Locality Place Based Primary Care Plan: South East Oxfordshire Locality

Contents

Foreword

Locality Clinical Director:
Dr Edward Capo-Bianco

This is an exciting opportunity for the South East Locality to form a plan around how primary care will be delivered to our patients in the next 5 years and possibly extending out to 10 years. This might involve working at greater scale, sharing some services between practices at a Neighbourhood and Locality level.

Patients value the services that are provided by GPs in the locality, which is reflected in the high scores from the patient satisfaction survey. Given the geographic spread of our area, maintaining individual practices is important for on-going patient care. Practices wish to maintain their own services, continuing the GP partner model in the main, although there could be potential for mergers or third party ownership.

We have an opportunity to work more closely as a federation, building on the excellent work in setting up the GP Access Fund (GPAF) as a rotating hub thereby benefiting all of our patients rather than a few. This offers more appointments for patients in all practices. Information technology hurdles for this were overcome fairly quickly given the scale and Dr Mark Bish and Dr Andrew Burnett are to thank for this.

There are challenges with practice infrastructure and succession planning, but these are opportunities to look at the model of primary care in the South East. Recruiting new GPs is becoming more difficult across England and Oxfordshire, and although we are relatively protected in SE Oxfordshire, this is likely to become more of a reality and problem for us in the coming years. Those practices that are not training practices reportedly find it more challenging to recruit GPs.

Increased building in the locality and rising demand from an older population will have a great impact on our facilities. Practices themselves are likely to need to expand to create additional consulting rooms, and also consider alternative elements to the workforce. Practices have already looked at upskilling their own workforce, developing the healthcare assistant and nurse role, employing advanced nurse practitioners to broaden the scope of who the patient can see and what can be offered by the practice, whilst working with colleagues in wider teams to support increasingly frail and older patients in the community. We look forward to working with all practice staff and other stakeholders to make this plan a reality.

South East Oxfordshire Locality Executive Summary

Locality Overview:

Our locality consists of ten GP practices covering a population of 93,302 (January 2018). There is no single population centre and primary care provision is based on small town and village centres.

The population is generally more affluent than the Oxfordshire average and has a higher level of private healthcare use, which might take some of the pressure off local NHS & secondary care services but not primary care.

What is working well:

- Rotating hub for practices to host extended hours sessions for all patients with record sharing
- Practices see any patient with an urgent health care need on the same day and offer routine appointments within a week
- 7 of the South East practices are approved for GP training
- New ambulatory care service at Townlands in Henley
- Minor Eye Conditions Service provided by optometrist in Oxfordshire
- Good individual practice links with voluntary sector/services.
- 7 practices have excellent PPGs which collaborate to form SELF
- Training to ensure there is a 'Carers Champion' in all practices.

Key locality challenges:

- South East Oxfordshire has a much older population than average in England and Oxfordshire and is largely rural, creating challenges for access.
- There is no single population centre and care is quite dispersed.
- South East also contains a number of practices which are close to capacity, both in terms of rooms and clinicians.
- As patient numbers rise due to the increased housing developments this will become a key challenge for the locality.

Key priorities for the South East Oxfordshire locality

We have identified three key priorities for the locality and 15 specific workstreams which will support us to deliver each priority.

#	Workstreams	Sustainable Primary C…	…rc for an …ion	Preventative & Self Care
1	Estates expansion	■		
2	Succession planning for practices	■		
3	GPAF – rotating Hub	■	■	
4	Sustainability Fund	■	■	
5	Ambulatory Care Model (Henley)		■	
6	Ambulatory Care Model (Thame)		■	
7	Support for patients at risk of dementia		■	■
8	Care Home Initiative		■	
9	Better integration of Social Care	■	■	
10	Mental Health Services – closer working with locality teams for adults and young people		■	■
11	Good access to local diagnostics	■	■	
12	EMIS Clinical Services interoperability			■
13	Carers Support		■	■
14	Locality Expertise - Dermatology service			■
15	Signposting and social prescribing	■	■	■

Part A: Introduction: Approach to developing the plan for the South East Oxfordshire locality

Part A describes how the South East 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

Good primary care is the bedrock of a high-quality and cost-effective health system. The NHS has traditionally given greater priority to primary care than other health systems worldwide, which is generally accepted as key to its success and pre-eminence internationally in effective, safe, coordinated, patient-centred care and in efficiency. However it is well known and clear that investment in primary care has not kept pace with investment in other parts of the healthcare system, which is why there are currently such pressures on practices and services.

The Oxfordshire Primary care Framework highlighted the importance of investing in the sustainability of General Practice, and supporting it to be the lynchpin in our health and care services. Transformation of these services will require new thinking and new models of care and delivery. The new model of primary and community care in Oxfordshire will be based on a number of operational principles:

- Delivering appropriate services at scale
- Organised around geographical population-based need based on the practice registered list
- Delivering care closer to home
- A collaborative, proactive system of care
- Delivered by a multidisciplinary neighbourhood team
- Supported by a modernised infrastructure, including an improved and fully integrated IT system.

This together with the GP Forward View (GPFV) and local implementation plan will ensure that primary care remains the cornerstone of the NHS in the future. The plans will remain iterative: as the population changes and the way we deliver healthcare evolves, we will continue to work with patients and clinicians to ensure that primary care remains responsive, accessible and of high quality.

This locality plan forms part of the Oxfordshire transformation programme.

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 care 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 and patients to both describe and develop a South East locality place based plan for the delivery of sustainable primary care and support for the model of moving care closer to home. It involves using the Oxfordshire CCG Primary Care Framework and opportunities outlined in the GP Forward View to achieve this aim.

2.1 Clinical Locality Forum meetings:

- The South East Locality meeting on 6th June 2017 was used to discuss the plan and was assisted by an external facilitator with representatives from each practice. This built on work previously outlined by Andrew Burnett before retirement.
- The locality plan has been on the agenda at all the recent South East Locality Group (SELG) meetings from June to September.

2.2 Patient participation:

- There is an active forum of patient participation groups in the locality whose representatives meet as South East Locality Forum (SELF).
- Information from PPGs is delivered through SELF to SELG and SELF was involved in the 6th June locality meeting.
- The Locality Clinical Director met separately with our locality deputy chair in September to go through the plan in detail, which resulted in expanding the detail on certain aspects of the workstreams.
- In addition, Oxfordshire CCG held an event in Wallingford on 28 November 2017. The workshop allowed local people to share their views on how GP and primary care services in their localities could be organised. The workshop and an online survey (for anyone unable to attend the workshops) enhanced the direction of the plans agreed by the CCG, local GP practices and patient representatives during the past six months.
- This feedback has helped to shape and inform the locality plans, in particular:
    - Updated housing projections in line with updates from SODC including incorporating Chalgrove into projections and estates
    - Inclusion of financial assumptions and affordability of the plan
    - Additional information on proposals to pilot care navigation.
- A full summary of feedback from the Patient Forum, from the workshop in Wallingford and subsequent patient feedback on the draft plan published in November 2017 are highlighted in Appendix 1.
- If any proposals require significant changes that could adversely impact patients a more formal consultation will be undertaken for the specific service area.

Key messages:

The South East 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 the South East clinical community is adequately captured.

Part B: The demographics of the South East Oxfordshire population

1. Summary

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

1.1 Population

Our locality consists of ten GP practices covering a population of approximately 93,302[1]. There is no single population centre and primary care provision is based on small town and village centres. The population has low levels of deprivation and has a higher than average level of private healthcare use, which might take some of the pressure off local NHS & secondary care services but not primary care. As the population is mainly rural, there is difficulty accessing local services such as GP practices and social support. Consequently, services struggle to provide to these patients/service users. Poor public transport between the villages can make it difficult for residents to access services.

1.2 Age

21% of the locality population is over 65 years of age (Oxfordshire average: 17%). The number of people over 65 in the South Oxfordshire district as a whole increased by 24.6% between 2001 and 2011.

There are expected to be significant increases in the older population in the locality over the next ~15 years.
Currently, 3 of the wards in Oxfordshire with the highest rates of over 65 year olds
are in the South East locality, Goring (second in the County) has 1,654 people aged over 65 years,
representing 28.7% of the population, Henley North (fourth) has 1,560

