



Locality Place Based Primary Care Plan: West Oxfordshire Locality

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Foreword

The NHS is facing challenging times: There is growing demand, constrained resources and workforce shortages at every level in both the health and social care systems.

West Oxfordshire faces specific challenges:

- Population increase of 20,000 over the next 10 years due to housing growth
- An older population than the Oxfordshire average which is expected to continue to grow at a higher rate than other parts of the county
- For the rural cluster of West Oxfordshire, 43% of GPs are aged over 55 and potentially nearing retirement
- General practice is becoming a more stressful and a less attractive career option resulting fewer GPs working full time and practices struggling to recruit new GPs and other staff
- There is limited practice space
- Resources are not keeping pace with soaring demand.



Dr Miles Carter, Locality Clinical Director (left) and Dr Amar Latif, Deputy Locality Clinical Director (right)

The traditional primary care model has worked well over the years. However, with all these challenges, we, as local GPs and patients, recognise that the traditional model needs adaptation if it is to survive.

We want to build on the strengths of the services already available in West Oxfordshire. We plan to improve urgent same day access so patients can see a healthcare professional urgently when needed, to boost the workforce by diversifying the team so that patients can benefit from a range of different skills, to optimise the management of our growing elderly population and to develop our buildings to meet the needs of the increasing demand.

As local GPs, we do not want to miss this opportunity to improve local services for our growing population. With the multiple challenges we face there is not one easy solution. Through sharing resources across the locality, coordinating services and using the expertise of local clinicians and patients, we can all work together to strive for a system that is both resilient and excellent for the future.

This plan also addresses the recommendation of the Independent Reconfiguration Panel (IRP) to the Secretary of State for the development of a plan to ensure sustainable primary care in Witney and surrounds.

We congratulate Dr Kiren Collison, Deputy Locality Clinical Director of the West Locality, who was elected to the position of chair of Oxfordshire CCG and was instrumental in the development of this plan, and welcome Dr Amar Latif as the new Deputy Locality Clinical Director.

West Oxfordshire Locality Executive Summary

Locality overview:

West Oxfordshire Locality is home to a registered patient population of 81,638 (January 2018). The locality is made up of market towns and villages. Witney is the main urban area (over 27,000 people), and Carterton the second largest town (16,000 people). West Oxfordshire is the most rural district in the county and residents are older than average. This creates specific challenges around transport links and access.



What is working well:

- Extended access hubs in Witney
- Use of broader skillmix, including emergency care practitioners and pharmacists
- Activity-led website signposting patients in Windrush
- Optimised reception rostering to improve retention recruitment
- Longer appointments in some practices



Key locality challenges:

- Estates that can match the pace of their growing population, in particular Witney, Carterton and Eynsham
- Parts of the locality have a significantly older population, which causes challenges for access to services
- Recruiting enough staff for the growing ageing population



Key Priorities for the West Oxfordshire Locality

We have identified four key priorities for the locality and thirteen 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 West Oxfordshire.

#	Workstreams	Priorities			
		Meet the healthcare needs of the ageing population in the locality	Ensuring safe and sustainable primary care that delivers high quality services	Improving prevention services	Planned care closer to home
1	Maximise benefits of Emergency Multidisciplinary Unit				
2	Community gerontologist or interface physician for complex multi-morbidity patients in care homes and assisted living				
3	Locality diabetes service, and extend to other conditions, such as heart failure and COPD				
4	Increased primary care visiting service				
5	Same-day care services in Witney and Carterton with increased capacity				
6	Urgent Treatment Centre in Witney, integrating current services				
7	Wider primary care clinical skill mix delivered through practice-based and cluster services to supplement existing GP and practice nurse staffing				
8	Practice based mental health practitioners for rural West				
9	Enhanced signposting role for receptionists and development of practice websites for signposting				
10	Development of practice website				
11	Development of social prescribing model				
12	Shared back office services				
13	Estates prioritisation				

Note on the geography of the West Oxfordshire Locality

The West Oxfordshire locality (WOLG) is contained entirely within the West Oxfordshire District Council area. However, localities do not map onto constituency or district council boundaries. This is because Oxfordshire CCG's localities reflect patient flow and long standing working relationships of GP practices that pre-date the formation of OCCG in 2013. A number of services are arranged around or report on the basis of these well-established boundaries.

All references to West Oxfordshire in the plan are to the locality as described in figure 1, unless otherwise explicitly indicated. A summary of key challenges and priorities for practices and patients in the area covered by West Oxfordshire District Council is set out in table 1.

