Locality Place Based Primary Care Plan: North East Oxfordshire Locality

Contents

Foreword **4**
North East Locality Plan Executive Summary **5**
Part A: Introduction: Approach to developing the plan for North East Oxfordshire **6**
1. The purpose of this locality place based plan 6
2. Who helped to inform our plan? 7
Part B: The demographics of the North East Oxfordshire population **9**
1. Summary 9
2. The health of our community in North East Oxfordshire locality 11
Part C: How our population accesses services **12**
1. Urgent and Emergency Access 12
2. Overview of Current Locality Primary Care 13
Part D: How we will meet the needs of our community **19**
Priority 1 – Sustainability of Primary Care 19
Priority 2 - Developing increased capacity within primary care to meet housing and population growth 21
Priority 3 – Developing new models of clinical care for planned care and long term conditions management 23
Priority 4 - Developing new models of clinical care for Urgent Care, particularly frail elderly patients 25
Priority 5 - Increased self-care and promotion of health and wellbeing 27
Planning for the future: 30
Part E: Making a success of our plan **34**
1. Workforce: 34
2. Estates 36
3. Digital 38
4. Funding 39
5. Outline Mobilisation Plan 41

Appendix 1: Patient and Public engagement and involvement 43
Appendix 2: References 49
Appendix 3: Glossary of abbreviations 50

Foreword

The North East locality is undergoing a period of exciting and dynamic change, and the planning of future services for the locality is set against a backdrop of:

- Significant planned population growth in the locality
- Unprecedented cuts in social care
- Significant reductions in Primary care funding through MPIG withdrawal
- Challenges in primary care staff recruitment
- Increases in demand for services
- Challenges in the provision of social care.

Locality Clinical Director: Stephen Attwood

This will be a challenge and emphasises the need for practices to work at scale and together with social care to look at common areas.

This locality plan draws on previous local aspirations, a history of shared working and planning by clinicians in the locality and the views of local patients. We have all seen primary care services under increasing pressure with the closure of one practice in Bicester and the merger of practices in Kidlington and Bicester. Whilst doctors and patients may look back with some fond nostalgia at a very traditional model of primary care, I believe that to meet the current and future needs of our population we will need to develop different models of care. Future models must both provide timely access to same day acute medical care and time for GPs and primary care clinicians to deal with an ageing population with increasingly complex medical needs.

We will need to work across practices and neighbourhoods to provide care efficiently within the resources available against a backdrop of rising demand. The changing nature of medical care involves more patients being treated at home or closer to home; this involves a blurring of traditional primary / secondary care boundaries but will also need to involve a shift of resources into the community commensurate with the current and future shift of work.

This plan sets out a framework to deliver the sustainability of primary care services into the future and a comprehensive range of services closer to patients' homes. Its success depends on ownership of the vision from clinicians and patients and adequate resourcing for both staffing and infrastructure.

North East Locality Plan Executive Summary

Locality Overview:

North East Oxfordshire is home to around 83,000 patients and is divided into two natural neighbourhoods based in the market towns of Kidlington (incorporating Woodstock and Islip), and Bicester and surrounding villages.
The locality is served by 7 GP practices and a community hospital. The Principal Medical Limited (PML) federation provides same day urgent home visits and 7-day access hubs at Bicester and Kidlington. Bicester was selected as one of 10 Healthy New Towns nationally, which will provide an opportunity to test new ways of delivering health services. There will be significant growth in the next 5-10 years, which will require changes in ways of working and investment in infrastructure.

What's working well:

- Urgent Access Hubs provide urgent access appointments to all patients in the locality.
- An improved integration of services through a single point of access, a bank of staff and training and education co-ordinated by a Community Locality Services Group.
- A research and teaching ethos within the locality.
- Strong Patient Forum representation and leadership.
- A population based approach to promotion of health and wellbeing is being tested through the Bicester Healthy New Town programme

Key locality challenges:

- Significant planned population growth in the locality with significant impact on the sustainability of primary care c 30,000 by 2031
- High cost of living is a barrier to recruitment
- Higher than average A&E attendance
- A need for changes in estates and infrastructure to deliver a new model of primary care
- A background of significant loss of primary care funding through national reduction in MPIG which disproportionately affects NE practices

Key priorities for the North East Oxfordshire locality:

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

		Priorities				
#	Workstreams	Sustainability of Primary Care	Increased capacity in primary care to meet housing and population growth	New models of clinical care for planned care and long term conditions management	New models of clinical care for Urgent Care, particularly frail elderly patients	Increased self-care and promotion of health and wellbeing
1	Primary Care Urgent Access Hubs	■	■	■		
2	New models of urgent care in Bicester	■	■		■	
3	New staff models of working	■				
4	Expansion of Primary Care Visiting Service		■		■	
5	Deliver prevention services through the wider primary care / community team		■			■
6	Explore benefits of social prescribing		■			■
7	Consolidate the local diabetes service			■		
8	Extend the Locality diabetes model to COPD			■		
9	Deliver planned care clinics and diagnostics locally			■		
10	Development of integrated locality team				■	
11	Estates prioritisation	■	■			

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

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

1. The purpose of this locality place based plan

Good primary care is the bedrock of a high-quality and cost-effective health system, and the NHS has traditionally prioritised primary care compared to many other health systems worldwide. This is generally accepted as key to its success and pre-eminence internationally in effective, safe, coordinated and efficient patient-centred care.

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
- Organising care around geographical population-based needs based on the practice registered list
- Delivering care closer to home
- A collaborative, proactive system of care
- Delivering care using a multidisciplinary neighbourhood team
- Be 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 care is dependent on releasing funding from secondary care to invest into primary care.

A systematic review of the locality's plans against a matrix of good practice, developed by the National New Models of Care team, has been undertaken with the support of the Bicester Healthy New Town programme to identify gaps and opportunities for service improvement.

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 North East Locality place based plan for the delivery of sustainable primary care and support a model of moving care closer to home. This process included:

2.1 Patients:

- NE Locality is committed to encouraging patient participation at all of its service change meetings.

- Discussion of the Plan in June and September 2017 at the NE Locality Practice Participation Group (PPG) Forum was chaired by Dr Helen Van Oss. The PPG Forum meets privately 4-6 times per annum as a committee with a Chair and Deputy, and also holds two meetings in public per year. It includes one or two patient representatives from the each of the practices' PPGs.

- In addition, Oxfordshire CCG held an event in Bicester on 30 November 2017. The workshop gave local people the opportunity 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:
    - Further clarity on the decisions regarding future primary infrastructure for new estates, in particular Heyford Park
    - More information regarding affordability of the plan
    - Proposals to improve urgent access to primary care, in particular for working adults and children, and to improve continuity of care.

- 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 the feedback from the North East Locality Forum and public events are collated into themes and highlighted in Appendix 1. The locality wishes to record its thanks for the support that the PPGs and Forum have given to CQC visits, and welcomes input to all planning opportunities.

2.2 Member practices and other health stakeholders:

- NE main locality meetings were attended by the GP lead for each of the seven practices, together with representation from ONEMed and Oxford Health NHS Foundation Trust, between April and June 2017. These key meetings were used as the main focus of discussion for the place based plans.
- The plan is also built on work previously undertaken by the locality in meetings in November 2016 as well as March 2016.

Key messages:

The North East Locality based Primary Care plan builds on the principles identified by the Oxfordshire Primary Care Framework to create a 5 year strategy for the region.

The plan has received input from Locality PPG Forum Meetings and member practices. Patient participation ensures that the knowledge and experience of our community in North East Oxfordshire is adequately captured.

Part B: The demographics of the North East Oxfordshire population

Part B describes the primary care services currently available in North East Oxfordshire as well as offering insight into the current health needs of the population. This section also provides growth forecasts, showing how locality need is likely to change in the future.

1. Summary

1.1 Population

The North East Oxfordshire locality covers a registered population of approximately 83,000 located in Bicester and Kidlington (in Cherwell District Council and Woodstock in West Oxford District Council). The locality is served by 7 practices who provide core primary care services and a range of additional services outside the hospital setting. Health outcomes are generally better than average in Oxfordshire, although small areas of Bicester have the highest rates of poverty (both child and older people) in Oxfordshire.

1.2 Age

The age profile in the North East Oxfordshire locality varies significantly across the locality. 2.3% of the North East locality population are aged 85 and over (just below the Oxfordshire County average of 2.4%), although there is significant variation across the locality, as practices in Kidlington and Woodstock have a significantly older population than Bicester (4.4% in Woodstock and Bladen locality). Between 2017 and 2022, the broad age group with the highest growth in all districts and Oxfordshire County is expected to be aged 75 to 84.

The current age distribution of the population is shown in *Figure 1*.

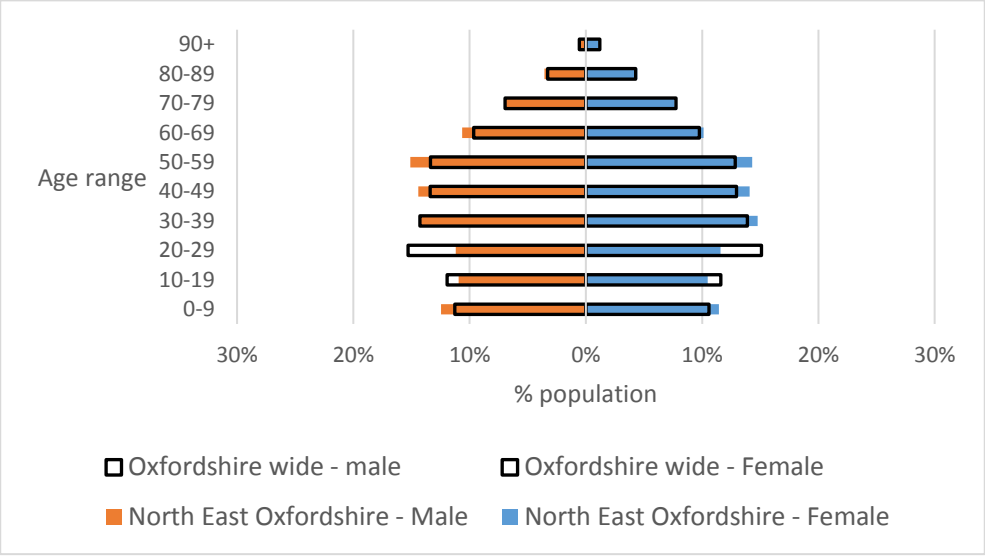


Figure 1: Age distribution of population registered in North East Oxfordshire practices and all Oxfordshire practices (Oct 2017)
Source: NHS Digital October 2017

1.4 Deprivation

Levels of deprivation are lower than average, although small areas of Bicester had the highest rates of child and older people poverty. In total 1,250 children and 1,265 older people are affected by poverty in the North East locality (from IMD 2015)[1].