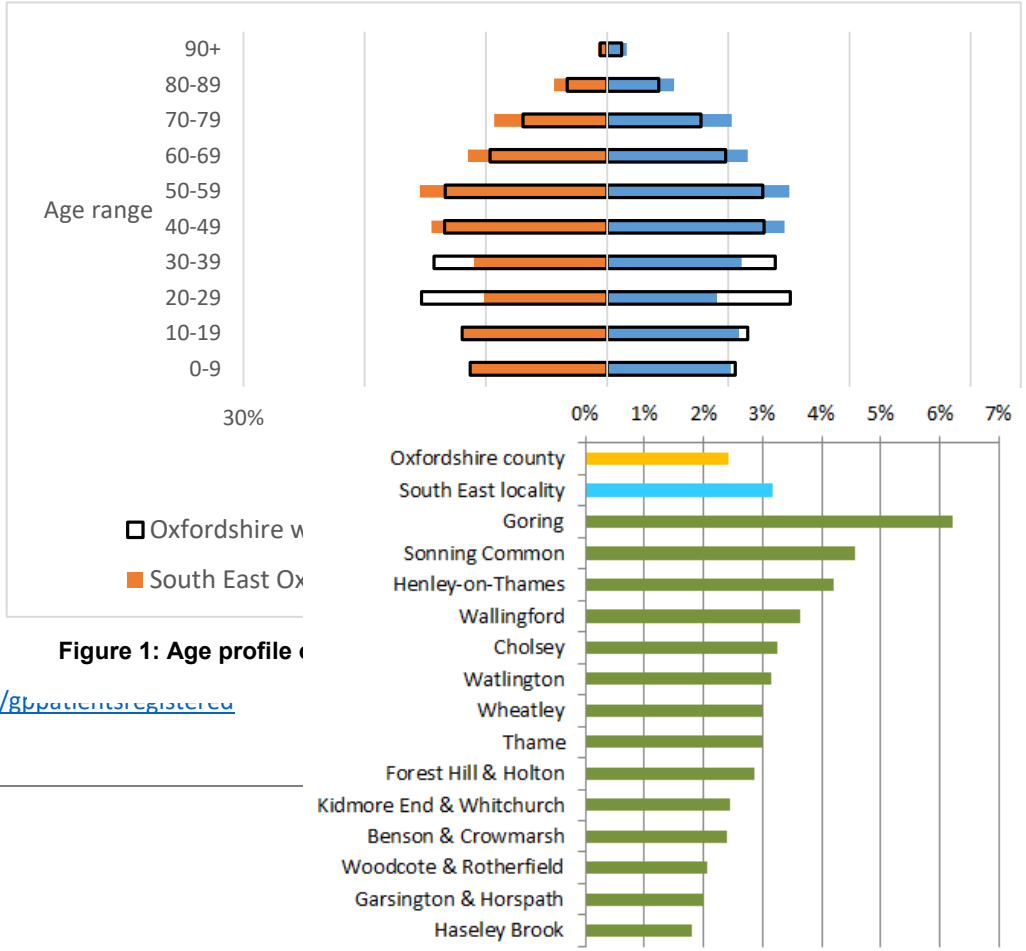


Figure 1: Age profile

[1] Practice list size data published by NHS Digital Jan 2018 at: http://content.digital.nhs.uk/gppatientsregistered

representing 27.8% and Sonning Common (sixth) has 1,478 representing 27.1%. It is estimated that 3,000 people in South East Oxfordshire are aged 85 or over. This is accounts for 3.2% of the population, significantly above the Oxfordshire county average (2.4%). The ward of Goring has three times the average population aged 85+ (6.2%).[2]

1.3 Deprivation and rurality

There are no significant areas of deprivation in the South East as per the Oxfordshire Joint Strategic Needs Assessment (JSNA), but there are pockets which each practice can identify. The area is quite rural, with poor transport links, so accessing healthcare and other services can be difficult if patients do not have their own car. Equally, provision of services to those patients is also difficult due to the large area and cost of living for the health and social care workforce, e.g. providing care for people in their own homes.

Elderly patients, living in their own home with early dementia or who are physically frail, are reliant on formal/informal carers, family, community transport services to access care etc. To address these issues it will be important to maximise the offerings of with 3rd sector, e.g. Age UK, befriending service and PPGs. For example, Age UK has opened a new falls services in Goring – Generation Games, as well as other locations around the locality, which supports the frail elderly in South East Oxfordshire.

Figure 2: % of the population in SE Oxfordshire aged over 85 years

1.4 Care home population

There is a large number of care homes and beds in the locality, which brings with it an increased demand on primary care and frail, multi-morbid, dependent patients. As of June 2017 there were a total of 21 care homes with 795 care home beds in wards in South East locality, not taking into account some care homes outside Oxfordshire e.g. Coombe House in Streatley, Berkshire with 24 residents and registered with Goring Surgery. This is very likely to grow as the population ages and we are working closely with the planners on the impact on provision of primary care.

1.5 Carers

[2] Source: ONS mid-2015 population estimates by ward

From the 2011 census, 61,000 people in Oxfordshire said they provided some level of informal care to a relative or friend. The proportion of carers by district mirrors the age structure of each district so for the South approximately 10% of people are providing informal care[3].

Demands on carers are well recognised: their caring role can have an impact on their own health and make it difficult for them to access healthcare for their own needs. Having an up to date register of carers in a practice is important, as well as supporting carers groups and having a carers champion in the practice who can act as a point of contact and be able to signpost patients and their carers to information on services.

1.6 Housing growth

The population of South East Oxfordshire has risen by 2.1% over the last 3 years and will continue to rise, with substantial housing development expected in the South East locality.

Projected growth based on number of homes planned is 20% in the next 10 years to 111,000, as set out in table 1. This includes significant growth at Chalgrove airfield site with up to 3,000 homes to be built by 2033. The current primary care workforce capacity and infrastructure in the locality are not sufficient for this challenge.

Table 1: Projected housing increases in South East Oxfordshire to 2026/27 by neighbourhoods[4]

	Housing Growth – 5 years	Population Growth 5yrs	Housing growth – 10 years	Population Growth 10yrs

[3] https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/publichealth/PH_AR_2016-17.pdf

[4] Data provided by OXIS - Oxfordshire County Council 2017-2035; population growth assumes average 2.4 people per dwelling. The South Oxfordshire draft Local Plan 2033 is going through a period of consultation (Oct/Nov17) prior to submission for Independent Examination.

	2017/18	2018/19	2019/20	2020/21	2021/22	5 year total	5 Year Total	2022/23	2023/24	2024/25	2025/26	2026/27	10 year total	10 year total
Neighbourhood 1 (Henley and Sonning Common)	112	161	221	201	309	1,005	2,411	211	105	73	43	43	1,478	3,548
Neighbourhood 2 (Wallingford, Goring and Woodcote)	165	357	324	427	324	1,598	3,834	306	291	177	60	56	2,486	5,967
Neighbourhood 3 (Thame, Watlington and Wheatley)	274	286	170	399	450	1,580	3,791	436	436	461	369	309	3,589	8,614
South East Oxfordshire	**552**	**803**	**716**	**1,026**	**1,084**	**4,182**	**10,036**	**952**	**831**	**710**	**471**	**407**	**7,554**	**18,130**

2. The health of our community in the South East Oxfordshire locality

2.1 Health status

No wards in the South East locality have a higher death rate for people aged under 75 than predicted by the age of the local population. There are no wards in South East locality that had an average admission ratio for intentional self-harm above the England average.[5] However, areas with a younger population appear to have higher rates than the rest of the locality, which should inform community mental health team services and input/location. This suggests that the location of Community Mental Health Teams (CMHT) for the South East are well sited in Wallingford Community Hospital.

The SE locality has lower than CCG average prevalence for diabetes, but higher prevalence of Asthma, atrial fibrillation (AF), hypertension and COPD as per QOF data 2016-17[6]. The variance in AF and hypertension is likely explained by the older population; asthma and COPD is possibly down to air quality variance. Prevalence data for a number of conditions is set out in table 2.

Table 2: Prevalence of QOF conditions

	2016/2017 Prevalence %						
	Hypertension	**Atrial**	**Asthma**	**COPD**	**Depression**	**Dementia**	**Diabetes**

[5] Data source: Hospital Episode Statistics (HES), NHS Digital. Self harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year.
[6] http://content.digital.nhs.uk/qof

		Fibrillation					
Neighbourhood 1 (Henley and Sonning Common)	13.6%	2.5%	6.3%	1.2%	6.9%	1.1%	3.5%
Neighbourhood 2 (Wallingford, Goring and Woodcote)	14.5%	2.5%	6.5%	1.5%	9.9%	1.2%	3.9%
Neighbourhood 3 (Thame, Watlington and Wheatley)	13.5%	2.2%	6.5%	1.4%	7.5%	0.7%	4.2%
Oxfordshire	**12.1%**	**1.7%**	**5.7%**	**1.4%**	**7.7%**	**0.7%**	**5.0%**
England	**14.1%**	**1.8%**	**6.1%**	**1.8%**	**9.3%**	**0.8%**	**6.7%**

Key messages:

South East has 10 GP practices covering a population of approximately 93,300. The locality has no areas of significant deprivation although it does have a high number of care homes and beds. As of June 2017, there were a total of 21 care homes with 795 care home beds in wards in South East locality The locality is generally healthy.

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

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

1. Overview of Primary & Community Care

1.1 Summary of practice provision

Two of the practices cover the same area in Henley but otherwise practices in the South East locality are geographically distinct. The GP patient survey shows generally good satisfaction with the practices.

The population is spread across groups of distinct villages with 3 small towns on the periphery – Henley on Thames, Thame and Wallingford. A map of all practices in the locality is at figure 5.

Table 3: Neighbourhoods and practices in the South East Locality

#	Neighbourhood /Practice	List Size (1st Jan 2018)
	Neighbourhood 1 – Henley and Sonning Common	**31,727**
1	The Hart Surgery (Henley)	10,424
2	The Bell Surgery (Henley)	8,577
3	Sonning Common	8,830
4	Nettlebed	3,896
	Neighbourhood 2 - Wallingford, Goring and Woodcote	**31,423**
5	Wallingford	16,819
6	Goring/Woodcote	9,732
7	Mill Stream (Benson)	4,867
	Neighbourhood 3 – Thame, Watlington and Wheatley	**30,157**
8	Rycote (Thame)	11,824
9	Chalgrove/Watlington	7,430
10	Morland House (Wheatley)	10,903
	South East Oxfordshire Locality Total	**93,302**

1.2 Access to general practice in South East Oxfordshire Locality

The GP patient survey reports a high level of satisfaction with GP practices in the South East locality. Themes from the survey were that access was good, the vast majority of respondents were able to make an appointment that was convenient, though not necessarily with a GP of choice, confidence was high across all practices with GPs/nurses, and patients would generally recommend their practice to new patients to the area. Low satisfaction in a couple of practices with seeing a GP of the patient's choice could be improved by having a well-advertised 'buddy' system with another GP or their registrar if that GP is a trainer.