Plans for primary care in the northern part of West Oxfordshire District Council (Chipping Norton and surrounds) are covered in the North Oxfordshire Locality Place Based Primary Care Plan.

Plans for primary care in the eastern part of West Oxfordshire District Council (Woodstock) are covered in the North East Oxfordshire Locality Place Based Primary Care Plan.

All locality plans are on the Oxfordshire CCG website at:
<http://www.oxfordshireccg.nhs.uk/about-us/locality-plans.htm>

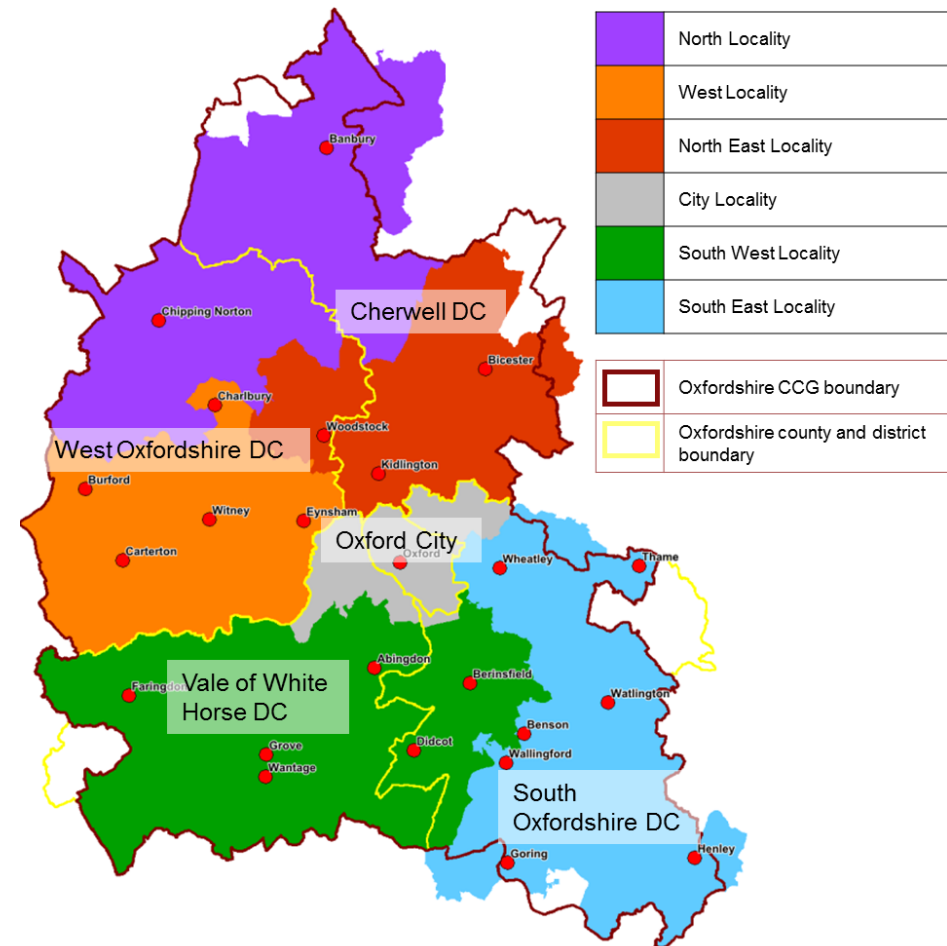


Figure 1: Oxfordshire CCG localities mapped against Oxfordshire county and district boundaries

Table 1: Summary of the Locality Place Based Plan for patients resident in West Oxfordshire District Council boundaries

