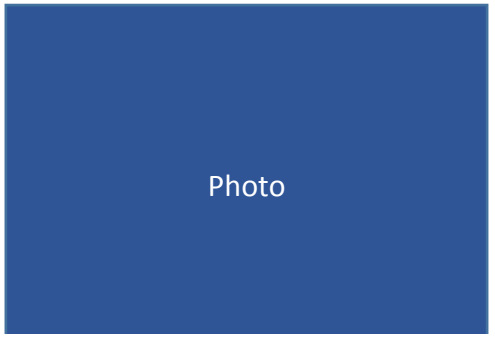
SOUTH WEST OXFORDSHIRE LOCALITY PLAN

Foreword



Locality Clinical Director: Jonathan Crawshaw

It is a challenging time for our local NHS: public spending has not kept pace with growing demand for NHS services; there are shortages of qualified staff at every level of the health and social care system; population growth in South West Oxfordshire is set to accelerate over the next 10 years. These challenges are the context for our drive for better quality and safety of patient services.

It is unlikely that in the context of a whole system under pressure, any single GP practice or healthcare provider can provide a solution. This plan represents an opportunity to map out how primary care teams will work together in pursuit of sustainability and improvements across the whole system. We recognise that having a shared vision, writing down a plan, or granting shared membership of a new organisation will not automatically lead to integration or cooperation. For this to happen in a meaningful way requires action and change on the part of individual clinicians, clinical teams and practices. This plan is intended to provide a framework for individual action – responsibility for its implementation rests with every person working for South West Oxfordshire Primary Care organisations. Leadership is required at every level.

The South West (SW) Oxfordshire locality covers 12 GP member practices of Oxfordshire CCG and a registered population of 146,278. Practices are geographically spread across the locality in market towns Abingdon, Didcot, Wantage and Faringdon, and the rural villages of Berinsfield and Clifton Hampden. Our aim of continuing to deliver primary care services close to home can only be met by a plan which addresses each of these local populations according to their unique needs. However, it is clear that not all primary care services can or should be reproduced independently in each town and village.

GPs and our colleagues in the community healthcare system therefore seek to retain the local strengths of what we have now, while moving positively towards far greater integration and cooperation between services. We cannot afford to miss any opportunities to reduce duplication of work, share expertise and information, and use technology to communicate more effectively with patients and each other.

SIGNATURE

South West Oxfordshire Locality Executive Summary

Locality Overview:

South West Oxfordshire locality covers 12 GP member practices of Oxfordshire CCG and a registered population of 146,278.
The population of South West Oxfordshire is rapidly growing – in the three years to April 2017, the practice registered population has increased by 5%.
The proportion of older people is also increasing.
There are small pockets of deprivation in South Oxfordshire, whose residents are affected by poorer health and well-being outcomes

What is working well:

- Abingdon Health and ValeMed Federations: GP Access Hubs provide additional appointments outside of normal practice opening hours across the whole locality
- The Early Visiting Service providing additional home visits for practices in the ValeMed Federation.
- Clinical pharmacists are already established in some practice teams
- Diagnostic physiotherapists are employed by some practices
- Development of My Coach website for local health information and resources.

Key locality challenges:

Our central challenge in the next 5-10 years relates to **growing population size and complexity**, and the requirement to **build and staff new premises** to accommodate the additional services which will be required.

Key Priorities for South West Oxfordshire Locality

We have identified six key priorities for the locality and 20 specific workstreams which will support us to deliver each priority.

		Priorities					
#	Workstreams	Expansion of premises	Expansion and integration of clinical workforce to ensure sustainable primary care	Efficiency	Integration of records	Improving health outcomes for frail/ elderly patients	Improving general access to primary care services
1	Using existing GP premises more efficiently	■	■				
2	Estates Workstreams	■	■				
3	Culham Science Park	■					
4	Design of new teams at neighbourhood level		■				
5	Integrated training framework for healthcare assistants		■				
6	More attractive portfolio roles for GPs		■				
7	Recruitment of care navigators		■				
8	District nurses and Practice Nurses should work more closely together as a team of Primary Care Nurses		■				
9	Federations to employ specialist doctors and nurses in primary care		■				
10	Shared admin at a federation level (short term)		■	■			
11	Shared training at a locality level (short term)		■	■			
12	Participation in primary care research			■			
13	Shared admin at a neighbourhood or federation level (long term)			■			
14	Shared training at a neighbourhood or federation level (long term)			■			
15	Explore possibilities of e-consultation			■	■	■	■
16	Expanded use of EMIS capability				■	■	■
17	Improved interoperability				■	■	■
18	Urgent visiting service (in hours)					■	■
19	Expand capacity in EMU in Abingdon						■
20	Coordinated care home support from practices					■	

Part A: Introduction

Part A describes how the North plan was developed. It provides the reasoning behind the creation of the plan, the methodology behind the plan's design and the sources for the data which have been used as an evidence base.

1. The purpose of this locality place based plan

The aim of the locality plan is to set out how we will deliver a sustainable primary care in South West Oxfordshire in line with the broader Oxfordshire Primary Care Framework and the GP Forward View. 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

The Oxfordshire 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. The result of this is detailed in this locality place based plan clearly describing the future model for delivery of primacy care across the locality.

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 some of the funding released as a result of moving activity from hospitals into the community.

Gap analysis and prioritisation:

- The plans have been tested against the priorities set out in the Oxfordshire CCG Primary Care Framework, the opportunities outlined in the GP Forward View and local transformation programmes. Proposals with funding consequences have been further assessed according to need across Oxfordshire. A sustainable model of primary is dependent on releasing funding from secondary care to invest into primary care.

2. Who helped to inform our plan?

This document draws on the knowledge and experience of Oxfordshire's clinical community to both describe and develop a South West Oxfordshire locality place based plan for the delivery of sustainable primary care and support for the model of moving care closer to home. This process included:

2.1 Patient participation:

- Draft plans have been discussed in the South West Oxfordshire Patient Forum, which includes representatives from patient participations. Feedback from these meetings has been used in the development of priorities and an additional meeting of this forum was held in October 2017 to discuss the plans:
- Outcomes and outputs from October SWOLF meeting

2.2 Locality Forum meetings:

- Discussion at a series of meetings involving representatives (GPs and practice managers) from each practice in the locality and from the two GP federations operating in the locality, and involving a representative of the South West Oxfordshire Patient Forum. These meetings held in June, July, August and October 2017.

Key messages:

The South West locality based primary care plan builds on the principles identified by the Oxfordshire Primary care framework to create a 5 year strategy for the region.
The plan has received input from locality forum meetings as well as patient participation input to ensure that the knowledge and experience of South West's clinical community is adequately captured.

Part B: The demographics of the South West Oxfordshire population

Part B outlines the current population need in South West Oxfordshire and how this will change over time. This section also lays out the current primary care provision in and the workforce mix required to sustain primary care for the future.

1. Summary

1.1 Locality Needs based assessment

The population of South West Oxfordshire is rapidly growing, and the proportion of older people is increasing. In the three years to April 2017, the practice registered population has increased by 5%[1]. This has been unevenly distributed across the locality with a number of practices having experienced significant growth:

Cluster	Population change over April 2014 baseline		
	April 2015	April 2016	April 2017
Abingdon	0.6%	1.0%	2.2%
Didcot	3.2%	6.2%	10.1%
Faringdon	1.9%	4.8%	6.4%
Wantage	0.6%	1.9%	3.7%
SW locality total	**1.4%**	**2.9%**	**5.0%**
England	**1.0%**	**2.1%**	**3.3%**

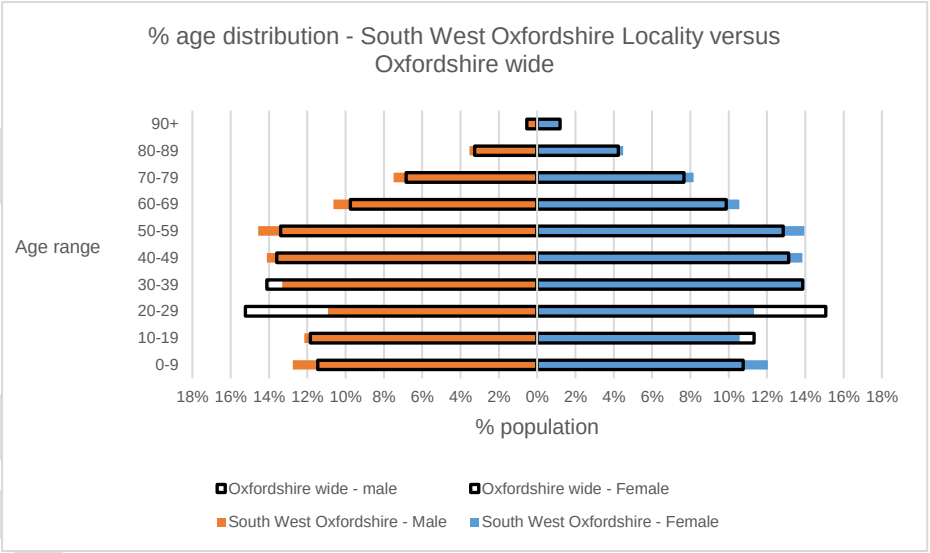
GP practice consultation rates per patient have consistently risen since 1995 across the NHS, and this trend is likely to continue given the ageing population. The overall consultation rate in England rose from 3.9 consultations per person per year in 1995 to approximately 8.3 consultations in 2013/14. Even though some of this rise is for other staff (eg practice nurses and AHPs), it likely that there has been a rise in the complexity of patients who require longer and more in-depth consultations specifically with GPs.

