**Oxfordshire Keep Our NHS Public's response to the Oxfordshire Clinical Commissioning group (OCCG) 'Locality Place based Primary Care Plan: Oxford Locality'**
(published on 4th December 2017 for comment by December 17th)

Introduction

Despite being assured earlier in the year that there would be a full consultation on the second Phase of Oxfordshire's Transformation Plan (OTP), this appears to have been overtaken by events. The five place-based plans for primary care seem to us to be key parts of what was going to be in Phase 2 of the public consultation. The remaining part of Phase 2, not included in these locality plans, was to have been Community Care. It is very hard to comment on one part in isolation. Also these services were definitely to be considered in phase 2. Asking for public comment ahead of phase 2 will incrementally erode the consultation - and scrutiny - process. This is extremely worrying to us.

To summarise our understanding of the progress to an agreed 'whole system' transformation plan, Oxfordshire's part of the Sustainable and Transformation Programme (STP) for West Berkshire, Buckinghamshire and Oxfordshire –

Phase 1[1] finished in August, with a pending Judicial Review on changes to the Horton (likely not to be concluded until January 2018) which effectively meant decisions have not been accepted that were to underpin Phase 2.

The government has announced a further mechanism, that of 'accountable care organisations' (ACOs) which can cut across STP footprints. In our case, our STP partners, West Berkshire and Buckinghamshire, have both secured early implementation status for their ACO plans, leaving Oxfordshire on its own. These systems worry us because they make decisions without the open accountability and governance systems that characterize the NHS and Local Authorities.

Oxfordshire CCG have confirmed they are working towards being an accountable care system, described as being a stage on the path to becoming an Accountable Care Organization. We are concerned that this has not needed any consultation period at all. They have further confirmed their commitment to this approach by appointing an NHS England insider, Louise Patten as acting CEO of OCCG. She successfully moved Buckinghamshire into a shadow ACO last year. This signals even more clearly our suggested direction of travel in Oxfordshire.

Locality Place-Based Primary Care Plans

This autumn saw the beginning of CCG discussions with clinicians and patients or special interest groups on their plans for primary care 'transformation' in Oxfordshire. This has not been called part of the STP, or a Phase 2 consultation, which we have queried with the CCG but are still awaiting an answer. In the meantime, we are taking the opportunity to respond to one of these Locality Plans, the one for the Oxford City Locality.

Response to the City Locality Plan

1 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation

This plan is about primary care alone. As the original OTP consultation on Phase 1 emphasized, no part of health and social care can stand alone; each part of the system is interdependent on the other sections. We consistently pointed out that having Phase 1 consulted on apart from Phase 2 made no sense. Consulting on primary care, itself only one part of Phase 2, makes even less sense. We are given an admirable amount of detail to mull over in this 67 page document, but every proposal would draw a different answer from us in different circumstances. If there was adequate funding for the proposals, if there were permanent community beds and services available through the OHFT, if the OUHFT were losing zero beds – or as looks more likely well over 300 – if the social care offered through the county council was raised from its current dire level – in all these cases, our answers would be different.

Measuring the proposals against the grim reality facing Oxfordshire

The reality we are faced with, against which all these proposals have to be measured, is zero extra funding from the government, a practically non existent free social care system and a self funded system which is inadequate, a catastrophic loss of hospital beds, an equally catastrophic staffing situation at all levels that will take years to rectify – even were the funding available to train and retrain staff, which is apparently not forthcoming – and a large predicted rise in population, in deprivation, in inequalities. We are sorry that the OCCG did not make this clear – too many of their proposals end with the proviso that this would only be possible if there were released funding, or adequate social care.

Challenges and Priorities

We recognize that the plan acknowledges some of these issues – referred to as 'challenges. [2] However, stating that ' A sustainable model of primary [care] is dependent on releasing funding from secondary care to invest in primary care'[3] shows just how hollow these carefully sketched proposals are in the current climate.

We applaud many of the stated priorities – to improve access, 'close the health gap' and target those most in need; to improve 'collaborative working' and reduce fragmentation. But all of this needs proper funding. Instead, one of the stated aims is 'closing the money gap (achieving system savings). Our view is that the laudable model of primary care outlined in this report is not possible without significant extra funding, and that this will need to come to health and to social care through general taxation.

**We take issue with the steps proposed in a variety of ways.**

1. It is suggested (Part B – 2) [4]'that the 20 practices across the city be combined into 6 neighbourhoods [each with populations of 20-45000] to align staff, and work to scale.' This if implemented would cut at the very heart of the NHS system, where a family has a GP practice they can trust, that is small enough to give a personal touch.
2. It is stated that to make our primary care system 'sustainable' we will need 'enhanced skill-mix'; 'new general practice support staff to take workload off GPs, such as physician associates, medical assistants, clinical pharmacists and advanced practitioners'.[5] Our view is that, although very helpful, such people decrease the access of patients to the skilled practitioner (at best they put one more hurdle in the way of access; at worst they risk the less skilled practitioner missing some vital symptom in a life threatening

2 pp4-5 of the foreword and throughout
3 p8
4 p20
5 p47

situation). Such 'skill mix' solutions also arguably end up costing more – since they often lead to more staff being involved. It can also be difficult for a frail or acutely ill patient to have to get to know more people, who will ask more questions.