[1] English Indices of Deprivation 2015 - https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.5 Care home population

There are currently nine care homes within the North East locality. Other than Heathfield House, which is jointly covered by Islip Medical Practice and Bicester Health Centre, and Manor House which is covered under a private arrangement, homes are supported under the Oxfordshire CCG Care Home Locally Commissioned Service (LCC). This model works well for practices and homes, and emerging evidence suggests it is reducing attendance at A&E, so no changes are currently planned.

1.6 Housing growth

There are plans for significant housing expansion in North East Oxfordshire in the coming years. For example, Bicester is planning 13,000 new homes, the former RAF Upper Heyford have a total site capacity of 2,361 by 2031 and Cherwell District Council is considering additional housing in Woodstock, the A44 corridor, Kidlington and North Oxford to meet unmet housing need in Oxford City. In 2016, Bicester was selected as one of 10 'Healthy New Towns' across the country, supported by Public Health England (PHE). The Healthy New Town programme is using the opportunity of strategic growth to test out how the built environment, community activation, and new models of care can promote health and wellbeing.

Table 1 indicates the number of houses planned at August 2017 for the next 10 years and associated population predictions[2].

Table 1: Projected Housing Increases by neighbourhood:

	Housing Growth – 5 Years						**Population growth 5 years**	**Housing Growth – 10 years**						**Population growth 10 years**
	2017/18	2018/19	2019/20	2020/21	2021/22	5 Year Total		2022/23	2023/24	2024/25	2025/26	2026/27	10 Year Total	
Bicester Neighbourhood[3]	424	671	931	1,002	1,053	4,079	9,788	967	888	892	723	673	9,090	19,726
Kidlington Neighbourhood	63	79	129	106	236	611	1,465	401	586	615	615	645	3,711	8,332
North East Total	486	749	1,059	1,107	1,288	4,689	11,254	1,367	1,473	1,507	1,338	1,318	12,801	28,057

It is not possible for this overall level of growth to be met through existing estates infrastructure and therefore s106 or CIL funding for infrastructure changes will be essential to enable health services to be provided to an increased number of patients.

[2] Data from Cherwell Local Plan and from West Oxfordshire District Council Local Plan. Cherwell's Local Plan Part 1 was adopted in July 2015. A partial review of the plan is underway on housing to provide housing to meet Oxford's unmet need. Population projections are based on 2.4 residents per dwelling.

[3] This includes significant growth in the ex RAF Heyford Park area, for which we expect use of primary care services to be split between practices in the North and the North East localities.

2. The health of our community in North East Oxfordshire locality

2.1 Morbidity and Mental Health

Health outcomes in the locality are generally better than average.

Public Health England publishes a range of health indicators to a local level at www.localhealth.org.uk. These indicate that:

- In the Bicester neighbourhood:
  - Caversfield ward has higher than average deaths from stroke and from all causes among patients under 75
  - Bicester East has higher than average standardised admission ratio for intentional self-harm.

- In the Kidlington and surrounds neighbourhood:
  - Kidlington South has higher than average standardised admission ratio for intentional self-harm.

However, no wards in either neighbourhood has higher than average deaths from cancer (aged under 75) and coronary heart disease (all ages).

Prevalence of certain long term conditions as measured on NE practices' QOF registers is indicated in table 2.

Table 2: Prevalence of selected long-term conditions and mental health

	2016/2017 Prevalence %					
	Atrial Fibrillation	**Hypertension**	**Dementia**	**Depression**	**Asthma**	**COPD**
Bicester	1.6%	11.5%	0.6%	8.8%	6.0%	1.3%
Kidlington	2.4%	15.0%	1.0%	7.6%	5.8%	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%**

Key messages:

North East Oxfordshire has a varied population: older in Woodstock and Kidlington and younger in Bicester. There are significant plans for housing growth in the coming years which will impact NE practices, in particular Heyford Park and Kidlington. Bicester was selected as one of 10 National Healthy New Towns, which will test new ways of delivering health services and improving public health.

Part C: How our population accesses services

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

1. Urgent and Emergency Access

In terms of the utilisation of health services, the rate of GP referred first outpatient appointments is in line with levels across the county, although is highest for trauma and orthopaedics and diabetic medicine. A&E attendances and emergency admissions are marginally higher than the Oxfordshire average *(Figure 2)*. North East Oxfordshire also has the highest use of GP OOH services *(Figure 3)*. As the population of Bicester and North East Oxfordshire grows significantly in the coming years it will be necessary to have appropriate access points to avoid high use of A&E.

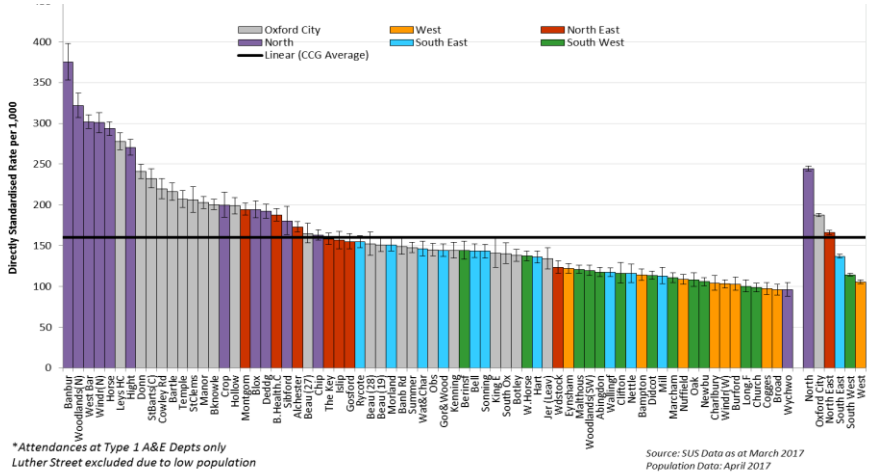


Figure 2: Urgent Care – A&E Attendances (April 2016 – March 2017)
Source: SUS data March 2017

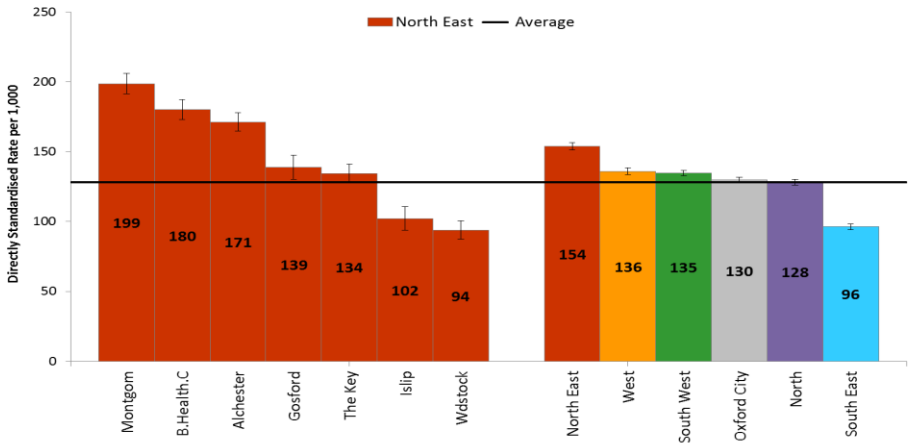


Figure 3: Out of Hours GP Service Attendance (April 2016 – March 2017)
Source: SUS data March 2017

2. Overview of Current Locality Primary Care

2.1 GP Practices in the North East Locality

There are seven GP practices in North East Oxfordshire that provide services from ten locations. The practices are grouped into a neighbourhood configuration as set out in table 3. This enables some services to be delivered at a greater scale.

Table 3: GP Practices in North East locality

#	Practice	Location		Branch surgery site	Population[4]
1	Alchester Medical Group • Victoria House Surgery	OX26 3EU	3	Ambrosden Branch Surgery, (OX25 2RB)	19,717
2	• Langford Medical Practice	OX26 6XX			
4	Bicester Health Centre	OX26 6AT			13,912
5	Montgomery House Surgery	OX26 6HT			14,445
	Bicester Neighbourhood				48,074
6	Islip Surgery	OX5 2TQ			5,881
7	Gosford Hill Medical Practice	OX5 2NS			7,176
8	The Key Medical Practice	OX26 2EU	9	Yarnton Branch Surgery (OX5 1LT)	12,862
10	Woodstock Surgery	OX20 1UD			9,153
	Kidlington and Surrounds Neighbourhood				35,072
	North East Locality				83,146

The location of the practices and branch surgeries is shown in *Figure 4.*

[4] Data from NHS Digital January 2018: http://content.digital.nhs.uk/gppatientsregistered

2.2 Access to Primary Care in North East locality

As described above, North East Oxfordshire has a varied population in terms of need, age and working circumstances. This means that different dimensions of access are valued differently by different people, with some people preferring rapid access to any clinician and some requiring continuity of care with the same clinician. Seven day access is provided within the locality and neighbourhoods through the Neighbourhood Access Hubs based in Bicester (at Bicester Health Centre) and Kidlington (KEY and Gosford Hill Surgeries) in the daytime, and Saturday mornings. This service is provided by the ONEMed federation with an evening rota provided by the majority of the NE practices. Patients also benefit from access to further extended hours GP appointments on Sundays in Banbury. This service is available through cross locality working via the federated group, ONEMed aligned under Principal Medical Limited (PML). 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, and it frees up time for GPs to concentrate more resources on patients who need a level of continuity.

Urgent access for patients with a high level of need is also a priority for the locality. Urgent access for housebound patients is provided through the federation, with a team of experienced Emergency Care Practitioners (ECPs) reviewing patients and liaising with GPs to form treatment / action plans. This Primary Care Visiting Service (PCVS) was a product of the Prime Minister's Challenge Fund (PMCF) and continues via sustainability funding. Because this service is provided across all four of PML's Oxfordshire Federations, the service is more sustainable and flexible, providing cross locality cover, as well as keeping costs down. This service could be expanded by one to two emergency care practitioners to meet increases in demand, especially over the winter period. It will be important that cover remains appropriate in line with demographic changes in the locality.

