Locality Place Based Primary Care Plan: North Oxfordshire Locality

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Foreword

Locality Clinical Director: Dr Paul Park

The north Oxfordshire locality, as defined by the **North Oxfordshire Locality Group (NOLG)**, comprises the practice populations served by twelve member practices, which comes to about 110,000 patients. NOLG is arguably the most mixed locality in OCCG, consisting as it does of six urban practices in Banbury and six rural practices outside Banbury, which vary in size between the smallest in Oxfordshire (about 3,000 patients) and among the largest (about 17,000 patients) and among the most and least socio-economically deprived practices in Oxfordshire. In recent years, it is also fair to say that it contains among the most stable and the most vulnerable practices in Oxfordshire – one of our practices made the national press in 2016 when it became the largest practice in the country to hand in its contract, albeit temporarily.

This variation has also made NOLG arguably the most innovative locality for general practice in Oxfordshire. It was the first locality to form a GP federation (NOXMED) in 2014. It was the first locality to bid nationally for services to transform and sustain general practice to the Prime Minister's Challenge Fund (PMCF) in 2014; it was successful the following year in conjunction with three other locality federations, and instituted the neighbourhood access hubs (NAH) for urgent primary care and the primary care visiting service (PCVS, initially called the early visiting service) in 2015. These valued services, provided by **Principal Medical Limited (PML)** on behalf of NOXMED, still form the core of the locality plan for north Oxfordshire.

Transformation and sustainability in primary care are essential in north Oxfordshire as in every locality in the county and every county in the country; general practice must change in order to survive, and it must survive in order to deliver the high-quality, comprehensive, and holistic primary care service to our patients that is the bedrock of the National Health Service. This locality plan for NOLG, therefore, is aimed primarily at defining how that change and that survival will be delivered over the next few years, in partnership with all the other essential providers of health and social care to our patients, such as acute and planned secondary and tertiary care, mental health services, community health services, the ambulance service, social care, and the voluntary sector.

All of these plans and developments are aimed at supporting and reformulating general practice for the future, providing the high quality clinical services to their patients, while ensuring that they will be able to continue doing so, shoulder to shoulder with their colleagues and with the patients themselves. It is important to note that the plan does not prescribe a single new and transformed model of primary care to be adopted top-down by all practices, but rather allows each practice to use their own strengths and knowledge of the needs of their patients to adapt for the future.

North Oxfordshire Locality Executive Summary

Locality Overview:

The North Oxfordshire Locality Group (NOLG) locality has a patient registered patient population of approx. 112,000 served by 12 GP practices. The North locality has some of the most deprived areas, centred in Banbury.

The locality contains some of the most stable and vulnerable practices in the country, which has propelled innovative working. There is also a strong GP Federation that supports at scale working, including extended access and rapid access for frail / elderly patients.

What is working well:

- Our practices are leading the way in introducing innovative skillmix in practices that relieves pressure on GPs and means patients can be seen by specialist staff.
- Extended access and primary care visiting service, providing additional capacity in primary care at convenient times and for frail elderly patients who may otherwise need to be admitted into hospital

Key locality challenges:

- The population is slightly older than average and ageing.
- There are pockets of deprivation in Banbury
- Significant housing growth of over 6,000 homes in the next 5 years and 9,800 (≈23,000 patients) in next 10 years
- Use of urgent care services is particularly high (9,200) in Banbury with confusing access points
- The primary care workforce is varied: traditional model of care in rural cluster, but high number of vacancies and significantly under pressure.

Key priorities for the North Oxfordshire locality:

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

Successful delivery of the plan will depend on local and Oxfordshire wide planning for future workforce, estates and technology that will deliver the changes needed for a sustainable primary care that can meet the needs of the population in North Oxfordshire.

		Priorities			
#	**Workstreams**	**Safe and sustainable primary care**	**Improving outcomes for the complex and frail/elderly**	**Ensuring patients can access right primary care at the right time**	**Addressing deprivation and health inequalities**
1	Clinical pharmacist support in practices				
2	Mental health worker support in practices				
3	Targeted recruitment for Banbury				
4	Continuation and expansion of primary care visiting service				
5	Coordinated care home support from practices				
6	EMIS Clinical Services interoperability		1		
7	Additional access services in the locality				
8	Social prescribing extension and support				
9	Rural cluster – services appropriate to local need				
10	Estates prioritisation				
11	Brighter Futures in Banbury Programme				

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

1. The purpose of this locality place based plan

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

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, patient-centred care and in efficiency.

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

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

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

This locality plan forms part of the Oxfordshire transformation programme, which includes Urgent Care and Planned Care. As part of the Transformation Programme it will give the population of Oxfordshire a complete picture of future health services.

Gap analysis and prioritisation:

The plans have been tested against the priorities set out in the Oxfordshire CCG Primary Care Framework, the opportunities outlined in the GP Forward View and local transformation programmes.

Proposals with funding consequences have been further assessed according to need across Oxfordshire. A sustainable model of primary is dependent on releasing funding from secondary care to invest into primary care.

2. Who helped to inform our plan?

This document draws on the knowledge and experience of Oxfordshire's clinical community and patients to both describe and develop a North Oxfordshire locality place based plan for the delivery of sustainable primary care and support for the model of moving care closer to home. It involves using the Oxfordshire CCG Primary Care Framework and opportunities outlined in the GP Forward View to achieve this aim. This process included:

Patient participation:

- The North Oxfordshire Locality Public & Patient Forum (NOLF) held a public meeting on 6 July 2017 to discuss the draft priorities identified by clinicians with local people. The NOLF Steering Group has additionally discussed draft priorities from the plan on 12 July and 3 October 2017.
- In addition, Oxfordshire CCG has held events in Chipping Norton on 14 November 2017 and in Banbury on 21 November 2017. The workshops gave local people the opportunity to share their views on how GP and primary care services in their localities could be organised. These workshops 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 and Chipping Norton
    - Retention of primary medical services from the Banbury Health Centre site
    - Strengthening of locality intentions on prevention
    - More information regarding affordability of the plan
    - Proposals to strengthen primary care sustainability in Banbury and maintaining access for patients.

- A full summary of feedback from the NOLF and public events are collated into themes and highlighted in Appendix 1.

- If any proposals require significant changes that could impact patients a more formal consultation will be undertaken for the specific service area.

GPs and member practices

- North Oxfordshire Locality Group (NOLG) has discussed the priorities for primary care and the emerging draft locality plan at each of its monthly meetings from April 2017 to October 2017. As well as practice GP representatives and some practice managers, attendance has included:
    - The community provider, Oxford Health Foundation Trust (in April, May and June 2017)
    - The PML Federation at all meetings, and the federation chair, Dr Neil Fisher is also a practice GP representative at NOLG.
    - The NOLF patient forum chair in all NOLG meetings except October 2017.

Key messages:

The North locality place based primary care plan builds on the principles identified by the Oxfordshire Primary care framework.

The plan has received input from locality forum meetings as well as patient participation input to ensure that the knowledge and experience of North's clinical community is adequately captured.

Part B: The demographics of the North Oxfordshire population

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

1. Summary

1.1 Population

The North Oxfordshire Locality Group (NOLG) of practices has a patient registered patient population of 112,039 as of 1 January 2018[1]. Banbury (c 50,000 population) is the main urban area. Chipping Norton (c 6,000 population) is the second largest town. The locality comprises many villages and rural communities between these two towns.

The NOLG locality is mostly contained within the Cherwell District Council area, with two practices situated in the West Oxfordshire District Council area. There are also significant patient numbers outside the Oxfordshire county boundary, especially in South Northamptonshire. As with other rural parts of the county, patients in the locality face increasing difficulty travelling from rural areas to healthcare provision with the anticipated reductions to local bus services and the increasing frailty of those patients.

1.2 Age

North Oxfordshire has an older than average population and, as with other parts of Oxfordshire, the population is ageing. Almost 20% of the population is aged over 65 and 2.5% of the population is aged over 85. This is associated with increased average frailty, especially in the rural areas of the locality, and with an increased prevalence of housebound patients, which puts pressure on community services, especially district nursing.

Rural wards have a higher proportion of the oldest age group (85+); the rural wards of Ascott & Shipton, Deddington, Kingham, Rollright and Enstone, Cropredy, Adderbury, Chadlington & Churchill each had over 3.5% of the ward population aged 85+. The number of patients aged over 85 is expected to grow by 50% in the next 10 years.