3. The proposed array of specialist services, from the hospital at home for frail elderly, to the range of stand alone services for Drug and Alcohol, a service to address social deprivation, Drug and Alcohol, Combined Health & Social care teams, sound admirable. But they have attendant risks: they stand to increase fragmentation, and with it increase duplication of effort. If we take the case of MSK services, currently provided across Oxfordshire by a single private provider, the evidence shows that being outside the NHS family has downsides for the MSK staff, and for the patients, and for the referring primary care staff. [6] Yet fragmentation is something these proposals purport to address. For a patient coming out of hospital, in a frail state of health, not to be delivered directly back to a known trusted and much frequented GP surgery is already bewildering, under the current HART arrangements, which are set to get worse under this new scheme with its complex handovers between care teams.

4. Arising from the proposals for the array of specialist services is the spectre of many different agencies being awarded rigid contracts to provide services to a particular pattern for a certain number of years (typically 3 or 5 with the possibility of a 2 yr extension). Yet
   a) all these services will need to interact smoothly with each other
   b) they will be operating a rigid contract in a fluctuating environment as the changes take shape and
   c) such service boundaries will inhibit the smooth staff sharing and flexibility envisaged in the plan.

   If the services are placed with private operators, each one will be focused on profit for the company, which will further reduce funds available for the services.

5. Our view is that the way to achieve the kinds of aspirations expressed in the Plan is to have all services in the NHS family, and to eliminate the competition element between agencies – competition for staff, competition to divest themselves of costly or unpredictable procedures. This is the way to 'enhanced career paths' [7], making Oxfordshire 'an attractive place to work', promoting 'mergers' [8]

6. The changes proposed require capital and ongoing funding: [9]… 'the primary Care Estate across Oxfordshire needs considerable investment to make it fit for the future'.[10] The proposals include suggestions that there will need to be recourse to non NHS funding. [11] This will lead to further reduction in funds available for services themselves, as loans or PFI like contracts have first call on NHS resources. The cost of these will further undermine the NHS finances.The guiding principle has to be that Oxfordshire not saddle itself with these kinds of debts, and these kinds of 'solutions' where a building of today becomes a white elephant with a debt still to be serviced in ten years time.

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6 Oxfordshire KONP Newsletter https://keepournhspublicoxfordshire.org.uk

7 p47
8 p49
9 p50-54.
10 p50
11 ditto

Conclusion

- This Plan contains some very useful detail and some important priorities, such as reducing inequalities in health, increasing the quality of health care for those most in need, and promoting integration. However, in our view the proposals to provide 6 GP neighbourhood services for populations of 30-4500 will provide **a more fragmented, and more impersonal service that is less accessible for patients.**

- We also see the development of **specialized services in the current climate as a move towards further fragmentation and further opportunities for the private sector – which will be bad for staff, and for patients, through the rigidity of such contracts and the profit focus of the companies.**

- **Skill-mix, while attractive and helpful may end up costing more** (increasing numbers of patient visits and contacts) and reducing efficiency (having a GP as the first port of call remains the best and most efficient way to diagnosis and treatment).

- **The costs of the proposals are considerable, as acknowledged by the authors. At a time when the government has systematically starved health and social care of funding, we hold that the Plan as presented can not happen, and therefore it is disingenuous to ask us to agree or disagree. What is likely to happen in the absence of funding is that this Plan will be half- implemented, using private companies to build the new centres, and staffing them with under-qualified staff for the task in hand. The likely effect for patients will be that services will become more impersonal, harder to access, more fragmented, and that waiting times will continue to grow. At the same time even more of the government funding for the NHS will be siphoned into the hands of private company shareholders and directors.**

- Finally - this conversation which has lasted from Dec 4th-17th 2017 is not what we were promised, and without a whole system of proposals to slot this Plan into none of us have enough information to make a 'fully informed' choice. **We seem to be propelled by you, the CCG, into a set of 'solutions' (including ACOs) and 'efficienciesthat are driving us fast in the wrong direction. There is a move in parliament and through the Courts to halt STPs, ACOs and the like.**

- This period of public involvement in December 2017 is lacking in several vital ways. First it is not a formal consultation, though it plans huge reorganization of services and therefore should be a consultation. Second it will erode the formal consultation process we await in Phase 2. Third, it claims to be the best solution in the current climate, but still puts forward a plan which will not work without money released from elsewhere and staff availability dependent on training and housing not currently there. So although claiming to be realistic and achievable, it is not. WHY NOT SAY SO?

  **We urge you to concentrate on demanding more funding, and training recruiting and retaining more health staff in particular GPs and nurses, while truly working collaboratively with local authorities and all NHS bodies to get the housing and staff and buildings we need .**