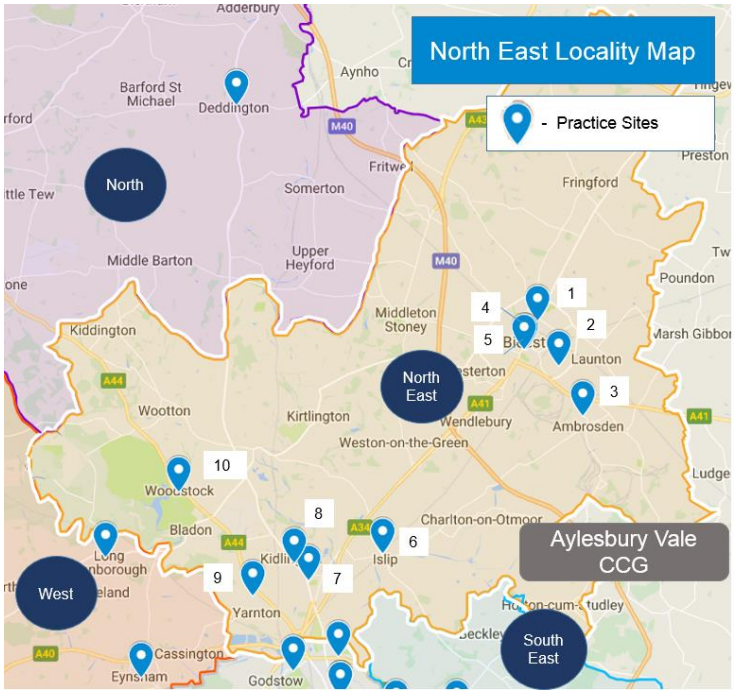


Figure 4: Map of practices and branch surgeries in North East Oxfordshire

2.3 Urgent Care

As part of NHS England's Urgent and Emergency Care Review, there are plans to standardise access to 'Urgent Treatment Centres' through booked appointments via NHS 111. These facilities will have an increasingly standardised offer - open 12 hours a day and staffed by clinicians, with access to simple diagnostics. We are exploring the viability of an urgent treatment centre type model of care in Bicester. This could possibly comprise of:

- GP urgent access hub
- Minor injuries unit
- GP out of hours

- Ambulatory frailty assessment unit, perhaps supporting a hospital at home service for a locality virtual ward.
- Access from 111 and OOH following refinement of the services and
- Have the ability to optimise the use of any spare capacity for extended access primary care services.

Patients also benefit from a range of out-of-hospital services delivered in primary care, for example minor surgery, LARCs (long acting reversible contraceptives) including IUD and implant fittings. Until recently other locality based services have included dermatology, urology, ENT, ophthalmology and sports and exercise medicine. Work is currently in progress through federations to re-instate ENT and urology clinics within the Locality (Bicester). Ultrasound scanning and Echo cardiography is also available locally.

Cross-provider links with community providers (Oxford Health NHS Foundation Trust) continue, with community nurses and health visitors working from local practices. Sexual Health clinics and Drugs and Alcohol clinics led by Turning Point are run from local GP surgeries in Bicester. Oxford Health continues to work from premises at Bicester Health Centre, providing an essential local service for patients requiring mental health support outside of primary care.

2.4 Community Care

There is one community hospital within the locality, namely Bicester Community Hospital, which hosts:

- A First aid unit
- Out of Hours GP services
- SCAS – South Central Ambulance Service
- An inpatient facility for 12 beds which currently has medical cover provided by Bicester Health Centre.
- The Integrated Locality Team is based at the hospital, with a nearby practice supporting a District Nursing Hub.
- Extended access appointments are practice based in the evenings and on Saturday
- OUHFT Outpatient services – running as follows:
    - Rheumatology - twice monthly clinics
    - Paediatric constipation/Eczema - monthly clinic
    - Adult Bladder/Bowel - monthly clinic
    - Metabolic Bone Clinic (Osteoporosis) - monthly clinic
    - Community Paediatrics - monthly clinic
    - Diabetes – monthly clinic
    - Orthopaedic – monthly clinic
    - Gynaecology – monthly clinic
    - Local diagnostics – x-ray

The Hospital at Home team of Registered Nurses, Emergency Practitioner and Assistant Practitioners, work closely with the patient's own GP who provides medical oversight of the patient's needs. In addition, PML provides rapid community assessment and intervention to people in their homes to avoid hospital admissions and facilitate discharge from hospital. Hospital at Home teams work closely with hospitals and GP practices to facilitate early discharges by supporting patients and continuing treatments initiated in hospital after they have returned to their own homes. The service is available to patients in the north and north east of Oxfordshire every day between 8:00am and 10:00pm.

2.5 Primary care workforce

Primary Care is currently delivered across the locality in a fairly conventional way, with all practices operating as traditional partnerships, also employing salaried GPs. Most practices have a role in training, from medical students through to Foundation Year 2 Doctors and GP registrars. Some practices employ Advanced Nurse Practitioners to complement their traditional practice nursing teams while also supporting the GPs in extended roles caring for patients with minor illness and same day urgent need.

The locality has enjoyed excellent working relationships between practices over the years, and continue to work across practice boundaries providing a range of alternative care pathways for patients. The locality undertook a workforce survey in 2017 to assess current capacity in practices. Previous work on capacity undertaken with practices in June 2016 showed that none of the practice buildings were at capacity, and there was the capacity for up to 9,000 additional patients, as long as GP and staff recruitment were possible. In the 2017 workforce survey, this is still significantly below the capacity required to meet the expected housing growth. Table 4 indicates the number of sessions currently delivered and the future number of sessions and GPs required to deliver general practice in the same way as currently.

Future numbers of GPs is likely to be impacted by:

- Intentions across Oxfordshire to move to longer 15 minute appointments for patients with greater needs
- Potential changes in skill-mix and a greater role for signposting and community champions to support patients manage their long term conditions.
- The number of GPs expected to retire, which – based on national trends – is expected to be 30% in the next 5 years.

This indicates a clear need to develop a different approach to workforce in primary care to ensure that it is resilient and able to meet the future needs of the population.

The model of dealing with urgent same day access for non-complex primary care patients is likely to be through two centralised urgent access hubs: one in Bicester and one in Kidlington. These will be GP led but will make use of a range of professionals including ANPs and may extend to diagnostic physiotherapists or mental health workers.

Table 4: GP workforce in North East Oxfordshire locality

Locality	Current workforce			Future projected workforce requirements			
	Current number of sessions delivered*	Number of sessions delivered if no vacancies*	Assumed number of GPs if no vacancies (8 sessions per week)	Number of sessions required in the future		Number of GPs required (FTE) – assumes 8 sessions per week	
				5 years**	10 years**	5 years*	10 years**
Bicester Market	184	199	27.6	240	281	33.3	39.0
Kidlington and Surrounds	146	146	20.3	152	181	21.1	25.1
North East Oxfordshire	330	345	47.9	392	462	54.4	64.2

* Data from workforce survey; **Data calculated from housing projections

Practices are already considering the broader skill mix required to deliver primary care in the future (*Table 5*). The locality approach to delivering this is set out in more detail in under Part E (workforce).

Table 5: Future intentions to recruit other clinical staff (from workforce survey)

Are you considering recruiting any of the staff groups below in the next year?	Yes	No	Maybe	We have already in place	We'd like to share with another practice	Total	Weighted average
Advanced Nurse Practitioner	2	2	1	1	1	7	2.57
Minor Illness Nurse	0	4	1	1	0	6	2.50
Pharmacist	1	5	0	0	0	6	1.83
Paramedic	0	5	0	0	1	6	2.50
Assistant Practitioner	0	4	0	1	0	5	2.40
Physicians Assistant	0	4	2	0	0	6	2.33
Physiotherapist	1	2	2	0	1	6	2.67

2.6 Future Service Delivery

Discussions have taken place across the member practices around what could be delivered at individual practice level, what at Neighbourhood level, and what at Locality level. At present the thinking is as set out in the diagram at *Figure 5*.

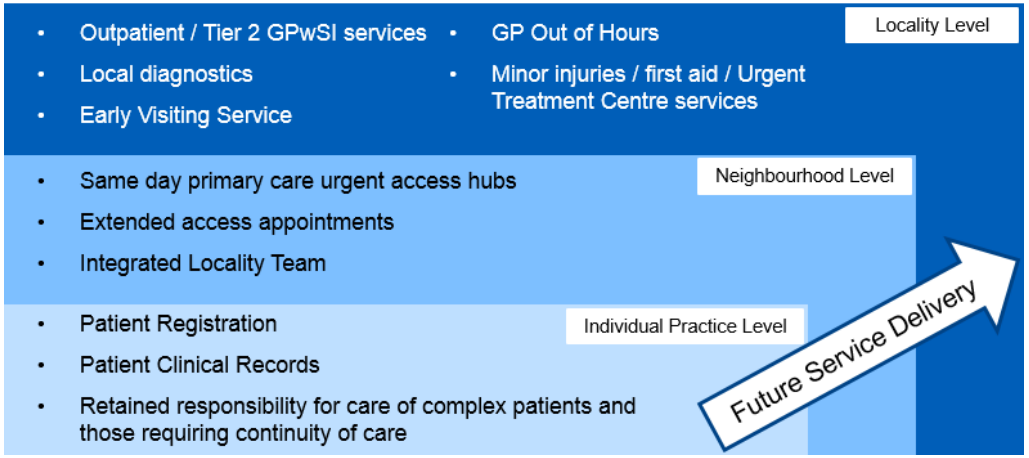


Figure 5: Range of services delivered in primary care at practice, neighbourhood and locality level

2.7 Oxford health / GP federation alliance:

PML, which oversees the ONEMed federation, is in advanced talks with OxFed (the Oxford city federation) and Oxford Health NHS Foundation Trust to create a joint enterprise. Agreement has been gained at board level of the provider organisations to pursue this alliance in more detail.
The aims of this alliance would be to bring the best of both primary and community care together and to achieve:

- Resilient Primary Care and Community Services
- Integrated Care where it benefits Patients / Carers
- More Care Closer to Home.

As a result the perceived benefits for patients would be:

- Better joined-up care with less organisational bureaucracy allowing clinicians to prioritise patient need above historic contractual constraints
- A service able to support more patients at home during crisis or through recovery / rehabilitation phase
- Delivery of care closer to home and therefore beneficial to patients and environmentally friendly.

Key messages:

General practice is delivered largely according to a traditional partner model in North East Oxfordshire.

Both rapid access and continuity of care are priorities for the population in NE Oxfordshire. The federation provides 7-day access hubs at Bicester and Kidlington and same day urgent home visits.

