Locality Place Based Primary Care Plan: South West Oxfordshire Locality

Refresh June 2019

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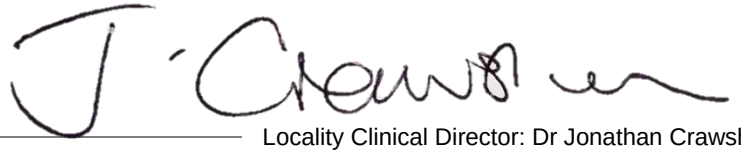
Foreword

Since the first publication of this local plan for primary care services, general practice has begun its biggest transformation for at least 15 years: the creation of primary care networks (PCNs). People living in South West Oxfordshire will be served by one of five PCNs in our locality. The NHS sees PCNs as a central part of its Long Term Plan.

Much of our locality plan relies on greater integration of GPs and community services, and greater sharing of skills, information and learning between NHS organisations which have traditionally worked separately. PCNs provide a potential vehicle for these changes, but not an automatic solution. Demands on the health and social care system (and on primary care in particular) continue to grow more quickly than either funding or available workforce, and much of the work which NHS England has earmarked for primary care networks will be funded from within existing budgets. Traditional primary care services will continue to provide the majority of patient care, and the rapid population growth in our locality is not solved by better integration of organisations. We will still require (for example) more GPs, more nurses, more carers, and more consulting space and infrastructure if we are to deliver high quality services to everyone living in South West Oxfordshire.

Delivering the NHS Long Term Plan will require ongoing substantial transformation of primary care services. This will take many years, not months, and will require our health and social care organisations to work ever more closely with each other and with local communities. We have made a good start.



Locality Clinical Director: Dr Jonathan Crawshaw

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 151,320 (Jan 2019). The population of South West Oxfordshire is rapidly growing – in the three years to April 2017, the practice registered population 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.
- A specialist community dermatology service has been established by two GPs in the locality. This offers treatment (including surgery) for low risk skin cancers, and is available to all patients South West Oxfordshire via GP referral.

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 the South West Locality

We have identified 5 key priorities and 25 workstreams which will enable us to deliver these.

		Priorities				
#	Workstreams	Expansion of premises	Transform workforce to ensure sustainable primary care	Efficiency	Integration of records	Improving health outcomes for frail/ elderly patients
1	Using existing GP premises more efficiently	■	■			
2	Managing the growth in Wantage population	■	■			
3	Didcot: Great Western Park	■				
4	Faringdon practice expansion	■	■			
5	Faringdon enhanced service offering		■			
6	Abingdon expansion	■	■			
7	Berinsfield		■			
8	Culham Science Park		■			
9	Design of new teams at neighbourhood level		■	■		
10	Integrated training framework for healthcare assistants		■	■		
11	More attractive portfolio roles for GPs		■	■		
12	Active signposting in practices			■		
13	District nurses and Practice Nurses should work more closely together as a team of Primary Care Nurses			■		■
14	Federations to employ specialist doctors and nurses in primary care		■	■		
15	Shared admin at a federation level (short term)			■		
16	Shared training at a locality level (short term)			■		
17	Participation in primary care research		■			
18	Shared admin at a neighbourhood or federation level (long term)		■	■		
19	Shared training at a neighbourhood or federation level (long term)		■	■		
20	Explore possibilities of e-consultation		■	■		
21	Expanded use of EMIS capability			■	■	
22	Improved interoperability					■
23	Urgent visiting service (in hours)					■
24	Expand capacity in EMU in Abingdon	■				■
25	Coordinated care home support from practices					■

Part A: Introduction

Part A describes how the plan for South West Oxfordshire 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 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.

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 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 locality place based plan for South West Oxfordshire 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 participation groups. 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.
- In addition, Oxfordshire CCG held an event in Didcot in November 2017. The workshop allowed local people to share their views on how GP and primary care services in their localities could be organised. This workshop and an online survey (for anyone unable to attend the workshops) follow and expand the work involving the CCG, local GP practices and patient representatives, who have been discussing plans for the future of primary care services in Oxfordshire for the past six months.
- This feedback has helped to shape and inform the locality plans, in particular:
    - Updating information on the process regarding decisions on primary care infrastructure in line with the latest district council plans and patient feedback
    - More information regarding affordability of the plan
    - Impact on children of strengthening primary care access
- If any proposals require significant changes that could impact patients a more formal consultation will be undertaken for the specific service area.
- A full summary of feedback from the Patient Forum, from the workshop in Didcot and subsequent patient feedback on the draft plan published in November 2017 are highlighted in Appendix 1.

2.2 Locality Forum meetings:

- The draft priorities and plans were discussed 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 were held in June, July, August and October 2017.

Key messages:

The South West Oxfordshire Locality Place Based 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 the locality, 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:

Table 1: Population change in South West Oxfordshire 2014-2017[2]

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

[1] NHS Digital: Numbers of Patients Registered at a GP Practice: http://content.digital.nhs.uk/gppatientsregistered
[2] A map of practices in each cluster is provided on page 14.

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. Analysis from the Nuffield Trust suggests that 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[3]. Some of this rise represents consultations with other staff (eg practice nurses), but there has been a rise in the number of patients who require longer and more complex GP consultations.

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 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 +23% in Vale of White Horse).

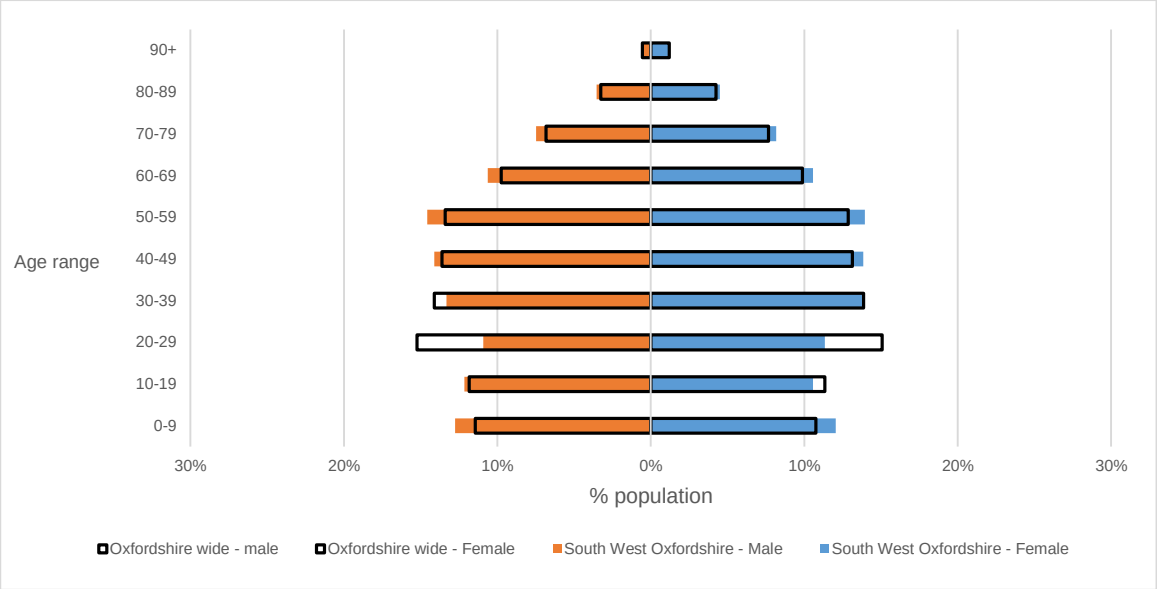


Figure 1: Age profile of South West Oxfordshire and Oxfordshire population
Source: NHS Digital October 2017)

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. Parts of Faringdon have relatively higher levels of compared to the rest of the District, and this has increased in recent years with more provision of new social housing in the area.