The GPs in the locality have established a provider federation, SEOX. It has enabled the introduction of the GP Access Fund extended hours service, providing routine GP and HCA/nurse appointments to patients outside of core practice hours. Each practice hosts an extended hours session on a pro rata basis covering Monday to Friday 1830 to 2000 and Saturday and Sunday 0900 to 1200 for routine GP and HCA/nurse appointments. Patients can be seen at any practice but have to be booked through their own practice so that their record is visible to the clinician. Informal feedback from practices is that most practices see their own patients and there is very little travel between practices. This suggests that this service is being used as an overflow appointment system, with the advantage that as a rotating service it is fairly benefitting all patients, rather than a few which might be the case if there were a hub in a single location. Feedback from patient engagement on the future of primary care in the locality indicates that patients value both the number of same day appointments and the continuity of care that is offered by practices working in this way.

Figure 5: Map of practices in the South East locality

Through the sustainability fund, practices have also signed up to a commitment to see any patient with an urgent health care need on the same day and to be able to offer a routine appointment within a week, although not necessarily with a clinician of the patients' choice. Practices have achieved this either through operating a triage system, training their nurses to be nurse practitioners to see minor illness or employing more salaried doctor sessions. This is important for patients as it improves access to their GP surgery, which is one of the key features patients rate their practice on, as well as continuity.

Care for more complex, elderly patients is provided through an ambulatory care model that reduces demands on secondary care and helps to keep patients at home. Patients in the Henley area can be referred to the Rapid Access Care Unit (RACU) at Townlands Hospital in Henley which is run by specialist doctors in elderly care, nurses, an occupational therapist and physiotherapists. As the service is not always at capacity, they have proactively contacted practices to support them. Patients in Thame can access a Community Assessment and Treatment Service, which provides rapid access to a community geriatrician and multidisciplinary assessment and treatment. There is potential scope to expand this to Wheatley, Chalgrove & Watlington and Wallingford.

For patients in care, a care home initiative funds GPs and care homes to work together to manage their patients/residents. One of the aims of this is to prevent unnecessary use of acute services through proactive care plans and discussions with family, which is a key way of keeping these patients in the community rather than acute trusts, sharing this information with the out of hours and ambulance services. This also relies

on other members of the primary care team, including district nurses and the palliative care team, e.g. expansion of the Sue Ryder CNS to facilitate end of life care in the community. In addition Sue Ryder Hospice provides support and expertise to patients with palliative care needs, through their Clinical Nurse Specialists, visiting patients at home and providing day therapy services.

2. Secondary care

The southern half of the SE locality looks to the Royal Berkshire Hospital NHS Foundation Trust for secondary care services, whilst the rest looks to Oxford University Hospitals with some of Thame looking to Buckinghamshire Health Trust.
Patients in the South East locality are generally lower than average users of A&E, MIU and emergency admissions for 2016/17 (figure 3), but had higher levels of first outpatient appointment referrals (figure 4), particularly the Reading facing practices. Reasons for this are not absolutely clear, but referral pathways and patterns for those practices may be reviewed.

More routine care may explain the reduction in emergency care, or the elderly multi-morbid population, or the relative waiting times for appointments in Oxford compared to Reading.

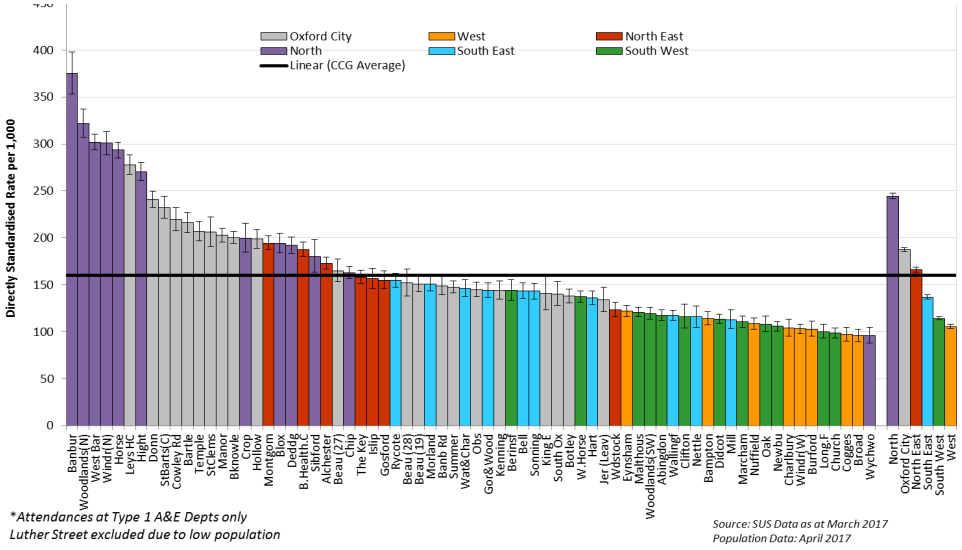


Figure 3: Emergency Admissions: direct age-sex Standardised Rate per 1,000 (April 2016 – March 2017)

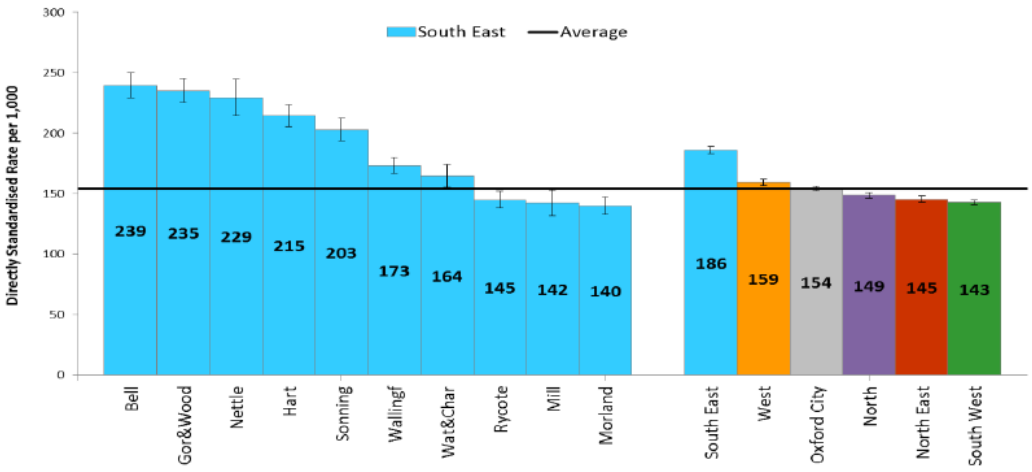


Figure 4: First Outpatient Appointments GP Referred, rate per 1,000 (April 2016 – March 2017

3. Community care

A range of community services are provided in the locality by Thame Community Hospital, Henley (Townlands) Community Hospital and Wallingford Community Hospital. Wallingford also hosts the integrated locality team. Full details of the services provided can be found in appendix 2. Many of the small rural communities have local voluntary organisations that support patients by, for example, providing transport to health appointments and carers groups. As many of the services for patients in Thame are run by Buckinghamshire Healthcare, it is important to ensure that is good integrated working between organisations across the two counties.

4. Primary care workforce

Primary care is delivered in South East Oxfordshire according to the traditional partnership model. Clinician recruitment is difficult but our successful practices are generally seen as good places to work. The majority of practices are training practices and there is good retention among trainees. Recruitment difficulties are partly due to a national failure of workforce planning but also due to the high cost of living in Oxfordshire.

We have asked practices for capacity details, gaps in current staffing and known/planned for retirements. An assumption has been made of 2,000 patients per WTE GP, although this is likely to be impacted by:

- Intentions across Oxfordshire to move to longer 15 minute appointments for patients with greater needs
- Potential changes in skillmix and a greater role for signposting and community champions to support patients manage their long term conditions.
- The impact of future housing growth on GPs if services are delivered as currently is set out in table 4 at neighbourhood level. The overall projected shortfall in GPs does not include retirements over a 5/10 year period. Nationally, it is expected that up to 30% of the current workforce will retire in the next 3 years.

Table 4: Neighbourhood populations and future workforce requirements

Neighbourhood:	Projected population		
	Apr-17	Apr-22	Apr-27
Neighbourhood 1 (Henley and Sonning Common)	31,664	32,838	32,996
Neighbourhood 2 (Wallingford, Goring and Woodcote)	31,231	33,537	34,029
Neighbourhood 3 (Thame, Watlington and Wheatley)	29,897	32,158	32,278
South East Oxfordshire	**92,792**	**98,533**	**99,303**

Staff	Current workforce		
	Jul-17	Vacancies	Projected retirements 2-4 years
GPs	18.1	0	4.25
Nurses	7.2	0	-
HCAs	2.9	0	-
GPs	17.08	0	1.25
Nurses	6.44	0	-
HCAs	5.04	0	-
GPs	16.29	1	5
Nurses	6.69	0.6	-
HCAs	3.9	0	-
GPs	51.47	1	10.5
Nurses	20.33	0.6	-
HCAs	11.84	0	-

Required number GPs (FTE)		**Shortfall GPs excluding retirements (FTE)**	
Apr-22	Apr-27	Apr-22	Apr-27
19.5	20.1	-1.4	-2.0
19.2	20.3	-2.1	-3.3
18.4	21.0	-2.1	-4.7
57.0	61.5	-5.5	-10.0

Key messages:

Results from the patient survey demonstrated a high level of satisfaction with GP provision in South East Oxfordshire. Care for more complex, elderly patients is provided through an ambulatory care model that reduces demands on secondary care and helps to keep patients at home. By 2022 it is forecast that, due to planned housing developments and retirements, South East Oxfordshire will have a shortfall of 11 GPs in the locality.

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

Part D outlines the highest priority areas for primary care in South East 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 – Sustainable Primary Care

Background

Achieving sustainable primary care in South East Oxfordshire requires adequately responding to two key challenges:

- Infrastructure
- Workforce Succession planning.