Growth projections suggest that a further 7 GPs (FTE) will need to be recruited to meet demand in the next 5 years if there is no change in the way services are delivered.

In the future more services will be provided through neighbourhood teams to enable more integrate care and care closer to home.

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

Part D outlines the highest priority areas for North East Oxfordshire's primary care service, describing both the current challenges and objectives for improvement. This section also outlines North East's proposed workstreams. These are plans for initiatives targeted towards meeting the objectives of the different priorities. The workstreams act as this report's key recommendations for developing primary care in the locality.

Priority 1 – Sustainability of Primary Care

Background
Recruitment across all clinical and non-clinical fields presents a major challenge for primary care. The reasons for this are well documented and include a historical lack of training of a sufficient workforce to keep pace with increasing demands. The Locality Place Based Primary Care Plan will address the training needs of a workforce fit for the future.

Objectives
The locality will need to align the provision of primary care services into a sustainable model for the future. This is likely to be built around:

- bigger practice units of 30-40,000 patients, with sharing of some back room functions
- streaming of urgent demands to urgent access hubs
- A greater use of professionals other than GPs.

Larger practices, and practices working together within the locality, will be well placed to provide traditional undergraduate and postgraduate training positions for both doctors and nurses. New supporting roles such as Physicians' Assistants, Advanced Nurse Practitioners and Clinical Pharmacists will be further developed, and practices encouraged to provide high quality training places for these clinicians.

We will also develop the role of non-clinicians working in primary care. This includes 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. Oxfordshire Training Network is delivering this training across Oxfordshire.

Larger practices and practices working together will be able to provide:

- Back-room functions more effectively, e.g. payroll, HR, purchasing, call and recall services for chronic disease management, website maintenance, note summarising etc.
- Shared employment of some staff who can work across practices.
- Administration of Call and Recall services – e.g. for chronic disease management, and patient safety assessment (PSA) surveillance.
- Over time, a centralised triage and appointment booking service for the locality, perhaps provided by a future iteration of the 111 service if the clinical model supports doing this effectively.

Given current pressures within primary care and the increasing number of visits to general practice each year, we will prioritise providing urgent same day access where clinically appropriate, which is currently being achieved but which should be maintained. As resources allow, we will work to reduce the wait for routine appointments depending upon the pace of investment in primary care capacity. In the short term, we aim for the waiting time of routine appointments to be within 2-3 weeks. This will be reduced to 1 week within 4 years (or earlier if investment allows). This is subject to both staff being able to be recruited, and patients' willingness to be seen by the most appropriate person (not necessarily a GP), and not necessarily at their own practice site.

We will continue to support vulnerable practices via OCCG Quality Team input, in a variety of ways depending on the practice issue and CQC requirement. This may also be in discussion with ONEMed Federation, as working at scale is the preferred option.

A workforce to support this will require the retention of staff currently operating in primary care and the recruitment of new staff with a broad mix of clinical skills to support patient care. These staff will need to be recruited across a broad range of pay-grades and could be headed-up by a GP acting as an executive decision maker. There is also a role for the federation in options for a federated employment model and cross-provider agreements/contracts.

Priority 2 - Developing increased capacity within primary care to meet housing and population growth

Background
In addition to the increased demand from patients for timely access to primary care, significant housing growth in Bicester and Kidlington & surrounding areas will have an impact on the ability of practices to perform, expand or re-locate to provide care for the increases in list-sizes. Practices will require:

- Funding to be available under a medium to long term plan to allow growth and early models to be supported from the outset knowing future support will follow
- Population modelling to understand future population needs.

Future primary care infrastructure will need to respond in a timely and appropriate way to future housing growth so that patients will be able to access primary care services at the surgery. The locality is working with planning authorities at Cherwell and West Oxfordshire District Councils 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. Future locations of surgeries will be subject to an options appraisal which will include considerations regarding accessibility, capacity and expected utilisation and how best to provide services.

Increased capacity to meet changing demand is met through Neighbourhood Urgent Care Hubs which provide on the day appointments during core hours and through extended access appointments at evenings and weekends. The urgent care hubs provide appointments for patients as an alternative to an appointment at their own GP surgery at short notice and avoid attendance at A&E. Extended access appointments are particularly beneficial for people who wish to avoid taking time off for work. Both help GP practices meet the increasing demand for urgent appointments and enable GPs more time for planned care. Services includes:

Bicester:

- Urgent Care Hub service Monday to Friday between the hours 9am to 6pm with extended access appointments through to 8pm, and Saturday morning.
- Contributing towards the provision of Sunday morning access to routine appointments for Bicester patients on a cross county basis, in alternative locations.

Kidlington, Islip & Woodstock:

- Urgent Care Hub service Monday to Friday between the hours of 9am to 6pm split across Gosford Hill & KEYs with extended access appointments through to 8pm, and occasionally Saturday mornings.
- Contributing towards the provision of Sunday morning access to routine appointments for Kidlington, Islip and Woodstock patients on a cross county basis, in alternative locations.

Access to a locality frailty unit together with an enhanced hospital at home and virtual ward function should reduce admissions, allow earlier discharge and reduce the number of patients with delayed transfer of care (DTOCs).

Objectives
The locality aims to increase the capacity within the urgent care hubs and offer:

- Additional appointments as funding and recruitment allows, and
- Appointments for more services, including near patient testing.

Urgent demands will be streamed to the urgent access hubs, which will increase capacity both in acute primary care services and in times of pressure. These will work in synergy with the combined urgent treatment centre facility locally.

The additional capacity will have workforce implications and we will explore skill mix within practices. Rotation into the GP Access Hub with flexible clinical roles will be a core offer to attract more young GPs to work within the local practices.

Additional capacity in the urgent care hubs also supports Priority 3 (planned care) as it releases clinical time within practices to enable GPs and other clinicians to work at the top of their grade and have longer appointments to manage patients with complex co-morbidities, and allows more work at the primary / secondary care interface, in liaison with integrated locality teams.

Priority 3 – Developing new models of clinical care for planned care and long term conditions management

Background
North East Oxfordshire is already leading the way with integrated care between primary, community & secondary care for patients with diabetes enabling patient empowerment and self-management. A Bicester practice already hosts the Community based Specialist Diabetes Nursing service. From April 2018, we will consolidate the developing local diabetes service with an alliance contract with community / secondary care for the provision of all outpatient and community services. This will be an alliance contract between the GP federation, Oxford University Hospitals NHS Foundation Trust, and Oxford Health NHS Foundation Trust to deliver an integrated diabetes service co-ordinated by a locality clinical board with an outcomes based contract and resources and responsibility shared between the alliance parties.

Objectives
Following the success of the local diabetes service, we will build on the model to bring chronic disease management closer to home, enabled by extending the model to other chronic diseases, starting with COPD, and over time to heart failure and asthma (adults).

There are also plans for the following:

- delivering a range of planned care clinics and diagnostics locally, some including pathways led by GPs with a specialist interest, such as urology, ENT, neurology (headache clinics), cardiology and potentially urology, considering the range of services that can be provided in the community
- Musculoskeletal (MSK) Hub
- Bladder & Bowel service,
- Local optometrists offering a minor eye condition service,
- Extension of vascular leg ulcer telemedicine clinics to include other specialties like geriatrics
- Possibly locally based CT scanning in the future (if cost effective)
- Develop minor ailment treatment schemes with local pharmacists.

The model needs to:

- Build on the work that is being piloted with diabetes
- Deploy staff based on their clinical skill, not on whether the patient is housebound
- Encourage the spread of clinical expertise – using experts in primary care and community nursing as a source of advice
- Consider other ways of consulting e.g. group sessions, webinars, Skype
- Encourage the use of expert patients (in the same way that the Recovery College does)
- Be cognisant of the major cultural change that is required to encourage staff to work beyond traditional boundaries – as a result change needs to be led locally and incrementally
- May involve non practice staff using practice space to provide care/run clinics.

Priority 4 - Developing new models of clinical care for Urgent Care, particularly frail elderly patients

Background
The population in Oxfordshire is ageing at a higher rate than the rest of the country; in the 5 year period between 2017 and 2022, the age group with the highest growth in all districts and Oxfordshire county is expected to be people aged 75 to 84 (+23% in Oxfordshire).

Currently, a Primary Care Visiting Service (PCVS) operates in North East Oxfordshire. The service is made up of a team of Emergency Care Practitioners (ECPs) who work closely with GP practices to provide home visits to the elderly and housebound providing care from Monday to Friday 9am-6pm. The service enables earlier access to ambulatory care services, improving the chances of providing patient's care at home, or providing more timely admission and treatment for improved clinical outcomes, signposting patients to ongoing support services e.g. hospital at home (north), social services, integrated locality teams. It is considered a valuable resource to practices, and it will be important that provision continues to meet demand.

The PCVS exists as a shared central resource across all the areas covered by the PML GP Federation as this is an effective, efficient and economical way for it to operate with the administration and call handlers based centrally at PML head offices in Banbury. Frail patients needing secondary care assessment are either admitted to Oxford or Banbury or seen in the Ambulatory assessment units at either the John Radcliffe Hospital in Oxford or the Horton General Hospital in Banbury our future model would aim to have a local ambulatory assessment centre in the community hospital in Bicester.

Objectives
Our aim is to develop a locally based ambulatory care assessment facility with near patient diagnostics and secondary care input, either within a local Urgent Treatment Centre, or virtually in a hub and spoke model.

Working together with an extensive **integrated locality team with a single point of access** to support frail older patients at home with:

- Links to the ambulatory assessment service with secondary care input
- The ability to facilitate early discharge from hospital
- The ability to maintain physiologically unstable patients at home or in Nursing Homes with some secondary care input from a locally co-ordinated ambulatory care facility with provision of a dedicated service for medical advice (perhaps part interface medic/secondary care provided) and support 24/7 with access to medical notes and care plans as a cost effective part of sustaining a group of medically unstable patients in the community perhaps as part of a virtual ward.
- Improving long term conditions care – we believe that a combination of more time within primary care, and liaison with community based hospital clinicians and specialist nurses will allow us to optimise the care of patients with long term conditions. The aim is to anticipate

decompensation and allow us in the most part to care for these patients in the community, with hospital admission becoming an exception.

- We will aim to improve patient care by the consistent and rational application of clinical pathways, patient education, and robust anticipatory plans for patients who have the potential to decompensate.

We intend to continue the home visiting service and include undertaking palliative care training. This includes continuation of previous work undertaken on digital Proactive Care Plans in place for all patients who are considered end of life. This enables co-ordination of care for patients through a directory of services when support is requested via 111, South Central Ambulance Service. Information on services which are available can also be via the COACH website, and Care Navigators. The 2% of patients with high intensity needs will be targeted in particular.