[1] NHS Digital: Numbers of Patients Registered at a GP Practice

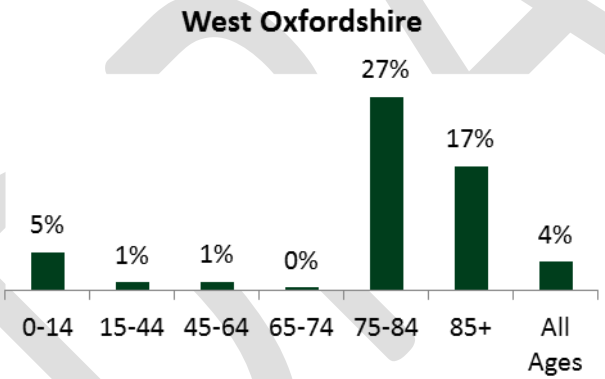
1.2 Age

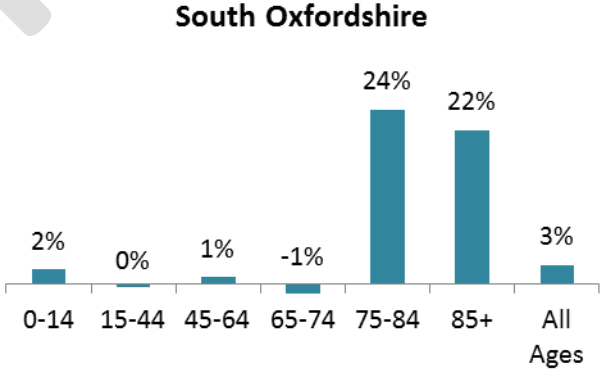
The current age distribution of the population in South West Oxfordshire locality is shown in figure 1 adjacent.

In the 5 year period between 2017 and 2022, the broad age group with the highest growth in all districts in Oxfordshire county is expected to be aged 75 to 84 (+24% in the South Oxfordshire council and +27% in West Oxfordshire).



Expected change in number of residents of Oxfordshire by age 2017 to 2022





1.3 Deprivation

There are areas in South West Oxfordshire whose residents are affected by poorer health and well-being outcomes. These areas tend to be more economically deprived, including parts of Abingdon, Didcot and Berinsfield. About 8% of children live in poverty overall. Parts of Faringdon have relatively higher levels of deprivation compared to the rest of the District, and this has increased in recent years with more provision of new social housing in the area.

1.4 Housing Development

Didcot and the Science Vale area are strategic priority areas for new housing growth, for both South Oxfordshire District Council and Vale of White Horse District Council. Throughout the next 10 years, there will be major new housing developments affecting all neighbourhoods and most practices in South West Oxfordshire.

Table X indicates:

- The number of homes that have received planning permission at August 2017
- An estimation of the development opportunities arising from the Local Plan Consultation (Housing and Economic Land Availability Assessment) earmarked within the catchment area of Wantage practices. This assumes that 50% of the 12,000 proposed new homes will be taken forward.

Table X: Projected Housing/population growth by Locality and Cluster [check VOWH figures for Faringdon]

	Housing Growth – 5 years						Population growth 5 years	Housing Growth – 10 years						Population Growth 10 years
Neighbourhood	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**5 yr Total**	**5yr Total**	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**10 yr Total**	**10yr Total**
Abingdon Cluster	773	602	584	389	210	2,558	6,139	125	90	90	90	80	3,033	7,279
Didcot Cluster	722	1,026	1,058	864	848	4,518	10,843	1,140	1,083	1,070	1,035	985	9,831	23,594
Wantage Cluster	612	1,125	956	900	885	4,478	10,747	845	845	845	845	795	8,653	20,767
Faringdon Cluster	223	350	358	265	130	1,326	3,182	90	90	90	100	40	1,736	4,166
Total	**2,330**	**2,708**	**2,561**	**2,023**	**1,678**	**11,300**	**30,912**	**1,805**	**1,713**	**1,700**	**1,675**	**1,505**	**19,698**	**55,807**

Data provided by OXIS - Oxfordshire County Council 2017-2035 *Assumes average of 2.4 people per dwelling

Current primary care premises cannot absorb the anticipated population growth, with some practices already struggling to find consulting and administrative space for their existing patients. Wherever possible, the capital costs of new or extended premises will be supported using developer contributions via s106 or community Infrastructure Levy (CIL) funding. However, this is not expected to meet more than a small fraction of funding required for GP premises. Recent experience shows that public funding is simply not available for capital projects, either from OCCG or from NHS England, and most practices will therefore look to private companies to provide the required capital. Lessons have been learned from the PFI deals of the last 20 years, and the CCG will work with practices to ensure that such private finance is sustainable for the local health economy.

Current funding arrangements for primary care mean that OCCG's budget for ongoing primary care rental costs will not necessarily increase in line with population growth. This introduces a significant additional pressure on estates growth, even assuming that capital costs can be met from developer contributions and private finance.

2. The health of our community in South West Oxfordshire locality

The health of people in South West Oxfordshire is generally better than the England average. Life expectancy for both women and men is higher than the England average. Rates of chronic illness are comparable with national averages, and are fairly consistent between neighbourhoods while varying significantly at a more local level (e.g. COPD prevalence in the village of Berinsfield is twice that of neighbouring Dorchester-on-Thames).

	2015/2016 Prevalence %					
Cluster	**Hypertension**	**Asthma**	**COPD**	**Depression**	**Dementia**	**Mental Health**
Abingdon	13.83	6.45	1.57	9.70	0.80	0.68
Didcot	11.78	6.14	1.53	13.27	0.49	0.68
Faringdon	14.26	6.07	1.79	10.26	0.98	0.67
Wantage	14.22	5.94	1.22	7.74	0.98	0.58
Oxfordshire	12.21	5.74	1.33	7.50	0.74	0.81
Nationally	13.81	5.91	1.85	8.26	0.76	0.90

The locality covers a large area of Oxfordshire and **public transport** links are a vital component of any model involving work carried out in neighbourhood hubs. All buses which directly linked Berinsfield/Clifton Hampden with Abingdon have been withdrawn and this makes it harder for those patients to access neighbourhood services in Abingdon. An important bus route linking Faringdon with Wantage has also been withdrawn, with similar consequences for design of joint neighbourhood services in the area. Patients in Berinsfield now have better transport links with Wallingford than Abingdon. Patients in Faringdon now have better transport links with Witney than Wantage.

Key messages:

The health of people in South West Oxfordshire is generally better than the England average. However, there are areas in South West Oxfordshire whose residents are affected by poorer health and well-being outcomes.

Parts of South West Oxfordshire have grown rapidly in the past three years and there is significant housing development planned that will have an impact on primary care.

In the 5 year period between 2017 and 2022, the broad age group with the highest growth in all districts in Oxfordshire county is expected to be aged 75 to 84.

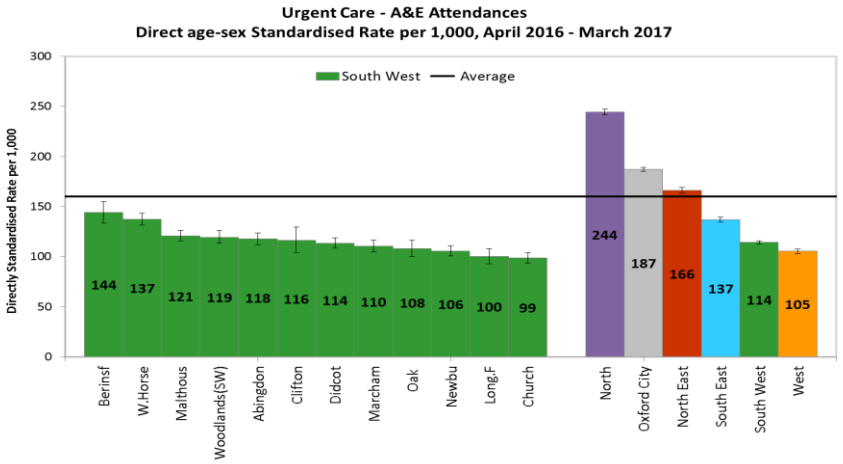
Part C: How our population in South West Oxfordshire accesses services

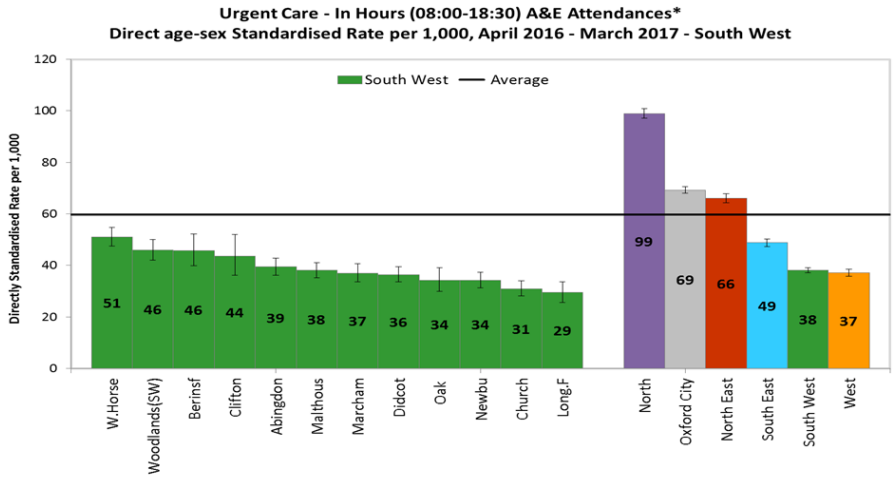
Part C outlines how current services are used by the population in South West Oxfordshire. This includes A&E and MIU attendances, current workforce and primary care provision as well an overview of urgent and community care.

1. Use of health services

The use of health services varies across the locality, and arguably the most significant factor in this variation is the difference in availability of local services. For instance, the two locality practices with the highest rates of A&E attendance are in Berinsfield and Faringdon, the practices most distant from a Minor Injury Unit.