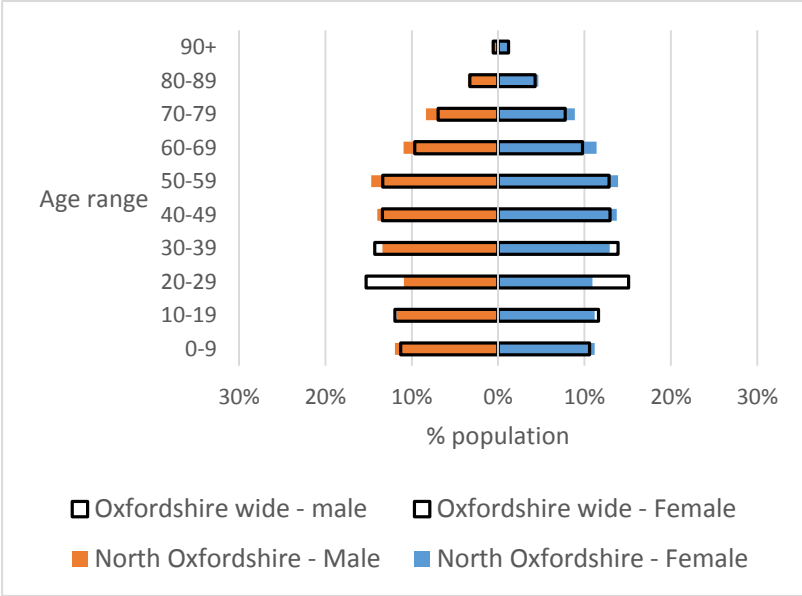


Figure 1: % age distribution of patients in North Oxfordshire compared to Oxfordshire (October 2017)
Source: NHS Digital October 2017

[1] Practice list size data published by NHS Digital (Octo 2017) at: http://content.digital.nhs.uk/gppatientsregistered

1.3 Ethnicity

The ethnic minority population in Oxfordshire is concentrated in urban areas of Oxford and Banbury. Banbury has two main ethnic minority population groups – Polish and Pakistani. This is clearly illustrated in the map at figure 2, which shows the non-white British "out of term time" population in Oxfordshire.

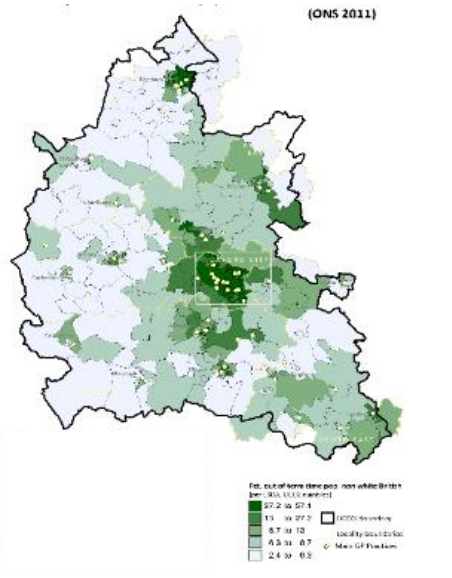


Figure 2: Percentage of population out of term time non-white British (ONS, 2011)

1.4 Deprivation

Banbury is a fairly average town demographically by UK standards (IMD score 19), but contains some of the most deprived wards in Oxfordshire (Oxfordshire average IMD score 13), which are themselves in the top 10% of deprivation nationally. In total, 7% of the population are considered as deprived, the second highest in the county. 6 of the 12 practices are above the Oxfordshire average deprivation score and the average across the locality as a whole is higher the Oxfordshire average. Income deprivation in the North locality is concentrated in 3 areas of Banbury (within Banbury Neithrop, Ruscote and Grimsbury & Castle wards).

1.5 Care home population

As of June 2017 there was a total of 27 care homes with 972 care home beds in wards in North locality. The wards with the greatest number of care home beds were Chipping Norton, Banbury Grimsbury & Castle and Ascott & Shipton wards. There is further growth in care home numbers underway.

1.6 Housing growth

The NOLG locality has a growing population, with many planned housing developments across the locality with notable developments around Banbury (6 500 homes to 2031) as well as at Upper Heyford (2 300 homes of which around a third are expected to register in the North locality) and in Chipping Norton. This equates to an increase of about 15,000 patients (13.5%) across the locality over the next five years, and about 23,000 (21%) over ten years.

Table 1: Housing growth in North Oxfordshire to 2026/7

	Housing Growth – 5 years						Population growth 5 years	Housing Growth – 10 years						Population growth 10 years
Year	2017/18	2018/19	2019/20	2020/21	2021/22	5yr Total	5yr Total	2022/23	2023/24	2024/25	2025/26	2026/27	10 Year Total	10yr Total
Banbury Cluster	719	1,362	1,410	1,083	876	5,450	13,080	610	535	472	470	392	7,929	19,030
Rural North	216	265	188	200	156	1,025	2,460	158	158	168	168	168	1,844	4,424
North Total	**935**	**1,627**	**1,598**	**1,283**	**1,032**	**6,475**	**15,540**	**768**	**693**	**640**	**638**	**560**	**9,773**	**23,454**

Data provided by OXIS – Oxfordshire County Council 2017
Assumptions:

- Population growth assumes an average of 2.4 people per dwelling
- 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 Oxfordshire locality

2.1 Morbidity and Mental Health

- Banbury Neithrop had higher than average % of children aged 10-11 classified as overweight or obese.
- Banbury Grimsbury & Castle had higher than average hospital admissions for alcohol attributable conditions, whilst Banbury Ruscote is similar to the England average.

Table 2: Disease and mental health prevalence – North locality practices
Source: QOF Data 2017

	2016/2017 Prevalence %					
	Atrial Fibrillation	**Hypertension**	**Dementia**	**Depression**	**Asthma**	**COPD**
Banbury	1.6%	12.1%	0.7%	8.8%	5.7%	1.5%
Rural North	2.4%	14.8%	1.0%	6.7%	6.1%	1.5%
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%**

2.3 Mortality

- 3 wards in the locality had a higher death rate from Stroke than predicted by the age of the local population: Ascott and Shipton, Chipping Norton and Banbury Ruscote. Wroxton ward had a rate that was higher than average for Stroke but not significantly. The ranking of Ascott and Shipton and Chipping Norton wards may have been influenced by the number of care home beds in these areas.
- Banbury Ruscote also had a higher death rate from cancer for people aged under 75 than predicted by the age of the local population.

Key messages:

Almost 20% of the population is aged over 65 and 2.5% of the population is aged over 85. These patients are more likely to be frail and/or housebound which puts pressure on community services and district nursing. 7% of the population in North Oxfordshire are considered deprived - the second highest in the county. The population is also growing, expected to increase by 13% over the next 5 years.

Part C: How our population in North Oxfordshire accesses services

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

1. Overview of Primary and Community Care

1.1 Summary of practice provision

There are 12 general practices in the locality, varying from unusually large urban practices (two practices with over 16,000 patients) to some very small practices (two village practices with two partners apiece and fewer than 3,500 patients). The NOLG locality contains a relatively well developed GP federation, in the form of NOxMed, which is supported by eleven practices. NOxMed is affiliated to the Principal Medical Limited federation group, which covers four localities in Oxfordshire and one locality in Northamptonshire.

Table 4: GP Practices in North locality and patient population at October 2017

#	Practice	Location	#	Branch surgery site	Population[2]
1	Windrush Surgery (Banbury)	OX16 9SA	2	Bretch Hill branch	7,839
3	West Bar Surgery	OX16 9AD	4	Hardwick branch	17,061
5	Horsefair Surgery	OX16 9AD			15,881
6	Cropredy Surgery	OX17 1FB			3,846
7	Hightown Surgery	OX16 9DB			11,453
8	Woodlands Surgery	OX16 3WT			7,253
9	Banbury Health Centre	OX16 5QB			5,935
Banbury Cluster					**69,268**
10	Chipping Norton Health Centre	OX7 5FA			15,351
11	Wychwood Surgery	OX7 6BW			6,043
12	Deddington Health Centre	OX15 0TQ			10,991
13	Bloxham Surgery	OX15 4ES	14	Hook Norton branch	7,681
15	Sibford Gower Surgery	OX15 5RQ			2,705
Rural North Cluster					**42,771**
North Locality					**112,039**

[2] NHS Digital: http://content.digital.nhs.uk/gppatientsregistered

1.2 Access to general practice in North Oxfordshire Locality

The model of access in North Oxfordshire is highly varied as a result of the differences in practice stability and workforce across the locality. This is reflected in feedback from patients, which has the widest range of results across Oxfordshire. This variation means that the locality is also the most innovative for general practice in Oxfordshire, leading the way in developing a federation (NOXMED) and delivering services at scale that could transform and sustain general practice.

North locality has extra provision through a GP-access hub located at Banbury Health Centre and run by PML for the NOXMED federation. This offers a Monday to Friday service 0900-1800, and Saturday and Sunday mornings. Access is by GP referral. The rural cluster practices offer additional evening hours in house but available to other surgeries, 1830-2000 on a rotation basis. The provider is still working to deliver to full capacity. The hub is also funded through GP Access Fund. Use of the hub by practices has been very variable, with take-up not necessarily proportional to practice population size. Currently, Banbury Health Centre is open seven days a week, 365 days a year from 8:00am to 8:00pm every day, providing services for both registered and unregistered patients. As this may not be the best use scarce GP resource, we are considering options to combine GP services and the urgent care services already in place which we will consider at the next stage of our plans.