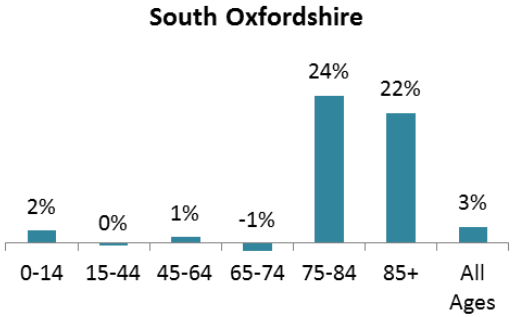
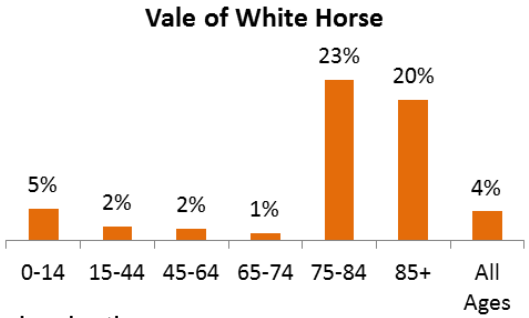


Figure 2: Expected change in population of South Oxfordshire by age 2017 to 2022
Source: ONS 2016



deprivation

Figure 3: Expected change in population of Vale of White Horse by age 2017 to 2022
Source: ONS 2016

[3] https://www.nuffieldtrust.org.uk/news-item/fact-or-fiction-demand-for-gp-appointments-is-driving-the-crisis-in-general-practice

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 2 indicates the number of housing developments submitted in the District Local Plans, based on the Oxfordshire Infrastructure Strategy housing site completions and trajectories reviewed in January 2018. This is within the context of over 100,000 additional homes planned in Oxfordshire in the period 2011-2031. The South Oxfordshire draft Local Plan 2033 is going through a period of consultation (Oct/Nov17) prior to submission for Independent Examination[4]. The Vale of White Horse Local Plan 2031 Part 1 was adopted in December 2016[5]. Part 2 of the Local Plan is currently in draft form prior to examination in 2018.

Table 2: Projected Housing/population growth by Locality and Cluster

	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	452	476	414	455	464	2,262	5,428	468	363	413	558	558	4,620	11,089
Didcot Cluster	554	557	865	1,100	1,243	4,319	10,365	1,096	1,001	949	770	724	8,858	21,258
Faringdon Cluster	232	409	478	256	209	1,582	3,798	155	151	111	111	111	2,221	5,331
Wantage Cluster	270	389	640	617	607	2,523	6,056	413	366	366	367	366	4,401	10,563
Total	**1,508**	**1,830**	**2,397**	**2,427**	**2,524**	**10,686**	**25,646**	**2,132**	**1,881**	**1,839**	**1,806**	**1,758**	**20,101**	**48,241**

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

[4] http://www.southoxon.gov.uk/services-and-advice/planning-and-building/planning-policy/emerging-local-plan
[5] http://www.whitehorsedc.gov.uk/services-and-advice/planning-and-building/planning-policy/new-local-plan-2031-part-1-strategic-sites

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. With ongoing national economic austerity, funding for building on premises projects is severely constrained. This means that practices need to be supported in reviewing the full range of options available from traditional sources (NHS capital) to developer grants and private finance.

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 smoothly from developer contributions and private finance.

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

The health of people in the locality is generally better than the England average. Life expectancy for women and men is higher than the England average. Rates of chronic illness are comparable with national averages, and are 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).

Table 3: Prevalence of long term conditions in South West Oxfordshire
Source: QOF data 2016/17

	2016/2017 Prevalence %					
Locality	**Atrial Fibrillation**	**Hypertension**	**Dementia**	**Depression**	**Asthma**	**COPD**
Abingdon	2.1%	14.1%	0.8%	9.4%	6.3%	1.6%
Didcot	1.5%	11.9%	0.5%	10.5%	6.0%	1.5%
Faringdon	2.2%	14.5%	1.0%	8.7%	6.3%	1.9%
Wantage	2.1%	14.1%	1.0%	6.7%	6.0%	1.3%
Oxfordshire	**1.7%**	**12.1%**	**0.7%**	**7.7%**	**5.7%**	**1.4%**
England	**1.8%**	**14.1%**	**0.8%**	**9.3%**	**6.1%**	**1.8%**

The locality covers a large geographical 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 is currently under review with limited service, giving similar consequences for design of joint neighbourhood services in the area. Patients in Berinsfield now have better transport links with Wallingford than Abingdon.

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. The broad age group with the highest growth in all districts in Oxfordshire County is expected to be aged 75 to 84.

Transport links have a significant impact on the way patients access services in the locality.

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 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) together with access to the Great Western Hospital in Swindon (for patients in Faringdon) provides good urgent access for most patients.

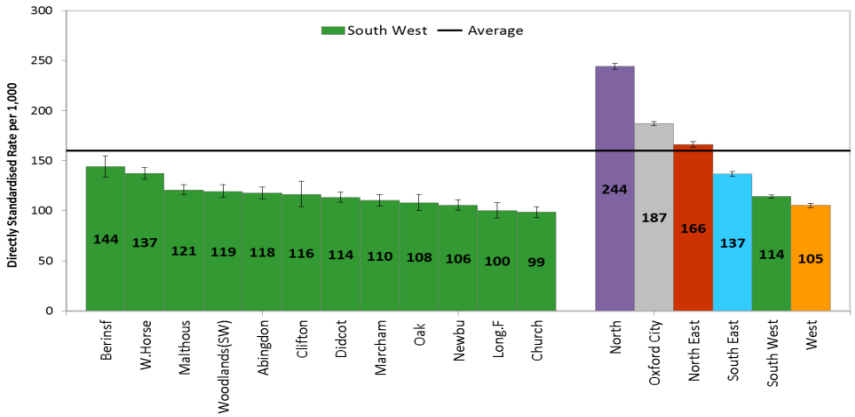


Figure 4: A&E attendances, rate per 1,000 (April 2016 – March 2017)
Source: SUS data March 2017

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.