Objectives

- Increase capacity in GP practices, especially in areas where the greatest patient increase is forecast.
- A greater use of clinicians other than GPs.
- Succession planning to ensure demand is met over the next 5 years, including consideration of how to make buying into a partnership attractive without the barriers of estates and support with mergers if required.
- Admin - Back office sharing and support, e.g. procuring of contracts, writing of policies/protocols, and training. All time consuming roles that might be more easily delivered at scale across practices/neighbourhoods and thereby reducing duplication of work.
- Greater working and sharing across the locality of GP expertise e.g. referring to dermatology service from Woodlands medical centre in Didcot for low and intermediate risk BCCs.
- A greater role in signposting for non-clinical staff, including for care navigators to support patients manage their long term conditions and signposting for receptionists so they can connect patients more directly with the most appropriate source of help or advice..
- Further development of IT/network. Now that the practices are linked in with EMIS Web, it would be ideal if the community nursing teams can use this system as their record of choice, so that the patient record is more or less in one place. The agreement and drive for this needs to come from Oxford Health.

- Whilst IT development in Oxford University Hospitals is continuing through their Cerner programme, which will interface better with primary care, it is important that this is also worked on at the Royal Berkshire Hospital where half of our patients receive care.

Infrastructure/Estates

Practices in the South East are close to capacity and the projected rise in patient numbers will require investment. Practices will need to expand their premises as well as increase staff in order to care for these new patients and it is important that infrastructure/estates plans develop in parallel with population increase and are available to meet demand in time and do not lag. In the short term, most practices currently report that they can sustain a small increase in patients, brought about by the increased house building, by an average of 250 per practice. This means that in the immediate short term, estates appear sufficient, however very quickly practices will reach capacity and need to expand, with some practices having limited scope for this on their current sites.

Some housing development plans are further ahead than others, and some funding has been secured for practice expansion e.g. Wallingford and Thame. There are examples of some housing plans in their early stages which could have a significant impact on the nearby practice. For example, Chalgrove airfield brings potential for 3,000 new homes resulting in 10,000 new patients. The locality co-ordinator continues to link in with all Neighbourhood Development plans (NDP) to ensure primary care remains high on the agenda in terms of developer funding to assist practices to expand.

Workforce succession planning

Given the challenges facing GP recruitment and a number of impending GP retirements, the South East realises that more must be done to realise the potential of utilising different kinds of clinical staff. Alternative solutions might need to be investigated, such as a pharmacist completing medication reviews, or a physiotherapist seeing MSK patients. The practices who are not training practices may want to consider becoming accredited for this, perhaps with support from current training practices. Our approach to this, and support from the CCG, is set out in part E.

The model of general practice in South East Oxfordshire works well and patient survey results suggest that it is appreciated by patients. Practices have said that they wish to maintain their own services, continuing the GP partner model in the main. Although recruitment within the locality has been good with a large number of training practices, a step change in the number of GPs will be required to maintain this model. In addition, there is an increasing trend for GPs to prefer different models of employment and ownership of estates can create a barrier to partnership. The aim of the plan is to address the needs of a workforce that is fit for the future.

We will work with practices to plan other services that can be developed, building on the success of the dermatology service. Memory clinics are a good example of services that can be delivered well in practices closer to home.

Priority 2 – Care for an ageing population

Background

The age profile of the population in Oxfordshire is becoming older compared the rest of the country; this challenge is compounded by the rurality of many patients which causes problems for immediate access.

Practices wish to continue to look after their frail elderly patients, but to have quick access to secondary care support if required for example at the RACU or in Thame. Linking in with this is social care for patients who require support in their own home to get over an acute illness. At present we use Single Point of Access (SPA), which works well in terms of having a single contact number, but capacity can often be an issue, particularly if urgent.

Practices in the South East, particularly the 5 RBH facing practices, are some of the highest referrers of patients in the County. Practices are low users of Oxford email advice lines when they tend to use RBH services, so developing new ways to access clinical advice, rather than outpatient appointments would be beneficial. e.g. use of advice and guidance on the e-referral system.

Patients with no or few complex needs (low-intensity patients) who require episodic urgent care are currently cared for by their own practices, rather than through a central hub. However, this is less appropriate for this part of the county, as a central hub is not beneficial for the majority of practices.

Objectives

In order to make improvements to urgent care provision, South East will look to establish a more integrated set of services that better reflect the needs of the population. By expanding capacity of the community and assessment treatment service at Thame to Chalgrove & Watlington, Wallingford and Wheatley more patients can be cared for in their homes and fewer will be inappropriately transferred into the acute setting. The care home initiative will seek to support care home services to also be more proactive in supporting those acutely unwell patients to enable them to reduce their length of stay in secondary care and recover at home where possible. We have a care home initiative across Oxfordshire to support patients with proactive care, which is being developed to include more care homes and to ensure that the wishes of patients and relatives are more accurately recorded so that care is personalised where possible to suit the needs of individual patients. This will be delivered directly by practices in the South East to ensure a high level of continuity care for patients.

South East will draw on the experience of the 3rd sector, e.g. Age UK, befriending service, PPGs and Public Health initiatives to promote self care prior to contacting the GP practice. The clear focus needs to be on prevention with the patient encouraged to take responsibility for their own health. Pharmacists can also play an important role in reducing the demand on services. This scheme will be delivered by the practices directly who will be able to ensure a greater level of continuity of care for patients, rather than through the federation or locums.

Better integration of Social Care with the Primary care team will ensure a more responsive acute care service for patients who need support acutely. Similarly, closer working between members of the CMHT and locality teams – based either on Neighbourhood or practice level – including older adult CMHT for dementia patients and CAMHS service for increasing adolescent/young adult patients - will provide more joined up care for patients with mental health needs and help them access the most appropriate services.

Priority 3 – Preventative and Self Care

Background

A central tenet of the GPFV is commitment to more initiatives around preventative care. Clear signposting and increased access to self-care information and resources can empower patients to play a more pro-active role in their healthcare. The benefits of this are that patients are less reliant on acute services and feel confident using services such as pharmacies to control their symptoms where appropriate.

Objectives

South East intends to use the COACH website as a key signposting tool to support patients. Practices/Patient groups will hold lists of the different services available to patients, and this information will be held/led by receptionists. We will pilot a care navigation programme that best serves the patient profile of South East Oxfordshire to help give advice, direct patients to appropriate services and empower patients with the confidence and information to look after themselves.

Care navigators in each practice will also be available to support and signpost carers in the community, looking after and supporting the carers to continue their care. If carers are better supported they are less likely to become ill themselves, impacting on the care that they can provide. In addition, we will continue to roll out active signposting training for receptionists to support them in sensitively exploring safe and appropriate options for patients so they can see the right clinician.

Oxfordshire CCG is also supporting all interactions across healthcare with a strategy for “Making Every Contact Count”. This is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. This approach will be rolled out across all health and social care services in Oxfordshire.

Planning for the future

In response to the key objectives outlined in each of the priorities, we have recommended 15 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**	**Sustainable Primary Care**	**Care for ageing population**	**Preventative & Self Care**
1	Estates expansion	■		
2	Succession planning for practices	■		
3	GPAF – rotating Hub	■	■	
4	Sustainability Fund	■	■	
5	Ambulatory Care Model (Henley)		■	
6	Ambulatory Care Model (Thame)		■	
7	Support for patients at risk of dementia		■	■
8	Care Home Initiative		■	
9	Better integration of Social Care	■	■	
10	Mental Health Services – closer working with locality teams for adults and young people		■	■
11	Good access to local diagnostics	■	■	
12	EMIS Clinical Services interoperability			■
13	Carers Support		■	■
14	Locality Expertise - Dermatology service			■
15	Signposting and social prescribing	■	■	■

The table below provides additional detail for each workstream. 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 solutions	Delivery scope	Benefits	Implementation steps	Duration
Estates expansion	Investment in GP practices to expand/increase capacity for rising population. Practices might consider mergers where it makes sense for logistical and financial reasons Use of £500k section 106 money to develop estates in Thame Use of £250k in Wallingford for developing estates Work with the developers and district council on appropriate primary care services to meet expansion at Chalgrove airfield.	Sustaining Primary Care. Continue to provide care closer to home	To confirm prioritisation process	Ongoing
Succession planning for practices	To look at Succession planning with practices, raise awareness and make sure plans are in place. This is particularly relevant for non training practices, e.g. Nettlebed and Chalgrove/Watlington with impending retirements or plans for population expansion.	Sustaining Primary Care.	Scope requirement Support	2017/18
GPAF – rotating Hub	While funding allows, to maintain the GPAF rotating hub model, to benefit access to all patients	Increased appointment availability to patients for routine care	N/A	Ongoing
Sustainability Fund	Current use of the STF £4/patient is to be able to offer good access to our patients. This includes same day access for urgent problems and the offer of routine appointments within a week.	Sustaining Primary Care	N/A	Ongoing
Ambulatory Care Model (Henley)	Continue the work in setting up Townlands RACU	Patient more able to be cared for in community rather than acute trust	Confirm capacity	Ongoing
Ambulatory Care Model (Thame)	Expand capacity of the community and assessment treatment service at Thame to Chalgrove & Watlington, Wallingford and Wheatley.	Patient more able to be cared for in community rather than acute trust	Confirm capacity Agree contract	Ongoing
Support for patients at risk of dementia	Increase uptake of memory assessment service in individual practices, or cross practice referral if not willing to sign up	Increased care and better identification of patients with dementia		Ongoing
Coordinated Care Home Support from practices	Proactive care and discussions with frail elderly, care plans reducing acute admissions and facilitating discussions with family. Care home support service to be more proactive in supporting those acutely unwell patients.	Recording patient and relative wishes, reducing unplanned admissions.		Ongoing
Better integration of Social Care	Better integration of Social Care with the Primary care team, more responsive acute care service for patients who need support acutely	Helping patients to stay in own home or finding intermediate bed out of acute hospital e.g. temporary care home placement	Tbc	From 2017/18