The Chipping Norton FAU is open weekday evenings, 5pm to 9pm and 10am to 9pm for weekends and bank holidays. This is a drop-in service with no appointment necessary. At present the service is provided by SCAS from the Community Hospital Site with activity for 2016/17 at 2,261. This is a 3.95% increase in

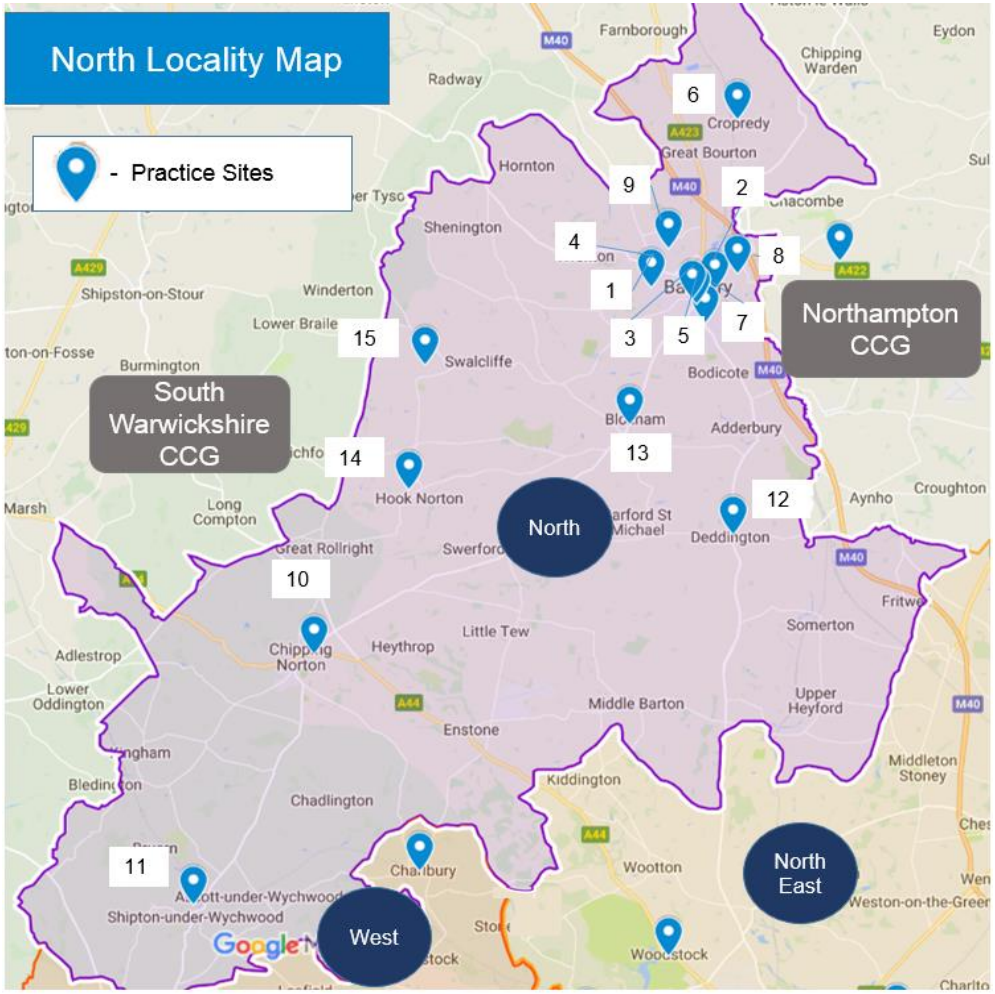


Figure 5: Map of practices in the North Oxfordshire locality

attendances compared to 2015/16. Although it is not possible to break this down by practice, previous audits have shown that most patients come from the Chipping Norton Health Centre area.

Patients with high needs are supported by a primary care visiting service, which provides urgent home visits to the elderly and housebound, and hospital at home, which provides rapid community-based assessment to patients and a sub-acute alternative to non-elective admission to hospital. Both services are provided by PML.

2. Urgent care

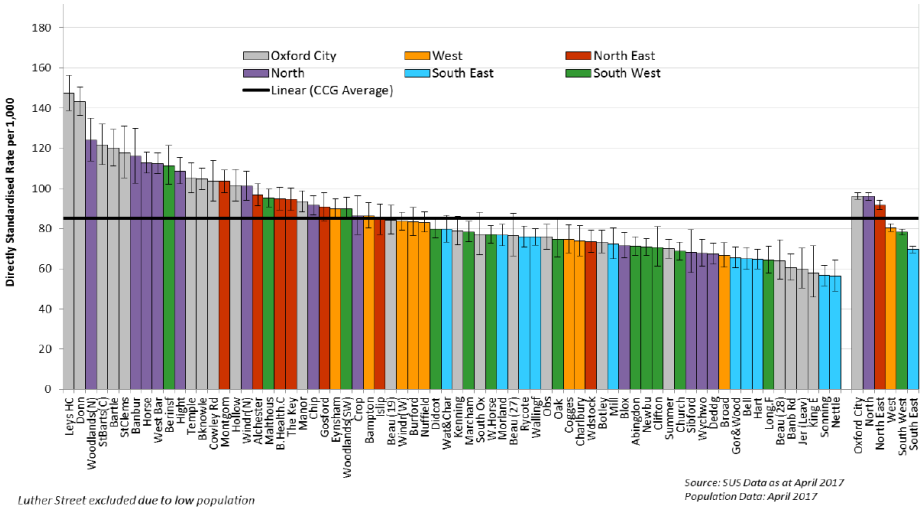
Banbury contains the Horton General Hospital (HGH), which has an Emergency Department and Chipping Norton a first aid unit. This means that in Banbury patients have a number of options for access to urgent care, contributing to the high use of urgent care services as set out in figures 3 and 4.

The Emergency Department (ED) at the Horton General Hospital shows consistently high usage, especially by relatively low intensity patients from Banbury, due to the ease of access that the ED there represents. Even taking into account all urgent care attendances (A&E and MIU), 6 out of the 7 highest attendances are from patients registered with practices in Banbury, in spite of the fact that there is no MIU in the locality.

Emergency admissions for the NOLG locality was higher than the OCCG average April 2016 – March 2017. There is a higher incidence of emergency admissions from several Banbury care homes relative to the rest of the county. These care homes currently only receive medical cover from GPs on an individual patient basis. During summer 2017 the practices and care/nursing homes in Banbury have moved to a model where each home is linked to just one GP practice. This should improve both continuity of care and access for patients and make supporting care home patients more streamlined for practices.

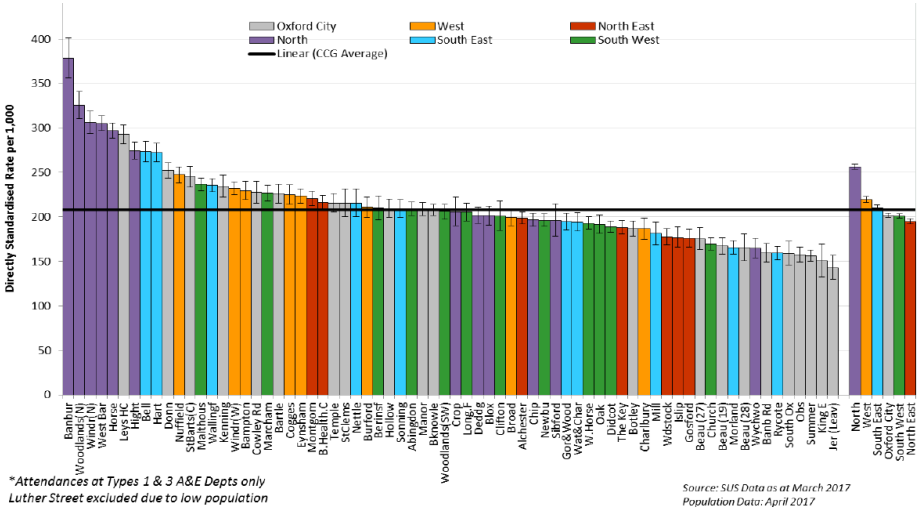
For April 2016 – March 2017 the first outpatient appointments from GP referral average in NOLG locality was below the OCCG average, but for trauma and orthopaedics the NOLG locality average was above the OCCG.

Figure 3: Urgent Care – Emergency Admissions per 1,000 (April 2016 – March 2017)
Source: SUS data March 2017



Luther Street excluded due to low population

Figure 4: Urgent Care – A&E and MIU Attendances per 1,000, (April 2016 – March 2017)
Source: SUS data March 2017



**Attendances at Types 1 & 3 A&E Depts only*
Luther Street excluded due to low population

3. Community and secondary care

Chipping Norton contains the only community hospital in north Oxfordshire, which hosts the First Aid Unit, a midwife-led maternity unit, and intermediate care beds. There are now more out of hospital services in Chipping Norton as part of moving care closer to home, reducing travel time for patients in this part of the locality. Banbury also contains the Horton Independent Sector Treatment Centre (ISTC), which is provided by Ramsay Healthcare and provides roughly 20% of NHS secondary care orthopaedic services to Oxfordshire. The presence of both the HGH and ISTC hospitals ensures that the local provision of secondary care hospital services is high quality and relatively accessible to patients. Outpatient referral rates in the locality are close to the county average. In line with the CCG's intentions to invest in care closer to home, we will provide more outpatients and planned care services at the Horton.