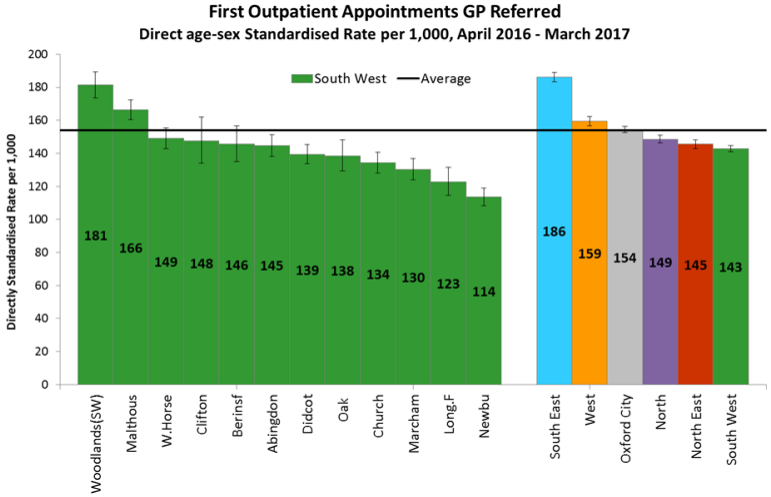
Viewed against figures for the whole county, patients in South West Oxfordshire rely less on the A&E department during the hours in which their GP surgery is open. This suggests that the combination of general practice and Minor Injury Units in Abingdon (for patients in Didcot, Wantage and Abingdon) and Witney (for patients in Faringdon) provides good urgent access for most patients.

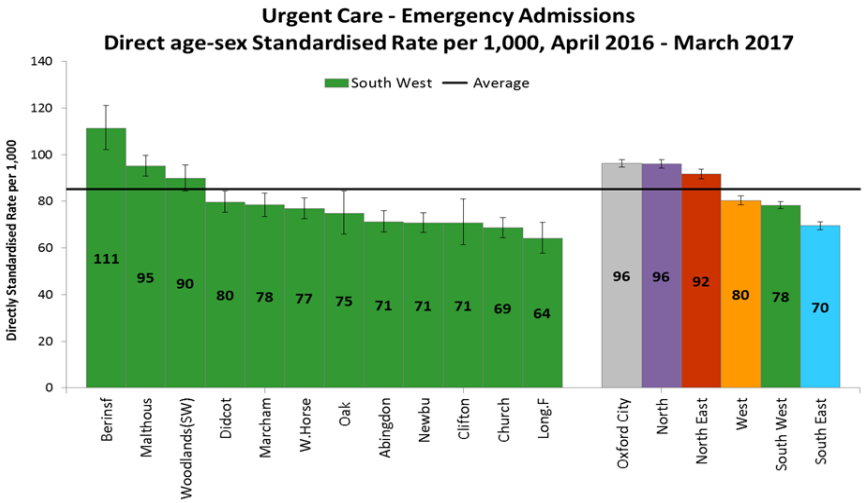




South West Oxfordshire has the lowest rates of outpatient referrals for specialist care, among the six Oxfordshire localities. Although there is significant variation between practices in rates of outpatient referrals, most practices are close to the CCG average.

Rates of emergency admissions to hospital are lower than all but one of the other Oxfordshire localities, although there is significant variation between individual practices. Rates of emergency admission are correlated with indices of deprivation in practice populations.





2. Overview of Primary and Community Care

2.1 Access

Summary of practice provision

There are 12 practices in SW Oxfordshire serving nearly 150,000 patients (July 2017). Most primary care services and consultations are delivered by individual practices, exclusively to their own registered patients. Out of hours primary care services are delivered primarily from a hub on the Abingdon Hospital site; Oxford Health Foundation Trust holds the contract for delivery of out of hours services, although most clinicians working in this service are partners or employees of practices in the locality.

A Neighbourhood is defined (in the Oxfordshire Primary Care Framework) as a group of practices that cover populations of between 30,000 and 50,000. Practices are considered in this configuration as this is considered a suitable population across which to deliver some services. South West Oxfordshire is a predominantly rural area; the aim to deliver care closer to home means that some neighbourhoods (e.g. Faringdon) are necessarily smaller than others by virtue of being more geographically remote from other practices. It is recognised that Berinsfield and Clifton Hampden are more distant from the other practices in the Abingdon neighbourhood, but currently have fewer patients than is required to deliver services at neighbourhood scale.

Practices in South West Oxfordshire are all members of one of two GP Federations: ValeMed and Abingdon Healthcare. These organisations already coordinate and deliver a limited range of services to patients of their member practices, and in future may allow more GP-led services to be delivered at a larger scale.

PA will insert map here

Map of 12 practices (ideally showing practice boundaries, but at least showing on the map the full catchment area for each practice, esp Faringdon and Berinsfield) and any branch surgeries (only one of these – Woodlands Medical Centre has a branch site in Blewbury)

Figure 5: Locality practice map

Locality	Federations	Neighbourhoods	Practices (patient population)
South West Oxfordshire Locality (146,278)	ValeMed Federation (84,203)	Faringdon (15,272)	White Horse Medical Practice (15,272)
		Wantage (29,296)	Church Street (13,841)
			Newbury Street (15,455)
		Didcot (39,635)	Didcot Health Centre (18,027)
			Oak Tree Health Centre (10,059)
			Woodlands Medical Practice (11,549) (Branch site in Blewbury)
	Abingdon Healthcare Federation (62,075)	Abingdon with Berinsfield and Clifton Hampden (62,075)	Abingdon Surgery (14,423)
			Long Furlong Surgery (9,283)
			Marcham Road Surgery (12,245)
			Malthouse Surgery (18,082)
			Berinsfield Health Centre (4,820)
			Clifton Hampden Surgery (3,222)

2.2 Access to general practice in South West Oxfordshire Locality

Core primary care services are delivered Monday-Friday from 0800-1830hrs by all practices in the locality.

Outside normal practice opening hours, all patients have access to GPs and nurses working in the Out Of Hours Urgent Care Service. Oxford Health Foundation Trust holds the contract for delivery of out of hours services, although most clinicians working in this service are partners or employees of practices in the locality. The service is delivered primarily from a hub on the Abingdon Hospital site (patients in Faringdon also access these services at the Witney Hospital hub). Appointments are accessed via the NHS 111 service, and cannot be booked in advance or for routine problems.

GP Federations also provide additional appointments outside of normal practice opening hours, which are funded by the GP Access scheme. Unlike the Urgent Care service, these appointments are pre-bookable and are intended largely to provide routine appointments to those patients for whom normal practice opening hours are not convenient. Appointments are available from 6-8pm Monday-Friday, and for a several hours on both Saturday and Sunday. Appointments are available to patients registered at any practice in the federation, regardless of the location of the clinic. The Abingdon Federation delivers this service in rotation from practice sites in Abingdon, Clifton Hampden and Berinsfield; for ValeMed practices the GP Access appointments are provided at Woodlands Medical Centre in Didcot.Practices in the ValeMed Federation have access to an Early Visiting Service, which provides an additional resource to housebound patients who are acutely unwell (see Examples of Recent Innovation, below).

For patients in care homes, OCCG commissions an enhanced service for Proactive Care Home Support from primary care. This is an optional scheme which involves a practice forging a closer working relationship with one or more care homes, and providing GP services to the majority of the residents in these homes. Currently only a minority of practices in the locality deliver this service (White Horse Medical Practice, Berinsfield Health Centre and both Wantage practices).

2.3 Urgent care

The presence of a Minor Injury Unit and GP Out of Hours hub at Abingdon Hospital means that this already has some of the components of an Urgent Treatment Centre. Further transformation to deliver an Urgent Treatment Centre here or elsewhere in the locality would effectively mean extending the GP Urgent Care service through the day. Due to the geographical spread of patients in the locality, an Urgent Treatment Centre in one place would not improve equality of access. For this reason, the locality proposes to support existing primary care services in each town rather than diverting resources.

Patient views on general practice – graph results from GP Patient Survey re access.

2.4 Community care

District nursing and health visitor offices are sited at the following locations:

- Berinsfield Health Centre – district nurses covering Berinsfield and Clifton Hampden
- Clifton Hampden Surgery – health visitors covering Berinsfield and Clifton Hampden
- Didcot Health Centre – district nurses covering Didcot Health Centre, Woodlands Medical Practice and Oak Tree Health Centre
- Abingdon community hospital - district nurses for patients of all Abingdon practices (single hub)
- Wantage – district nurses based at Church Street/Newbury Street site
- Faringdon – district nurses based at White Horse Medical Practice

There are three community hospitals in South West Oxfordshire that provide the following services:

Abingdon community hospital (located alongside Marcham Road Family Health Centre):

- Approx 55 inpatient beds including 10 for stroke patients, 6 beds supporting the Emergency multidisciplinary unit, and the remainder "generic rehabilitation beds" for frail patients (including occupational and physical therapy, and speech and language therapy), and for palliative care.
- Other outpatient specialist clinics including: orthopaedics, ophthalmology, cardiology, falls clinic and rapid access geratology clinic.
- Older adults mental health team outpatient clinics and team base.
- Midwifery outpatient clinics
- Emergency Multidisciplinary Unit providing ambulatory care (and a small number of inpatient beds) including specialist geratology, physical and occupational therapies and social care.
- Minor Injuries Unit
- GP out of hours services (co-located with Minor Injuries Unit)
- Radiology services offering plain X-rays for patients referred by their GP or by the Minor Injuries Unit
- District nursing hub
- Integrated Locality Team for South West Oxfordshire

Didcot community hospital (located alongside Woodlands Medical Practice):

- Approx 16 inpatient beds providing rehabilitation for frail patients (including occupational and physical therapy, and speech and language therapy), and palliative care
- Outpatient podiatry
- Outpatient adult mental health services are provided on the adjacent site by Oxford Health community mental health team

Wantage community hospital:

- Maternity services: midwife-led unit with two inpatient beds for low risk deliveries

Services at Didcot and Wantage community hospitals have been significantly reduced in recent years. Wantage hospital closed its rehabilitation beds due to safety concerns about Legionella in the water system, and Oxford Health Foundation Trust has not signalled any intention of reopening these beds prior to Phase 2 of the STP consultation.

Given the pressure on primary care premises in Didcot and Wantage, the outcomes of the Phase 2 consultation on community hospital services are of great significance. Patients and practices do not wish to see further loss of local services, and the STP is an opportunity to bring more services to the area. If the community hospital sites can be used more efficiently, and integrated with primary care services, there may be opportunities for a richer mix of services to be delivered while also supporting investment in estates for general practice.