Mental Health Services – closer working with locality teams for adults and young people	Closer working between members of the CMHT and locality teams – based either on Neighbourhood or practice level – including older adult CMHT for dementia patients and CAMHS service for increasing adolescent/young adult patients		tbc	From 2017/18
Good access to local diagnostics	Continue good access to local diagnostics e.g. US, Echo & X-ray facilities		To confirm with planned care team	From 2017/18
EMIS Clinical Services interoperability	Key for Drs, District Nurses, AHPs to have access and can input to same clinical system, linking into both the OUHFT and Royal Berkshire Trust	Joined up record	CSU to manage implementation steps for digital support	From 2017/18
Carers Support	Carers champions in each practice, available to support and signpost carers in the community	Looking after and supporting the carers to continue their care	N/A	2018/19
Locality Expertise – eg dermatology service	Dermatology service at Woodlands available to South East practices for removal of low risk BCCs and other services that can be delivered in practices.	Planned care closer to home	Work with practices to agree referral routes	From 18/19 ongoing
Signposting, social prescribing and care navigation	Use of COACH website. Practices/Patient groups to hold lists of services available to patients, best held/led by receptionists. Appropriate care navigation programme piloting across 2 – 3 practices initially. Using the well-established local services to help inform and set up in other practices for the benefit of their patients.	Reduced social isolation; More sustainable use of primary care Better self care for patients.	July – Sept 2018: soft launch Oct 2018 onwards: service fully operational Sept 2019: annual review to assess impact	One year (tbc)

Key messages:

In response to South East Oxfordshire's 3 key priorities:

- sustainable primary care
- caring for an ageing population and
- preventative and self care

In response to these priorities the locality have designed 15 workstreams which act as the central recommendations for this plan and a strategy for the future of primary care within the locality.

Part E: Making a success of our plan

Part E 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.

Delivery of this plan represents a significant ambition for service improvement and requires strong collaboration from all parts of the NHS, local authorities, Health Education Thames Valley, the Oxford Health Science Network and the voluntary sector. This section sets out the support the CCG will provide, working with partners, across all localities and how they will apply in the South East. A key aim across all enablers is to strengthen practice sustainability.

1. Workforce:

A workforce of appropriate number, skills and roles is essential for delivery of the plans in the context of significant housing growth across Oxfordshire and an ageing population. In line with the Oxfordshire Primary Care Framework, the CCG is developing a workforce plan across the staff groups with the aim of

- increasing capacity in primary care;
- upskilling existing staff; and
- bringing in and expanding new roles.

This includes concrete working with partners to:

- Make Oxfordshire an attractive place to work, in particular areas that have had historical difficulties in recruiting
- Facilitate a flexible career path through developing specialist roles and encouraging professional integration
- Increase training capacity and encourage GPs to remain in the area where they have trained
- Consider implementing a local bursary or training and refresher scheme
- Recruit internationally
- Develop a career development framework for staff working in primary care
- Implement mentoring schemes for all staff groups with the support of experienced professionals
- Continue to support the introduction of new general practice support staff to take workload off GPs, such as physician
- associates, medical assistants, clinical pharmacists and advanced practitioners, building on the success of pharmacist and mental health workers in general practice
- Develop a standardised approach to the development and training of healthcare assistants

- Increase community-based academic activity.

Federations will have an important role in ensuring resilience in primary care and enabling practices to work at scale, for example offering employment models that enable practices to use resources flexibly across clusters and neighbourhoods.

Effective workforce planning requires:

- a detailed understanding of the health and wellbeing needs of the population
- opportunities to develop and design roles that are fit for the demand and needs of the population

The CCG will provide support at locality level for practices to model and plan the workforce appropriate for populations of 30-50,000. This may include sharing staff across practices provided the risks are mitigated or providing support for mergers, where requested by practices, to provide a greater level of sustainability. In the South East, particular consideration will need to be given to retirement planning, as a number of practices have 1 or 2 GPs planning to retire in next 2-4 years. With the proposed building development and anticipated increase in patient numbers across the locality, this would mean an additional 5.5 WTE GP in the next 5 years on top of the proposed retirements under current ways of working.

If broken down into Neighbourhoods:
N1 – retirements = 5, expansion = 0.5 WTE
N2 – retirements = 2, expansion = 1 WTE
N3 – retirements = 6, expansion = 1 WTE

Future plans in South East for federation development are currently being explored, in particular the potential to align SEOX with PML. Were this to go ahead, the federation might take on certain services.

2. Estates

The Primary Care estate across Oxfordshire needs considerable investment to make it fit for the future: some practices require capital investment now and large areas of housing growth will mean that infrastructure will need to be improved in order to deal with the population increase. As set out in the Oxfordshire Primary Care Framework, capital investment will only be partially through NHS sources and we will need to consider other sources (e.g. local authority bonds, developer contributions).

Neighbourhood	Current estates requirements and capacity	Future estates requirements

The CCG will need to prioritise schemes for estates developments in line with the overall resourcing available. Some practices need to improve or extend their premises so that they can continue to deliver mainstream primary care more sustainably and to a larger number of patients. Other practices have larger-scale ambitions to deliver services over and above what is generally provided in general practice, often in collaboration with other practices and in partnership with other NHS organisations, local authority and voluntary sector agencies. Both types of scheme will need to demonstrate innovation and maximise opportunities to work collaboratively, but for the larger-scale schemes, which are likely to come at a higher cost, a more comprehensive range of criteria will be used for prioritisation that are in line with the CCG's estates strategy and plans for primary care.

	Number of practices that require additional capacity now	Number of additional patients that could be taken without changing the estates	Number of additional patients in 10 years	Space available for future development
Neighbourhood 1 (Henley and Sonning Common)	1	approx. 3,000	3,500	Yes (2 of 4 practices)
Neighbourhood 2 (Wallingford, Goring and Woodcote)	0	approx. 500	6,000	Yes (2 of 3 practices)
Neighbourhood 3 (Thame, Watlington and Wheatley)	0	approx. 900	8,600	No
South East Oxfordshire	**1**	**4,400**	**18,100**	

Table 5: Current and future estates capacity and requirements

The CCG will additionally provide support for appraisal of estates solutions together with community health and local authorities, where relevant. This includes solutions that respond to developments in new models of care, or which have the potential to deliver direct financial efficiencies, for example through digitisation of notes or merged partnerships.

Currently, all practices within the South East are well sited to se [illegible] population area. The survey of practices asked whether there was an immediate or future need requirement for expansion. NHS Property Services estimates of space required to deliver primary medical care services was used to indicate future requirements. A summary of estates requirements is set out at table 5. Currently one practice requires additional capacity now; this will increase over the next 10 years as set out in the table.

The proposed significant population growth in Chalgrove is likely to necessitate a new facility or a significant expansion of current practice. The capital contributions for this are expected to be met by developer contributions under the community infrastructure levy (CIL) in line with the Planning Act 2008.

Some capital funding has been secured for practice expansion eg Wallingford and Thame, whilst others are in early stages. Revenue consequences for any future estates requirements will need to consider the use of current estates, including for community services and how efficiently current estates are utilised in line with changes to patients access services and the breadth of services delivered in primary care.

Clearly there is a balance between economies of scale and greater number of services that larger practices can deliver and the need for easy accessibility in a rural part of Oxfordshire. Support will be provided to practices that wish to consider merging with nearby larger practices to maintain their services while ensuring that they are appropriately sited to maintain access for patients.

Strategic estates requirements

The community hospitals (Thame, Townlands, Wallingford) all provide outpatient appointments for various specialties that are well liked and used by patients, rather than having to travel to the acute trust. Availability of diagnostics in these centres are also preferred by patients, so to maintain these services is important. Both Thame and Townlands have lost their inpatient bed units, in moving towards a more ambulatory care model. The low usage of the First Aid Unit in Wallingford does not justify its costs; however the higher volume of patients attending the MIU in Henley point to a well-used and well liked service that would be good to maintain.

3. Digital

'Digital' has a significant role to play in sustainability and transformation, including delivering primary care at scale, securing seven day services, enabling new care models and transforming care in line with key clinical priorities. In line with Oxfordshire's Local Digital Roadmap, the CCG's focus will be to support:

1. Records sharing for cross-organisational care, in particular Advanced CareNotes which are used by community and mental health services and are currently not interoperable with any other health record used by general practice (EMISweb and Vision) or secondary care (Cerner Millennium)
2. Citizen facing technology, including aligning portal plans and auditing apps that empower patient self management
3. Risk stratification and modelling to support care co-ordination, clinical decision support and referral management tools
4. Infrastructure and network connectivity, including shared network access and access to records by care home staff
5. Information Governance, developing confidence in primary care over how data is accessed.

We have been successful in the South East in setting up a link through EMIS Web and Vision so that records can be shared across practices to enable GPAF appointments to go ahead. There needs to be a way to share and see records entered by other professionals e.g. DNs, HVs, podiatry etc. Widespread use of EMIS Web seems most logical way of managing this.

Given half of the practices face RBH, it is really important that the work being done with digital interoperability at OUHFT, OH and GP practices, is also then shared with RBH (from a South East perspective).

Email and Skype consultations are not without risk, in particular as the model of face to face and telephone consultations works well in the South East. However, there may be scope for a Skype consultation service provided by the federation/locality given our link with EMIS Web. OCCG are looking at developing an online consultation tool that may help provide patients with an effective way of engagement with primary care resources. Patients should be strongly encouraged to use the current online services, in particular, access to their medical records providing them with rapid access to test results. Access to patient medical records will also allow patients to share their medical details with other NHS providers outside Oxfordshire who are not able to access patient records directly.