4. Primary care workforce

Practices were asked for an assessment of capacity, gaps in current staffing and planned retirements. Table 5 indicates the number of GP sessions offered each week and vacancies, followed by the number of sessions and GPs required over the next 10 years based on the housing projections in table 4 above and table 6 the number of other clinical staff. This demonstrates the need to deliver primary care in a different way in future. Primary care is already delivered very differently across the locality, with some practices in the rural cluster providing a GP-centred model and practices in in Banbury operating with a much wider workforce.

Table 5: GP workforce in North Oxfordshire locality

Locality	Current number of sessions delivered*	Number of sessions if no vacancies	Patients per GP as delivered	Vacancies (FTE)	Number of sessions required in the future		Number of additional GPs required (FTE) – does not account for vacancies or retirements	
			assumes 8 sessions per week		5 years**	10 years**	5 years*	10 years**
Banbury Cluster	177	263	3,134	-10.8	313	313	6.9	6.9
Rural North	210	214	1,591	-0.5	227	237	1.8	3.1
North Locality	**387**	**477**	**2,333**	**-11.3**	539	549	8.6	10.0

Table 6: Nurse / HCA workforce in North Oxfordshire locality

	Treatment room sessions	Advanced nurse practitioners	Health care assistants	Phlebotomist
Banbury Cluster	57	**76**	**14.7**	**36**
Rural North	87	**16**	**15**	**61**
North Locality	144	**92**	**29.7**	**97**

North Oxfordshire practices are currently leading the way in the **innovation of skill-mix** in practices; in the last three years, the introduction of clinical pharmacists, emergency care practitioners (ECPs) and musculoskeletal (MSK) practitioners have revolutionised health care delivery in those practices.

Table 7: Future intentions to recruit other clinical staff (from 9 responses out of 12 practices)

Are you considering recruiting any of the staff groups below in the next year?	Advanced Nurse Practitioner					Emergency Care Practitioner					Assistant Practitioner					Physician's Associate				
	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share
Banbury Cluster	1	3	1	0	0	0	2	1	0	1	0	2	1	0	0	0	2	1	0	0
Rural North	1	2	1	0	0	0	3	1	0	0	0	3	0	0	0	0	3	1	0	0
North Locality	2	5	2	0	0	0	5	2	0	1	0	5	1	0	0	0	5	2	0	0

Are you considering recruiting any of the staff groups below in the next year?	Pharmacist*					Physiotherapist					Phlebotomist					Mental health practitioner*				
	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share	Yes	No	Maybe	Already in place	Would like to share
Banbury Cluster	1	2	1	2	0	0	1	1	1	1	1	2	1	1	0	1	1	3	1	0
Rural North	3	1	0	0	0	1	1	1	1	1	0	2	1	2	0	0	1	0	4	2
North Locality	4	3	1	2	0	1	2	2	2	2	1	4	2	3	0	1	2	3	5	2

Case Study: Clinical pharmacists in three practices

- Hightown has employed a clinical pharmacist since 2014, and now has two clinical pharmacists. West Bar has had one since 2016, and Woodlands since 2017.
- The clinical pharmacists have been invaluable in performing tasks that previously required a GP, such as medicines reconciliation from discharge summaries and clinic letters, medication queries, reviewing and optimising medications, and starting and coordinating treatments requiring close monitoring and shared care with the hospital.
- In addition, they have also led on optimising treatment approaches in practices, including reducing unnecessary antimicrobial prescribing, reducing polypharmacy and medication waste (especially for our most frail and complex patients), delivering electronic prescribing and repeat dispensing, and keeping others clinicians aware of current prices and availability of prescribed medications.
- One pharmacist has also carried out visits to care homes in conjunction with GPs to reach patients who would not normally be able to attend the practice.
- Review of clinical pharmacist roles at those practices has shown that they have significantly improved practice sustainability and quality of care, and have been very well received by patients. It is estimated that they are roughly as cost-effective as GPs (generally delivering just over half the workload at just over half the cost) but are much more available for recruitment in the current climate.
- It is planned to continue expanding the clinical pharmacist role at these practices and at others who wish to take part, including training them to become independent prescribers and deliver care for long-term conditions such as asthma and diabetes.

Case Study: Musculoskeletal (MSK) practitioners in general practice

- Horsefair has employed a physiotherapist in a musculoskeletal (MSK) practitioner role since 2016; Chipping Norton and Hightown have done so since 2017.
- As with other skill-mix roles, the purpose of the MSK practitioner role is to replace the GP function in musculoskeletal presentations using the therapist specialist skills, not offer an additional and possibly unnecessary service. So the MSK practitioner is tasked with assessing patients who present with an MSK problem to general practice and triaging them effectively and efficiently for self-care, simple treatment, or referral for investigation or further treatment. As with other skill-mix roles, this requires receptionist training to direct patients correctly.
- Review of the MSK practitioner role at those practices so far has shown that they do replace the GP role effectively and appropriately, and do not increase referral rates.

1.6 Joint working across primary and community care

There has been significant redevelopment of the organisation of the district nursing (DN) team in north Oxfordshire by Oxford Health Foundation Trust (OHFT) in the last 12 months, improving coordination and access to that very necessary service for patients and other clinicians such as GPs. At the same time, the primary care visiting service (PCVS) has become a routine and valued service for housebound patients in the locality, and has worked closely with Hospital at Home (HAH) to update and hand over patients in need of more follow-up at home but who would not benefit from admission to hospital; this has been natural given that both services are provided by PML. All three services have also been working more closely with the nascent integrated locality team (ILT) who includes adult social care provided by Oxfordshire County Council (OCC) and Age UK.

Therefore, as all the services have got used to each other and to communicating with each other to improve patient care at home or closer to home, the last six months have seen a genuine quiet revolution in seamless handover between those services and general practice. This has been quite noticeable to GPs, who in previous years would have had to contact each service separately to coordinate care for a frail or complex patient, but who now can track how patients are instead moved between services with good communication of issues, management, and planning and without GP input unless required.

This development, of course, requires continuity and stability of those services, and encouragement from commissioners, to be sustained or improved; disruption or discontinuity of any of the services may in turn destroy the fragile organic growth that has occurred.

Key messages:

North Oxfordshire has 12 GP practices and a well developed federation in the form of NOXMed. North Oxfordshire practices are currently leading the way in the innovation of skill-mix in practices; forecast growth in housing means that this will need to continue in the future in order to be able to meet forecast demand.

Use of urgent care is higher than in other parts of Oxfordshire – this is partly because of the number of access points in Banbury. This can be confusing for patients and needs consideration to simplify access.

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

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

Priority 1 – Ensuring safe and sustainable primary care services for the population of North Oxfordshire locality

Background

The North locality contains some of the most stable and the most vulnerable practices in Oxfordshire. The sustainability of primary care in the locality is under threat; with practices reporting growing difficulty recruiting and retaining clinical staff. Nationally, the number of full time GPs is reducing and the average age of the workforce is growing. The number of partners is falling as there is a growing trend for younger GPs to prefer more portfolio careers where they combine different roles. This means there are more part time GPs. Few are interested in the traditional model where they would buy into a practice as a partner and even fewer are interested in or able to invest in the buildings and property owned by primary care. Furthermore there is projected population growth of about 15,000 patients (13.5%) over the next five years, and about 23,000 over ten years, adding further pressure to primary care in the locality. In addition, the contract at Banbury Health Centre is due to come to an end in March 2018.

Objectives

The plan proposes a **coordinated public relations campaign to boost recruitment**, with local practices and health and social care providers working with Cherwell District Council, Banbury Town Council, the Banbury and District Chamber of Commerce, and other organisations. This would not only hopefully increase recruitment and relieve workforce pressures in health and social care locally, but also improve morale among health and social care staff and among the population in general, who have recently become somewhat demoralised by planned changes at the Horton and local and national media coverage of developments in health and social care.

Future **primary care infrastructure** will need to respond in a timely way to housing growth so that patients can access primary care services at their surgery. The CCG is working 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.

Banbury Health Centre contract ends on 31 March 2018. PML hold this contract. PML have been working with Woodlands and West Bar practices discussing and progressing plans to bring their practices together to create a new large practice in Banbury that would bring together the patient lists for the three practices current practices. This would improve the long term sustainability of primary care in Banbury and provide significant advantages to patients of all three practices including:

- A wider range of services could be offered by the bigger practice including specialist clinics run by clinical staff with specialist skills.
- Improved recruitment and retention of staff because the practice would be an attractive place to work with career opportunities for clinicians and other staff. This is particularly important in relation to GPs where significant difficulties have been had in recruiting to vacancies in small practices.
- Resilience in coping with changes in the future whether they were staff changes or changes in expectations for services to be provided.
- Improved financial viability with greater efficiency in 'back office' functions of the practice that would mean more resources available for direct patient care.

