Oxford Patient Network

Our response to draft BOB Primary Care Strategy

Who we are:

Oxford Residents

Oxford Patients

PPG Chairs

Experience of

- NHS management
- Education
- Academia
- Clinical services
- Voluntary sector service provision

Response summary

- Access to the survey
  - Less than 1 star
- Comments on the survey
  - Unanswerable questions posed in impenetrable NHS management speak
- Our view of the Draft Primary Care Strategy
  - Needs rose-tinted glasses

Access to the survey

- Why pre-registration?
- Why 2 stage authorization?
- Takes nearly an hour – not less than 5 minutes
- Fails any kind of patient engagement test before starting

The survey (1)

The Vision "Everyone who lives in BOB should have the best possible start in life, live happier, healthier lives for longer and be able to access the right support when they need it".

What's not to like?

How will the 3 priorities deliver this?

How will patients be involved in the design or evaluation?

Our opinion – it is designed to deliver the results BOB/KPMG want

The Survey (2)

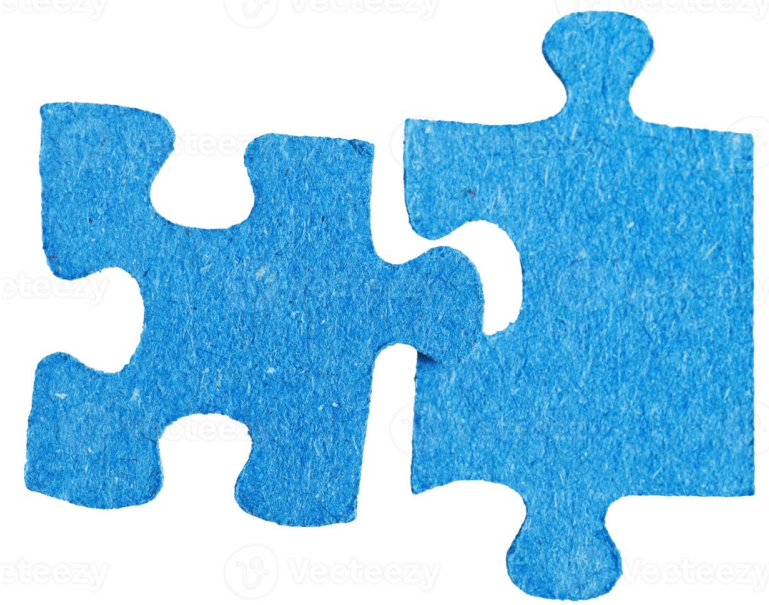
The Challenge Today

"Where people's needs are not well managed, they often end up requiring mor urgent and costly treatment, that does not provide a positive experience or improve their longer-term health and wellbeing. Groups from more deprived areas tend to use the emergency care system more often."

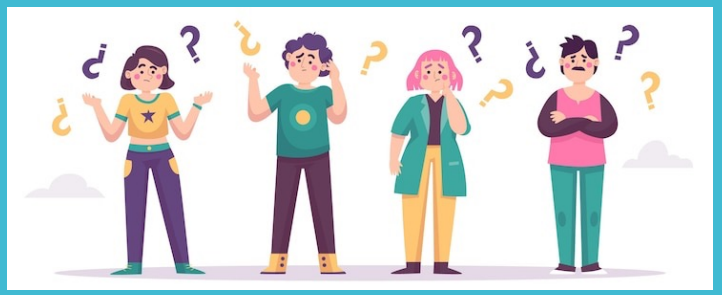
Both sentences may be true

But they are not related

We strongly suggest that they be disaggregated



The draft primary care strategy: Observations



Deja Vue

Pretty much the same!

2017/18

Oxfordshire Transformation Programme

OXFORDSHIRE PRIMARY CARE FRAMEWORK

Ensuring the sustainability of General Practice and supporting it to be the lynchpin of our newly transformed health and care service will requires 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 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

2023/24

BOB DRAFT PRIMARY CARE STRATEGY

The challenges – and – opportunities – facing primary care result from complex system-wide factors and a whole system response is required. BOB's Joint Forward Plan commites the system to developing new models of care and primary care is at the heart of that. This is our future vision for primary care, but it requires other system partners to also work differently to deliver it.

- We will ensure people get to the right support first time to meet their needs
- We provide personalised proactive care for people with complex needs, supported by Integrated neighbourhood teams
- We design targeted support for everyone to stay well by understanding our population by a review of the information

As patients we agree:

- The four pillars of primary care are under great pressure and crumbling:
- January 2024 Layla Moran MP says county risks being NHS 'dental desert'
- Cowan's pharmacy (previously in Boswells) not allowed to open in Oxford city – opposed by Boots
- Waiting times for GP appointments can be several weeks

We need more doctors: Strategy is treating the symptoms not the cause

The future of general practice
House of Commons Health & Social Care Committee, October 2022

- Root cause is straightforward: there are not enough GPs
- One of the most concerning impacts is the lack of continuity of care
- Trade off between access and continuity has shifted too far towards access
- Seeing your GP should not be like phoning a call-centre or booking an Uber driver who you will never see again
- Patient interface should be simplified – patients not left wondering whether to call the GP, the OOH service, NHS111 or go to A & E

We can find no reference to this comprehensive review or its recommendations in your strategy.