4. Funding

Implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. The vast majority of investment in primary care is determined through a nationally agreed formula. However, some additional funding that was secured through the Prime Minister's Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. Remaining funding will be allocated to the plans according to agreed criteria for prioritisation, including:

- Patient outcomes and experience
- Primary care sustainability
- Health inequalities and deprivation
- Alignment with national and regional strategies and other transformation programmes
- Whether they are able to be delivered successfully within the required timeframes, and
- Population coverage.

Oxfordshire CCG has responsibility for the review, planning and procurement of primary care services in Oxfordshire, under delegated authority from NHS England. The Oxfordshire Primary Care Commissioning Committee (OPCCC) carries out these functions and is chaired by a lay member[7]. Funding recommended by OPCCC for delivery of the plans across Oxfordshire in addition to current funding in the initial years is set out in table 6 below. This covers part of a longer term investment over the period of the plans and does not include investment in estates or future demographic growth, which is determined nationally.

[7] The papers and minutes of the OPCCC are available at: http://www.oxfordshireccg.nhs.uk/oxfordshire-primary-care-commissioning-committee-(opccc)-meetings

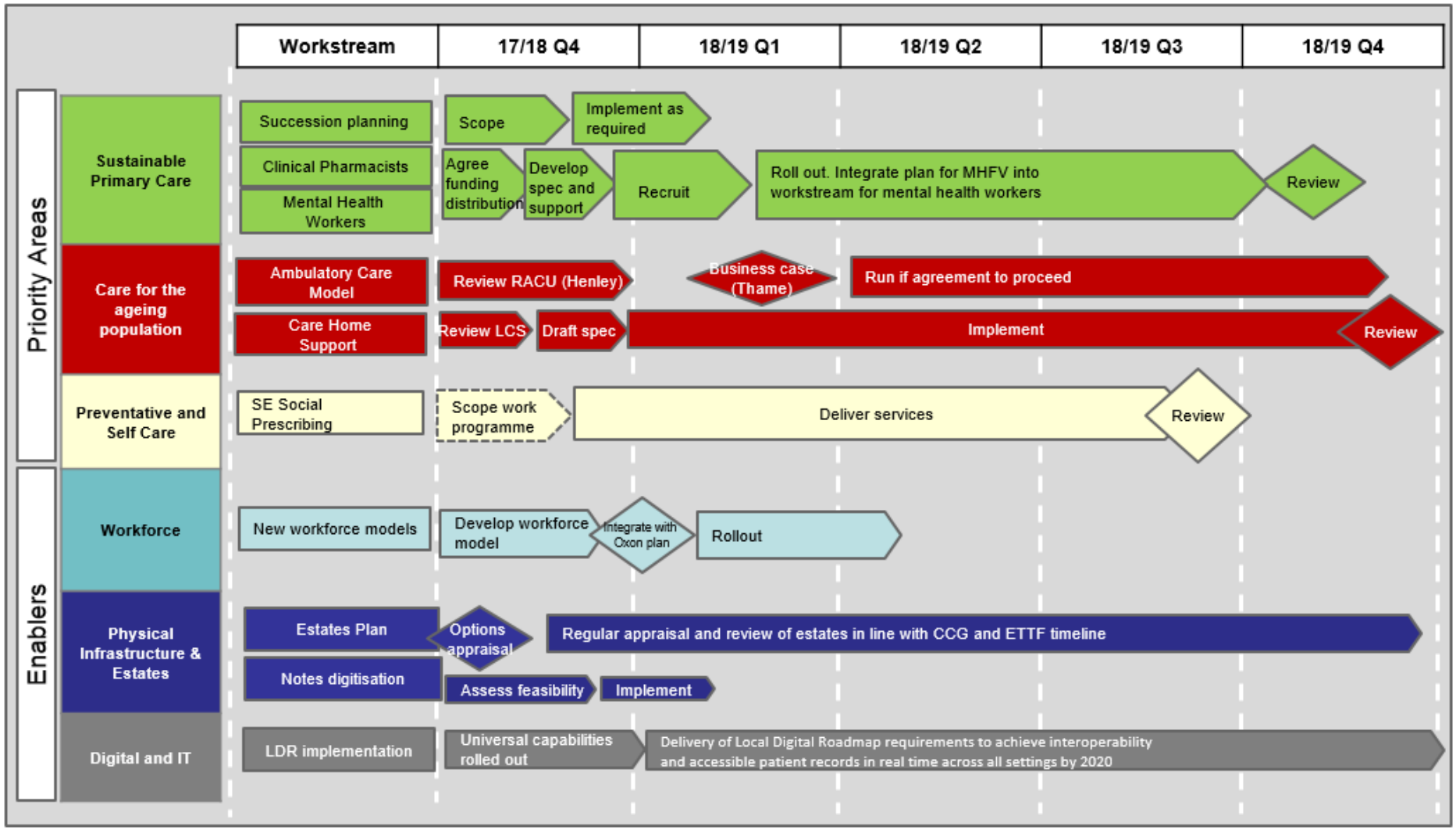
Table 6: Funding approved for initial delivery of the locality plans across Oxfordshire:

		Examples of schemes to be funded and relevant localities	Benefits for patients	Recurrent (full year) (£000)	Non-recurrent (000)
Priority areas	Sustainable primary care	New posts for mental health workers and clinical pharmacists in practice (all localities)	Improved outcomes for patients with mental health conditions and support for family members; Proactive reviews for patients with asthma, diabetes and other conditions, better treatment coordination.		£850
	Caring for the frail / elderly	Expansion or introduction of Primary Care Visiting service (N, NE, W, City, SW) Additional proactive support in care homes (all localities)	More patients at point of crisis assessed in their homes and less likely to be admitted to hospital	£531	
	Access to the right care at the right time for a growing population	Additional overflow appointments (NE, W)	Additional same-day appointments to ensure that patients who need to can be seen on the same day.	£189	£25
	Prevention, self-care and health and wellbeing	Social prescribing initiatives (City, N, NE, W, SE) Health and wellbeing hub (City)	Patients better able to care for their own conditions, reduced social isolation, improved prevention	£337	£55
	Reduction in deprivation and inequalities	Expansion of services to address deprivation (all localities) Expansion of minor ailments scheme (City)	Improved access for patients who do not need to see a GP through pharmacy consultations; Improved outcomes for patients in most deprived parts of the county	£100	£36
Enablers	Workforce redesign	Headroom to design new teams (all localities)	Workforce more responsive and better designed around patient needs		£300
	Physical infrastructure	Digitisation of notes (all localities) Efficient use of space through different work patterns (SW)	Better use of estates for delivery of front line services		£410
Total				**£1,157**	**£1,676**

Key messages:
In order to deliver this plan, there are 4 key enablers 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 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.

5. Outline Mobilisation Plan


Workstream
17/18 Q4
18/19 Q1
18/19 Q2
18/19 Q3
18/19 Q4
Priority Areas
Enablers
Sustainable Primary Care
Succession planning
Scope
Implement as required
Clinical Pharmacists
Mental Health Workers
Agree funding distribution
Develop spec and support
Recruit
Roll out. Integrate plan for MHFV into workstream for mental health workers
Review
Care for the ageing population
Ambulatory Care Model
Review RACU (Henley)
Business case (Thame)
Run if agreement to proceed
Care Home Support
Review LCS
Draft spec
Implement
Review
Preventative and Self Care
SE Social Prescribing
Scope work programme
Deliver services
Review
Workforce
New workforce models
Develop workforce model
Integrate with Oxon plan
Rollout
Physical Infrastructure & Estates
Estates Plan
Options appraisal
Regular appraisal and review of estates in line with CCG and ETTF timeline
Notes digitisation
Assess feasibility
Implement
Digital and IT
LDR implementation
Universal capabilities rolled out
Delivery of Local Digital Roadmap requirements to achieve interoperability and accessible patient records in real time across all settings by 2020

Appendix 1: Patient and Public engagement and involvement

Patient Participation Forum

Ensuring that the opinions of patients and the public are adequately captured has been an important part of developing the South East locality plan. Comments and insights from the South East Locality Forum (SELF) meetings have been fed back into the process, and have helped to provide a greater sense of public perspective within the locality plan. Input from patients has been solicited through consultation with patient representatives on the locality forum and through the patient participation groups. The locality are very grateful to those in the community who have given up their time to support the development of the plan in this way.

In the South East locality, 7 of the GP practices have a Patient Participation Group (PPG) that participates in SELF. Each PPG meets face to face and communicates virtually. SELF meets every other month and is attended by PPG representatives, the Locality GP lead, OCCG representatives, and the Locality Coordinator.

There have been 3 meetings of SELF at which the Locality Plan was discussed. These took place on 20th July, 14th September and 23rd November, along with a further meeting with the SELF deputy chair on the 15th September to discuss the plans specifically.

The issues discussed were related to:

- ensuring good access for patients to their GP surgery
- maintaining a local practice
- concerns about retaining GPs
- better integration of social care,
- digital linking between all forms of care,
- high use of RBH by SE patients/practices,
- use of sign posting and promoting self-care,
- linking in with voluntary organisations,
- Transport, and
- Continuity of care.