All the practices in north Oxfordshire will have new clinicians at both practice and cluster level, with initial support for **clinical pharmacists** in each practice who request this and **mental health workers** across the whole locality. Patients needing help with medication queries – such as not having enough medication when discharged from hospital, having been started on new medications in hospital or clinics, or concerns about medication allergies or interactions – will be able to discuss them and have them resolved by the practice pharmacist without having to see a GP. Also, clinical pharmacist input into each practice will improve prescribing practices and quality of medication use by other clinicians in that practice. Patients with mental health issues or medically unexplained symptoms will be able to see a mental health worker in their practice without waiting for a referral to the community mental health team, without having to see a GP. **In both cases, this will free up GP time to see patients who can only be seen and treated by a GP**.

Many patients who attend primary care appointments do not need clinical input, but have come there because there is no other obvious place to go. While the so-called traditional parish priest function of general practice has its merits, it is increasingly less appropriate for GPs to provide this function, and so in future all practices would have access to **care navigation via social prescribing**. Patients with important but non-clinical needs would be directed smoothly and compassionately to more appropriate services such as Citizens Advice, social services, and third

sector providers such as Age UK. In addition, we are providing 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.

What is social prescribing?

Social prescribing is a mechanism for linking patients in primary care with non-medical sources of support within the community. It offers a non-medical referral option that can operate alongside existing treatments to improve patient health and wellbeing. Example interventions include community education groups, exercise and dance classes, debt advice, befriending and mutual aid.

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

Priority 2 – improving outcomes for the complex and frail / elderly

Background

There is a high population of frail and elderly patients with subacute/acute illness in the North locality; these are focussed across rural wards where there are 2,600 people aged 85 or over. There is also a large care home population spread over 27 care homes in the locality. Patients in care homes are some of the most complex and unwell patients in the community, being among those most likely to have multiple long-term conditions and polypharmacy, and to be admitted acutely and sometimes inappropriately to hospital. Frail and elderly patients value a high level of continuity of care. Paradoxically, because they are housebound and complex, they can receive a lower quality of holistic care from their GPs.

Frail and elderly patients require primary care to be delivered in an integrated way and close to home, where possible. The Primary Care Visiting Service delivered by PML Federation ensures that patients who require urgent home or are housebound receive appropriate same-day urgent care, therefore avoiding unnecessary admissions.

Objectives

In future, **all care homes in north Oxfordshire will be assigned an individual practice** who will be responsible for the care of all their patients, and who will visit regularly to assess and treat patients. This will improve the quality of care that patients in care homes receive by improving holistic care and working between GPs, care home staff, and community services, and also because the new practice **clinical pharmacists** will be oversee prescribing in each care home, aiming to optimise treatment and reduce waste.

All care homes in north Oxfordshire will be encouraged and supported to obtain HSCN (formerly known as N3) access, which will allow sharing of clinical record data directly with care home computers. This would not only mean that **care home staff could access GP records for their patients**, but also that visiting clinicians (whether GPs, clinical pharmacists, Hospital at Home, primary care visiting service, community nurses, or others) would be able to access GP records on-site and be able to **use the care home HSCN wi-fi to access their own record systems on their own devices**. This will greatly facilitate effective care for those patients on-site at the care home, since the quality of care in home visits is often hampered by incomplete or unreliable access to the patient's electronic health record (whether GP or not) and time is wasted in entering consultation data long after the visit back at base.

The developing strategy in north Oxfordshire is for **seamless integration between the many teams and providers of care for patients in the community** – GPs, Hospital at Home, community nursing, community mental health teams, third sector organisations – this will be dependent on the record sharing across providers.

The **Primary Care Visiting Service** will continue to provide an urgent service for all patients who require this service in the locality and will be expanded so more patients can be visited at home during the day.

Priority 3 – Ensure that patients can access the right primary care at the right time

Background

There is increasing patient demand for GP services both in and out of hours; especially patients with low-intensity conditions and chaotic, homeless, or otherwise unregistered patients. This is driving activity into ED and increasing the stress on GMS primary care. In particular, in Banbury, patients who cannot see their own practice have several options, including Banbury Health Centre, the neighbourhood access hub, and out of hours (OOH) GP services at the Horton. This can lead to significant confusion for those patients, who may end up going to A&E at the Horton instead.

Different dimensions of access are valued differently – some prefer rapid access to any clinician and some require continuity of care with the same clinician. There are many different models of access to primary care in the North – some practices operate telephone triage, others operate walk-in services on certain days. Practices will need to assess what is most appropriate for the specific needs of their patients, responding to feedback from patient groups – patients in the more rural parts of the cluster, for example, will have different considerations around access than in Banbury.

Access to local, non-clinical services is only coordinated in a small group of practices in the locality, primary care clinicians are unable to effectively refer patients to self-care and advice signposting to some patients in a consistent manner across the locality.

Objectives

Given the challenges to sustainability that practices in Banbury continue to face, and the high use of ED services by Banbury patients, it is essential that the neighbourhood access hub providing acute primary care to Banbury patients be well-resourced and reliable. However, the number of additional appointments per head at the Banbury hub is currently less than the other hubs run by the federation (Principal Medical Limited) in Bicester and Witney. This makes it hard for Banbury practices to plan their rotas and own GP provision ahead of time. This is partly because the Banbury hub is more dependent on GP locums than the Bicester or Witney hubs due to recruitment and capacity. It is therefore proposed that provision of hub appointments at Banbury be provided based on the population, in line with funding allocations, and that the provider rotate its salaried hub GPs across their locations, including Banbury, to provide more reliable care. This should have no recurrent or non-recurrent funding implications, and may indeed reduce the cost of providing appointments at the Banbury hub, since locum GP sessions are generally much more costly than salaried GP sessions. We will work with PML through its contract to deliver contract compliance and greater reliability. Reliable, rapid access to the hubs for patients – in particular patients of working age and children who often do not need to

see the same GP for episodic conditions – should free up time for GPs to concentrate resources on patients who do not require the same level of continuity of care. We will continue to use appropriate information channels to encourage use of the hubs and other appropriate access to primary care, including working with the councils to draw on the extensive networks of for older people, the voluntary sector, faith communities and young people.

Continuing to develop a broader skillmix in practices and access to social prescribing, as set out in priority 1, will also contribute to increasing access for patients in the North locality.

Priority 4 – Addressing deprivation and health inequalities

Background

- There is significant deprivation in parts of the locality; Banbury has some of the most deprived wards in Oxfordshire which are themselves in the top 10% of deprivation nationally. In total, 7% of the population are considered as deprived, the second highest in the county.
- The area is associated with a number of health inequalities; e.g. child obesity, stroke and cancer, in addition there were higher than average hospital admissions for alcohol attributable conditions.

Objectives

Each of the priorities include aims to reduce health inequalities and are in line with the Oxfordshire Health Inequalities Commission recommendations. In particular:

- The vast majority (up to 90%) of depressive and anxiety disorders that are diagnosed 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 improves the knowledge, confidence and capacity of the other primary care professionals in the practice.
- Good access to primary care services is a key determinant in addressing health inequalities. Additional and more reliable access, in particular in Banbury, will provide patients with a clear, identifiable point of access throughout the day, including for unregistered patients.
- The social prescribing initiatives will support vulnerable groups of patients and provide them with specific support for services that can be most appropriately addressed through this service, include help with debt problems, loneliness and isolation, parenting issues, exercise and homelessness, including through Citizens Advice, social services, and third sector providers.
- A system wide approach to health promotion recognises the importance of the local community in improving health and wellbeing. We continue to support the Brighter Futures in Banbury Programme, which has as a long term aim ‘to create brighter futures for Banbury people’, by tackling evidenced disadvantage and health inequality and break the cycle of deprivation. The three core principles for the Programme include community engagement and consultation, raising aspiration and ambition and capacity building through multi agency working.

Planning for the future

In response to the key objectives outlined in each of the priorities, we have recommended 11 workstreams. Each workstream responds to the challenges of at least one priority. The chart below indicates how each initiative aligns to the different priorities.