Right support first time Some questions?

- Initial contact – is not after triage – it is the triage itself.
- Triage & navigation
  - How will you deal with complex or ambiguous symptoms?
  - What about people unable to articulate their problems?
  - Will patients without access to IT/smartphones be at a disadvantage?
  - How will you maintain continuity of care?
- Patient education/information:
  - Who are all these people? What do they do? Why can't I see my GP?
  - Will there be a public information campaign?
  - Will you involve patient groups in developing this information?
- Staff retention
  - Do GPs just want to see complex patients?
  - Does the variety of patients not make the job more interesting?
  - A recipe for burnout?

Why not reference that this is already happening in NW London ICS?

- From April 2024 the same-day access (SDA) model will deliver a single point of triage for same-day, low complexity needs.
- The model has been trialed with 10 PCNs and will be introduced to the other 35 PCNs.
- KPMG is working with the ICB to deliver this transition.

Integrated Neighbourhood Teams

Your future vision

- Resource moving to the community from secondary care
- Teams coming together daily or weekly, virtually or physically
- & so on

Our comments

- Lovely idea
- Been around for years
- Evidence shows it is not cheaper
- Financial flows in the NHS not helpful
- In some cases, it increases hospital activity

Nuffield Trust March 2011
We have not found evidence that the eight POPP interventions reduced rates of emergency hospital admissions. In fact, in some cases there were increases in hospital use.

The Health Foundation,February 2023
Despite widespread policy support, evidence on the impact of community based MDTs is mixed. Our three IAU evaluations found that MDTs did not reduce emergency hospital use – and may even have led to increases – at least in the short term. Our longer term evaluatons of the broader programmes in which these teams were implemented found some evidence of reductions in hospital use, but this took between 3 and 6 years.

Why focus on the Clalit System?

- Are there no examples from the UK that you could use?
- אם אין דוגמאות מבריטניה שבהן אתה יכול להשתמש?
- The model of general practice in Israel is different to the UK

- The NHS Confederation Community Network published a paper in July 2020 with some excellent examples:
  - One Northern Devon
  - Care home –in-reach in Worcestershire
  - The Jean Bacon Integrated Care Centre, Hull
  - https://www.nhsconfed.org/system/files/media/Delivering-neighbourhood-integrated-care-shared-practice.pdf

CVD prevention

BOB statistics (courtesy of British Heart Foundation)

- Around 16,000 people have heart failure
- Around 254,000 people have high blood pressure
- 5,300 out of hospital cardiac arrests each year (only 1 in 10 survive)
- 47,000 people are living with coronary heart disease
- 32,000 stroke survivors

So why no focus on this topic until at least March 2025?

Where is the public health involvement?

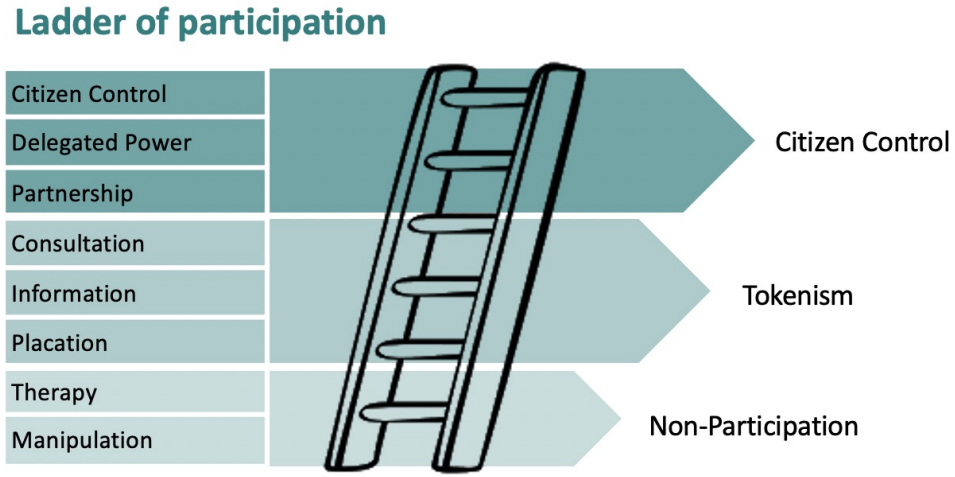
Why reduce 797 heart attacks and 290 strokes in 4 years? Can't we do better than this?

Delivering the strategy:

- What role will service users play?
- Which rung of the ladder of engagement is BOB ICS on?
- What are your plans to climb up the ladder?

Do you have plans for:

Co production?
Patient Engagement?
Patient Participation Groups?



Thank you for reading.

Do we think our comments will change anything?

Probably not.

But in the words of Carole King:

"Winter, spring, summer or fall
All you have to do is call
And we'll be there
You've got a friend"

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