The chair of SELF attends the monthly Locality commissioning meetings. The vice-chair of SELF attends meetings every 2 months with the chairs of the other Locality forums and OCCG, where he raises issues on behalf of patients. A summary of meetings held is as follows:

South East Locality Forum (SELF) 20th July 2017: A summary of the minutes from the meeting

The Locality Commissioning Director discussed the Plan so far and explained that the locality would very much like SELF/PPG input throughout the process. He made it clear that large population growth would be a central theme as a 50% increase in population in South East Oxfordshire is forecast in the next 5 – 10 years. This brings challenges around workforce and estates. Feedback from SELF included:

- The importance of including the airfield Neighbourhood Development plan
- The significance of the 'Harrington' development which could be happening in the next 5+ years
- Concern was raised about the wider workforce e.g. District Nurses and Integrated Locality Teams etc.
- There should be significant inclusion of signposting, self-care, shared admin across practices and use of Federation to share services.
- There should be adequate inclusion of Public Health and 3rd Sector schemes in the locality within the plan.

South East Locality Forum (SELF) 14th September 2017: A summary of the minutes from the meeting

This meeting was attended by John Howell MP who addressed a selection of topics which had been submitted to him in advance. The group also discussed how best to input into the plan and ensure that their views were heard. In particular it was mentioned that concerns around IT, mental health services, and children's services needed to be captured. The Locality co-ordinator updated the group on the progress of the plan since the previous meeting.

15th September – Locality plan meeting. Present: Locality Commissioning Director and SELF Deputy Chair

A further meeting was held on the 15th September between the Locality Commissioning Director, Ed Capo-Bianco and Jeremy Hutchins (SELF Deputy Chair.) Together they went through the plan in detail, adding in additional details to the overall narrative with particular focus on the individual workstreams and how they addressed the priorities.

23rd November – SELF meeting

Further discussion on elements to be included in the draft plan before publication, including self care.

Key themes from the patient engagement: November – December 2017

A period of engagement was undertaken between 3 November 2017 and 3 December 2017 for each of the locality plans. The plans were presented and discussed at a series of public workshops around Oxfordshire, and discussed at various stakeholder meetings including Wallingford on 28 November 2017. An online/paper survey was available on OCCG's engagement website - Talking Health. People also had the opportunity to give direct feedback via email, letter, phone, or freepost. Following this period of engagement the draft plans were published and were available for further comment until 17 December 2017.

60 people in South East Oxfordshire registered and followed this engagement activity on Talking Health. Respondents felt that their GP practices were working well, with friendly and supportive staff. There was concern about the layout and design of some of the surgeries, in particular, that they do not offer a lot of privacy. Waiting times for routine appointments was also an area of concern. People felt that there needed to be more emphasis on self-care and prevention, as well as considering different models of care for managing care of the elderly in care homes. Rurality was another strong theme because of limited access to public transport. Integration of health and social care was a key theme, with concern for people requiring support at home. Some of the keys themes included:

- Encourage patients to self-care, eg purchase their own equipment such as blood pressure monitors
- Establish an independent service to provide health care to residents in care homes
- There is no mention of Thame in the plans and there should be.
- Access difficulties including lack of parking and public transport
- Lack of staff
- Suggestion that patients should be charged if they miss appointments.

In addition, the CCG received responses relevant to the South East Oxfordshire locality from:

- South Oxfordshire District Council – Planning Department
- Keep our NHS Public
- Mid Cherwell Neighbourhood Plan
- Pegasus Group
- Patient representative from the Primary Care Co-commissioning Group
- Locality Forum Chair representatives.

This feedback, together with the feedback from the stakeholder events has been incorporated into this updated plan. A summary of the responses is set out below:

Key Themes	Summary of issues	CCG response
Readability	• The plans are long • How do we know how to navigate the plans?	Alongside the locality plans, OCCG will also publish short summaries for each of the localities, in addition to an Oxfordshire-wide document, which draws out the key priorities in each locality and our approach to delivering the plans in a coherent and planned way. The CCG will consider other comments relating to readability in the next iteration of the plans.
Relationship between the plans and BOB STP and Accountable Care Systems	• Are the aims of the plans consistent with the BOB STP objectives? • Do the plans aim to contribute to the BOB STP objectives • Are the plans part of a process to turn Oxfordshire into an ACS	The Oxfordshire-wide plan sets out how the plans integrate with the wider OCCG strategy and documents such as the BOB STP and the Oxfordshire Primary Care Framework. Of the 8 STP objectives the plans contribute to achieving 6 of them directly. The Oxfordshire Summary document also highlights how the plans have been developed from both a population based, locality driven perspective as well as a 'top down' county wide perspective. In this way the plans provide a holistic strategy for primary care in the county. The CCG will support future investment in workstreams that are intended to deliver savings elsewhere in the system subject to a robust business case. This will provide a significant step forward in delivering accountable care, in which resources are allocated according to the needs of the population of Oxfordshire and in which partners in the health and social care system share financial and clinical accountability to deliver better outcomes.
Funding Implications	• Is there enough funding for the recommendations in the plans to be implemented? • To what extent is the feasibility of the plans unknown / unlikely?	Not all aspects of the plans require long term investment. Some elements include, for example, different ways of working or delivering efficiencies that reduce bureaucracies. However, full implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. The vast majority of investment in primary care is determined through a nationally agreed formula. However, some additional funding that was secured through the Prime Minister's Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. In the longer term, the sustainability of health and social care in Oxfordshire will be dependent on releasing funds from secondary care and investing this into primary and community care.
Phase two STP transformation programme	• Why are you producing the plans now when the consultation on phase 2 of the STP transformation programme has not yet started?	The plans aim to set out how primary care can best meet the needs of the local population and remain resilient and fit for the future, building on the national GP Forward View and Oxfordshire Primary Care Framework. They also aim to provide a locality plan for health services drawing out key components from other work streams in Phase 2 of the Transformation Programme. This is an iterative process, as the plans will both inform the work to develop options for services within the scope of phase 2 and respond to the outcomes of the consultation process related to the transformation programme. We will provide a clear narrative of this in future versions of the plans.

Continuity of Care	• Continuity of care a big concern for patients and not having this is counterproductive overall. It is important to see the same GP for people with long-term conditions important to see same GP if possible. • Over 75's have named GP / some patients can only see own GP rarely. Potentially it is about speed for kids - elderly want continuity • Choice re see own GP or other	The plan recognises that different dimensions of access are valued differently by different people, depending on their need, age and working circumstances. Practices in the South East rotate extended access, which fairly distributes and increases capacity for routine pre-bookable appointments and enables GPs to concentrate more resources on seeing patients who require a higher level of continuity of care and to be seen by the same GP where possible. It is our intention to maximise continuity where needed and we are supporting primary care to ensure GPs see those patients who need to see a GP.
Ambulatory Care/Rapid Access Care Unit (RACU).	• RACU is good, near practices can access. Is it possible to expand the service and, if so, how would this work? • There are good examples of care in the RACU in Henley and the similar unit in Thame (frailty assessment unit) • Was agreed that there needed to be some sort of ambulatory unit in or close to Wallingford as North and South of the locality were supported • Recognition that people did not want to give up their community beds but that the RACU model did seem to be working and the community were happy with it.	The Rapid Access Care Unity (RACU) in Henley provides quick access for frail elderly patients in the south of the locality and we will consider ways to increase capacity here. In addition, we will work with the community and assessment treatment service in Thame to expand capacity so patients in Chalgrove & Watlington, Wallingford and Wheatley can be cared for in their homes and fewer will be inappropriately transferred into the acute setting.
Care Homes	• Less care homes in Henley, putting a strain on GP times - need more young families • Care home initiative good but also need to include end of life patients who want to stay at home therefore their specialist needs have to be addressed. They also need to fit into the model. They also need to have choice. • Care home initiative - done by partners, affects local service. Could this be done by locums?	There are a large number of care homes in the locality and we are working with planners to consider the impact on the provision of primary care as the number continues to grow. End of life care has to be of high quality with clear communication between clinicians and their patients and carers. A Digital Proactive Care Plan (dPCP) has been produced to ensure we reflect the needs and wishes of patients. More information on the care home initiative and end of life care will be provided in the next draft as the proposal is developed. We have a scheme to fund practices who support care homes and this is being further developed to be more flexible. This scheme will be delivered by the practices directly who will be able to ensure a greater level of continuity of care for patients, rather than through the federation or locums.
Structure of GP services	• Henley practices working together - what level of collaboration is there? Not all practices/GPs in the area work effectively together • Locums do not always understand patient needs,	The South East locality covers a large geographical area which brings challenges to further integration. However, the practices do already work in a federation for the purposes of extended access appointments and are considering other opportunities for future collaboration, for example sharing staff.

	which means we need to come back twice • It is essential for GPs to get to know their patients • Part-time GPs is this realistic? • Centralising services doesn't always work • NHS 111 should be abolished - money to GPs, to respond to needs, employing additional GPs to do that • Practice nurse tasks - some devolved to health • Receptionists triage - didn't like - can be both ways	The traditional model of general practice continues to be popular among patients and GPs are among the most trusted profession. However, changing working patterns and concerns around burnout mean that the model has to adapt to ensure future resilience, for example through greater collaboration, making better use of other clinical professions and harnessing the benefits of IT. NHS England has made funding available for training in active signposting, so receptionists can be skilled and confident to connect patients more directly with the most appropriate source of help or advice.
Waiting Times	• Waiting times for appointments needs to be improved • Seeing your named GP earlier than 3-5 weeks later • Seen on day access vs own doctor - won't build up relationships • Tried so hard appointments on the day - but if not needed on that day feel guilty to pick a much needed appointment. Online = 28 days / needs triage re on today eg = phone discussion by GP. Some practices do. Patients to understand this	Practices in the locality have signed up to a commitment to see any patient with an urgent health care need on the same day and to be able to offer a routine appointment within a week, although not necessarily with a clinician of the patients' choice. Practices have achieved this either through operating a triage system, training their nurses to be nurse practitioners to see minor illness or employing more salaried doctor sessions. We are working with practices that report concerns about seeing a GP of the patient's choice by, for example, having a well-advertised 'buddy' system with another GP or their registrar if that GP is a trainer.
Integration	• Integration with Bucks and Berks • More sharing of staff across organisations to meet the needs of the patients • There needed to be more joined up thinking across the SE and especially across borders as many patients live on the borders • Linking GPs better into the depth of NHS services • GPs and other providers (mental health) working across practices – liked	Some district nursing is provided by the Buckinghamshire community team, where there are good links. There is room for improvement on engagement/integration with social care and better integration between social care and the primary care team is a key focus of the plan. Records sharing is an essential component of good joined-up care delivered across organisations and there is a programme for records to be interoperable across primary care, community and mental health services and secondary care.