		Priorities			
#	Workstreams	Safe and sustainable primary care services for the population	Improving outcomes for the complex and frail / elderly	Ensuring that patients can access the right primary care at the right time	Addressing deprivation and health inequalities
1	Clinical pharmacist support in practices				
2	Mental health worker support in practices				
3	Coordinated public relations campaign for Banbury focused recruitment				
4	Continuation and expansion of primary care visiting service				
5	Coordinated care home support from practices				
6	EMIS Clinical Services interoperability		1		
7	Additional access services in the North locality				
8	Social prescribing extension and support				
9	Rural cluster – services appropriate to local need delivered through the practices				
10	Estates prioritisation				
11	Brighter Futures in Banbury Programme				

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

Proposed solutions	Delivery scope	Benefits	Implementation steps	Duration	CCG Support
Clinical pharmacist support in practices	5 NOLG practices (Chipping Norton, Hightown, Horsefair, West Bar, Woodlands) currently employ clinical pharmacists in practice, which has been very effective. This would be rolled out to all NOLG practices and supported both with funds and potentially supervision from the OCCG Medicines Management team.	Clinical pharmacists in practice have been shown both nationally and in NOLG to be able to take on previously GP-only tasks, and also improve quality and safety of patient care and practice processes.	1) Agree funding 2) Set out scope of work for pharmacists and employment model 3) Recruit	From 2018/19	The Medicines Management team previously agreed to supervise practice clinical pharmacists in NOLG. Their input in coordination would be welcome.
Mental health worker support in practices	The rural cluster of four NOLG practices (Bloxham, Chipping Norton, Deddington, Wychwood) currently employs two mental health workers across those practices. This has been successful and could be extended to all NOLG practices, initially on a non-recurrent basis, and may become recurrent depending on need and alignment with the wider Mental Health Forward View.	These mental health workers would be able to see patients with medically unexplained symptoms, mental illness, and other patients whose complex mixed physical and mental symptoms are challenging in primary care, freeing up GP time and providing better and more appropriate care for those patients.	1) Agree funding 2) Set out scope of work for pharmacists and employment model 3) Recruit	From 2018/19	The project is dependent on the availability of appropriate clinicians for recruitment.
Coordinated public relations campaign for Banbury-focused recruitment	Recruitment to almost every role in health and social care in north Oxfordshire has been challenging in the last few years. A coordinated public relations campaign with OUHFT, OHFT, Cherwell DC, Banbury TC, OCC, and the local chamber of commerce is proposed.	The introduction of a positive and coordinated campaign would improve morale among both staff and confidence among the population locally, and would aim to improve recruitment across the locality.	External support could enhance deliverability.	From 2018/19	CCG to coordinate the campaign. Assent and collaboration from other stakeholders (OUHFT, OHFT, Cherwell DC, OCC, Banbury TC, Banbury and District Chamber of Commerce, and likely others) and media.
Continuation and expansion of primary care visiting service	Continuation of locality-based home visiting service led by GPs who provide assessment and treatment in the working day in addition to planned GP home visits and EOL care.	Prompt access to care for acutely ill frail, elderly or housebound patients or those at risk of deterioration or admission thereby reducing unplanned admissions. Supports best use of GP time (to see as many patients as possible) and free up GP capacity.	PML to recruit additional staff to start from 2018/19	From 2018/19	none
Coordinated care home support from practices	The NOLG practices would continue and finish the process of ensuring that all care homes in north Oxfordshire are covered by a single	Patient care would be much better coordinated for those care homes, who also have among the highest rates of	To agree with PML process for managing care homes not currently	From 2018/19	The care homes will require support from the CSU to get HSCN and EMIS access.

	practice responsible for regular care and staff support in those homes. The care homes would also have HSCN digital support and EMIS access, allowing on-site GP record access and updating for care home staff and visiting clinicians.	urgent admission and stroke incidence in the county. This would not just be in better access to GP care, but also would support better care by DNs, care home support staff, and paramedics now able to access GP records for those patients.	managed by single practice. CSU to manage implementation steps for digital support.		
EMIS Clinical Services interoperability	Currently the EMIS Clinical Services module makes it possible for all NOLG practices to share their GP records with the NAH and with each other in GPAF services. This would be extended to community and mental health services in north Oxfordshire, starting with community nursing teams (including specialist community nurses).	Full sharing of the EMIS GP record with colleagues in community and mental health services would make care of patients across those services better informed and coordinated, removing the need for regular and unreliable telephone and letter contacts for information.	CSU to manage implementation steps for digital support	From 2017/18	Gain assent and collaboration from OHFT and their teams.
Increased and more reliable access for patients in Banbury	Well-resourced and reliable neighbourhood access hub in Banbury. Additional hub appointments	Practices better able to plan their rotas and own GP provision. Clearer access for patients and confidence that they can get an appointment. More reliable care.	1) Assess scope of centre within current contracts 2) Model capacity requirements 3) Confirm site 4) Agree new contract model, patient flows and infrastructure 5) Set up	From 2018/19. Current additional funding for NAH hours will be retained before start of service.	Project management resources
Social prescribing extension and support	Currently, the social prescribing project supported by Cherwell DC is available to the six Banbury practices and mainly offers self-care and advice signposting to some patients. The proposal is to expand the project with OCCG funding both in Banbury and to the rest of north Oxfordshire. The rural cluster practices have recently made proposals for projects to deliver: Proactive Care for the frail elderly and Housebound Populations, and Integrated Social Prescribing and Self-management hubs. These will be subject to further discussion and development with the locality.	The wide and coordinated availability of social prescribing to patients across north Oxfordshire would be of great benefit in directing patients to the most appropriate resources including self-care advice, financial and social support and advice, and other resources from third sector organisations.	1) Agree funding and resources available in other sectors (financial and people) 2) Determine cohorts of patients 3) Agree siting and employment 4) Agree how to structure scheme and socialise	From October 2019	Assent and collaboration from other stakeholders (Cherwell DC, Banbury and Witney CABs, Oxfordshire MIND, Age UK, etc.)
Rural cluster – services appropriate to local needs delivered through the practices	Integrated community nursing (services) pilot which includes the more proactive management of housebound / frail. Practices to provide neighbourhood based step up / step down care for frail / elderly patients who have acutely deteriorated, overseen by a neighbourhood matron working alongside the	Expected outcomes from this approach would be: • Reduction in the number of reactive home visits • Reduction of hospital admissions • Reduction in falls • Improved wellbeing and reduced social isolation	1) Agree funding and resources available in other sectors (financial and people) 2) Determine cohorts of patients 3) Agree employment model, commence	From 2019/20	CCG to agree strategic model and support locality in local delivery.

	duty teams in the practices within the neighbourhood. Implementation of this workstream is dependent on the wider Oxfordshire wide frailty pathway which is being developed and will be rolled out in 2018/19.		training and implement		
Estates prioritisation	New housing developments, in particular around Banbury, Chipping Norton 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	18/19 onwards	Prioritisation exercise of current estates. Assessment of cost and availability of estates Options appraisal
Address inequalities in the deprived Super Output Areas in Banbury, through the Brighter Futures in Banbury Programme	The actions for the health and wellbeing theme of the programme for 2018-19 will focus on: 1. supporting local primary schools to increase their physical activity offer, specifically through the Walk Once a Week initiative; 2. facilitate dementia friendly communities through training; 3. provide a framework for local businesses to adopt healthy workplace actions and initiatives.	• Embedding physical activity as part of the school ethos, to support pupils and their families to adopt healthy habits. • Providing training to local stakeholders to be able to support people in the community with early stage dementia. • Supporting workplaces to consider the wellbeing of their employees.	Joint working with Cherwell District Council (CDC), through CCG staff member as Health & Wellbeing Theme Lead	Schools engaged and signed up. Partners and stakeholders for training identified. Working with CDC to develop the workplace health framework.	Ongoing

Key messages:

North Priorities:

1. Improving health outcomes and reducing clinical variation for complex/frail/elderly (high intensity) patients
2. Ensure safe and sustainable primary care that delivers high quality services and addresses the needs of a growing and aging population
3. Ensure that patients can access the right primary care at the right time
4. Address health inequalities

The 11 workstreams above each respond to at least one of the 4 locality priorities and operate as the core recommendations of this plan.

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. 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.

The growth in population in the North locality and the historic difficulties of recruiting to practices in the North require specific interventions which are set out above:

- Targeted GP recruitment in Banbury; and
- Using other skillmix that will mean that patients are seen by the most appropriate clinicians and enable GPs to focus on patients that can only be seen by them.

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. Hightown Surgery, for example, has received funding to move to more appropriate accommodation and plans to move to the new Longford Park development. The proposed new facility will be able to accept several thousand additional patients in the fastest growing part of Banbury.

Other practices have larger-scale ambitions to deliver services over and above what is generally provided in general practice, often in collaboration with other practices and in partnership with other NHS organisations, local authority and voluntary sector agencies. Both types of scheme will need to demonstrate innovation and maximise opportunities to work collaboratively, but for the larger-scale schemes, which are likely to come at a higher cost, a more comprehensive range of criteria will be used for prioritisation that are in line with the CCG's estates strategy and plans for primary care.

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

Across the North locality, the population growth is forecast as 15,000 people over next 5 years between Banbury, Upper Heyford and Chipping Norton. The largest single site of these is the Upper Heyford airfield site, which may create infrastructure such as schools and a village centre. The CCG is considering options to meet the needs of the future population, including capacity in neighbouring practices (covering both the North and North East locality). The options appraisal will need to balance the benefits of practices working at scale in larger units that are better able to deliver high quality services with appropriate clinical leadership and proximity of services for patients.

The practice in Chipping Norton sites a number of the planned care services in the locality and future estates requirements depend on growth in the area. Practices in Banbury are currently at capacity; one practice has plans to move to the area with the largest growth. There are also opportunities to use the estate better and most appropriately within the context of changing workforce requirements and the intention to develop a single accessible location for urgent care in Banbury. Support from the CCG includes:

- Mergers or use of shared space to improve efficiency
- Alternative use of estate currently used by the district council or Oxford Health
- Prioritisation of upgrades following assessment of all practices recently undertaken in the 6 Facet survey undertaken on behalf of the CCG/NHS PS by Oakleaf Group earlier in 2017.