Until September 2017, **musculoskeletal physiotherapy services** were provided by Oxford Health FT at all three community hospital sites and at the White Horse Medical Practice. Musculoskeletal physiotherapy services are now provided by HealthShare, and Oxford Health has not provided any community hospital space for the new provider. Currently this means that all musculoskeletal physiotherapy for South West Oxfordshire is being provided by HealthShare at two sites: Woodlands Medical Practice and White Horse Medical Practice. This has reduced local access to physiotherapy, in particular for patients in the Abingdon and Wantage neighbourhoods. It is a priority for the locality to find new consulting space for HealthShare's physiotherapists in these neighbourhoods.

2.5 Primary Care Workforce

In 2017 the locality conducted a survey of member practices' current GP staffing and estates capacity, and forecast GP retirements over the next 2 years. Table X indicates the current GP workforce at July 2017. Table X indicates current vacancies and planned retirements.

Table X: GP workforce in South West Locality

Neighbourhood	Patient list size	Number GPs (FTE)	Patients per GP (FTE)
Abingdon	62,075	32	1,940
Didcot	39,635	19.92	1,990
Faringdon	15,272	9	1,697
Wantage	29,296	13.28	2,206
South West Oxfordshire	146,278	74.2	1,940

Table X: Current vacancies and planned retirements

Neighbourhood	Current vacancies (FTE)	Planned GP retirements		
		2017/18	2018/19	2019/20
Abingdon	0.5	2.44	3	1.44
Didcot	3	2.1	0	1
Faringdon	0.66	0	1	1
Wantage	0	2	1	1
Cumulative Total	**4.16**	**10.7**	**15.7**	**20.14**

Current GP staffing varies widely between practices in the locality, with between 1,600 patients and 2,200 patients per WTE GP. This reflects variation in models of care, roles of other clinical staff, and short term changes in staffing and list size. A target list size of 2,000 patients per WTE GP has been assumed in the following calculations.

The available GP workforce is not growing to keep pace with population growth, and some practices already report difficulty in GP recruitment. Table X indicates the GP recruitment required to 2022 based on projected growth and table X projected GP workforce requirements over a 5 and 10 year period based on the housing projections in table X and assuming no change in the way that primary care is delivered.

Table x: Projected shortfall in FTE GPs based on housing growth

Neighbourhood	Required number GPs (FTE)		Shortfall GPs **excluding** retirements (FTE)	
	Apr-22	Apr-27	Apr-22	Apr-27
Abingdon	34.1	34.7	-2.1	-2.7
Didcot	25.2	31.6	-5.3	-11.7
Faringdon	9.2	9.7	-0.2	-0.7
Wantage	20.0	25.0	-6.7	-11.8
South West Oxfordshire	88.6	101.0	-14.4	-26.8

Table X indicates the number of practice nurses and HCAs / phlebotomists employed in the SW locality. In addition one practice employs an advanced nurse practitioner and one employs an emergency care practitioner. It is likely that some of the additional forecast GP recruitment will be replaced by non-GP staff who can undertake a focused range of "traditional" GP activities and consultations, for example physiotherapists, clinical pharmacists and nurse practitioners/nurses with enhanced training.

Since 2016, sustainability and Transformation Funding has been used to upskill existing practice staff across the whole locality, for example:

- Training new or existing healthcare assistants and practice nurses
- Enhanced training for reception teams or care navigators
- To provide additional resources at practice level to establishing triage systems for urgent appointments

Table x: Current nurses, HCAs and phlebotomists employed in SW Oxfordshire locality

	Current WTE practice nurses	Patients per practice nurse	Current WTE Health Care Assistants / phlebotomist
Abingdon	13.2	4,703	6.8
Didcot	10.8	3,667	4.1
Faringdon	3.0	5,091	3.0
Wantage	7.0	4,161	5.3
SW total	**34.1**	**4,296**	**19.3**

Key messages:

There are 12 practices in SW Oxfordshire serving a population of nearly 150,000 patients (July 2017). These are supported by 3 community hospitals which provide a range of outpatient and inpatient services. There are 71 beds between them. L Current forecasts predict that South West will have a shortfall of 14 GPs (FTE) minimum by April 2022.

Part D: How we will meet the needs of our community

Part D outlines the highest priority areas for primary care in South West Oxfordshire, describing both the current challenges and objectives for improvement. This section also outlines our proposed initiatives that will support us to deliver our key priorities. These form the key recommendations for developing primary care in the locality.

Priority 1: Expansion and development of primary care estates

Background

There are widespread and large scale planned increases in housing across the South West locality. Multiple practices face significant increases to their list sizes in the next 5-20 years that require a coordinated and strategic estates approach so that primary care capacity can meet the demand of the future population.

Planning permission has been accepted for 11,300 homes in the next 5 years and almost 20,000 homes in the next 10 years. In addition, there are proposals for large new housing developments on the following sites:

- **Wantage:** 12,000 proposed new homes
- **Dalton Barracks site (northwest of Abingdon):** 6,000 - 14,000 additional patients expected, all requiring registration with Abingdon practices.
- **Berinsfield:** 1700 new homes in the next 10 years, which would increase the practice population from 4,850 to 9,000
- **Culham Science Park:** ~9,600 patients in the next 5-10 years

Objectives

Planning support - Short term (within one year)

The CCG are working with planning authorities at South Oxfordshire District Council and Vale of White Horse District Council to secure land and financial contributions to assist with estates growth across the locality. The CCG has linked in with all local Neighbourhood Development Plans (NDP) to ensure Primary Care Services are on the agenda for planning decisions.

Due to the complexity of the estates requirement in South West Oxfordshire, with a huge population growth across several sites, it is the intention of the locality to engage a planning officer to work at least two days per week in support of primary care development. This will use funds which had been allocated to the (currently vacant) post of Deputy Clinical Director for SWOL. The planning officer will perform the following functions:

- Act as a link person/project manager at the pre-planning and planning stages of new developments, coordinating between individual practices, OCCG, district councils and developers
- Help to prepare needs assessments, business cases and plans for new developments
- Ensure that an appropriate level of community infrastructure funding attached to new housing developments is allocated to healthcare infrastructure within the locality.

Forecasting increased rental costs for the CCG

Currently there is a brake on new primary care estates due to uncertainty about OCCG's budget for primary care rent reimbursement over the next 5-10 years. Greater clarity regarding the planned financial envelope for primary care rent is urgently required so that the locality can work more effectively with planners and developers: this work is already underway at OCCG.

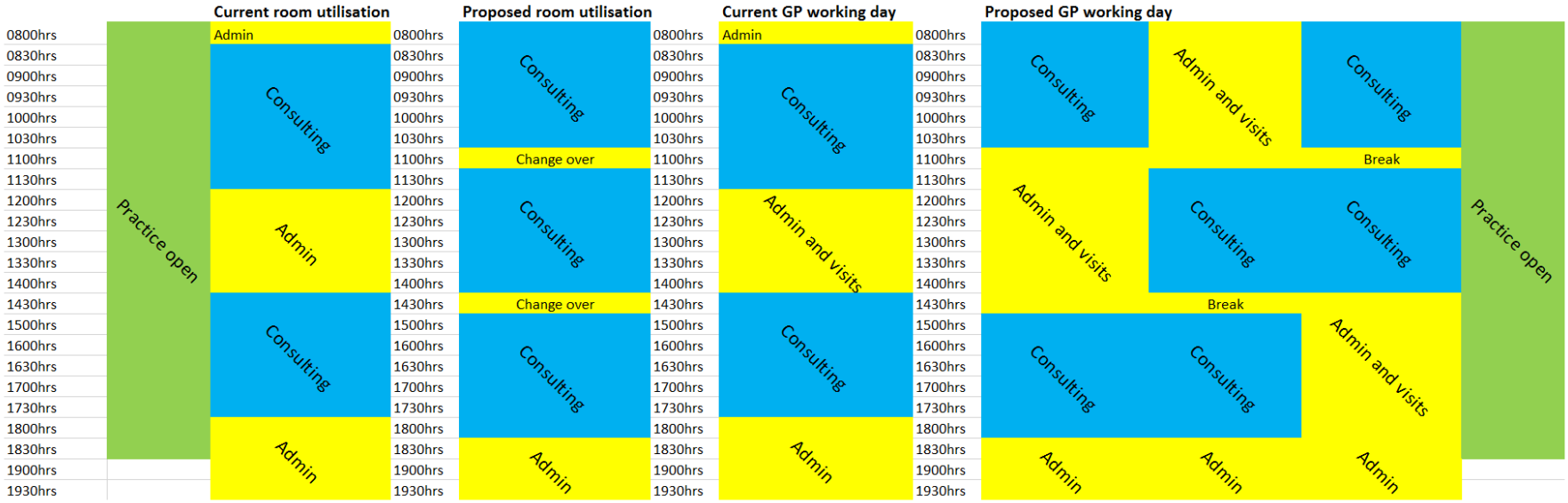
Using existing GP premises more efficiently

It is clear that a 30% population increase will necessarily result in higher overall rental costs for GP premises. However, the available budget is unlikely to grow by 30%. Practices need to start planning their room utilisation in light of this fact. For most practices, the limiting factor is the number of consulting rooms available for clinicians to meet with their patients. Some practices are already working towards solutions which increase the daily utilisation of each consulting room in the practice. Over the next three years, practices in which consulting space is (either already or forecast to be) problematic will consider the following changes:

- Currently a GP consulting room is used not only for consulting, but also for: checking of laboratory results and correspondence, writing or dictating letters, telephone calls, and personal administration such as continuing professional development. Typically the practice will be open for 10.5 hours, but any given consulting room only used by patients for 6-7 hours (divided between two surgeries of 3-4 hours).
- If a consulting room is used for 3 surgeries of 3 hours each, this would increase the capacity of the room as a consulting space by 30-50%.
- All other tasks (such as those listed above) could be carried out in a much smaller footprint, for example in a communal office with "hot-desking".