IT	• Should use Skype or facetime to give more appointments • Ageing population - IT a problem (not all have mastered) • What IT do older people use / feel comfortable with? • Some older people are fine with IT • Sharing of patient records - cross border comms • IT up to date - Dr had old DELL / nothing countywide central hardware. Systems all fall over sometimes. • Monitor in home re falls and if no main carer - sensory technology eg buttons to press (eg soles shoe - door frame where frequently walk eg loo and not back to bedroom in middle night) Call made helps admission avoidance • More technology to support better working and patient access as well as record sharing • Sonning Common info useful to spread about. Helps even if only tells Sonning Common own patients. Vehicle used to communicate / email and online get more info than if not. Tec savvy benefits more. Sonning Common 24% on email • IT - some practices reluctant to use emails. Could this be used for simple medical queries? Have national policy setting out what can be done by email	Feedback from patient forums is that the model of face to face and telephone consultations works well in the South East locality. Email and Skype consultations may be appropriate in some cases; however, there may be scope for a Skype consultation service provided by the federation / locality. OCCG is considering developing an online consultation tool that may help provide patients with an effective way of engagement with primary care resources. Patients should be strongly encouraged to use the current online services, in particular, access to their medical records providing them with rapid access to test results. Access to patient medical records will also allow patients to share their medical details with other NHS providers outside Oxfordshire who are not able to access patient records directly.
Health Promotion	• Prevention - eg obesity - healthy eating • More prevention info on basic biology / kids to understand to manage self-care and go for advice. NOT GP. • Monthly short para from a GP on key messages eg flu jab records • Ideas: keep people out of surgery = early warning indicators eg. UTI's in place and contact GPs when concerns	We agree that initiatives around preventative care are essential to a healthy population in the South East locality and we are committed to working with partners to achieve this, including consideration of the options presented. This also involves clear signposting and increased access to self-care We will pilot a care navigating programme that best serves the patient profile of South East Oxfordshire to help give advice, direct patients to appropriate services and empower patients with the confidence and information to look after them.
Information/Communication	• Information needs to be on website • Newsletters / emails • Signposting to other services • Using local communication channels - insert sheets of magazines, newsletters, etc	As part of the active signposting initiative we will develop a directory of services for staff and patients. Practices and patient groups will hold lists of the different services available to patients, and this information will be held/led by receptionists. In addition, the pilot social prescribing programme, described above, will consider how to signpost patients to other organisations and reach out to patients who may not access the surgery.

	• Directory of services - voluntary / other support organisations • GPs and other providers (mental health) working across practices – liked • Reaching older patients who may not come into the surgery	

Appendix 2: Services provided at community hospitals in South East Oxfordshire

Thame Community Hospital

- provides Adult Community Healthcare Teams (DNs, physio, OT), Thame day hospital at present is piloting an ambulatory care model for 2 days a week (Mon & Thurs), Outpatient Services, Musculoskeletal Physio, Health Visitors, Podiatry

Outpatient clinics include:

•Audiology (children)
•Continence
•Dermatology
•Ear, nose and throat (ENT)
•Falls prevention
•General surgery
•Genetics
•Heart failure
•Musculoskeletal physiotherapy
•Occupational health
•Orthopaedics
•Orthoptics
•Pulmonary rehabilitation
•Rheumatology
•Smoking cessation
•Speech therapy (children)
•Tissue viability
•Urology
•Vascular

Henley (Townlands) Community Hospital

- provides an MIU service and RACU as an alternative to acute hospital admissions, outpatient appointments, OOH GP service, X-ray facilities, small amount of inpatient beds – 12 at Chilterns Court provided by Order of St John

Outpatient clinics include:

- Audiology
- Cardiology
- Dermatology
- Elderly Care
- Endocrinology
- Endocrinology (bariatric)
- ENT (ear, nose and throat)
- Gastroenterology
- General Surgery
- Gynaecology
- Nephrology
- Neurology
- Ophthalmology
- Orthoptics
- Paediatrics
- Paediatric T&O
- Pain Management
- Podiatric Surgery
- Rheumatology
- Trauma & Orthopaedics
- Urology

Wallingford Community Hospital

- provides Maternity services, inpatient beds, Adult Community Mental Health Team, Integrated Locality Team, Physio and OT, outpatient appointments, Community Dental Services, Ultrasound, First Aid Unit

Outpatient clinics include:

- Audiology
- Cardiology
- ENT
- Rheumatology

Urology

Appendix 3: References

1. Oxfordshire CCG Primary Care Framework, Oxfordshire CCG, March 2017
2. GP Forward View, NHS England, April 2016

3. Transforming our health care system Kings Fund, March 2011
4. Berkshire, Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Plan, October 2016
5. Patients registered at GP practices by age and gender, NHS Digital, updated quarterly
6. Oxfordshire Joint Strategic Needs Assessment, March 2017
7. Oxfordshire Growth Board, including the Oxfordshire Infrastructure Strategy (OxIS) and the Oxfordshire Strategic Housing Market Assessment

Appendix 4: Glossary of Abbreviations

A&E	**Accident and emergency department in hospital that deals with life threatening emergencies.** In Oxfordshire, these are sited at the John Radcliffe in Oxford city, the Horton General Hospital in Banbury. Patients in Oxfordshire also attend the Royal Berkshire Hospital in Reading and the Great Western Hospital in Swindon.
AF	**Arterial Fibrillation**
BCC	**Basal Cell Carcinoma**

BOB STP	**The Sustainability and Transformation Partnership for Buckinghamshire, Oxfordshire and Berkshire West** NHS and local councils have formed partnerships in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations.
CAMHS	**Child and Adolescent Mental Health Services**
CCG	**Clinical Commissioning Group** Clinical Commissioning Groups commission most of the hospital and community NHS services in the local areas for which they are responsible. Oxfordshire CCG also has delegated responsibility from NHS England for commissioning primary care services.
CMHT	**Community Mental Health Teams** Community mental health teams are multidisciplinary, multi-agency teams offering specialist assessment, treatment and care to adults with mental health problems, both in their own homes and in the community.
COACH	**County of Oxfordshire Advice on Care and Health** COACH is an online website which acts as a one stop, 24/7 health and care resource centre.
COPD	**Chronic Obstructive Pulmonary Disease**
DN	**District Nurse** District nurses play a crucial role in the primary health care team. They visit people in their own homes or in residential care homes, providing care for patients and supporting family members. As well as providing direct patient care, district nurses also have a teaching role, working with patients to enable them to care for themselves or with family members teaching them how to give care to their relatives.
GP	**General Practitioner**
GPFV	**General Practice Forward View** The GP Forward View was published in April 2016 and sets out NHS England's commitment to improving patient care and access, and investing in new ways of providing primary care.
HCA	**Health Care Assistant** A healthcare assistant works under the guidance of a qualified healthcare professional. In a GP surgery an HCA typically takes blood samples or does health promotion or health education work.
HV	**Health Visitor** All health visitors are nurses or midwives with specialist training in family and community health. They work with parents and their families to improve health and wellbeing.
LIS	**Local improvement scheme** Local use of CCG resources to pay for improvements in services provided under their GP contract or to support activities such as clinical audit or peer review.
MIU	**Minor Injuries Unit** Minor Injury Units are run by highly experienced Emergency Nurse Practitioners who will assess and either treat a minor injury or, if they find a more serious problem, arrange for you to be transferred elsewhere. They can treat a range of injuries including sprains, burns and simple fractures.
MSK	**Musculoskeletal**

OH	**Oxfordshire Health** OH is an NHS Foundation Trust, providing community and mental health services in Oxfordshire.
OT	**Occupational Therapist**
OUHFT	**Oxford Health Foundation Trust** provides mental health and community services in Oxfordshire. OHFT also holds the contract for the Luther Street homeless service in Oxford.
PML	**Primary Medical Ltd –** GP practice federation covering North, West and parts of South Oxfordshire and Northamptonshire
PPG	**Patient Participation Group** All practices have, or are setting up, a PPG. Their role is to advise practices on the patient perspective and providing insight into the responsiveness and quality of services. They may also encourage patients to take greater responsibility for their own and their family's health, support communications with patients and undertake research on behalf of the practice.
QOF	**Quality and Outcomes Framework** An annual reward and incentive programme for practices, the QOF also provides registers for practices and the public of numbers of patients with specific conditions to support better management of these patients.
RACU	**Rapid Access Care Unit** The RACU at Townlands Hospital offers ambulatory (non-bed based) care to the local population of patients registered with an Oxfordshire GP Practice.
RBH	**Royal Berkshire Hospital**
SE	**South East**
SELF	**South East Locality Forum** 7 practices have patient participation groups which come together to form SELF, the South East Locality Forum
SELG	**South East Locality Group** Information is passed through the SELF meetings to SELG, the South East Locality Group
SEOX	**South East Oxfordshire LTD** – A GP federation operating across south east Oxfordshire
SUS	**Secondary User Services** The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services
WTE	**Whole Time Equivalent / Full Time Equivalent**