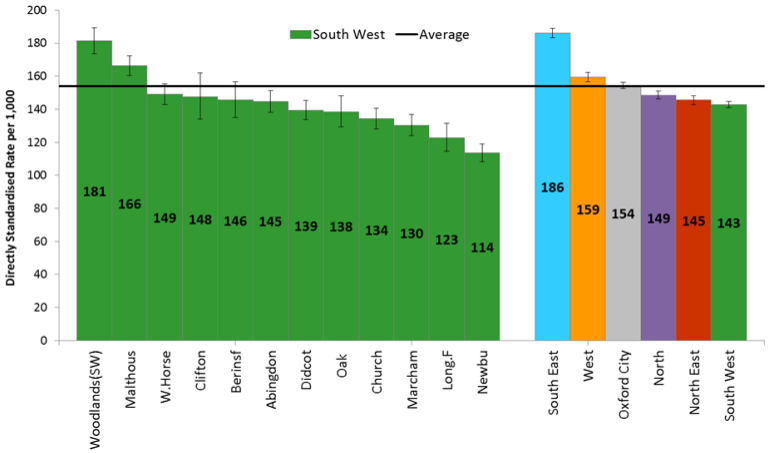


Figure 5: First Outpatient Appointments GP Referred, rate per 1,000 (April 2016 – March 2017)
Source: SUS data March 2017

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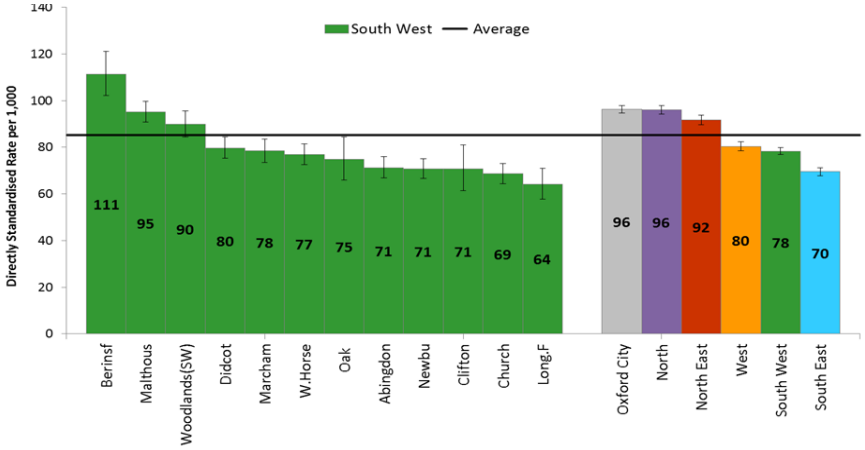


Figure 6: Emergency Admissions, rate per 1,000 (April 2016 – March 2017)
Source: SUS data March 2017

2. Overview of Primary and Community Care

2.1 Summary of practice provision

There are 12 practices in South West Oxfordshire serving nearly 150,000 patients (January 2018). 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.

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, as this provides a good population basis at which to deliver certain services at scale but remain at local level. 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.

Table 4: Practices in SW Oxfordshire

Locality	Federations	Neighbourhoods	#	Practices (patient population at January 2018)
South West Oxfordshire Locality (151,320)	ValeMed Federation (87,620)	Faringdon (15,648)	1	White Horse Medical Practice (15,648)
		Wantage (30,070)	2	Church Street (14,547)
			3	Newbury Street (15,503)
		Didcot (41,902)	4	Didcot Health Centre (18,365)
			5	Oak Tree Health Centre (10,247)
			6	Woodlands Medical Practice (13,290) (Branch site in Blewbury)
	Abingdon Healthcare Federation (63,700)	Abingdon with Berinsfield and Clifton Hampden (63700)	7	Abingdon Surgery (16,204)
			8	Long Furlong Surgery (9,624)
			9	Marcham Road Surgery (12,200)
			10 10a	Malthouse Surgery (17,453) The Village Hall – Appleton
			11	Berinsfield Health Centre (4,928)
			12	Clifton Hampden Surgery (3,291)

Figure 8: Map of practice locations in South West Oxfordshire

2.2 Access to general practice in South West Oxfordshire Locality

Core primary care services are delivered Monday-Friday from 0800-1830 hrs by all practices in the locality. Results from the national GP Patient Survey[6] report consistently good access to appointments in South West Oxfordshire.

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 may be booked in advance, and are intended 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 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 in Didcot (Woodlands Medical Centre), Wantage and Faringdon. This provides rapid access for patients, in particular for those of working age and for children who, except in certain circumstances do not need to see the same GP for episodic conditions. It also frees up time for GPs to concentrate more resources on patients who need a level of continuity. 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 and it is a priority for the remaining care homes to have the same level of proactive care.

[6] 79% of patients in SW Oxfordshire practices reported that it was easy to contact the practice, compared to 78% Oxfordshire average and 68% England average (July 2017) https://www.gp-patient.co.uk

2.3 Urgent care

There is currently a Minor Injury Unit and GP Out of Hours hub at Abingdon Hospital. As part of the Urgent and Emergency Care Review, NHS England intends to establish commonality in the specification for urgent care through urgent treatment centres (UTCs),[7] and urgent care provision in Abingdon already has some of the components of a UTC. The CCG will need to undertake a gap analysis and options appraisal on existing identified sites against UTC standards. A preferred option is expected by March 2018, with all services designated as UTC to be meeting minimum standards by December 2019.

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 and health visitors based at Church Street/Newbury Street site
- Faringdon – district nurses and health visitors based at White Horse Medical Practice

South West Oxfordshire has three community hospitals, more than any other locality, which 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.

[7] https://www.england.nhs.uk/urgent-emergency-care/urgent-treatment-centres

- 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 and 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 Oxfordshire Transformation Programme.

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 at two sites: Woodlands Medical Practice and White Horse Medical Practice. It is a priority for the locality to find new consulting space for HealthShare's physiotherapists in the Abingdon and Wantage neighbourhoods and we are working with the provider to identify suitable sites.

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 5 indicates the current GP workforce at July 2017. Table 6 indicates current vacancies and planned retirements.