Federations and some practices may 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 would be expected 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 need to be used for prioritisation.

3. Digital

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

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

Particular priorities for the North locality include:

a. Access for care homes:
All care homes in north Oxfordshire will be encouraged and supported to obtain HSCN access, which will allow sharing of clinical record data directly with care home computers. This would not only mean that **care home staff could access GP records for their patients**, but also that visiting clinicians (whether GPs, clinical pharmacists, Hospital at Home, primary care visiting service, community nurses, or others) would be able to access GP records on-site and be able to **use the care home HSCN wi-fi to access their own record systems on their own devices**. This will greatly facilitate effective care for those patients on-site at the care home, since the quality of care in home visits is often hampered by incomplete or unreliable access to the patient's electronic health record (whether GP or not) and time is wasted in entering consultation data long after the visit back at base.

b. Interoperability of records:
Community and mental health services in North Oxfordshire are provided by Oxford Health Foundation Trust (OHFT), as they are in the rest of the county, who use Advanced CareNotes as their electronic health record. CareNotes is not currently interoperable with any other health record (such as EMIS in general practice or Cerner Millennium in hospital), and so community and mental health workers cannot see any other record or share their record with anyone else. In future, **community and mental health workers in the locality would be able to at least access the EMIS GP record via EMIS Clinical Services**, allowing them to see valuable clinical information about patients in their care and to enter their own information into those records for other clinicians (such as GPs) to see. This would significantly reduce the current problem of patients expecting GPs to be updated on their recent discussions with, for example, the mental health team and lead to more streamlined and more effective care for all patients. This would be part of the developing strategy in north Oxfordshire of **seamless integration between the many teams and providers of care for patients in the community** – GPs, Hospital at Home, community

nursing, community mental health teams, third sector organisations – which would be significantly assisted by improving health record sharing.

4. Funding

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

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

Oxfordshire CCG has responsibility for the review, planning and procurement of primary care services in Oxfordshire, under delegated authority from NHS England. The Oxfordshire Primary Care Commissioning Committee (OPCCC) carries out these functions and is chaired by a lay member[3]. 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 8 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.

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.

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

Table 8: Funding approved for initial delivery of the locality plans across Oxfordshire:

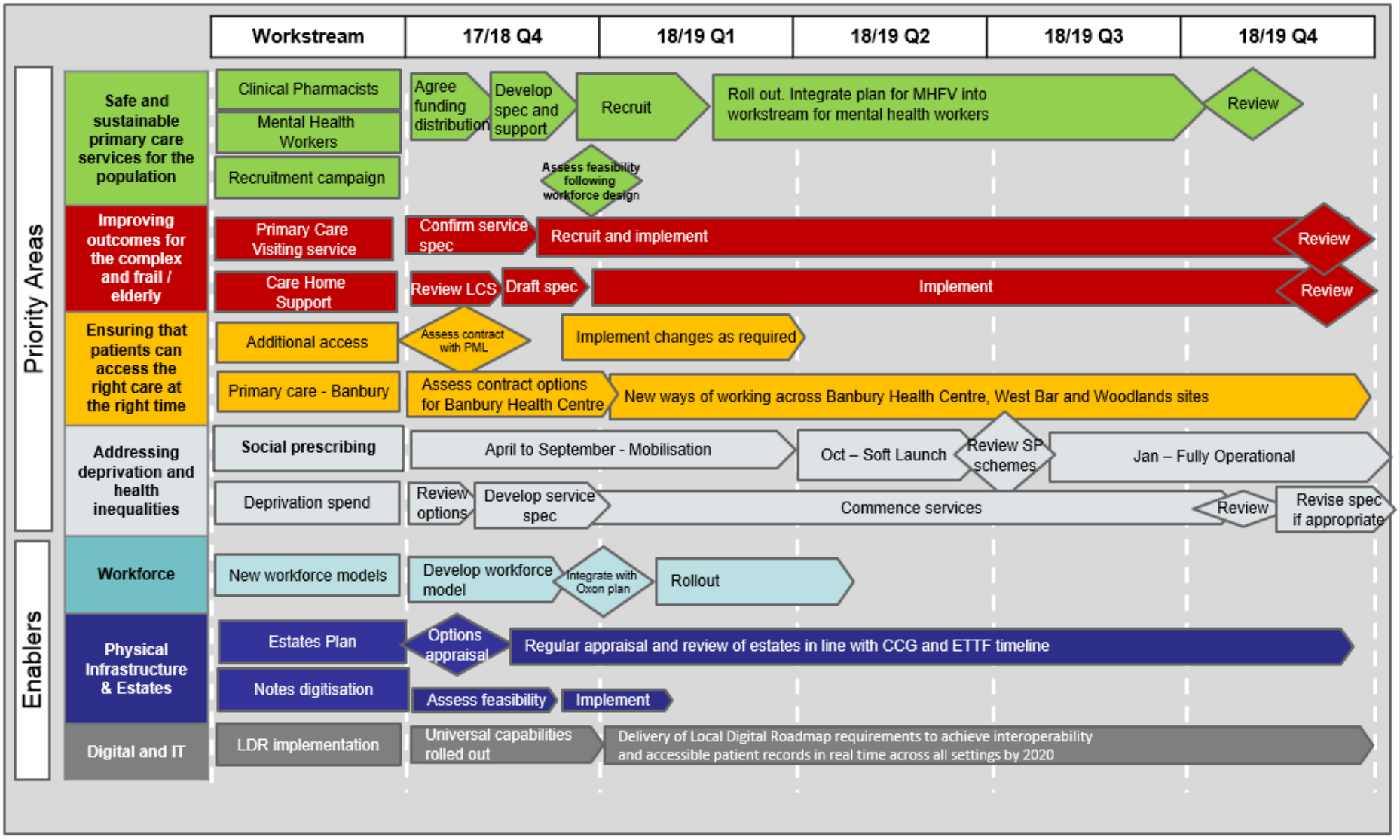
		Examples of schemes to be funded and relevant localities	Benefits for patients	Recurrent (full year) (£000)	Non-recurrent (£000)
Priority areas	Sustainable primary care	New posts for mental health workers and clinical pharmacists in practice (all localities)	Improved outcomes for patients with mental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

Key messages:

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

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

5. Outline Mobilisation Plan



Appendix 1: Patient and Public engagement and involvement

North Oxfordshire Locality Public & Patient Forum

Public meeting 6 July 2017 – summary record

Context

About 25 local people (not including OCCG staff) attending a well-publicised evening meeting at Banbury Town Hall to discuss primary care developments locally.

Case for change and Primary Care Framework

Dr Shelley Hayles (Deputy Locality Clinical Director) presented the issues facing primary care and the direction set out in the Oxfordshire Primary Care Framework.

The meeting broke into groups for a brief discussion of their experience of primary care, and highlighted the following:

- Lack of same day response for individual patient in pain – how should this work?
- Importance of recruitment AND retention of GPs
- Difficulty of travel from villages
- Difficulty getting through to some surgeries on the phone – esp. Mondays
- Access is an issue and a worry
- Prevention is important
- Educating patients NB debate about whether the onus is on the patient to know how to navigate the system or the service to guide the patient

Discussion of North Oxfordshire draft priorities for primary care

Groups chose to highlight the following points in the closing plenary session:

- role of practice managers to make work easier in practices
- public transport – affects ability to travel and access care, especially cluster
- lack of knowledge about Hubs, out of hours GP service etc – publicise services
- should patients be charged a fee for missing appointments?

- Discuss potential for key-worker housing with Cherwell DC
- Find ways to take the admin burden off GPs
- Assurance of confidentiality when patients being triaged
- use of 'key words' to assist signposting
- Better use of videos in surgeries to highlight info and services available
- more funding for primary care
- Long delays for appointments worrying
- Education in schools on using the health service, and staying health
- Communications with patients crucial to success
- Workforce – note likely long delay in filling posts
- Use of video calls – perhaps for follow-ups

Further 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 including in Chipping Norton (14 November 2017) and Banbury (21 November 2017), and discussed at various stakeholder meetings. 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 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 Oxfordshire locality from:

- Cherwell District Council
- Chipping Norton Action Group
- Bloxham Parish Council
- Banbury and Bicester Labour Party
- Hightown surgery Patient Participation Group
- Keep our NHS Public
- Mid Cherwell Neighbourhood Plan
- Pegasus Group
- Robert Courts MP
- Councillors
- Patient representative from the Primary Care Co-commissioning Group.

A strong theme from respondents to the initial draft of this plan published in December 2017 was the future of primary care services in Banbury and the knock on impact that this may have on the Horton Hospital and Chipping Norton Community Hospital. Both hospitals are highly valued and supported, and people welcomed the idea that more services could be delivered in the community, so long as it was not at the expenses of any urgent care provision on these sites. People were very concerned that there had been insufficient time to respond to these proposals and also felt that the plans were too vague. People were keen to see more detail on how the plans would be implemented and the impact that these would have on Phase 2 of Transformation. The key themes highlighted were:

- Affordability of the plans
- Access to other health professionals
- How will you deliver the plans
- Maintain acute services at the Horton
- Improve the retention of staff
- Insufficient time to digest and respond to the plans
- Proposals are too vague to comment on

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.