Priority 5 - Increased self-care and promotion of health and wellbeing

Many of the diseases affecting Bicester residents – cardiovascular disease (CVD), chronic obstructive pulmonary diseases, type 2 diabetes and cancer – are linked by common and preventable risk factors. It is estimated that 80% of cases of heart disease, stroke and type 2 diabetes and 40% of cancer cases could be avoided if 'high risk behavioural factors', including poor diet, lack of exercise and tobacco use, were eliminated.

A Kings Fund report identifying priority areas for Clinical Commissioning Groups states that expenditure on prevention is 'an excellent use of resources'. In a review of more than 250 studies published on prevention in 2008, nearly 80% were within the National Institute for Health and Care Excellence's threshold for cost effectiveness.

While specific prevention services can be commissioned e.g. a smoking cessation or weight management service, the locality is testing a system wide population based approach to promotion of health and wellbeing and increased self-care through the Healthy New Town Programme at Bicester.

System wide approaches to health promotion recognise that individual behavioural change is enabled and sustained through social influences of family, friends and work colleagues as well as the wider environment. A population based approach which looks at how different parts of the system need to work together to make healthier lifestyles the norm is illustrated in *Figure 6*.

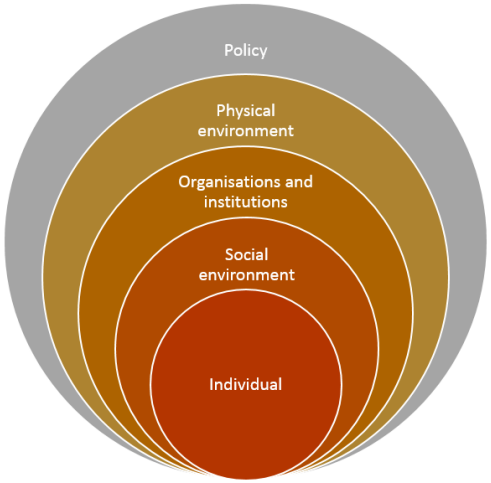


Figure 6: Population based approach to healthcare

The programme aims to increase individual capacity for self-care and ill health prevention, activate support from the local community (family, friends, voluntary organisations, businesses and schools), and develop a physical environment which makes it easier to have a healthy lifestyle. The programme consists of a range of activities that influence behaviour through the built and natural environment, community networks, and health and social care service remodeling. Its key priorities are supporting residents in maintaining a healthy weight and reducing social isolation and loneliness. Digital Innovation is a key enabler for the programme led by Oxford Academic Health Science Network. This includes new digital technologies and health related applications to promote self-diagnosis, self-testing and monitoring and self-care. Some of this work may include the use of approved app site information.

The key programme objectives are as follows:

Built Environment: making the best use of Bicester's built environment to encourage healthy living in order to:

- Maximise the use of Bicester's green spaces for healthy living
- Create a 'walkable and cycleable community' with a comprehensive walking and cycling network
- Develop planning policies which support the creation of a healthy environment.

Community Activation: helping local people to live healthier lives with the support of community associations, schools, and employers, to:

- Build better connected communities with the creation of a network of volunteer community activators
- Support schools, nurseries, colleges and families to get young people more active and eating healthily in order to increase their physical and mental wellbeing and to develop family skills around self-care to give children a good start in life
- Encourage local workplaces to promote health and wellbeing at work.

New Models of Care: acting as a test bed for the new models of care articulated in the local plan, including:

- Increase patient self-care
- Create a 'primary care home' with integrated community care supporting GP clusters to care for people with complex care needs
- Deliver new care pathways for long term conditions which minimise hospital based outpatient care (focusing first on diabetes)
- Plan to meet future care needs through the provision of primary and community care from health campuses in the town.

Primary care has an important role in empowering patients to self-care, taking responsibility for their own health and wellbeing, and knowing how and when to seek help when they are unwell. It is seeking to do so through:

- Making every contact count: in which every contact with a patient (in primary, community and secondary care) is used as an opportunity to improve patient knowledge and level of involvement in their care
- Using personalised care planning as used in the 'House of Care' model to engage informed patients to work in partnership with health professionals to better manage their health and health care
- Referral to exercise on prescription, structured diabetes education and other initiatives that seek to support behaviour change and better self-management of long term conditions
- Making shared decision making the norm
- Increasing the use of Patient Decision Aids; condition specific information that is accurate and balanced and allows patients to think about the pros and cons of a particular treatment, clarifying what the patient hopes the treatment will achieve
- Development and testing an appropriate model of social prescribing
- Increasing access to NHS Health Checks, particularly for more vulnerable people, in particular those in the 2% high intensity group, and patients with autism or Learning Disabilities.
- Working with schools to promote healthy lifestyles, increase health literacy so that young people and their families use health services appropriately, and encourage students to consider the wide range of career opportunities within health care.

For the locality more broadly, we will aim to:

- **Generate a strategy to advance** prevention – looking at how the wider primary care / community team can deliver more prevention – an example of this is the Blue 0-5km lines now showing in Bicester to encourage people to exercise.

- **Increase patient self-care** through:
  - Encouraging take-up of screening opportunities within practices, and by promoting screening programme material within practices
  - Learning from the City discussions on influenza, and continuing to put in place robust immunisation services, both within practices and care homes. Focus areas will include under 65yrs in at risk groups, over 65yrs, and increasing uptake by pregnant women in particular, working more closely with midwives.
  - Signposting to patient information for self-management
  - Optimum use of voluntary agencies and local services to support patients' non clinical needs
  - Social prescribing directory of services – this will include considering centrally how existing the existing Directory of Service can be best used from other organisations, e.g. 111, South Central Ambulance Service, COACH, Care Navigators etc.
  - Publicising 'open door' services such as community Pharmacists, Optometrists, musculoskeletal services, IAPT etc through central service launches, other relevant networks such as fora for older people, the voluntary sector and faith communities, Patient Participation Groups, with a Did You Know approach.
  - Promoting patients' use of IT to support their chronic condition management, e.g. Map My Diabetes
  - Whilst not a significant issue for this locality, it is considered an important area of need, and practices will continue to support and co-operate with the work of the countywide Safeguarding Team.

- **Third Sector input –** working with the Integrated Locality Team (ILT) we wish to optimise the contribution from local third care sector organisations either in the direct provision of care to patients in the community or by signposting patients to appropriate channels of support.

- **Social Prescribing:** Social prescribing is a means of enabling GPs and other healthcare professionals to address the social, emotional and practical needs that patients often raise in consultations. It involves referring patients to a link worker who together with the patient co-design a non-clinical social prescription which addresses their needs and involves accessing services provided by local voluntary and community groups to improve their health and wellbeing. This understanding is based on the definition produced by the National Social Prescribing Network.

- **Increase the contribution of mental health workers in several practices**. Up to 90% of depressive and anxiety disorders are treated in primary care. The most common method of treatment for common mental health disorders in primary care is psychotropic medication. This is due to the limited availability of psychological interventions, despite the fact that these treatments are generally preferred by patients. Having a mental health worker attached to or working alongside GP practices, improved the knowledge, confidence and capacity of the other primary care professionals in the practice. Securing targeted investment in GP surgeries and primary care will provide better support to deprived groups, support increased access in higher need areas, and specifically address the needs of vulnerable populations.

Planning for the future:

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

Summary of workstreams to meet the North East Oxfordshire priorities

		Priorities				
#	Workstreams	Sustainability of Primary Care	Increased capacity in primary care to meet housing and population growth	New models of clinical care for planned care and long term conditions management	New models of clinical care for Urgent Care, particularly frail elderly patients	Increased self-care and promotion of health and wellbeing
1	Primary Care Urgent Access Hubs	■	■	■		
2	New model of urgent care in bicester	■	■		■	
3	New staff models of working and support for practices to work in larger units	■				
4	Expansion of Primary Care Visiting Service		■		■	
5	Deliver prevention services through the wider primary care / community team		■			■
6	Explore benefits of social prescribing		■			■
7	Consolidate the local diabetes service			■		
8	Extend the Locality diabetes model to COPD			■		
9	Deliver planned care clinics and diagnostics locally			■		
10	Development of integrated locality team				■	
11	Estates prioritisation	■	■			

Workstreams

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

Workstreams	Delivery scope	Benefits	CCG support	Implementation steps	Duration
Primary Care Urgent Access Hubs	Increase capacity in the hubs to be able to meet demand in acute primary care services and in times of pressure. Urgent demands will be streamed to the urgent access hubs	More services can be delivered through the hubs, including near patient testing Allows GP to have longer appointments. Studies have shown 7 day access can achieve: Overall reduction of A&E attendances of 9.9% Overall reduction of Emergency Admissions (via A&E) of 5.9%	Monitoring of utilisation and impact	Recruit and retain GPs and nurse practitioners , consider integrating some of them with practices	Over next year but ongoing expansion as new services develop and the town grows.
New model of urgent care in Bicester	Standardised offer - open 12 hours a day and staffed by clinicians, with access to simple diagnostics. To replace FAU at Bicester community hospital and include: • GP urgent access Hub • Minor injuries unit • GP out of hours • Ambulatory frailty assessment unit, perhaps supporting a hospital at home service for a locality virtual ward (considered separately below) • Access from 111 and OOH following refinement of the services	A system that is intuitive and helps people make the right decision; Alternatives to A&E that provides timely clinical access Focus resources in hospitals on the sickest patients Reduce pressure on staff enabling them to provide higher quality care	Set up	To be confirmed in business case	From later 2018
New staff models of working and support for practices to work in larger units	Support for sharing of staff within the locality – potentially a federated employment model, cross-provider agreements/contracts in conjunction with the Federation. • consideration of training / support / sharing best practice • Sharing of back office functions • Explore options for broader skillmix	Retention of staff in primary care Builds general practice sustainability Allows broader skill mix of primary care with GPs as the lead / working at top of licence	Support package for mergers	Some practices have mergers dependant on infrastructure changes, some will work ever more closely. Work to facilitate joint posts may help	Starting over next year ongoing 5 years
Primary Care Visiting Service	Increase the capacity of the visiting service Palliative care training Continuing the care homes support a suitable form	Supports primary care sustainability, allows assessment of frail elderly patients earlier in the day, supporting early	Federation-led	System established and working well just needs recruitment and funding to expand	Now and ongoing expansion over 5 years