Table 5: GP workforce in South West Locality

Neighbourhood	Patient list size (April 2017)	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 6: Current vacancies and planned retirements in South West Locality

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			
South West Oxfordshire	**4.16**	**10.7**	**15.7**	**20.14**			

Table 7: Required number GPs Projected shortfall in FTE GPs based on housing growt

Neighbourhood	Required number GPs (FTE)		Shortfall GPs **excluding** retirements (FTE)	
	Apr-22	Apr-27	Apr-22	Apr-27
Abingdon	35.3	38.3	-3.3	-6.3
Didcot	28.9	35.2	-9.0	-15.3
Faringdon	12.1	13.0	-3.1	-4.0
Wantage	16.0	18.1	-2.7	-4.8
South West Oxfordshire	92.3	104.6	-18.1	-30.4

Table 8: Current nurses, HCAs and phlebotomists employed in SW Oxfordshire

	Current WTE practice nurses	**Patients per practice nurse (April 2017)**	**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**

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 7 indicates the GP recruitment required to 2022 based on projected growth and 10 year period based on the housing projections and the shortfall in the number of GPs assuming no change in the way that primary care is delivered.

Table 8 indicates the number of practice nurses and HCAs / phlebotomists employed in the SW locality. In addition, some practices employ advanced nurse practitioners and emergency care practitioners. 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, CCG 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.

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.

Councils are planning for an additional 10,700 homes in the next 5 years and over 20,000 homes in the next 10 years. This includes proposals for large new housing developments on the following sites:

- Wantage cluster: 4,400 proposed new homes in the next 10 years
- Dalton Barracks site (northwest of Abingdon): 1,200 sites additional patients expected to 2031, with up to requiring registration with Abingdon practices.
- Berinsfield: 1,700 new homes in the next 10 years, which would increase the practice population from 4,850 to 9,000
- Culham Science Park: 1,150 sites with an additional 2,760 patients in the next 5-10 years with additional growth expected beyond the period
- Faringdon- 2,200 homes in the next 5-10 years

Practices were asked what capacity there was with current staffing, with results set out in table 8. Taking into consideration future housing developments this results in a projected shortfall in estates capacity as set out in table 9.

Table 8: Potential capacity for additional patients with no changes to sites

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

Table 9: Projected shortfall in primary care sites

Neighbourhood	Projected shortfall in capacity (number of registered patients above current estates capacity to nearest 100)				
	2017-18	2018-19	2019-20	2020-21	2021-22
Abingdon Cluster	- 500	- 500	- 400	- 500	- 500
Didcot Cluster	-	-	- 600	- 1,100	- 1,500
Faringdon Cluster	- 600	- 1,000	- 1,100	- 600	- 500
Wantage Cluster	- 600	- 900	- 1,500	- 1,500	- 1,500
South West Oxfordshire	**- 1,700**	**- 2,500**	**- 3,700**	**- 3,700**	**- 4,000**

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.

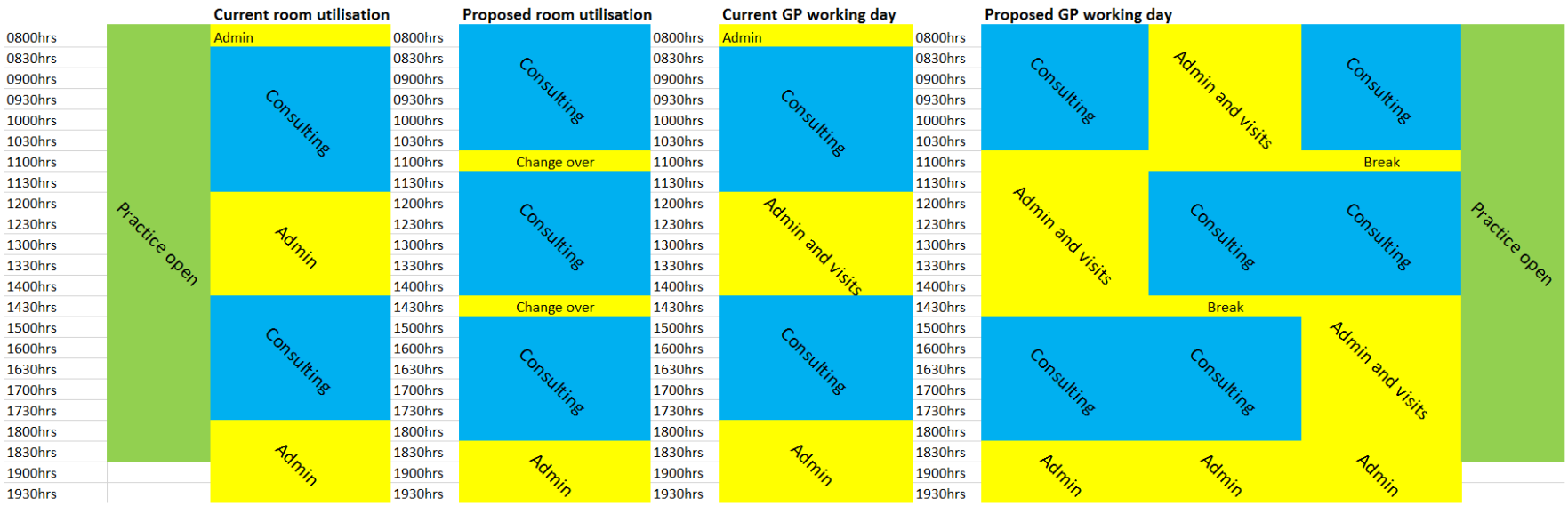
Clearly, future primary care infrastructure will need to respond in a timely and appropriate way to housing growth. Decisions regarding new contracts and the future location of any surgery will be subject to an options appraisal which will include considerations regarding accessibility, capacity and expected utilisation. Any relocation of current surgeries to meet changes in population will be subject to consultation with patients and future accessibility, including transport links, will be a key consideration. Future practice size will also need to balance the need for practices to have a certain scale in order to deliver services effectively with the requirement to retain local provision of general practice and ensure continuity of care for the growing number of patients with more complex health conditions.

Using existing GP premises more efficiently

It is clear that a 30% population increase as indicated by the growth in housing in table 2 will necessarily result in higher overall 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 in order to maintain access at current levels. 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 9: 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.

Wantage: The housing growth planned for the Wantage and Grove areas over the next 10 years will amount to around 20,000 new patients. Currently both Wantage practices (based in the same building, along with community nurses) 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 contribute to the Oxfordshire Transformation Programme over the future of Wantage Hospital's services (see below under Medium term). Should some services cease to be provided at Wantage Hospital it is highly desirable that these services be rehoused locally in the health centre on Mably Way. Due to short-term population pressures, the practice will need to be extended (for the purpose of GP services) before the STP consultation is complete. This short-term plan will retain sufficient flexibility so that other community services could be delivered at the Mably Way site, if this is supported by the Oxfordshire Transformation Programme plans for Wantage Hospital.

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 Oxfordshire Transformation Programme. 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 around £350,000, the practice could be reconfigured on its current footprint.
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 4,500 patients is required within the next 5 years.

The future of services at **Wantage Community Hospital** will be considered within the Oxfordshire Transformation Programme: there is a clear ongoing requirement for estates to support physiotherapy, midwifery, community nursing and visiting consultant clinics. The division of such 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 Transformation Programme. Wantage Hospital still has a small midwife-led

unit, but no longer has inpatient rehabilitation beds or other community services. Local patient representatives in Wantage have asked for options that the CCG considers both re-establishing inpatient beds for rehabilitation and palliative care, and for the establishment of a First Aid Unit or Minor Injury Unit.

