, dermatoscopy and minor skin conditions, leg ulcer and wound clinics;
9) 'Social prescribing' as a model will be developed to support Primary Care and the wider community. This would include the development of care navigators and support workers to help assess each person's needs and actively direct them to appropriate services as required. The services could be based in practices or neighbourhood;
10) Lifestyle centres – including stopping smoking, exercise promotion, Obesity, NHS checks, health promotions and screening;
11) Empowering people to take responsibility for their own health including promoting and encouraging individuals to use their own immediate resources to look after themselves. This will need to include work with the local population for people to understand their own responsibilities, and how they would usefully interact with the local health services;
12) Other Primary Care health services such as optometrists, physiotherapy, and dentistry can make their own referral direct to secondary care without accessing GPs;
13) Enhanced palliative care services to support people dying in their own home, ideally with staff who are trained in prescribing.

8. Funding the new model

One of the key hurdles in general practice is the funding stream determined by the global sum which is allocated to practices on a weighted population basis such that any increase in demand is not rewarded by an increase in funding. Whilst the CCG is unable to address the nationally determined formula, it must ensure that any national funding for general practice such as that which is part of the General Practice Forward View (GPFV) is accessed in a timely way and made available to practices in Oxfordshire.

Whilst developing the new model of Primary Care across each locality, it will be important to determine how funding can be moved across the system to further

deliver care in the community. Some recurrent funding was provided in 2016/17 and this will need to be used efficiently to ensure maximum benefit. It is likely that new models of providing more care in the community will release funding in Secondary Care which will be invested into Primary Care.

There is an expectation that the quality and outcome framework (QOF), which is part of the General Medical Services contract, will be reviewed nationally over the coming year. However, the CCG is keen to learn from those areas that have managed to do something innovative with this funding such as fund a diabetes souce of care model.

9. So what's next?

This document has been put together with the input of Primary Care workstream members (including patient representatives) and CCG GPs. However, for this to be meaningful, it needs a wider input and involvement from Primary Care clinicians and from patients. Each locality has reviewed the framework and both the Primary Care Patient Advisory Group and the Health Overview and Scrutiny Committee have reviewed and inputted to earlier drafts.

The aim, once agreed, is to further develop within localities involving other stakeholders such as Federations and Oxford Health with invitations to social care and Oxford University Hospitals Trust. This work will take place between April and June with the purpose of producing locality place based plans for Primary Care.

There also needs to be modelling of the workforce capacity and activity levels, as well as the finances in delivering the new model of care. This will be done to support the localities in their production of place-based plans.

Appendix 1

What delivering at scale could mean in practice?

What this means at *practice* level is:

- Where appropriate, Primary Care will be encouraged to consolidate, to form larger practices or groups of practices that can better serve the needs of their local populations longer term;
- Practices will typically operate on a list size of 10,000-20,000 registered patients; smaller practices may need to work together with others to provide the services we need in the long term. Taking the measures highlighted in this paper we believe gives the best chance of sustaining smaller GP sites closer to communities;
- A range of measures to develop and support practices will be undertaken in line with the General Practice Forward View and the BMA 'Responsive, safe and sustainable: our urgent prescription for General Practice'[4] and the Ten High Impact Actions[5];
- The CCG will only proactively procure, when necessary, stand alone new practices that support at least 8,000 patients unless there is a clear strategic need for the practice as defined by the CCG and locality. This will be dependent on a provider being identified through the procurement process;
- Working across practices will facilitate more specialist care to be provided in the community;
- Members of the practice-based team – not only the GP – will play an increasing role in providing day to day co-ordination and delivery of care. Better use of skill mix will be **the key to releasing capacity to enable GPs to provide longer consultations for those patients** with complex or multiple long term conditions;
- Each practice should have a named team of community nurses (as now) who will manage the practice population caseload on a day to day basis with an appropriate skill mix. This is expected to include all those on the caseload with support from the team's named senior nurse(s) where required. The practice team will consist mainly of practice nurses and health care assistants and will link in with the neighbourhood teams.

What this means at *neighbourhood* level is:

- Local practices will be supported to form new Primary Care 'neighbourhoods' adapted from the National Association of Primary Care 'Primary Care Home' model[6]. This is a 'functional' grouping rather than an actual 'structural' reorganisation. i.e. a change to the way people work together;
- A neighbourhood will typically serve a 30,000-50,000 population, such as that represented by a number of villages, or a market town, or a suburb of Oxford. In more rural parts of Oxfordshire the neighbourhood would need to provide a best fit;

[4] British Medical Association 2016 Responsive,safe and sustainable:our urgent prescription for general practice
[5] https://www.england.nhs.uk/expo/2016/11/14/releasing-time-for-care-10-high-impact-actions-for-general-practice-dr-robert-varnam/
[6] http://www.napc.co.uk/control/uploads/files/1445347156~Primary_Care_Home_Paper_without_Ack_v1.pdf