		assessment in an ambulatory care centre supporting care at home. Can help support care at home for frail elderly			
Deliver prevention services through the wider primary care / community team	Promote a healthier environment through the Healthy Bicester New Town work. - Increase patient self-care. - Signposting to patient information for self-management. - Optimum use of voluntary agencies and local services to support patients' non clinical need. - Social prescribing directory of services. - Promoting patients use of IT to support their chronic condition management, e.g. Map My Diabetes.	Improving patients general health and well-being and reducing future demands on the health services	Continued joint working with the Council	Building on healthy Bicester work and new models of care	Now and ongoing over 5 years
Social Prescribing	Social prescribing scheme for patients referred by GP to self-sustaining schemes working together with Cherwell council. People will be encouraged to get involved in activities that match their interests – they may promote physical exercise or simply social integration. If the voluntary activity involves a cost, vouchers will be provided so that the initial sessions are free. Voluntary groups to be reimbursed this cost.	Reduced obesity and social isolation; more sustainable use of primary care	Encourage practices to take part. Collaboration with other partners.	July – Sept 2018: soft launch Oct 2018 onwards: service fully operational Sept 2019: annual review to assess impact	Recurrent 5 years
Consolidate the local diabetes service	An agreed alliance contract between community & secondary providers for all outpatient and community services.	Better diabetic care and reduced cost to the system in the long through better outcomes for patients	Bringing providers together to deliver transformation initiatives	In train to start April 2018 subject to model and contract being agreed	From 18/19
Extend the Locality diabetes model to COPD	Apply the principles of the local diabetes model to other chronic diseases including COPD	Better care closer to home	Bringing providers together to deliver transformation initiatives	To explore in 2018 depending on success of diabetes model	From 18/19
Deliver planned care clinics and diagnostics locally	- Urology, ENT, Cardiology, Bladder & Bowel: develop a local service with GPwSI. - Urology: create a central "PSA database" for monitoring of patients with prostate cancer. - Neurology: develop a local GPwSI service for headache clinics. - Musculoskeletal (MSK): create a hub for services. - Optometry: offer a minor eye condition service. - Vascular leg ulcers: extend telemedicine clinics to include other specialties like geriatrics.	Better care closer to home	Project management and contract specification	All being pursued centrally by OCCG	From 18/19

	- CT scanning: determine if a local service is cost effective.				
Development of integrated locality team including Ambulatory Assessment Service	- Working together with an extensive integrated Locality Team to support frail older patients at home with : • Links to the ambulatory assessment service with secondary care input • The ability to facilitate early discharge from hospital • The ability to maintain physiologically unstable patients at home with some secondary care input from a locally co-ordinated ambulatory care facility with provision of a dedicated service for medical advice (perhaps part interface medic/ secondary care provided) and support 24/7 with access to medical notes and care plans as a cost effective part of sustaining a group of medically unstable patients in the community perhaps as part of a Virtual ward.	More co-ordinated care for the patient closer to home Reduction in A&E and ED admissions	Management of programme	Current work to be taken forward with the alliance contract with OH	18/19 Onwards
Estates prioritisation	New housing developments, in particular around Kidlington, Bicester and Heyford Park is likely to require additional primary care infrastructure. Options appraisals will need to consider accessibility, capacity and expected utilisation and how best to provide services. In addition, current estates needs to be reviewed to support organic growth and to allow the delivery of different models of care.	Fit for purpose and efficiently resourced estates that provides appropriate and accessible primary care and out of hospital care.	CCG-led working with district councils and private developers	Prioritisation exercise of current estates. Assessment of cost and availability of estates Options appraisal	18/19 onwards

Key messages:

North East Oxfordshire's key priorities are focussed on:

- Sustainability of Primary Care
- Increased capacity in primary care to meet housing and population growth
- New models of clinical care for planned care and long term conditions management
- New models of clinical care for Urgent Care, particularly frail elderly patients
- Increased self-care and promotion of health and wellbeing

In response to these priorities the locality have designed 11 workstreams to which act as the central recommendations for this plan and a strategy for the future of primary care within the locality.

Part E: Making a success of our plan

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

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

1. Workforce:

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

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

This includes concrete working with partners to:

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

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

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.

In the North East, we will aim to increase effective contributions from:

- Extended trained health care assistants
- Advanced Nurse Practitioners
- Pharmacists (scheme to encourage patients to obtain over the counter medications directly from the Pharmacists together with advice for simple medical problems)
- Physicians Associates
- Diagnostic physiotherapists
- Paramedics
- Practice based Mental Health workers
- Working within the Primary Care Locally Enhanced Service requirements, to improve the coordination of all aspects of health for patients with Learning Disabilities, Autism, and severe mental illness.

The locality recognises that the provision of good training attracts and retains staff and increases the morale of current staff. Working through the Community Education Provider Network will be supported through the measure above. The locality also acknowledges that all changes outlined in this document must be managed efficiently and carefully and that management teams must be trained and upskilled accordingly.

Buy-in from member practices and GPs is integral to effective changes. The key step to making change is a shared understanding/vision, without which we will struggle to succeed in our goals. We need to agree on our direction of travel as practices, as neighbourhoods and as a locality.

2. Estates

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

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

The CCG will additionally provide support for appraisal of estates solutions together with community health and local authorities, where relevant. This includes solutions that optimise use of existing local estate, 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.

Bicester has two natural campuses with Alchester Medical Practice; a newly merged practice over 2 sites with a Branch surgery in Ambrosden as one, and an alliance between Montgomery House Surgery and Bicester Health Centre forming the other. Apart from Islip practice, all practices in the Locality will need significant infrastructure investment to cope with the increase in population and to allow the delivery of different models of care. Woodstock practice are keen to re-locate to larger purpose built premises , the practices in Kidlington wish to re-locate to new central premises to allow the delivery of services at scale on a campus model. With Bicester's Healthy New Town Status, there are exciting opportunities to pioneer new models of care in the community which can be extended across the Locality. Any relocation will be subject to consultation with patients and future accessibility, including transport links, will be a key consideration.

Given the need to both expand current core services in response to population growth, and the need for clinical space to develop new models of care, the following table is an estimate of the additional space we will require. Clearly if more ambitious plans to move care into the community are developed it will require commensurate additional space.

Practice	Surgery	List size April 2017	Extra population absorbable within current premises	List size expected by 2021/22	List size expected by 2026/27	Current surgery area m² gross internal area	Required surgery area to meet population needs in 10 years' time m² gross internal area		Area required for extended service delivery
Alchester Medical Group	Victoria House Surgery	19,635	2,000	25,000	30,000	620	1,750		1000
	Langford Surgery					480			
Montgomery House Surgery		14,042	2,000	17,750	20,750	1,000	1,333	2,350	1000
Bicester Health Centre		13,652	2-3,000	17,250	20,250	910	1,333		
Bicester neighbourhood		47,329	7-8,000	60,000	71,000	3,010	4,415	4,100	2,000
Keys Medical Group		12,672	300	20,700	26,500	973	1,550		1,000
Gosford Hill Medical Practice		7,165	500			427			
Islip Medical Practice		5,829	100	5,900	6,000	682	500		1,000
Woodstock Surgery		9,076	600	9,400	10,500	280	916		1,000
Kidlington neighbourhood		34,742	1,500	36,000	43,000	1,680	2,966		3,000

We need to explore a more flexible model of funding buildings that have multiple inhabitants from different sectors of Health and Social Services. We are in active discussion with NHS England about how lessons learned from vanguard sites elsewhere can contribute. This will require NHSE and OCCG support to enable the expansion of the Locality, particularly around premises, financial investment and appropriate contractual arrangements.

The proposals in the plan consider best use of clinical and non-clinical occupancy accommodation at Bicester Community Hospital, including using the space to deliver EMU and MIU services together with GP urgent access and possibly extended access services within the current hospital. Moving some services located in current primary care premises to the hospital may free up clinical space for Core GMS within practices. This would require the space to be available on the same basis and with the same security as notional rent funded GMS space if it is to be offered as a substitute.

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:

- 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)
- Citizen facing technology, including aligning portal plans and auditing apps that empower patient self-management
- Risk stratification and modelling to support care co-ordination, clinical decision support and referral management tools
- Infrastructure and network connectivity, including shared network access and access to records by care home staff
- Information Governance, developing confidence in primary care over how data is accessed.

In North East Oxfordshire integrated/shared GP records between GP surgeries and other members of the Primary Care Team will be key to the development of our model of care within the community. Future developments will include:

- Telemedicine links – current vascular leg ulcer clinic model to be extended to other specialties - currently in 2 locations with plans to open the service to other practices in 2017/18
- Virtual out-patient appointments with Skype for business in the diabetes model to be explored in other specialties
- Diabetes in 2017/18 aiming to scope COPD in 2018
- Exploration of telemedicine for monitoring of patients in care homes.
- To look at Skype consultations supported by a local ambulatory care facility in 2018/19
- Exploration of remote monitoring of patients with complex chronic disease to anticipate and prevent decompensation and hospital admission.
- Patient access to records and digital enablers for the care of patients with chronic disease, such as 'Map My Diabetes' to be explored.
- Use of digital technology to enable seamless communication with secondary care for clinical advice, OP letters and discharge summaries
- Digital interaction with patients via practice websites and practice clinical systems to empower patient self-management and allow easier and more convenient access to clinical services
- Future technological advances will have an impact on our future digital strategy.

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. 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.

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[5]. Funding recommended by OPCCC for delivery of the plans across Oxfordshire in addition to current funding in the initial years is set out in table 6 below. This covers part of a longer term investment over the period of the plans and does not include investment in estates or future demographic growth, which is determined nationally.