Didcot: Building work on a new health centre should begin, currently proposed at Great Western Park (a 2,000m^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	2,280
NW Abingdon	200	480
NW Radley	240	576
Dalton Barracks	1,200-4,420 (numbers not fully submitted)	2,880-10,608
Totals	**2,590-5,810**	**6,216-13,944**

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 1,700 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 leisure centre, 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 4,000 units/9,600 patients, subject to adoption by the Council. The build out growth rates of this type of development would over an extended time period, dependent on road infrastructure planning and delivery, 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.

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. An alternative option would be a planned move of the Clifton Hampden practice to a new build on the Culham site, as the existing site would be problematic to develop to serve the new 9,600 patients and would give the practice sustainability for the future. Any decision regarding the future location of the surgery in Clifton Hampden and/or the future Culham Science Park will be subject to an options appraisal which will include considerations regarding accessibility, capacity and expected utilisation, and will be developed in consultation with registered patients.

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

Background

- South West Oxfordshire faces an unprecedented level of population growth in the next 5-20 years; patients are requesting a higher number of appointments each year and there is a continued demand for both urgent access and continuity of care with the same GP; 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 7 (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 roles of allied health professionals need to be developed in order to support the GP workforce.
- The fragility of the GP workforce, and the rurality of South West Oxfordshire, means that a system of neighbourhood hubs or urgent treatment centres would risk taking vital resources away from existing practices. Cooperative working between local practice teams is therefore preferred to centralised hubs in South West Oxfordshire.
- The increasing population is an inevitability as many planning applications for new housing are 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. Practices in South West Oxfordshire have been leading the way in training practice staff in HCA and care navigator roles, including injections, patient health checks, phlebotomy recording data for diabetic reviews. This has released significant GP time from routine chronic disease management work and freed up qualified nurses from many of the basic treatment room tasks to deliver more enhanced care. The ValeMed Early Visiting Service is a successful example of this at federation level.

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 (HCAs) 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 echocardiograms (ECGs) for checking heart activity
   - 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.

3. Individual federations will develop their own recruitment plans, which may include some of the following steps:

   - Appointing a federation GP recruitment lead (likely an existing practice manager)
   - Developing a short list of potential components to a local portfolio career. Some of these may need to be explored with existing GP colleagues with special interests, with specialist departments, or with the deanery.

- Producing a recruitment pack 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.
- Recently-retired clinicians have huge potential to contribute to education and management/governance in local practices. This would free other doctors to spend more time on patient care, and would not require retired doctors to continue complying with arduous requirements for professional registration and indemnity. Practices will consider this with their own recently-retired doctors and nurses, and report any successes/learning to the locality group.

4. The role/skillset of care navigators is of increasing importance in a more diverse primary care workforce, so that patients receive the right care, from the right person, at the right time. The locality will hold a care navigator workshop, open to all practices, and establish training and mentoring arrangements at neighbourhood or federation level. Potential dates for this workshop will be circulated to locality practices.

As part of the drive to empower patient decision-making, care navigators and patients will contribute to media like posters and leaflets which reinforce advice about best utilisation of NHS services, and these will be made available in pharmacies and GP waiting rooms. We will continue to supplement this with training in active signposting for receptionists, so they can be skilled and confident in sensitively ascertaining the nature of the patient's need and exploring with them safe and appropriate options.

We will also support 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.

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. This will be facilitated by the shared management structure currently being developed through a Joint Enterprise between the GP Federations and Oxford Health Foundation Trust. These nursing teams should be managed at neighbourhood level, but individual clinicians would be expected to work consistently with just one or two practices. The first steps towards this goal will be taken in the next year with formation of neighbourhood teams which include both GPs and district nurses. This Joint Enterprise is being developed using a consistent model across Oxfordshire.

Moving hospital services into the community: 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 (either in practices or community hospitals), and will have an additional role in educating and supporting clinicians in Primary Care. The locality views the movement of staff as the key resource necessary to provision of care closer to home.

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 co-operate in pursuit of common tasks such as protocols and ordering supplies.
- Some job advertisements 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.
- The Abingdon Federation will coordinate participation in primary care research for patients of its member practices. This enhances patient education and allows additional university-funded care processes and staff to be integrated with the primary care team. 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 collaboratively across practices (at federation or neighbourhood level), for example sharing 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 will improve integration of community and primary care services
- IT solutions will 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 piloting e-consultation using Engage Health, aiming to improve patient access for both clinical and administrative issues.

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 value continuity of care and 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 of the 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 (EMUs) 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.

The Integrated Locality Team for South West Oxfordshire, based in Abingdon, is a key point of communication between health and social care professionals who care for frail patients. GPs can refer patients to these teams through a single point of access.

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 medical services from the John Radcliffe and Great Western Hospitals to EMU and community settings in the locality.
- Continue to develop more flexible, responsive care for patients who need support from both health and social care teams, in partnership with the South West Integrated Locality Team.

Short term (1 year)

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.

The ValeMed Early Visiting Service has been successful in providing more responsive urgent care to frail patients in their own homes. This service is not currently available to patients registered with practices in the Abingdon Federation. The Abingdon Federation will develop an Early Visiting Service along similar lines, which would make this available throughout the locality.

Medium term (3 years or earlier, if possible)