- While office space may be at a premium in some practices, adding one extra office room that could allow four GPs to work simultaneously (thus improving utilisation of four consulting rooms) will be substantially cheaper than building four consulting rooms.
- This will mean a change to the standard model by which GP sessions are contracted, allocated and paid for: previously this has always been done on the basis of a GP working in units of half a day. In the proposed model, a GP working day would usually be divided into three parts, two being face to face consultations and the third containing home visits and other activities.
- This change in working patterns represents a considerable start-up cost to practices, which must be weighed against the potential saving for the CCG, and practices pursuing these changes will:
    - Submit a business case to the CCG for funding to support the change with a one-off payment to support additional management time.
    - Offer to share or jointly develop such a business case with other interested practices
    - Offer to share or jointly develop the necessary changes to GP job plans, contracts, indemnity arrangements etc.

Figure X: Example room utilisation and GP working day using space more efficiently



This model has potential advantages for patients: appointments are spread more evenly through the day (good for working patients who would like an appointment during their lunch break), and a visiting GP is available in the mornings and late afternoons. An example is shown at Figure X.

Wantage: The housing growth planned for the Wantage and Grove areas over the next 10 years will amount to around 15,000 new patients. Currently both Wantage practices (based in the same building along with district nurses and some other Oxford Health staff) are almost at full capacity, and are working with the CCG and (owners of the premises) Assura to look at utilisation of existing space, reconfiguration and extension of the health centre. The extended building must facilitate the development of neighbourhood working with space for community staff, social care workers, shared AHPs, visiting consultant clinics and diagnostics.

Church Street and Newbury Street practices will take a leading role in the Phase 2 STP consultation over the future of Wantage Hospital's services (see below under Medium term). Should some services cease to be provided at Wantage Hospital (e.g. physiotherapy, midwifery), it is highly desirable that these services be rehoused locally in the health centre on Mably Way. This decision is time-critical within phase 2 of the STP consultation, because of the urgency with which the practice site needs to be extended.

Didcot: OCCG have prepared a procurement notice for a new practice to serve 20,000 new patients from Great Western Park and Valley Park, under an APMS contract. Build-out rates in these areas are such that this population will accumulate steadily over the next ten years. Existing practices in Didcot have indicated that they will not be bidding to provide services at the new health centre, but support the commissioning of services here by a new provider.

NHS Property services are working with the local planners at South Oxfordshire District Council and Vale of White Horse to examine a 'statement of need' to ensure the large growth planned and on-going across Didcot will be assured of access to Primary Care health services. The GWP development has been allocated 0.2 hectares of land together with approximately £500K of Section 106 contributions to assist with a new GP practice build to serve the residents across both the GWP and the Valley Park developments. Building on this site may need to be phased, to avoid the extra costs of under-utilised buildings.

Didcot Hospital's services will also be considered within the Phase 2 STP consultation. This site could provide additional space for primary care by yielding space to the adjacent Woodlands Health Centre. Both the hospital and the adjacent mental health departments are possible sites for expansion of Woodlands Health Centre. Oxford Health will work with Woodlands and the CCG to develop this option during 2018.

Faringdon: The registered population is growing steadily, and is approaching the maximum capacity of the health centre. A number of possible opportunities have been identified to provide space for an additional 5,000 patients over the next 5-10 years:

1. For a capital investment of £350,000, the practice could be reconfigured on its current footprint, providing additional consulting space without additional ongoing rental increases for the CCG.
2. The health centre could be extended to give additional space, requiring the current owner of the building (Nexus Ltd.) to agree an increased rent with the CCG following these works.
3. Space currently occupied by district nursing, health visiting and physiotherapy services could be yielded back to the practice, and these services moved to new purpose-built premises close by (there are a number of potential sites within half a mile of the health centre).

The practice and CCG need to identify and begin developing their preferred option for the White Horse Medical Practice in the next six months.

Medium term (within 3 years)

The **Wantage** Mably Way health centre (incorporating the Church Street and Newbury Street practices) will be extended in order to provide additional capacity for population growth in Wantage and Grove. Additional capacity for 10,000 patients is required within the next 5 years.

The future of services at Wantage Community Hospital will be considered within the STP, but there will be an ongoing need for estates to support physiotherapy, midwifery, community nursing and visiting consultant clinics. The division of community services between the Mably Way site and the Wantage Hospital site needs to be planned carefully between Oxford Health and the Wantage neighbourhood primary care team. Consolidating community services on the Mably Way site may free up additional resources to fund development. This will of course be subject to the outcome of the Phase 2 STP consultation. Wantage Hospital still has a small midwife-led unit, but no longer has inpatient rehabilitation beds or other community services.

Didcot: Building work on a new health centre will begin, currently proposed at Great Western Park (a 2000m^2 site has been allocated for this).

Faringdon: consideration needs to be given to enhanced diagnostics and visiting specialist clinicians in Faringdon to serve the growing population. In the medium term a shared use of some of the current clinics in Wantage may help. The White Horse Medical Practice team will lead these proposals, with support from the federation and locality teams where required.

Abingdon:

There are a number of large housing developments planned around this area, currently on four sites:

Development	**Units**	**Patients**
North Abingdon	950	2280
NW Abingdon	200	480
NW Radley	240	576
Dalton Barracks	1200-4420 (numbers not fully submitted)	2880-10608
	Totals :2590-5810	**6216-13944**

At present we do not know the full extent of the growth on the Dalton Barracks site. We are working closely with the Vale of White Horse Planning team to secure initial developer funding from the other three sites, together with some land on the North Abingdon site. These plans have been discussed with the locality and the options would be looked at a branch practice of the Long Furlong Practice.

Berinsfield:

The Berinsfield regeneration scheme will have a direct impact on the delivery of Primary Care in this area, with plans to build around 1700 extra homes. This would double the current list size of the practice. This scheme was launched in September 2017 by South Oxfordshire District

Council (SODC) with major local community involvement. This is an area of noted deprivation and the CCG is keen to support the regeneration programme.

As part of regeneration scheme the Berinsfield practice have been given opportunity to move to a new and more central site in the area. The site would be a Community hub housing not only the GP practice but a gym, coffee shop with a potential for other secondary care services to support this community.

SODC are keen to continue to have health facilities for the local population if this area is to be successfully regenerated. The plan is to have this scheme up and running within 2-3 years and planning permission will be submitted by end of 2017. SODC are working closely with the local residents to regenerate this area. As part of this regeneration scheme other areas such as transport will be upgraded to improve access to other larger conurbations.

Culham Science Park:

Culham Science Village has plans for 4000 units/9600 patients, developers have allocated a site for new health provision to include a 4 GP practice and have suggested this as an option to SODC and the CCG. The 2 closest practices are Clifton Hampden and Berinsfield; the site is roughly equidistant from Didcot and Abingdon.

The Locality felt the best option would be to support the current Clifton Hampden practice with a planned move to a new build on the Culham site. Their existing site would be problematic to develop to serve the new 9,600 patients. This would give the practice sustainability for the future. The build out growth rates of this type of development would over a 5-10 year period but we do need to ensure the strategic planning is in place to support the new growth as a Locality. This development may not be built for a number of years, but the locality team will continue to shape plans over the next 3 years.

Priority 2 – Expansion and integration of clinical workforce to ensure sustainable primary care

Background

- South West Oxfordshire faced an unprecedented level of population growth in the next 5-20, this must be matched with a primary care workforce that ensures services are sustainable.
- The number of GPs required to meet the increasing population is shown in table X (Required GP recruitment to 2022 based on planned retirement and growth).
- This renders all practices potentially vulnerable because of the difficulty recruiting clinical staff, particularly GPs.
- The fragility of the GP workforce, and the rurality of South Oxfordshire, means that a system of neighbourhood hubs or urgent treatment centres would risk taking vital resources away from existing practices. Cooperative working between practice teams is therefore preferred to
- The increasing population is an inevitability as many planning applications for new housing already approved or are already being built; therefore primary care in the South West locality must build a workforce that can meet the population's demand for care.

Objectives

- Develop and implement a workforce model that is based on GP-led multi-disciplinary teams including (in all practices) nurses, HCAs and care navigators and (in all neighbourhoods) physiotherapists and clinical pharmacists; allied health professionals will work at practice or neighbourhood level depending on local need. The ValeMed visiting service is a successful example of this at federation level.
- All practices in the locality will work with OCCG and the Clinical Education Provider Network to plan training requirements and programmes for their non-GP clinical workforce. The locality expects that in turn the CCG and CEPN will foster partnerships with Oxford Health Foundation Trust and Oxford Brookes University as providers of training.

All practices are potentially vulnerable because of difficulty recruiting staff, and increasing list size. The roles of allied health professionals need to be developed in order to support the GP workforce.

The workforce model will be based on GP-led multi-disciplinary teams including (in all practices) nurses, HCAs and care navigators and (in all neighbourhoods) physiotherapists and clinical pharmacists; allied health professionals will work at practice or neighbourhood level depending on local need. The ValeMed visiting service is a successful example of this at federation level.

The fragility of the GP workforce, and the rurality of South Oxfordshire, means that a system of neighbourhood hubs or urgent treatment centres would risk taking vital resources away from existing practices, and moving primary care further from patients' homes. Cooperative

working between practice teams is therefore preferred to creation of new stand-alone primary care centres (with the exception of Didcot's new practice).

Short term (1 year)

All practices in the locality will work with OCCG and the Clinical Education Provider Network to plan training requirements and programmes for their non-GP clinical workforce. The locality expects that in turn the CCG and CEPN will foster partnerships with Oxford Health Foundation Trust and Oxford Brookes University as providers of training.

1. An integrated training framework for healthcare assistants will enable them to expand their roles into activities which are often performed routinely by practice nurses:
    - Immunisations and injections (this HCA training must include additional training for the practice in developing safe and efficient systems for patient-specific directions to administer treatment).
    - Ear syringing
    - Recording of physical observations
    - 12 lead and ambulatory ECGs
    - Ambulatory blood pressure monitoring
    - Simple wound care and dressings
    - Smoking cessation
    - Assistance with minor surgery
    - Doppler ultrasound measurements
    - Spirometry

The Royal Colleges of General Practitioners and of Nursing have produced a framework of competencies for healthcare assistants working in primary care, and this is a starting point for individual practices to consider priorities for development with their nursing and HCA teams. The CCG's practice nurse educational coordinator will help practices across the locality to find appropriate training and mentoring for HCAs wanting to develop new skills. Practices with experienced nurse mentors may be able to provide some training "in house" for others in the locality.