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

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

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

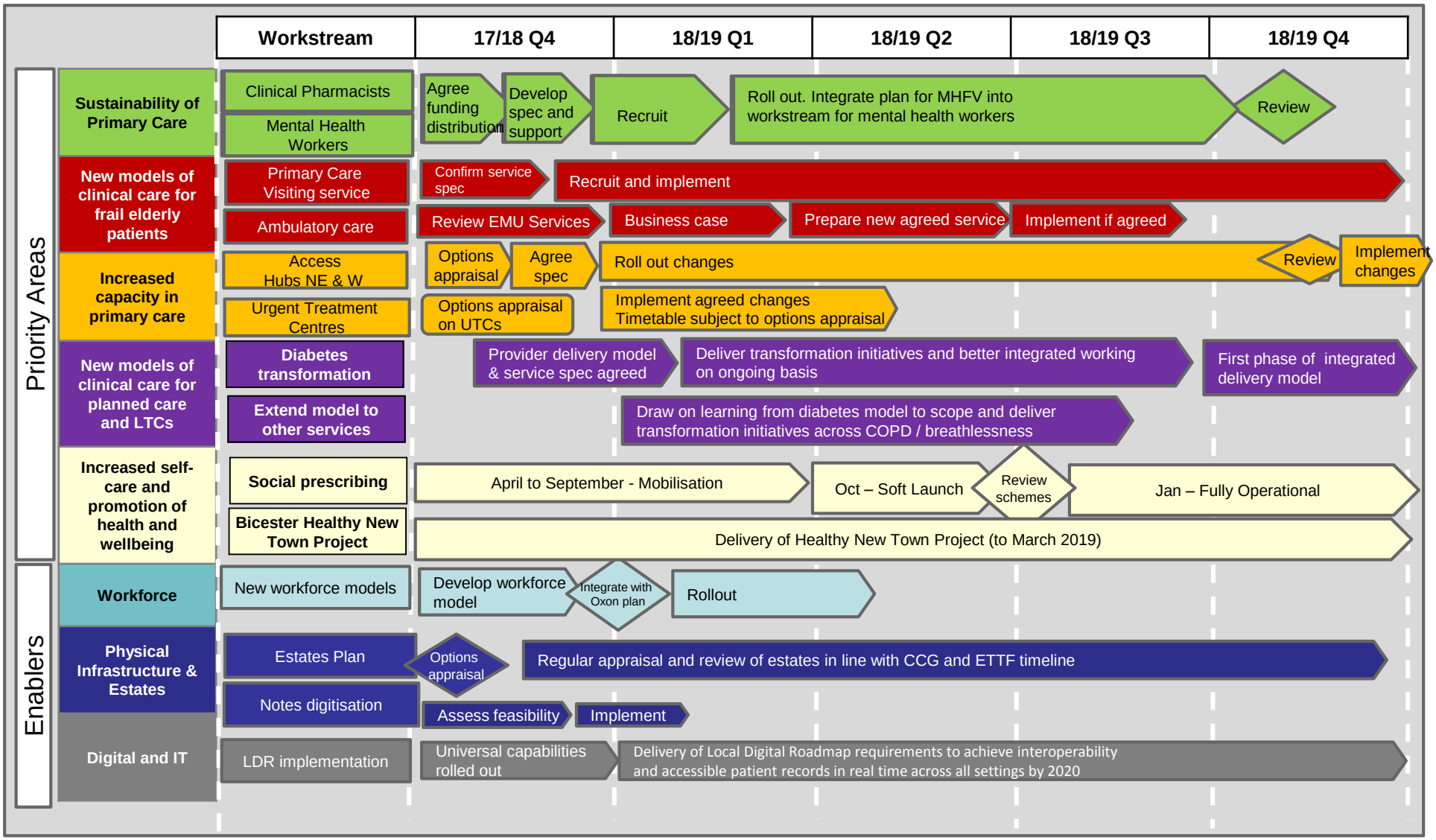
5. Outline Mobilisation Plan

See following page.

Key messages:

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

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


Workstream
17/18 Q4
18/19 Q1
18/19 Q2
18/19 Q3
18/19 Q4
Priority Areas
Enablers
Sustainability of Primary Care
Clinical Pharmacists
Mental Health Workers
Agree funding distribution
Develop spec and support
Recruit
Roll out. Integrate plan for MHFV into workstream for mental health workers
Review
New models of clinical care for frail elderly patients
Primary Care Visiting service
Confirm service spec
Recruit and implement
Ambulatory care
Review EMU Services
Business case
Prepare new agreed service
Implement if agreed
Increased capacity in primary care
Access Hubs NE & W
Options appraisal
Agree spec
Roll out changes
Review
Implement changes
Urgent Treatment Centres
Options appraisal on UTCs
Implement agreed changes
Timetable subject to options appraisal
New models of clinical care for planned care and LTCs
Diabetes transformation
Provider delivery model & service spec agreed
Deliver transformation initiatives and better integrated working on ongoing basis
First phase of integrated delivery model
Extend model to other services
Draw on learning from diabetes model to scope and deliver transformation initiatives across COPD / breathlessness
Increased self-care and promotion of health and wellbeing
Social prescribing
April to September - Mobilisation
Oct – Soft Launch
Review schemes
Jan – Fully Operational
Bicester Healthy New Town Project
Delivery of Healthy New Town Project (to March 2019)
Workforce
New workforce models
Develop workforce model
Integrate with Oxon plan
Rollout
Physical Infrastructure & Estates
Estates Plan
Options appraisal
Regular appraisal and review of estates in line with CCG and ETTF timeline
Notes digitisation
Assess feasibility
Implement
Digital and IT
LDR implementation
Universal capabilities rolled out
Delivery of Local Digital Roadmap requirements to achieve interoperability and accessible patient records in real time across all settings by 2020

Appendix 1: Patient and Public engagement and involvement

The NE Locality values the input of patient voices, and will continue to work closely with the Forum to support them in strengthening their PPGs, and working alongside Health Watch in the future. The NE PPG Forum has run a number of public events over the past 18 months, including one in Kidlington, one in Bicester, and one in Woodstock. These have taken the form of stallholders providing information to people attending, and were widely advertised. The approach of 'Have Your Say about Health Services' was used, and PPG participation promoted.

A number of themes have emerged from these events. Discussions at Forum and PPG meetings covered the following themes:

- Patients are anxious about changes which might mean they don't know their GP. This applies more to those with long term or complex problems.
- There is anxiety that amalgamation of practices into clusters covering 30,000 patients will mean never seeing the same 'trusted' GP twice. This will need to be considered in any linking up of services across practices.
- Patients will be happy to go locally for services (up to 5-6 miles) but want consistent advice and management from someone who 'knows them'.
- Urgent episodes in the 'usually well' do not have the above problem, and feedback from users of the Hub are usually very positive. Some practices are still able to 'fit in' urgent requests especially from their more elderly patients - who will have more complex needs, however with a move away from the more traditional way of practice working, this is becoming more difficult.
- The overall idea of 'care closer to home' is popular but anxiety is raised that GP availability will be reduced for all if they are having to take on extra for some. This also relates to extended hours, where many patients hold a view that Sunday access is not necessary and will have a detrimental effect on core hour GP cover as the overall capacity of GPs is limited.
- Patients with long term conditions very quickly manage to like and use other professionals such as respiratory or diabetic nurses, with confidence in the knowledge that they are highly competent and prepared to discuss complex problems with the GP. Long may this continue.
- Transport links to services need to be considered, or sufficient parking.
- IT use for some patients is an option (monitoring for some house bound patients who feel comfortable with this model is welcomed), however there is recognition that this will not suit all patients and visiting options also need to be available.
- Communication with patients on what information is available for all patients is important, as many are not aware of what local services are provided, and when to it is appropriate to attend locally or visit Oxford or Banbury A&E departments.
- The issues around prevention and education are important to patients; therefore reliable trustworthy information being widely available is key to self-care.
- PPGs have a valuable role to play in shaping services. One PPG group that has moved from virtual to face-to-face meetings has reported that they are now advertising:
    - Healthy Walks in the area, and "On Yer Bike" Healthy Cycling – a group set up by one of the F2F members,

  - working on how they can give some IT help to practice patients who are willing to book appointments and repeat prescriptions online, but need some tutoring or extra confidence to do this
  - increasing knowledge of the volunteer driver schemes serving the practice area.
- Other PPGs are supporting various Bicester Healthy New Town initiatives, or working to support their practices with the premises and capacity issues they face.

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 Bicester on 30 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.

In the North East Oxfordshire Locality, 46 registered to the Talking Health site to access the documentation, 13 people then responded to the survey and a further 29 took part in the second survey. In addition, the CCG received responses relevant to the North East Oxfordshire locality from:

- Cherwell District Council
- Banbury and Bicester Labour Party
- Keep our NHS Public
- Mid Cherwell Neighbourhood Plan
- Pegasus Group
- Robert Courts MP.

The workshop in Bicester on 30 November 2017 gave local people the opportunity 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 workshop) 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 plan.

Respondents to the initial draft of this plan published in December 2017 were positive about the plans and the services that they currently received, citing some welcomed initiatives including walk-in blood clinics, online services and access to nurse practitioners. There was concern about waiting times for non-urgent appointments, and the impact this has on continuity of care. Respondents were also aware of the planned

increase in housing and the population growth in area and so were keen to see more clinics in the community and services at the Horton Hospital retained. Some of the key themes included:

- Training of other health professionals
- Access
- Funding
- Bring secondary care consultations to GP surgeries
- Improve mental health services
- Increase provision, due to housing and population growth.

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?	Funding consequences for the initial years of the plans have been included in the updated plans. Not all aspects of the plans require long term investment. Some elements include, for example, different ways of working or delivering efficiencies that reduce bureaucracies. However, full implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. The vast majority of investment in primary care is determined through a nationally agreed formula. However, some additional funding that was secured through the Prime Minister's Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. In the longer term, the sustainability of health and social care in Oxfordshire will be dependent on releasing funds from secondary care and investing this into primary and community care.
Phase two STP transformation programme	• Why are you producing the plans now when the consultation on phase 2 of the STP transformation programme has not yet started?	The plans aim to set out how primary care can best meet the needs of the local population and remain resilient and fit for the future, building on the national GP Forward View and Oxfordshire Primary Care Framework. They also aim to provide a locality plan for health services drawing out key components from other work streams in Phase 2 of the Transformation Programme. This is an iterative process, as the plans will both inform the work to develop options for services within the scope of phase 2 and respond to the outcomes of the consultation process related to the transformation programme. We will provide a clear narrative of this in future versions of the plans.
Continuity of care	• Older people like to see the same GP • Long term conditions need continuity of care • Don't care who I see as long as I get sorted • Two types of patient care demand - access without continuity and also continuity first	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.
Access to GP appointments	• Extended access/hours services needs to be advertised more • Patients need more information around waits and how to access services such as the Hub • Good triage model is important • Issue of confidentiality around receptionist triage • Train receptionist to be professional – will be better accepted by patients • Feel OK about seeing other people other than GP	NHS England has made funding available for 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. Oxfordshire Training Network is delivering the training by March 2018. Extended access appointments were advertised in the summer 2017 in the local press and are now advertised through practices. Utilisation of available appointments has increased substantially to around 85% of additionally commissioned appointments and we will work with the practices to ensure that patients are made aware of the services