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 Oxford University Hospitals 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 25 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
1	Using existing GP premises more efficiently	■	■			
2	Managing the growth in Wantage population	■	■			
3	Didcot: Great Western Park	■				
4	Faringdon practice expansion	■	■			
5	Faringdon enhanced service offering		■			
6	Abingdon expansion	■	■			
7	Berinsfield		■			
8	Culham Science Park		■			
9	Design of new teams at neighbourhood level		■	■		
10	Integrated training framework for healthcare assistants		■	■		
11	More attractive portfolio roles for GPs		■	■		
12	Active signposting in practices			■		
13	District nurses and Practice Nurses should work more closely together as a team of Primary Care Nurses			■		■
14	Federations to employ specialist doctors and nurses in primary care		■	■		
15	Shared admin at a federation level (short term)			■		
16	Shared training at a locality level (short term)			■		
17	Participation in primary care research		■			
18	Shared admin at a neighbourhood or federation level (long term)		■	■		
19	Shared training at a neighbourhood or federation level (long term)		■	■		
20	Explore possibilities of e-consultation		■	■		
21	Expanded use of EMIS capability			■	■	
22	Improved interoperability					■
23	Urgent visiting service (in hours)					■
24	Expand capacity in EMU in Abingdon	■				■
25	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	Implementation steps	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.	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	Delivery over 3 years, benefits realised within 1 year Woodlands have allocated some shared office space for non-face to face consult & emails.
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	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	3 years – Regular meetings with Assura and 2 Wantage Practices to work on design and cost. OX12 Project working on a Health needs assessment of the whole area. Due to submit options to HOSC in June 2019.
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	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. 3. CCG working closely with the 3 Didcot practices looking at the hard deadline of 2021 when practices will be at capacity. 4. Plans for new Health Centre submitted and currently with LPA for consideration (April 2019) 5.	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	Practice/CCG/Nexus to agree preferred option from three listed in plan.	Completed
Faringdon enhanced service offering	- Offer enhanced diagnostics and visiting specialist clinicians, initially this could be in conjunction with Wantage clinics.	Move care closer to home	1. White Horse Medical Practice team to develop specification for enhanced 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	3 years
Abingdon expansion	- Expand premises to meet the housing expansion; this could be a branch practice of the Long Furlong Practice	- Patients have sufficient access to primary care services in the area	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	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	1. Work with the South Oxfordshire District Council (SODC) to determine if Berinsfield regeneration scheme will go ahead and the impact on primary care 2. Scheme has recently been re-examined by the SODC as to next steps and agreement on land to be developed (Dec 2018)	2-3 years
Culham Science Park	- Increase capacity of primary care to meet the plans for building 4,000 units (9,600 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	- 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	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:	1. Scope work 2. Secure funding 3. Practices now working towards PCN's and will have some funding to support new staffing model (May 2019)	PCN's commence from July 2019
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	- Enable HCAs to expand their roles into activities which are often performed routinely by practice nurses - Free up practice nurse capacity to	1. Work with OCCG and the Clinical Education Provider Network to plan training requirements and programmes for their non-GP clinical workforce	1. Training dates planned by Locality Nurse (April 2018)

	• 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 - CCG's practice nurse educational coordinator to direct practices to appropriate training and mentoring for HCAs	perform other tasks	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	
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.		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) 3. CCG has developed a workforce plan	1 year
Active signposting in practices	- Train existing staff to the role through delivering workshops for all practices, and establish training and mentoring arrangements at neighbourhood or federation level. - This should be supported by practice websites that offer enhanced signposting information for patients about local services.	- Patients are educated and signposted to what may be unfamiliar ways of accessing the care they need.	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	1 year PCN's to be given 100% of share Social Prescriber for a 5 year period (July 2019)
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	Federation and OH to scope	3 years PCN's will eventually overlay with the Community Services (April 2019)
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	Federation to scope	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.	Federation to scope With the new NHS Plan, there will be opportunities for PCN's to share admin roles across a number of practices	1 year
Shared training at a locality level (short term)	- 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	- Practices become more uniform in their systems, facilitating joint working and setting consistently high standards	Federation to scope	1 year This is underway in the AbFed.
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	1 year Currently lots of the SW Practices take part in research opportunities.
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	Federation to scope	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	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	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)	Pilot for e-consulting has been developed by the CCG and many of the SW practices have taken part in phase 1 of this scheme.	Pilot schemes underway (Dec 2018)
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	- 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	CSU to manage implementation steps for digital support	1 year This work is on-going with CSU support.

	Emis Online Triage, and the possibility of purchasing these services at either CCG or Federation level. 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.	CSU to manage implementation steps for digital support	3-5 years February 2018 SWOL meeting discussed on going work with OUH to share records under the Global Digital Exemplar project with CERNER.
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. -To be extended across the whole locality through provision of an urgent visiting service by the Abingdon Federation	Reduced admissions Relieves pressure on general practice in hours	1. Abingdon Federation will produce an implementation plan for this service, drawing on lessons learned by ValeMed. 2. Plan to be agreed by CCG's primary care team for allocation of STF funds	AbFed have now employed 2 Paramedics (May 2018) **complete**
Expand capacity in EMU in Abingdon	- Expand capacity at the EMU at Abingdon	Reduced admissions Better care closer to home	1. Gap analysis done by clinicians from general practice, ILT and EMU. 2. Business case for expanded role prepared by EMU team.	On-going work
Coordinated care home support from practices	- Amend the LES so care home support can be provided by the federation; partner with OUHFT to use beds for step down care from EMU as well as John Radcliffe Hospital.	Better care for patients in care home Reduced admissions	To scope	**complete**
Malthouse Practice	-increase estate capacity to produce 4 new consulting rooms using ETTF and S106 funding. This will allow for additional 4/5K patients	ETTF and S106 approved	Work commences January 2018	**complete**

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 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 South West Oxfordshire. 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.

An 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 or providing support for mergers, where requested by practices, to provide a greater level of sustainability.

2. Physical infrastructure:

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).

The CCG will need to prioritise schemes for estates developments in line with the overall resources 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.

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.

Strategic estates considerations form a significant part of the plan for South West Oxfordshire, with the overall future estates need set out under priority 2 above.

In addition, a 6 Facet Survey was carried out for all practices in Oxfordshire earlier in 2017. This survey forms the 'core' estates information required to base intelligent decisions about the future of an estate. It reported 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). Results from the survey will inform the funding for practices to meet minimum requirements in each of the 6 areas.

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.

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 for South West 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.

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.

In addition, the CCG aims to improve practice resilience by reducing the bureaucracy of reporting and streamlining payment systems where possible.

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[8]. 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 10 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.

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

Table 10: Funding approved for initial delivery of the locality plans across Oxfordshire