2. Federations will work with practices who are recruiting doctors, to develop more attractive portfolio roles for new GPs, for example combining work in one or more practices with a more specialised clinical role such as pain management or interface medicine, or an enhanced educational role across the federation.

    The first steps towards this goal are laid out below. Federations might choose to cooperate in some or all of these areas, in order to reduce duplication of workload:

    - Each federation to appoint a GP recruitment lead (likely an existing practice manager)

- Each federation to develop a short list of potential components to a local portfolio career. Some of these may need to be explored with existing GPwSI colleagues, with specialist departments, or with the deanery
- A recruitment pack will be developed to describe and promote this scheme. For example to be attached to job advertisements and to be presented/circulated to GP trainees in the region.
- Representatives from federations or from the locality will travel to local deanery groups of GP registrars at least once per year, to present local career opportunities to trainee GPs.
- Practices will cooperate within neighbourhoods or federations to offer short term contracts to GPs who are newly qualified or new to the area, allowing them to work regularly for a short period (weeks or a few months) in a number of different practices.

3. The role/skillset of care navigators is of increasing importance in a more diverse primary care workforce, so that patients are educated and signposted to what may be unfamiliar ways of accessing the care they need. The locality will hold a care navigator workshop open to staff of all practices, and establish training and mentoring arrangements at neighbourhood or federation level.

Medium Term (3 years)

District nurses and Practice Nurses should work more closely together as a team of Primary Care Nurses. This would reduce duplication of work, enhance communication and improve shared education and expertise. There would be obvious difficulties to overcome initially as they have different employers, but this could be facilitated by a shared management structure developed through a Joint Enterprise between the federations and Oxford Health. These nursing teams should be managed at neighbourhood level, but individual clinicians would be expected to work consistently with just one or two practices.

Federations will explore opportunities for employment of specialist doctors and nurses working in primary care, probably alongside their work within one of the Foundation Trusts. Initially this will focus on services for patients with diabetes and frail elderly patients, because these align respectively with the CCG's diabetes plans and the provision of ambulatory and outreach geratology services in the locality. Specialists will see patients locally and have an additional role in educating and supporting clinicians in Primary Care.

Priority 3 – Efficiency through shared administrative/support services

Background

- There is substantial duplication of administrative/support services across all practices in the locality, with every practice independently taking responsibility for activities such as contracts, human resources, estates management and services, telephony and websites.
- In many cases these activities could be supported more efficiently through shared management at neighbourhood/federation level.
- To build trust between practices, and prevent expensive short-term reorganisation of the non-clinical workforce, this will be a phased process over five years at least. However, there is acceptance among practices that our strategic thinking should be geared towards less duplication of non-clinical work, and the existence of federations allows us to take the first steps towards this goal.

Objectives

Short term (1 year)

- Federations will share staff and other resources in pursuit of the following common tasks: some elements of preparation for CQC inspections; infection control; protocols and ordering of supplies.
- Job advertisement and other recruitment activities will be coordinated at federation level. This will reduce duplication of workload, and facilitate practices to advertise split jobs or utilise existing employees within the federation.
- Participation in primary care research (which enhances patient education and allows additional university-funded care processes and staff to be integrated with the primary care team) will be organised and supported at federation level: in Abingdon, academic funding has been secured to pump prime this integration and help pay for a shared research nurse.
- Delivery of some mandatory training will be shared across the locality, e.g. basic life support training organised by one practice will be offered to staff from all practices.
- When new administrative staff are employed or take on new roles, practice managers will offer this as an opportunity for shared training with other practices (over the next three years this will be developed further so that practices become more uniform in their systems, facilitating joint working and setting consistently high standards).

Medium-long term (3-5 years)

- Practice managers will work flexibly across practices (at federation or neighbourhood level) with centralised responsibility for HR, recruitment, payroll, management of contracts.
- Back office services such as document scanning and summarising will be shared to produce efficiencies of time and costs
- Shared training of administrative staff has already started with medical terminology courses. Practices will further develop these shared educational sessions for non-clinical staff (at neighbourhood or federation level), with the long term aim of standardising non-clinical processes across practices
    - To allow centralisation of some of these processes at neighbourhood/federation level
    - To allow movement of staff between different practice sites when additional short-term resources are required

Priority 4 – Integration of clinical records

Background

- Information sharing agreements within Emis Web already exist between practices in each federation, for the purpose of delivering the GP Access Hub appointments.
- Other community services use a range of paper-based and electronic clinical records, which are not integrated with the main primary care health records held by practices.
- Emis Web is the system by which patients currently have access (should they wish) to their own health records.

Objectives

- Improved EMIS interoperability is essential if practices are to truly share workload and deliver either clinical or non-clinical services at neighbourhood/federation level
- Shared IT facilities are also essential for community and primary care services to become fully integrated
- IT solutions can improve patient access to primary care services.

Short term (1 year)

The Locality will invite a representative from Emis Web to one of our executive meetings to discuss:

- Use of resource publisher to share Emis reports, clinical templates and documents between practices in the locality.
- Opportunities for generating shared reports for contracts and research activities.
- New services coming on stream including Emis Online Triage, and the possibility of purchasing these services at either CCG or Federation level.
- How to bring Emis Web records into care homes.
    - How practices could improve uptake of patient online access

We will plan and initiate a pilot to allow bookable consultations using Skype or a similar service, with the aim of using this:

- To replace some face to face consultations for patients who are unable to attend the practice, including in care homes.

- To improve access outside normal practice opening hours (replacing some extended hours appointments currently delivered at the practice).
- To allow patients to attend their local practice for the purpose of consulting online with other health professionals (e.g. in secondary care clinics – a telemedicine vascular leg ulcer service is currently available for patients in Bicester)

ValeMed practices are exploring the use of e-consultations and will report on this work to the locality.

District nursing teams (initially as a pilot in Wantage) will use Emis Web to record limited but up-to-date information for all patients on their caseload. It is a longstanding ambition among GPs that district nurses should use Emis Web as their primary clinical record. This remains outside locality control, but we are committed to improving the use of Emis by community teams.

Care Navigators will feed into the development of the MyCoach website, improving the quality and breadth of information and social prescribing resources for patients.

Medium-Long Term ambitions

- There will be fully integrated, secure, fast and reliable IT systems enabling patient records to be shared across primary care, nursing homes, community services and mental health and hospitals.
- Patient records will all be held electronically
- Clinical letters will be sent in real time.

Priority 5 – Improving health outcomes for frail patients

Background

The population of 85+ year olds is expected to double by 2030. Frail and elderly patients require primary care to be delivered in an integrated fashion. These patients have often been identified already by GPs and community services. As the older population increases, so will the population living in nursing and residential homes. Most significant housing developments in South West Oxfordshire therefore include one or more new care homes. The prevalence of frailty in nursing homes is high by definition, and proactive care in these settings is enhanced by continuity of care and by good communication between medical and nursing staff. Locality GPs do not currently have a strategic role in planning of medical services to care homes.

The presence of two Emergency Multidisciplinary Units is a major strength for acute care of frail patients in the locality. Abingdon EMU is available to all patients in the locality, and Witney EMU is also used by patients in Faringdon.

Objectives

- Early identification of health/social care crises in frail adults
- Care of frail adults in the least acute setting which is appropriate to their needs.
- Move more acute services from the John Radcliffe and Great Western Hospitals to EMU and community settings in the locality.

Undertake a joint analysis with Abingdon EMU and the Integrated Locality Team, of rapid access (same day or same week) services available locally for frail/elderly patients. Aim to publish a short summary of care pathways and resources to GPs and integrated locality teams.

Meet clinicians from Abingdon EMU to explore the factors currently limiting their capacity, and ensure that primary care and other community services are making most efficient use of this resource. Work with EMU to develop a business case for increased capacity within this service.

Increase the number of care homes and practices who participate in the Proactive GP Support to Care Homes enhanced service: consider how these services might be organised at neighbourhood level. Federations could help the CCG by highlighting what changes need to be made to the enhanced service specifications, in order to facilitate this evolution of the service. Greater coverage of nursing homes by the enhanced service would allow creation of more intermediate care beds in the locality, with the possibility that these are used for step-up as well as step-down care.

Undertake further work in subsequent versions of this locality plan, to detail current plans for care home growth in the locality, including bed numbers and anticipated implications for local practices.

Explore with OUH the possibility of using existing intermediate care beds in nursing homes to support Abingdon EMU, so reducing the number of patients who need to be transferred to the John Radcliffe Hospital because care cannot be arranged at home.

Planning for the future

In response to the key objectives outlined in each of the priorities, we have recommended 26 workstreams. Each workstream responds to the challenges of at least one priority. The chart below indicates how each initiative aligns to the different priorities

		Priorities					
#	Workstreams	Expansion of premises	Expansion and integration of clinical workforce to ensure sustainable primary care	Efficiency	Integration of records	Improving health outcomes for frail/ elderly patients	Improving general access to primary care services
1	Using existing GP premises more efficiently	■	■				
2	Estates Workstreams	■	■				
3	Culham Science Park	■					
4	Design of new teams at neighbourhood level		■				
5	Integrated training framework for healthcare assistants		■				
6	More attractive portfolio roles for GPs		■				
7	Recruitment of care navigators		■				
8	District nurses and Practice Nurses to work more closely together as a team of Primary Care Nurses		■				
9	Federations to employ specialist doctors and nurses in primary care		■				
10	Shared admin at a federation level (short term)		■	■			
11	Shared training at a locality level (short term)		■	■			
12	Participation in primary care research			■			
13	Shared admin at a neighbourhood or federation level (long term)			■			
14	Shared training at a neighbourhood or federation level (long term)			■			
15	Explore possibilities of e-consultation			■	■	■	■
16	Expanded use of EMIS capability				■	■	■
17	Improved interoperability				■	■	■
18	Urgent visiting service (in hours)					■	■
19	Expand capacity in EMU in Abingdon						■
20	Coordinated care home support from practices					■	

The table below provides additional detail for each workstreams. Each row documents how each workstream would be implemented and what it will do and provides an approximate costing and list of benefits to the locality.