	• Possibility of using the most efficient /appropriate member of staff • Early visiting service a 'brilliant idea'	and encouraged to make use of them as an alternative means of fast, convenient access. This plan makes more appointments available and will ensure that patients know about them.
Structure of GP services	• Local practices are expected to implement national initiatives without resources which increases pressure • Work as individual practices but in a loose grouping • Working well together enables services to share specialists and expertise • Branch surgeries are good for access • When surgeries merge have to pay attention to integration of systems • We don't want to lose the good things • Share best practice	GP practices in NE Oxfordshire are now working in neighbourhoods and members of a federation of practices (ONEMED). This approach has a number of benefits, including: - Faster access to appointments at evening and weekends at local 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. Development of technological solutions will play a key role here.
IT/information	• Access and use of online services to save time • Text/email should be a two way dialogue • Email are not read by practice • Challenge of branch surgeries in rural locations - could benefit from technology access	Greater use of technology will be a key enabler in connecting primary care with others, for patients to manage their own conditions and for the provision of timely advice. This is included in the plan, with clear timelines set out in the countywide plan to be published alongside the 6 locality plans in January 2018.
Transport	• No bus service so no point in choose and book • If I couldn't drive I couldn't get to Horton General Hospital because there is no bus service • Early visiting services is a good idea if you can't drive to the GP surgery • Out of hours service difficult to get to without using taxi • Parking is limited at Deddington, Woodstock and Bicester practices which causes problems as direct public transport links are not good	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 closer working with District Councils to understand how patients can easily access services. The CCG recognises that 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.
Bicester Community Hospital	• Under-use • Could become a Minor Injuries Unit • Does have beds but not clear what's happening there	Community hospitals will be considered in the Oxfordshire Transformation Programme. The plan for North East Oxfordshire recommends better use of the space at Bicester Community hospital, including through the provision of ambulatory care facilities and a service model that reduces reliance on A&E.

Pharmacy/ prescriptions	• Why do I have to go through a GP to get low level medication? A pharmacist should deal with it • Better use of health workers to deal with repeat prescriptions • Do have services in rural practices to dispense directly to homes	Pharmacists have an important role in the management of patients conditions and enabling GPs to focus their skills where needed. This plans confirms how we will achieve through: • non-recurrent funding to support clinical pharmacists to work in general practice • Provision of a minor ailments scheme in more deprived areas of the county to enable people with minor health conditions to access medicines and advice they would otherwise visit their doctor for.
Heyford Park	• Need to create a new primary care centre at Heyford Park with reasonable car parking	There are ambitious plans for housing growth in Oxfordshire to deliver 100,000 homes by 2031 and we recognise that Upper Heyford is one of the large single sites in Oxfordshire for new homes. Future primary care infrastructure in the area will need to respond in a timely and appropriate way to future housing growth. Any future primary care infrastructure for Heyford Park, whether as a new surgery or as a branch site of an existing surgery, will be subject to an options appraisal which will include considerations regarding accessibility, capacity, expected utilisation and financial viability. An options appraisal will also be completed on how best to provide services. The process for this has been made explicit in the revised draft of the plan.
Vulnerable Groups	• Concern about whether the plans had enough in place for younger people and for people with LD and MH difficulties • Concerns around the pockets of deprivation in the North East which came out of the Bicester JSNA profile	Mental health services is a key priority for the locality plan and this will be strengthened in the next version. As part of the plan, the CCG is developing a programme of care for people with mental health conditions in partnership with neighbourhoods of local practices to address identified needs and provide mental health support. This may include screening, outreach, assessment of needs, advice, signposting and access to therapies and support of primary care workforce. 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. Health inequalities and deprivation is a key factor in determining how this funding is allocated. In addition, a number of specific projects aim to tackle deprivation and unmet health and wellbeing needs, including the introduction of a social prescription model in practices and other community settings. These will be included in the plan going forward.

Appendix 2: References

1. Oxfordshire CCG Primary Care Framework, Oxfordshire CCG, March 2017
2. GP Forward View, NHS England, April 2016
3. Transforming our health care system Kings Fund, March 2011
4. Berkshire, Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Plan, October 2016
5. Patients registered at GP practices by age and gender, NHS Digital, updated quarterly
6. Oxfordshire Joint Strategic Needs Assessment, March 2017
7. Oxfordshire Growth Board, including the Oxfordshire Infrastructure Strategy (OxIS) and the Oxfordshire Strategic Housing Market Assessment
8. Cherwell Annual Monitoring Reports, 2016
9. English Indices of Deprivation, 2015
10. QOF Data, 2016 - 2017

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.
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.
CIL	**Community Infrastructure Levy** A planning charge on developers used as a tool for local authorities to help deliver infrastructure, including health estates, to support the development of their area.
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**
CPN	**Community Psychiatric Nurse**
CQC	**Care Quality Commission** The independent regulator of all health and social care services in England.
DES	**Directed Enhanced Service** A service commissioned from GP practices by NHS England that involves an enhanced level of provision above what is required under core contracts.
DOS	**Directory of Services** The Directory of Services is a central directory which provides NHS 111 call handlers with real time information about services available to support a particular patient.
DTOC	**Delayed Transfer of Care** A 'delayed transfer of care' occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem for the NHS as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients.
ECPs	**Emergency Care Practitioners**
ED	**Emergency department** The emergency department assesses and treats people with serious injuries and those in need of emergency treatment. 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.

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.
ENT	**Ear Nose and Throat**
ESOL	**English for Speakers of Other Languages**
GMS	**General Medical Services** A type of GP practice contract which is nationally negotiated each year.
GP	**General Practitioner**
GPAF	**GP Access Fund / Prime Ministers Challenge Fund** In 2015/16, Oxfordshire received national funding as a second wave pilot to extend appointment access outside core hours, in order to provide a further 15,600 consultations on weekdays and at weekends (7:30am to 8:00pm), strengthening the support available for those with the most complex needs and introducing new ways of accessing services.
GPFV	**General Practice Forward View** The GP Forward View was published in April 2016 and sets out NHS England's commitment to improving patient care and access, and investing in new ways of providing primary care.
GPwSI	**GP with special interest**
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.
HEE	**Health Education England** HEE is a Non-Departmental Public Body that works with partners to ensure the healthcare workforce has the right numbers, skills, values and behaviours, at the right time and in the right place.
HGH	**Horton General Hospital, Banbury** Part of the Oxford University Hospitals Foundation Trust
HIP	**High input patients** Frail or elderly patients who require the most resource intensive care, typically 5% of a practice's registered list.
IAPT	**Improving access to psychological therapies**
IMD	**Index of Multiple Deprivation** A qualitative study of deprived areas in English local councils. Areas are ranked into quintiles of deprivation.
JE	**Joint Enterprise** Primary Medical Care Ltd, which is the GP Federation for North, West and parts of South Oxfordshire, is in advanced talks with OxFed (the Oxford city federation) and Oxford Health NHS Foundation Trust to create a joint enterprise. The aims of this alliance would be to bring the best of both primary and community care together and to achieve resilient Primary Care and Community Services, integrated care where it benefits patients / carers and more care closer to home.
JR	**John Radcliffe Hospital, Oxford** Part of the Oxford University Hospitals Foundation Trust

LD	**Learning disabilities**
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.
LIS	**Local improvement scheme** Local use of CCG resources to pay for improvements in services provided under their GP contract or to support activities such as clinical audit or peer review.
LSOA	**Lower Layer Super Output Area** A geographic hierarchy covering approximately 1,500 people in one area.
LTC	**Long term condition**
MH	**Mental Health**
MIU	**Minor Injuries Unit**
MPIG	**Minimum Practice Income Guarantee** Since 2004, when the new General Medical Services (nGMS) contract was introduced, the Minimum Practice Income Guarantee (MPIG) has been used to top up the global sum payments for some practices. This has matched their basic income levels before the new contract. The payments made under MPIG are called correction factor payments. As part of the GP contract settlement in 2013, the Department of Health decided to phase out MPIG top-up payments over a seven year period, starting in the financial year 2014/15 which means it will be phased out by 2021/2022.
NE	**North East**
NHSE	**NHS England**
OCCG	**Oxfordshire Clinical Commissioning Group**
OH / OHFT	**Oxford Health**
ONEMed	**GP Federation for North East Oxfordshire** Part of PML LTD
OOH	**Out of hours**
OP	**Outpatient**
OPCS	**Office of Population Censuses and Surveys**
OTN	**Oxfordshire Training Network**
OUHT	**Oxford University Hospital Trust** includes the John Radcliffe Hospital and the Churchill Hospital in the City and the Horton General Hospital in Banbury
OxFed	**GP Practice Federation for Oxford City**
PAs	**Physician Associates** A physician's associate is a new healthcare professional who supports doctors in the diagnosis and management of patients.
PCVS	**Primary Care Visiting Service** A service run by emergency care practitioners to provide emergency assessment and treatment of patients in the working day in addition to home visits.

PD	**Personality Disorder**
PMCF	**Prime Ministers Challenge Fund / GP Access Fund** In 2015/16, Oxfordshire received national funding as a second wave pilot to extend appointment access outside core hours, in order to provide a further 15,600 consultations on weekdays and at weekends (7:30am to 8:00pm), strengthening the support available for those with the most complex needs and introducing new ways of accessing services.
PML	**Primary Medical Ltd –** GP practice federation covering North, West and parts of South Oxfordshire and Northamptonshire
PMS	**Personal Medical Services** A type of GP practice contract. Following a review of contracts some funding from PMS contracts has been released to support local delivery of primary for all practices regardless of the type of contract.
POCT	**Point of Care Testing** Medical diagnostic testing at or near the point of care including at a patient's home.
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.
PSA	**Patient Safety Assessment**
QOF	**Quality and Outcomes Framework** An annual reward and incentive programme for practices, the QOF also provides registers for practices and the public of numbers of patients with specific conditions to support better management of these patients.
S106	**Obligations and Community Infrastructure Levy** A legal agreement between an applicant seeking planning permission and the local planning authority, which is used to mitigate the impact of new homes on services. Section 106 Agreements usually require a financial contribution.
SCAS	**South Central Ambulance Service**
SMI	**Severe Mental Illness**
STF	**Sustainability and Transformation Funding** Locally agreed funding for primary care services above the core contract as part of the GP Access Fund.
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
UTC	**Urgent Treatment Centres** Under NHS England plans, urgent treatment centres will be GP-led, open 12 hours a day, every day, and be equipped to diagnose and deal with many of the most common ailments people attend A&E for. By December 2019 all services designated as urgent treatment centres will meet the guidelines issued by NHS England.
WTE	**Whole Time Equivalent / Full Time Equivalent**