Better communication	• Challenge of communication between hospital and GP • Communications is key - needs more. Will help patients bear with this change. • Better communications about the extended access hub and how to use it; some patients are not aware of the hub. • Duplicated appointments due to lack of comms internally • Variety of communication approaches and formats needed for different people • More confidence in receptionists' people skills and confidentiality	The CCG recognises that communications between different healthcare professionals is essential in providing good integrated care. Records sharing for cross-organisational care, in particular between primary care, community and mental health services and secondary care is a key focus across the county to deliver more joined-up care. NHS England has made funding available for training in active signposting, 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. The plans assume health staff are properly trained.
Access and transport	• Pockets of deprivation - need for public transport greater than ever. • Physical access especially for those with mobility and getting appointments • Bus services and locations must have proper bus services or no point in considering it (moving to a new location). And frequency • Access. Waits- walk in /parking/transport. Phone lines needed. • Rural practice in Deddington has no pharmacy, how can patients self-care if they have to travel 6 miles to get supplies • Deddington has also seen practice numbers increase significantly over the last two years making it more difficult to get a speedy appointment. There is limited parking at the practice which causes problems for those in outlying villages. • Much of the locality is rural and remote from Banbury and Witney service bases, with transport challenges and risk of slow ambulance response.	This level of detail has not been possible in the first plans – however it is acknowledged as being a very important consideration. We will need future plans to evidence close working with Districts and City Councils to understand how patients can easily access services. The CCG will consider transport and infrastructure in deciding future primary care estates and in bringing services out of the hospital closer to people's home, working with local councils. The process for agreeing this will be clarified in the next draft of the plans. The Oxfordshire Health and Wellbeing Board regularly produces a Pharmaceutical Needs Assessment (PNA) in line with regulation. This reviews both access and services currently provided. The latest assessment in 2015 did not identify a need for improvement and better access to pharmaceutical services for residents in the North locality but recommended that all pharmacies should make full use of NHS Choices and other internet-based information sources to promote their services, to improve communications so patients and carers are aware of the range and availability of all services. The 2018 draft PNA is currently out for consultation and can be responded to here.
Concerns about future of Banbury Health Centre	• What will the impact be of any changes to Banbury Health Centre? Will there be more consultation?	OCCG have listened to patients at Banbury Health Centre and to the views of other stakeholders including HOSC, Cherwell District Council and the local MP. Further discussions are needed to agree the details but OCCG is working with PML federation on a solution that will allow services to continue to be provided from the Banbury Health Centre building. The plan is to bring together three practices in Banbury (Banbury Health Centre, West Bar and Woodlands). This will ensure practice resilience, continued

		access and the potential for a wider range of services to be delivered for patients currently registered with all 3 practices
Use of technology	• Far better use of technology, skype, proactive email messaging to patients • Lack of trust on online systems • User friendly websites • All social media sites • Link back office IT	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.
Recruitment	• What is being done to pull back GPs who have left the profession • How much of a recruitment issue? Facts/figures. Need to know scale of problem • More recruitment and invest in recruitment • What is OCCG doing to advocate and get Government to address GP recruitment?	The number of GPs in the locality and the future required workforce under the current model of care is set out in the locality plan. Future sustainability of primary care is dependent on introducing a wider mix of skills into general practice, and the North locality is leading the way in this, with many practices already employing, for example, clinical pharmacists or MSK practitioners. This will be supported by a countywide plan to recruit and retain GPs in Oxfordshire and the North locality.
Gaps in children's services	• No mention about children's services • Problems with fragmentation in children's services	The Oxfordshire Primary Care Framework confirms the important role of primary care services for the health of children and these are considered within the localities. The CCG will consider how these can be referenced more clearly. Examples include: • Support families and children especially those on with a child protection plan • Support for children's mental health • Increased access for children in primary care after school, during which time there is a higher than average level of attendance at A&E It is acknowledged that we need to build more into the plan around children services and this will be included in future versions.
Walk-in/urgent appointments	• Some practices have walk-in in the morning. Very booked appointments and disruption. • Need EMU at the Horton and a walk-in service • World wants walk-in. Employer issue re sit in waiting room half day and lose pay • More walk in to take the pressure off A&E. Also central as each practice can't offer this. • Walk-in system works well on a Monday at WestBar	The CCG recognises that practices have different appointment systems that work well according to patient preferences and they should work with PPGs to ensure that these are appropriate. The next iteration of the plans will confirm that the CCG is working towards an Oxfordshire wide standard, so patients can have access to urgent appointments when clinically necessary, regardless of how practices manage their appointment systems. We need our plan to simplify access routes for patients, offer choices of online or a range of alternatives to seeing a GP such as self referrals to Physiotherapists. Clearer and wider access routes would be a preference to blanket walk-in to primary care.

Continuity of care	• If ongoing health issues then want continuity • Continuity for diabetes needed • Patients want continuity of care by the appropriate specialist • Concerns over the waiting times for routine appointments	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 skillmix 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.
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 Heyford Park is one of the largest 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.
Prevention and health inequalities	• Need to work with the council and other agencies to build a system wide approach to improving health and wellbeing and reducing inequalities.	The CCG agrees on the importance of taking a broad approach to improving the health and wellbeing of people in our most deprived communities. The Brighter Futures programme in Banbury is an excellent example of a programme of projects designed to relieve deprivation by improving access and opportunity for individuals within certain areas of Banbury, in particular in education, financial inclusion, employability and health. This is highlighted in the revised plan.
Future of the community hospital in Chipping Norton	• Local services in the community hospital should be at least maintained, in particular: o First Aid Unit – frequent mentions of its local importance o Specialist Outpatient appointments and X-ray o Ultrasound suggested as an additional service	We recognise local services are valued. We will continually review how we achieve local access and make best use of clinical resources.

Appendix 2: References

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

Appendix 3: Glossary

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.
CABs	**Citizens Advice Bureau**
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.
COPD	**Chronic Obstructive Pulmonary Disease**
CSU	**Commissioning Support Unit** CSUs provide a range of support services to clinical commissioners. They were established in April 2013 as part of the NHS reorganisation.
DC	**District Council**
DN	**District Nursing**
ECPs	**Emergency Care Practitioner**
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.
EOL	**End of Life**
FAU	**Frailty Assessment Unit** The Chipping Norton FAU in North Oxfordshire is open weekday evenings, 5pm to 9pm and 10am to 9pm for weekends and bank holidays. This is a drop-in service with no appointment necessary.
GP	**General Practitioner**
GPAF	**General Practice Access Fund** – Additional funding to support extended general practice at evenings and weekends
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.
HAH	**Hospital at home** Service provided by Oxford Health for patients as an alternative to hospital admission support earlier discharges from hospital for people who are well enough to return home. The plan proposes neighbourhood community teams in place of HAH, providing a more robust clinical decision-making and risk-holding capability.
HGH	**Horton General Hospital, Banbury** Part of Oxford University Hospital Foundation Trust
HOSC	**Health Overview and Scrutiny Committee** – a committee of elected councillors and voluntary sector representatives that scrutinises (carries out an independent check on) healthcare services in Oxfordshire.
HSCN	**Health and Social Care Network** The Health and Social Care Network (HSCN) will provide a reliable, efficient and flexible way for health and care organisations to access and exchange electronic information.
ILT	**Integrated Locality Team** Integrated Locality Teams are responsible for joining up and coordinating the care provided by multiple professionals to patients within their defined locality**.**
ISTC	**Independent Sector Treatment Centre**
MIU	**Minor Injuries Unit**
MSK	**Musculoskeletal**
NAH	**Neighbourhood Access Hubs**
NOLF	**North Oxfordshire Locality Public & Patient Forum**
NOLG	**North Oxfordshire Locality Group**
NOxMED	NoxMed is the name given to the group of GP practices in North Oxfordshire that form part of the PML GP Federation.
OCC	**Oxfordshire County Council**
OCCG	**Oxfordshire Clinical Commissioning Group**
OHFT	**Oxford Health Foundation Trust** provides mental health and community services in Oxfordshire. OHFT also holds the contract for the Luther Street homeless service in Oxford.
OOH	**Out of Hours services**
OT	**Occupational Therapist**
OUHFT	**Oxford University Hospitals Foundation Trust,** includes the John Radcliffe Hospital and the Churchill Hospital in the City and the Horton General Hospital in Banbury
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.

PMCF	**Prime Ministers Challenge Fund**
PPG	**Patient Participation Group** All practices have, or are setting up, a PPG. Their role is to advise practices on the patient perspective and providing insight into the responsiveness and quality of services. They may also encourage patients to take greater responsibility for their own and their family's health, support communications with patients and undertake research on behalf of the practice.
QOF	**Quality and Outcomes Framework** An annual reward and incentive programme for practices, the QOF also provides registers for practices and the public of numbers of patients with specific conditions to support better management of these patients.
SCAS	**South Central Ambulance Service**
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 Centre** 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**