Proposed solution	Delivery scope	Benefits	Existing funding (£)	New funding (£) required	Implementation steps	CCG support	Duration
Using existing GP premises more efficiently	- Practices to consider changes to room utilisation/ usage: • Use each room for 3 surgeries of 3 hours each. • Non-clinical tasks occur in smaller rooms, e.g. hot-desking in a shared office. - Change the model by which GP sessions are contracted, allocated and paid for: • GP working day would be divided into three parts, two being face to face consultations and the third containing home visits and other activities.	More efficient use of rooms; - Changing room usage will increase consulting space capacity by 30-50%. - Shared office space will result in improved utilisation of consulting rooms - Appointments are spread more evenly through the day (good for working patients to visit in their lunch break), and a visiting GP is available in the mornings and late afternoons.	No	tbc	Individual or collaborating groups of practices: 1. Submit a business case to the CCG for funding to cover start up costs and additional management time 2. Determine the feasibility of changes to the GP model (job plans, contracts, indemnity arrangements etc). 3. Secure funding and agree changes to GP model 4. Implement changes to practices in a staggered manner	tbc	Delivery over 3 years, benefits realised within 1 year
Managing the growth in Wantage population	- Increase the estate capacity of Church Street and Newbury Street practices for 10,000 patients in the next 5 years and facilitate the development of neighbourhood working with space for community staff, social care workers, shared AHPs, visiting consultant clinics and diagnostics. - A decision will be made on how community services are divided between the Wantage Health Centre site and the Wantage Hospital site in phase 2 of the STP consultation; e.g. physiotherapy, midwifery, community nursing and visiting consultant clinics. This must be taken into account as part of any changes to primary care estates in Wantage.	- Potential to rehouse health services in centre - Patients have sufficient access to primary care services in the area	No	Yes	1. Oxford Health to meet practices and developers to discuss configuration of community services at Mably Way/Wantage Hospital. 2. After decision has been made, write and submit a business case to the CCG and NHSE for funding that is based on services that must be delivered (including Wantage hospital or not). 3. Secure funding 4. Commence building of new estate	tbc	3 years – dependent on STP consultation
Didcot: Great Western Park	- Build a new health centre at Great Western Park (GWP) for an additional 20,000 patients over the next 10 years, built in phases (or with shared occupancy in the short term) to avoid the extra costs of under-utilised building	- Patients have sufficient access to primary care services in the area	£500k of section 106 funding secured and 0.2 hectares allocated at the GWP development	Yes	1. Procurement notice for provision of APMS services for up to 20,000 patients in Didcot. 2. Either new provider or CCG (depending on provider preference) to then develop the site using capital from a private developer.	tbc	Building to commence within 3 years
Faringdon practice expansion	- Increase medical centre capacity to meet ongoing population growth in the area.	- Patients have sufficient access to primary care services in the area		Yes	Practice/CCG/Nexus to agree preferred option from three listed in plan.	tbc	Within 6 months
Faringdon enhanced	- Offer enhanced diagnostics and visiting specialist clinicians, initially this could be in conjunction with Wantage clinics.			tbc	1. White Horse Medical Practice team to develop specification for enhanced service offering	tbc	3 years

service offering					2. Practice team, the CCG and Vale of White Horse planning team to work together to secure developer funding for internal re-configuration of the practice with potential to expand the car park 3. Secure funding for enhanced services		
Abingdon expansion	- Expand premises to meet the housing expansion; this could be a branch practice of the Long Furlong Practice			Yes	1. Determine the model for expansion e.g. branch site 2. Work with Vale of White Horse Planning team to secure developer funding from all 4 sites together with some land on the North Abingdon site 3. Tender for further private finance to fund capital project 4. Submit business case to CCG for funding of ongoing rent 5. Secure funding 6. Commence building of new estate	tbc	3 years
Berinsfield	- Move the Berinsfield practice to a new and more central site in the area that would act as a community hub that also offers secondary care services - Provide services for the 2000 extra homes being built in the area (doubling the current list size)	- Support patients in a deprived areas with improved access to primary care services		Yes	1. Work with the South Oxfordshire District Council (SODC) to determine if Berinsfield regeneration scheme will go ahead and the impact on primary care	tbc	2-3 years
Culham Science Park	- Increase capacity of primary care to meet the plans for building 4000 units (9600 patients) in the area. - A possible solution is to build a new estate for the Clifton Hampden practice to move into on the Culham site	- Patients have sufficient access to primary care services in the area		Yes	- Work with the SODC and the CCG as plans for the Culham Science Park emerge for the size and timeline of the development so that a strategic plan can be developed	tbc	5-10 years
Design of new teams at neighbourhood level	- GP-led multi-disciplinary teams including (in all practices) nurses, HCAs and care navigators and (in all neighbourhoods) physiotherapists and clinical pharmacists; allied health professionals will work at practice or neighbourhood level depending on local need.	- Enable them to expand their roles into activities which are often performed routinely by practice nurses:	n/a	Tbc: Project manager / protected GP time	1. Scope work 2. Secure funding	tbc	
Integrated training framework for healthcare assistants	- Based on the Royal Colleges of General Practitioners and of Nursing framework of competencies, provide HCAs with training for: • Immunisations and injections • Ear syringing • Recording of physical observations • 12 lead and ambulatory ECGs • Ambulatory blood pressure monitoring • Simple wound care and dressings • Smoking cessation • Assistance with minor surgery • Doppler ultrasound measurements • Spirometry	- Enable HCAs to expand their roles into activities which are often performed routinely by practice nurses - Free up practice nurse capacity to perform other tasks	n/a	Yes	1. Work with OCCG and the Clinical Education Provider Network to plan training requirements and programmes for their non-GP clinical workforce 2. Test and agree training specification with locality GPs and the CCG 3. Determine how much training can be delivered in house by nurse mentors and at what scale 4. Secure funding from the CCG for training	tbc	1 year

	- CCG's practice nurse educational coordinator to direct practices to appropriate training and mentoring for HCAs						
More attractive portfolio roles for GPs	- Combining work in one or more practices with a more specialised clinical role such as pain management or interface medicine, or an enhanced educational role across the federation. - Federations will explore opportunities for employment of specialist doctors and nurses working in primary care.		n/a	Potential GP protected time	1. Test and agree with locality GPs and the CCG the schemes to be implemented 2. Each federation to appoint a GP recruitment lead (likely an existing practice manager)	tbc	1 year
Recruitment of care navigators	- Train existing staff to the role through delivering workshops for all practices, and establish training and mentoring arrangements at neighbourhood or federation level.	- Patients are educated and signposted to what may be unfamiliar ways of accessing the care they need.	No	Consider altogether better model / training of receptionists	1. Work with OCCG and the Clinical Education Provider Network to plan training requirements and programmes for their non-GP clinical workforce 2. Determine the number of care navigators required and how many can come from existing staff in the locality and how they will be integrated into the current primary care system 4. Communicate to practices the new training opportunity for care navigators 5. Conduct training and integrate into services	tbc	1 year
District nurses and Practice Nurses should work more closely together as a team of Primary Care Nurses	- Implement a shared management structure for a nursing team through the Joint Enterprise - Nursing teams would be managed at neighbourhood level, but individual clinicians would be expected to work consistently with just one or two practice	- Reduced duplication of work, enhanced communication and improved shared education and expertise	Existing OH contracts	Funding model to be agreed across OCCG (novation of contracts)	Federation and OH to scope	tbc	3 years
Federations to employ specialist doctors and nurses in primary care	- Federations will explore opportunities for employment of specialist doctors and nurses working in primary care, probably alongside their work within one of the Foundation Trusts, e.g. for patients with diabetes or frail elderly patients. - Specialists will see patients locally and have an additional role in educating and supporting clinicians in Primary Care	- Improved primary care services provided - Increased training opportunities offered to primary care workforce	n/a	tbc	Federation to scope	tbc	3 years
Shared admin at a federation level (short term)	- Some elements of preparation for CQC inspections; infection control; protocols and ordering of supplies - Job advertisement and other recruitment activities will be coordinated at federation level	- This will reduce duplication of workload, and facilitate practices to advertise split jobs or utilise existing employees within the federation.	n/a	tbc	Federation to scope	tbc	1 year
Shared training at a	- Mandatory training will be shared across the locality; e.g. basic life support training organised by one practice will be offered to staff from all practices	- Practices become more uniform in their systems, facilitating joint working and	n/a	No	Federation to scope	tbc	1 year

locality level (short term)	- When new administrative staff are employed or take on new roles, practice managers will offer this as an opportunity for shared training with other practices	setting consistently high standards					
Participation in primary care research	- Research organised and supported at federation level - In Abingdon academic funding has been secured to pump prime this integration and help pay for a shared research nurse	- Enhances patient education and allows additional university-funded care processes and staff to be integrated with the primary care team	n/a	No	n/a	tbc	1 year
Shared admin at a neighbourhood or federation level (long term)	- Practice managers to work flexibly across practices with centralised responsibility for HR, recruitment, payroll, management of contracts - Shared back office services; document scanning and summarising	- Efficiencies of time and costs for back office functions - This will reduce duplication of workload, and facilitate practices to advertise split jobs or utilise existing employees within the federation	n/a	No	Federation to scope	tbc	3-5 years
Shared training at a neighbourhood or federation level (long term)	- Shared training of administrative staff has already started with medical terminology courses. - Practices to further develop shared educational sessions for non-clinical staff	- Centralisation of some of these processes at neighbourhood/ federation level - Standardised non-clinical processes across practices - Allow movement of staff between different practice sites when additional short-term resources are required	n/a	No	This direction of travel is agreed by all practices, but we recognise that to build trust between practices, and prevent expensive short-term reorganisation of the non-clinical workforce, this will be a phased process over five years at least. This process will be a standing item on the agenda for regular practice manager meetings in the locality	tbc	3-5 years
Explore possibilities of e-consultation	- A pilot for first bookable online consultations using Skype, with the aim of using this facility	- Replace some face to face consultations for patients who are unable to attend the practice, including in care homes - allow patients to attend their local practice for the purpose of consulting online with other health professioals (e.g. in secondary care clinics)	n/a	Tbc	tbc	tbc	1 year
Expanded use of EMIS capability	- Engage EMIS and practices on the practicality of: • Use of resource publisher to share Emis reports, clinical templates and documents between practices in the locality. • Opportunities for generating shared reports for contracts and research activities. • Use of new services coming on stream including Emis Online Triage, and the possibility of purchasing these services at either CCG or Federation level.	- Practices have ability to share workload and see each other's patients - Shared IT facilities are also essential for community and primary care services to become fully integrated	Yes: EMIS clinical licence	Yes: EMIS Clinical Services license extension – current costs unknown but likely low.	CSU to manage implementation steps for digital support	tbc	1 year