- These neighbourhoods will have the capability and resources to co-ordinate the delivery of a broad range of health services for their population. A neighbourhood will be the unit of planning and investment for Primary Care;
- Each neighbourhood will be supported by an administrative hub that will act as a communication and coordination hub for those practices and community nursing teams;
- This may include providing new local services organised at scale across neighbourhoods of two to five practices (for example, after-school, evening or weekend clinics) where this is the best level at which to provide;
- Within neighbourhoods, the GPs coordinating the care of patients with long-term needs will work in partnership with patients and carers to achieve agreed goals. This will require offering longer or different types of consultation in local practices and, for some patients, delegating intensive day-to-day care to an extended neighbourhood team working in and around the practice, while retaining an overview of that patient's care;
- This extended, multi-layered model of care will align local practices much more effectively with other health, community, social care and voluntary organisations. This collaborative approach will help to utilising the skill-mix available to patients while still ensuring that everyone within the team knows everyone else, utilising continuity. The neighbourhood then links as a network to locality groups. Community nurses will provide at neighbourhood level (see below);
- Some workforce will be organised at neighbourhood level providing care across a range of practices e.g. community mental health worker; clinical pharmacists, some specialist nurses;
- Each neighbourhood has a named community nurse who supports the practice teams.

What this means at *locality and county* level is:

- A locality typically represents 100,000-250,000 population, such as the City of Oxford, or the North, North East, West, South West and South East of Oxfordshire;
- Working at scale localities can provide cost-effective and sustainable locally-managed outreach services (such as urgent home visiting services, weekend care for the elderly, or care home GP services) delivered through Federations or 'Multi-Specialty Community Providers';
- As well as directly providing at-scale services, each locality will provide the essential network infrastructure to enable data collection and evaluation, workforce development and other initiatives to improve practice collaboration, efficiency and sustainability. Some of these elements might be better done at county level;
- This might include shared staff pools, telephony and IT services, nurse practitioner and receptionist development and volunteering services. Each Locality will also implement systems to facilitate improved quality and decision-making, streaming of patients and communications between practices and coordinate input from a range of other care providers;
- GP federations working at Locality level will be able to provide the infrastructure and support for the neighbourhood and practice level teams;
- Existing community services will be 'wrapped around' Primary Care to enable fully integrated, multi-disciplinary working under a unified delivery framework;

- Working at locality level (and neighbourhood level where appropriate) will also improve access to same day urgent appointments, modelled on learning from the Prime Minister's Challenge fund access hubs depending on which is the most appropriate level at which to deliver. This level will allow more 8am-8pm, 7 days a week cover if commissioned;
- Each locality will have an integrated team of community health professionals and social workers, working together on common caseloads, sharing information and reducing duplication;
- Each locality should have a comprehensive range of community nurses to meet the needs of the local population and GP practices to support all out of hospital nursing care;
- Working within a Primary Care out-patient consultant and non-consultant clinics could be provided in the community supported by a community based diagnostic service providing faster diagnosis and treatment;
- Locality services will have GPs integrated with them which will be fundamental and will build relationships between teams a neighbourhood and practice level.

Appendix 2

Other elements of a collaborative system

Pharmacy

The public use pharmacies as a regular source of healthcare advice, for maintaining good health and to self-treat simple conditions without needing to see their doctor or practice nurse. Pharmacies routinely offer a range of services including Stop Smoking, sexual health and flu vaccinations. These services have proved popular with the public who like the ability to access the services without an appointment.

Pharmacy services could be extended to enable greater choice for patients instead of having to attend the GP practice. Community pharmacy has the opportunity to triage, treat, and refer or signpost to help patients access the right service at the right time, reducing duplication of effort and pressure on GPs. To support this, better links are needed between practices and community pharmacies including enhancing the use of GP prescriptions to be sent electronically to pharmacies.

Clinical Pharmacists embedded in Primary Care practice have been shown to deliver huge benefits in medicines management and avoidance of waste and reduce costly interactions, releasing GP's time.

Optometry

Optometry has for many years been active in promoting patient care in the community. Optometry as a profession is well equipped, well trained, geographically evenly spread and much underused, particularly when its wide skill set is taken into account.

The future strategy for eye care needs to develop attainable eye health promotion and care and move towards electronic referral across the county. All patients who can be appropriately and effectively seen by skilled community optometrists should be able to do so. There should be well-defined pathways to enable this, backed by robust and efficient technology. The minor eye condition scheme (MECS) is a good example of how optometrists can reduce GP workload. Other opportunities for reducing GP workload is to enable optometrists to refer direct to Secondary Care, perhaps with some sort of triage, rather than writing to GPs requesting them to do it.

Dentistry

The provision of dental care has never been joined up between high street dentists, community dental services and hospital services.

A dental system that is prevention-led is the most effective and efficient way forward in improving the health of the population. Dentists are able to provide patients with advice and information to encourage them to develop more healthy lifestyles leading to a reduction in disease risk through self-care in patients and carers. This reduction not only has an influence on patients' dental health but their general medical health as well.

Dentists must be able to refer directly to Secondary Care, if appropriate, as well as being responsive and robust so that dental issues are not coming through the door of Primary Care. Where this happens locally it reduces local GP workload.