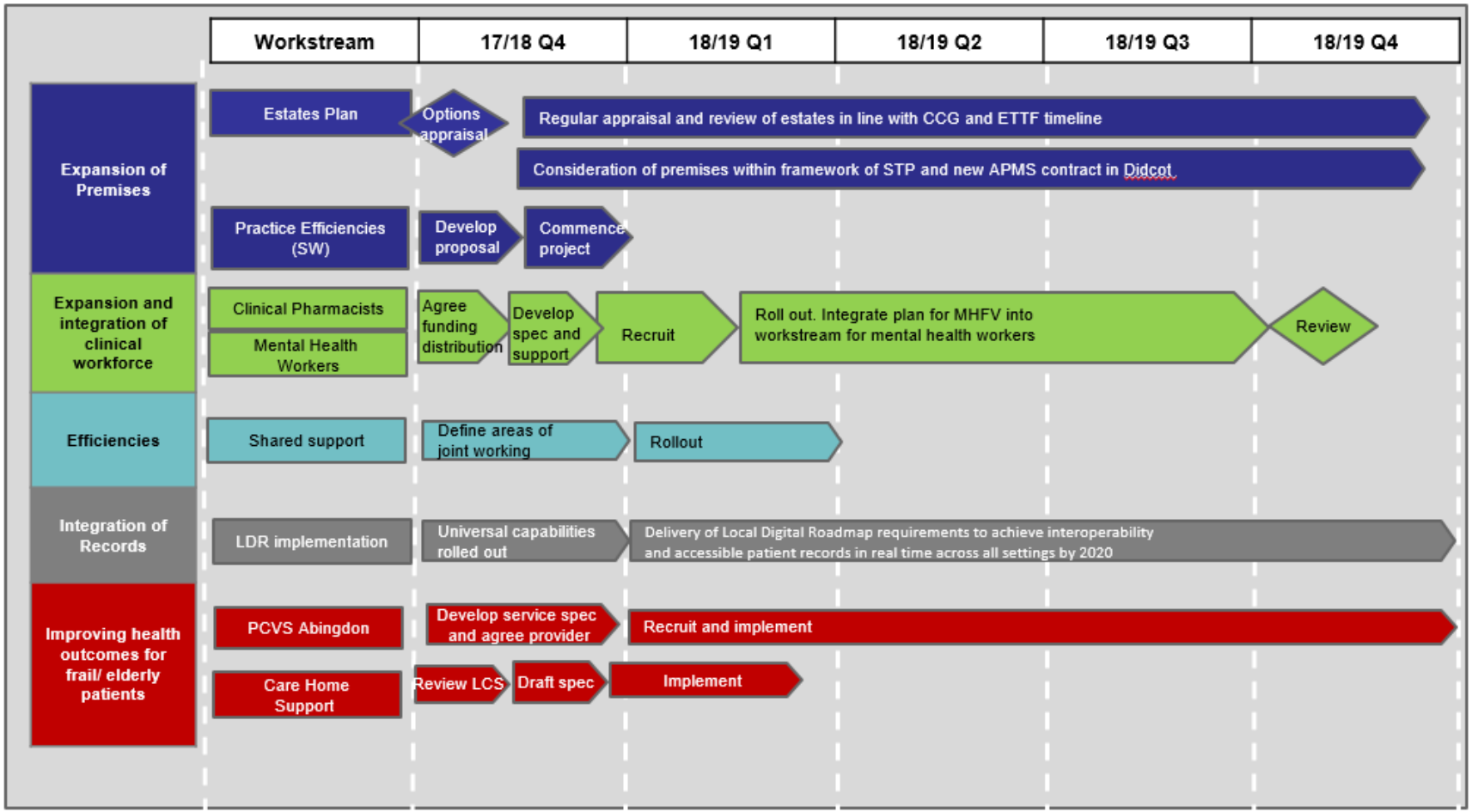
		Examples of schemes to be funded and relevant localities	Benefits for patients	Recurrent (full year) (£000)	Non-recurrent (£000)
Priority areas	Sustainable primary care	New posts for mental health workers and clinical pharmacists in practice (all localities)	Improved outcomes for patients with mental 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 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 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



Appendix 1: 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, which have influenced the development of the plan:

- SWOLF were supportive of the plan's priorities and general direction of travel: they indicated that patients are looking for evolution not revolution in the way that GP and community services are provided to patients.
- The future of local community hospitals is a key issue and it was recognised that decisions about these services cannot be made in advance of the outcomes of the Oxfordshire Transformation Programme.
- 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.
- More detail was needed 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 more coordinated information to practices to help with sign posting patients for self-care and health promotion.

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.

Key themes from patient engagement:

A period of engagement was undertaken between 3 November 2017 and 3 December 2017. The plans for each locality were presented and discussed at a series of public workshops around Oxfordshire, and discussed at various stakeholder meetings including Didcot on 22 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.

95 people registered and followed this engagement activity on Talking Health. Of these 95 people, 46 people then responded to the survey. There is a high level of concern, from respondents about the future housing growth in South West Oxfordshire, and how the CCG is able to harness funding from developers in a way that it can plan and develop health services in a timely manner. This is further impacted by concerns relating to Wantage Health Centre and practices in Wantage that have been unable to expand due to a lack of national funding. People felt strongly that, as a rural community, health services should be brought out into the community, making best use of the community hospital facilities. In addition people were also concerned about future funding of services and recruitment of staff. Some of the themes included:

- Section 106/CIL funding and allocation – how does this work in a timely way for planning of healthcare
- Transparency around the STP relating to the sale and redevelopment of NHS sites
- Concern that midwifery and children's services were not in the plan
- Recruitment of GPs
- Plans seem to be based around the South Oxfordshire District Council Local Plan which is not guaranteed or signed off
- Population growth/ageing population
- Expansion of GPs services
- Access to GP appointments

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

- South Oxfordshire District Council – Planning Department
- Vale of White Horse District Council – Planning Department
- Keep our NHS Public
- Clifton Hampden Parish Council

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 future versions 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.
Transport/Rurality	• Need subsidised transport • Can there be free transport to get people out and about? • Can there be free transport to get people out and about? • Volunteer drivers +++ • Better bus transport • Infrastructure - yet CCG can't influence buses • Population increase - public transport is an issue	This level of detail has not been possible in the first plans – however it is acknowledged as being a very important consideration. We will need future plans to evidence close working with Districts and City Councils to understand how patients can easily access services. Public transport links are a vital component of access, in particular if there are models involving neighbourhood hubs, and the withdrawal of bus services can have a negative effect on access. The CCG will consider transport and infrastructure in designing its model of care and in deciding future primary care estates. The district councils are also considering where transport can be upgraded to improve access to larger conurbations.
Patient Access to GP Appointments	• Waiting times 6 weeks to see a named doctor - continuity • Not acceptable to have to wait 5 weeks to see their own GP • What is being done to reduce the waiting times for people to see their GPs?	Patients in the South West locality generally report good access to their surgery. However, the plan recognises that different dimensions of access are valued differently by different people, depending on their need, age and working circumstances. Introducing a wider skill mix in practices, increasing overflow appointments for patients who prefer rapid access over continuity and new consultation types that release time for GPs and improve access for patients are a key priority for the South West locality. Our plan looks at how this might be done
Structure of GP Surgeries/NHS	• Staffing biggest problem a worry - realistically will jobs be filled? • A lot of GP practices risk instability due to lack of GPs available • People want local practices with GPs rather than one big locality hub • Move away from traditional working GPs schedules • Share admin support • Texting/reminding appointments useful • Shared training - this would help to save money • Smaller practices find it hard to manage if staff absences - look at supporting smaller practices and not abandoning them - thank you	GP practices in South West are now working across two federations of practices. This approach has a number of benefits, including: - Faster access to appointments at evening and weekends at neighbouring practices - Economies of scale for practices to increase their purchasing power - Greater resilience through sharing functions and creating a pooled resource of staff - Opportunities for staff to be involved in wider projects However, we recognise that successful primary care should retain the 'localness' that means that GPs know their patients' needs. Future development of primary care and the location of practices will need to balance the need to harness the benefits of working at scale with the importance of ease of access for patients.
Continuity of Care	• Locums - can be an issue with continuity of care for the older patient • Larger practices - loss of continuity between patient and staff - see Drs you don't necessarily see each time - not good for patient relations • There are patients who want convenience and not bother about continuity and the others that want	The plan recognises that different dimensions of access are valued differently by different people, depending on their need, age and working circumstances. Introducing a wider skill mix in practices and increasing overflow appointments for patients who prefer rapid access over continuity enables GPs to concentrate resources on seeing patients who require a higher level of continuity of care and to be seen by the same GP where possible.