	How practices could improve uptake of patient online access						
Improved interoperability	- Fully integrated, secure, fast and reliable IT systems enabling patient records to be shared across primary care, community services and mental health and hospitals. - Patient records will all be held electronically - Clinical letters will be sent in real time - Group consulting will be possible on-line using tele-medicine - Education for the patients and health professionals will be enhanced by use of MY COACH - Patients to have access to their own records on a portable basis	Full sharing of the EMIS GP record with colleagues in community and mental health services would make care of patients across those services better informed and coordinated, removing the need for regular and unreliable telephone and letter contacts for information.	Yes: EMIS clinical licence	As above.	CSU to manage implementation steps for digital support	tbc	3-5 years
Urgent visiting service (in hours)	- Locality-based home visiting service led by GPs who provide assessment and treatment in the working day in addition to planned GP home visits and EOL care. -(current plan to continue this for ValeMed practices only)	Reduced admissions Relieves pressure on general practice in hours	No – as delivered currently	No	n/a	tbc	Recurrent
Expand capacity in EMU in Abingdon	- Expand capacity at the EMU at Abingdon	Reduced admissions Better care closer to home	Yes	Funding from activity shifted within OUH contract	1. Gap analysis done by clinicians from general practice, ILT and EMU. 2. Business case for expanded role prepared by EMU team.	tbc	Recurrent
Coordinated care home support from practices	- Amend the LES so care home support can be provided by the federation; partner with OUH to use beds for step down care from EMU as well as John Radcliffe Hospital.	Better care for patients in care home Reduced admissions	Yes. Change to LES; change to OUH intermediate care budget	No (tbc)	To scope	tbc	Recurrent

Key messages:

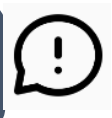
South West's key focus is on the following key areas:

- Expansion of premises
- Expansion and integration of clinical workforce to ensure sustainable primary care
- Efficiency
- Integration of records
- Improving health outcomes for frail/ elderly patients
- Improving general access to primary care services

In response to these priorities, our plan documents 26 different initiatives which act t as the key recommendations of this document as well as a strategy for the development of primary care within the locality.

Part G: Making a success of our plan

Part G describes what is required from different parts of the system in order to deliver the work streams proposed. It also lays out where CCG support is needed to achieve these desired outcomes.



Workforce

To confirm inclusion of this section.

Estates

Lack of current primary care estate capacity and shortfall in future capacity:

The survey of practices requested information on additional capacity with current staffing, with results set out in Table X. Taking into consideration future housing developments this results in a projected shortfall in estates capacity as set out in table x.

Table x: Potential capacity for additional patients with no changes to estates and staffing

Neighbourhood	Potential additional capacity with current staffing/estates
Faringdon	650 patients (White Horse Medical Practice)
Wantage	None
Didcot	1,500 patient (Oak Tree Health Centre)
Abingdon	600 patients (Clifton Hampden Surgery)
Total for Locality	2,750 patients

Table x: Projected shortfall in primary care estates

Neighbourhood	Projected shortfall in primary care estates (number of registered patients above current estates capacity to nearest 500)				
	2017-18	**2018-19**	**2019-20**	**2020-21**	**2021-22**
Faringdon	0	500	1,500	2,000	2,500
Wantage	1,500	3,000	4,500	6,000	7,000
Didcot	0	2,500	5,000	7,500	9,500
Abingdon	2,000	3,500	4,500	5,500	6,000
Total for Locality	**3,500**	**10,000**	**16,000**	**21,000**	**25,000**

Condition of current GP premises – 6 facet survey
Oakleaf surveyed 86 GP Practice Premises across Oxfordshire in 2017, reporting on 6 areas:

- Physical Condition
- Functional Suitability
- Space Utilisation
- Quality
- Statutory Compliance
- Environmental (only completed for a handful of sites)

They also surveyed the cost of maintenance work that is both outstanding (backlog) and which will be needed to be completed over the next 5 years (budget).

For this backlog and budget work they gave each item a risk score

The total backlog across 86 premises in Oxfordshire was £667K, of which £151K was classed as high or significant risk.
Only two premises in South West Oxfordshire were identified as having a (high or) significant risk backlog:

Premises	Total Backlog	High Risk Backlog	Significant Risk Backlog	Moderate Risk	Low Risk	Risk Adjusted Backlog
Malthouse Surgery inc. Appleton Village Hall	£86,750	£0	£10,000	£61,350	£14,800	
Marcham Road Health Centre	£2,300	£0	£800	£300	£1,200	£850

Functional, Physical, Utilisation and Quality of Buildings
This was split into 4 categories A to D with C and D deemed as the premises not being suitable. An overall grade was also given based on how the site scored on functionality, physical condition and quality.

Overall Grade of Site	Number of Sites
A - Good. Performing as intended.	3
B - Satisfactory. Performing as intended, minor deterioration.	69
C - Poor. Exhibiting defects and/or not operating as intended.	28

D - Bad. Life expired and/or serious risk of imminent failure.	0

The table below shows all the South West Locality sites that were unsatisfactory (a C or D) for at least one of the categories. It should be noted that no calculations on available space were done as part of the survey and therefore some of the categories are a little subjective.

Premises	Total Backlog	Budget	Physical Condition	Functional Suitability	Space Utilisation	Quality
Clifton Hampden Surgery	£2,000	£35,900	B	C	Fully used	B
Berinsfield Health Centre	£8,400	£27,900	C	B	Fully used	C
Malthouse Surgery inc. Appleton Village Hall	£86,750	£113,180	C	D	Overcrowded	C

Statutory Compliance

All sites were graded for statutory compliance (A to D), with Oaktree Health Centre being the only practice in Oxfordshire to achieve an A or B rating. Most sites didn't meet statutory compliance on safety glazing and compliance with disability discrimination act. The table below shows South West Locality sites which require at least £3K to resolve.

Premises	Areas of non-compliance	Cost to resolve (£)
Berinsfield Health Centre	Safety glazing, Disability Discrimination Act, Hot Water Outlets, Surface temp of devices	6,100
Marcham Road Health Centre	Asbestos, Safety glazing, Disability Discrimination Act	4,150
Malthouse Surgery	Safety glazing, Disability Discrimination Act, Hot Water Outlets, Surface temp of devices	17,600

Digital

Technology and digital health care provision will play an increasingly significant role in general practice service delivery, and will be a key enabler in delivering South West's workstreams and achieving proactive, accessible and coordinated care. In order to best address the needs described in this plan, there should be a focus on maximising the use of technology available; empowering patients and ensuring there is interoperability between systems and across providers. Primary care teams of the future will need to rely less on co-location, and instead be able to come together virtually around a patient to design services. People should be empowered with information about their care that supports them to participate in care planning; helps set personal health goals; and enables them to better manage their own health independently.

Particular priorities include:

- Interoperability of records: In future, community and mental health workers in the locality would be able to at least access the EMIS GP record via EMIS Clinical Services, allowing them to see valuable clinical information about patients in their care and to enter their own information into those records for other clinicians
- New consultation types that release time for GPs and improve access for patients.

Funding

Information on the costs of delivering the plans is drawn from current schemes and from assumptions on future activity, drawing on good practice from other sites, where appropriate. Assumptions on individual workstreams are set out within each priority area.

Future investment may be subject to a business case that set out the case for change and impact in greater detail.

Key messages:

In order to deliver this plan, there are 4 key enables that must be considered:

- **Workforce –** focus on retention and recruitment as well as utilising different staffing skill-mixes to meet community demand
- **Estates** - ensuring that services are delivered from appropriate venues in terms of geographical location, size and upkeep
- **Digital** – utilise digital technology to improve access and help deliver patient centric care through increased technological capability and improved interoperability
- **Funding** – understanding where funding can be allocated most efficiently to meet the needs of the community outlined in this plan

Appendix 1: References

1. Oxfordshire CCG Primary Care Framework March 2017
2. GP Forward View April 16
3. BOB STP plan

Appendix 2: Patient and Public engagement and involvement

The OCCG shared a draft version of the Locality Place Based Plan with the South West Oxfordshire Locality Patient Forum (SWOLF). The majority of PPG groups shared the whole plan with their PPG members. Please see below some of the comments made:

- If services are to be delivered from a more central location within the locality the CCG will need to factor in transportation as a major issue for patients who live out in rural communities.
- SWOLF felt there should be more detail on the housing growth in the Locality especially the Didcot Garden Town Development.
- SWOLF wanted to know where the current services are located, what the vision is for the future and what the offer and integration will be for each town.
- There were concerns raised about levels of staffing across the SW and how these would be addressed.
- SWOLF suggested a more information to practices to help with sign posting patients for self-care.
- The CCG should explain the detail of streamlining contracts

Evidence to support the locality place based plan

The information on the current estates configuration and suitability of the current estates infrastructure is drawn from 6 Facet survey undertaken on behalf of the CCG/NHS PS by Oakleaf Group in February to March 2017, as well as a local survey carried out by the locality in early 2017.

The information on current workforce has been provided by existing practices/organisations. This information has been aggregated and combined with the used to develop the future workforce model as below: Future capacity and workforce needs are estimated by modelling the impact on primary care of future demography and housing growth.

Information on the costs of delivering the current model is drawn from current schemes already in operation across Oxfordshire.

This plan will be iterative and aligned with emerging plans from other Transformation Programme workstreams such as Urgent Care and Planned Care.