	continuity - challenge to balance it out • Elderly patients need personal contact over the telephone, they do not all have mobiles/computers • Essential for patients to see the correct specialist	
Secondary Care	• Speed up communication especially with secondary care letter communication between primary care and secondary poor - impacts on GP ability to help patients - no communication	The CCG recognises that communications between different healthcare professionals is essential in providing good integrated care. Records sharing for cross-organisational care, in particular between primary care, community and mental health services and secondary care is a key focus across the county to deliver more joined-up care.
Pharmacy/Prescriptions	• Make sure patients get an email to say prescription is in at BOOTS! • Dispensing practice - can email repeat prescription	The CCG will share this feedback with practices to ensure this works effectively.
IT/Information	• Simple email route for non-sensitive information • Patient records are electronic, older ones kept on paper • Better use of IT, i.e. send an email instead of a letter to patients	The success of the plan will depend on maximising the use of technology available; empowering patients and ensuring there is interoperability between systems and across providers. This will be set out in more detail in the Countywide plan to be published alongside the locality plans.
Housing	• Growth will come from housing • Developer could blackmail councils? - Idea of what stages development are? What funding has been given? What land has been put aside? • Wantage issue relates to package - housing, schools, transport • Abingdon, 15000 houses which practices will absorb population • In Didcot there is a large housing growth so the infrastructure has to be addressed	There are large-scale planned increases in housing across the South West locality and a coordinated and strategic estates approach is required so that primary care capacity can meet the demand of the future population. We 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 and linking in with all local Neighbourhood Development Plans (NDP) to ensure Primary Care Services are on the agenda for planning decisions. This forms a key part of the plan for the SW locality. In Didcot we are considering our options of commissioning a new practice or expanding a local practice.
DNAs	• DNAs stats work well • DNAs could be improved • Why are people not charged if they DNA for their GP appointments?	NHS England and the CCG is working with practices to maximise the use of appointment slots and improve continuity by reducing DNAs. Changes may include redesigning the appointment system, encouraging patients to write appointment cards themselves, issuing appointment reminders by text message, and making it quick for patients to cancel or rearrange an appointment.
Health Promotion	• What plans do you have for engaging more with the public - to treat themselves first when they can, seek advice from a pharmacist, etc. and not just thing about going to see their GP? • Increase social prescribing • Need more communication/leaflets to help inform patients of signs to look out for as they get older •	There are some excellent examples from across the county of working with schools to promote healthy lifestyles and increase health literacy, which we will aim to build on. We agree that initiatives around preventative care are essential to a healthy population and we are committed to working with partners to achieve this. This also includes signposting to relevant services and increased use of pharmacists to provide appropriate care for a range of conditions and release the pressure on GPs.

Confidence in CCG	• Forward planning has to come first with the business case • Difficult to disagree with priorities - issue is how are you going to do it? • Is anyone in CCG in charge of making this happen? Limited levers to fix problem. • How soon is it likely to happen? • No confidence that it will be delivered	It will be important to maintain momentum and coherence on the delivery of the plans while there is engagement and enthusiasm across the system so that the plans can start to deliver benefits as soon as possible and be delivered in a planned way. Some aspects of the plans are already being implemented, where funding for primary care has been made available or if no funding is required. Future investment will be subject to a business case. As the plans are iterative, there will be opportunities for patients and the public to track the benefits and hold the CCG to account for delivery of the plans. The CCG has developed these plans to set out what change is needed. This has not previously been done. We have set aside some resources to deliver and also have detailed implementation plans which will be reviewed in the Oxfordshire Primary care commissioning Committee (OPCCC). The CCG has taken some important new steps and is working more closely with District and City Councils.

Appendix 2: References

1. Oxfordshire CCG Primary Care Framework, Oxfordshire CCG, March 2017
2. GP Forward View, NHS England, April 2016
3. Berkshire, Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Plan, October 2016
4. Patients registered at GP practices by age and gender, NHS Digital, updated quarterly
5. Oxfordshire Joint Strategic Needs Assessment, March 2017
6. Oxfordshire Growth Board, including the Oxfordshire Infrastructure Strategy (OxIS) and the Oxfordshire Strategic Housing Market Assessment
7. Long Term Plan : www.longtermplan.nhs.uk

Appendix 3: 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.
AHP	**Advanced Health Practitioner**
APMS	**Alternative Provider Medical Services** APMS is a contracting route available to enable primary care organisations to commission or provide primary medical services within their area to the extent that they consider it necessary to meet all reasonable requirements.
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.
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.
CEPN	**Clinical Education Provider Network**
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**
ECG	**Echocardiogram**
EMU	**Emergency medical unit** EMUs are developed to offer an alternative to A&E attendance for patients who are frail and vulnerable to acute admission. Patients may access the service in response to acute illness or because they require a multi-disciplinary assessment to prevent further deterioration of their condition. In Oxfordshire, there are EMUs currently in place in Witney and Abingdon.
FTE	**Full Time Equivalent/Whole Time Equivalent**
GP	**General Practitioner**
GWP	**Great Western Park, Didcot**
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.
HR	**Human Resources**
HOSC	**Health Overview Scrutiny Committee**

ILT	**Integrated Locality Team**
LCS	**Locally Commissioned Service** A service commissioned by Oxfordshire CCG from general practice to provide services that involve an enhanced level of provision above what is required under core contracts.
LES	**Locally Enhanced Services**
MIU	**Minor Injuries Unit**
NHS PS	**NHS Property Services**
OCCG	**Oxfordshire Clinical Commissioning Group**
OH	**Oxford Health**
ONS	**Office for National Statistics** The UK's largest independent producer of official statistics and the recognised national statistical institute of the UK.
OUHFT	**Oxford University Hospitals Foundation Trust,** includes the John Radcliffe Hospital and the Churchill Hospital in the City and the Horton General Hospital in Banbury
OxIS	**Oxford Infrastructure Strategy** The purpose of OxIS is to identify, map and prioritise Oxfordshire's strategic infrastructure requirements up to 2040.
PCN	**Primary Care Network**
PFI	**Private Finance Initiative**
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.
SODC	**South Oxfordshire District Council**
STF	**Sustainability and Transformation Funding** Locally agreed funding for primary care services above the core contract as part of the GP Access Fund.
STP	**Sustainability and Transformation Plan** See BOB STP
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
SW	**South West**
SWOL	**South West Oxfordshire Locality**
SWOLF	**South West Oxfordshire Locality Patient Forum**
WTE	**Whole Time Equivalent / Full Time Equivalent**