Locality Plan	Part of West Oxfordshire covered by the locality plan	Key challenges	Key priorities and how we will address them
West Oxfordshire Locality	Aston, Bampton, Burford, Carterton, Charlbury, Eynsham, Stonesfield, Witney (Patients who live in West Oxfordshire and are registered at Bampton Surgery (including Carterton Health Centre), Broadshires Health Centre, Burford Surgery (including Carterton Health Centre), Charlbury Medical Centre, Cogges Surgery, Eynsham Medical Group and Long Hanborough Surgery, Nuffield Health Centre, Windrush Medical Practice	<ul style="list-style-type: none"> • Estates that can match the pace of their growing population, in particular Witney, Carterton and Eynsham • Parts of the locality have a significantly older population, which causes challenges for access to services • Recruiting enough staff for the growing ageing population 	<ol style="list-style-type: none"> 1. Meet the needs of the ageing population in the locality: Community gerontologist or interface physician for complex multi-morbidity patients in care homes and assisted living Increased primary care visiting service 2. Ensuring safe and sustainable primary care that delivers high quality services: Estates prioritisation Wider primary care clinical skill mix delivered through practice-based and clusters, including clinical pharmacists 3. Improving prevention services Social prescribing and community activation 4. Planned care closer to home Urgent treatment centre in Witney and more planned care services in the locality
North Oxfordshire Locality	Chipping Norton, Kingham, The Wychwoods) (Patients who live in West Oxfordshire and are registered at Chipping Norton Health Centre and Wychwood Surgery)	<ul style="list-style-type: none"> • High number of care homes increasing the number of complex patients in the area • Significant housing growth projected, in particular around Chipping Norton • Ruralness of these areas poses access challenges 	<ol style="list-style-type: none"> 1. Safe and sustainable primary care services for the population: Clinical Pharmacist support in practices Social prescribing and support 2. Improving outcomes for the complex and frail / elderly: Expanding the primary care visiting service for frail patients Coordinating care home support from practices 3. Ensuring that patients can access the right primary care at the right time: Additional access services in the North Locality Review of primary care infrastructure in Chipping Norton in line with growth
North East Oxfordshire Locality	Bladen, Tackley, Woodstock (Patients who live in West Oxfordshire and are registered at Woodstock surgery)	<ul style="list-style-type: none"> • Additional 824 housing capacity projected by 2031 • Woodstock has a significantly older population which causes challenges for access to services • Access challenges at Woodstock due to lack of parking 	<ol style="list-style-type: none"> 1. Increased capacity in primary care to meet housing and population growth: Estates prioritisation Expansion of primary care visiting services 2. Sustainability of Primary Care: Primary Care Urgent Access Hubs 3. New models of clinical care Deliver prevention services through the wider primary care community team 4. Increased self-care and promotion of health and wellbeing: Explore benefits of social prescribing to support patients with non-medical needs.

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

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



1. The purpose of this locality place based plan

Good primary care is the bedrock of a high-quality and cost-effective health system, and the NHS has traditionally prioritised primary care compared to many other health systems worldwide, which 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 needs 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.

The Oxfordshire Primary Care Framework seeks to describe a framework for GPs and their teams, working with their patients, to describe how this model and the specific actions can work for their own local populations. The result of this is detailed in this locality place based plan clearly describing the future model for delivery of primary care across the locality.

This together with the GP Forward View (GPFV) and local implementation plan will ensure Primary Care remains the cornerstone of the NHS going forward. 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.

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 West 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:

West Oxfordshire Locality Group (WOLG) meetings:

- Membership includes GP commissioning leads from all 8 practices, some practice managers, patient representatives and district council officers
- Substantial discussions at West Oxfordshire Locality Group meetings on 20 April, 11 May and 8 June 2017
- Locality workshop with independent facilitator focusing on key questions 13 July
- 14 Sept. - detailed discussion of proposed workstreams, including ranking of priority.

Assessment of public health information:

- The data to assess health needs has come from numerous sources including:
 - Oxfordshire Joint Strategic Needs Assessment (JSNA)
 - NHS Digital
 - Oxfordshire County Council housing projections submitted to the Oxfordshire Growth Board by West Oxfordshire District Council.
- The JSNA examines the current and future health and care needs of the local population to inform and guide the planning and commissioning of health, well-being and social care services. It was developed in consultation with patients and other stakeholders. Elements of the JSNA that were applicable and appropriate for West Oxfordshire were shared with the public in draft plans and in presentations at public events.

Patient participation:

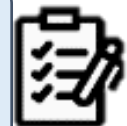
- Patient engagement is an integral part of developing the locality plans. In particular meetings with:
 - Stakeholders organised by Healthwatch
 - PPG groups of West Oxfordshire to plan engagement
 - Robert Courts MP
 - Witney town councillors

- Workshop session with councillors from West Oxfordshire District Council
 - West Oxfordshire Economic and Social Overview and Scrutiny Committee
 - Former patients of Deer Park Surgery
 - The locality patient forum (Public & Patient Partnership West Oxfordshire) discussed the draft priorities at their meeting on 13 June 2017. In addition, the forum chair and vice-chairs participated in the discussions at the locality group meetings listed above.
- In addition, Oxfordshire CCG has held events in Witney and Carterton in 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:
 - strengthening the role of prevention, including with partners in the voluntary sector, the council and schools
 - further clarity on the decisions regarding future primary infrastructure for new estates
 - inclusion of funding implications
 - additional information on greater skillmix, in particular through clinical pharmacists, and training for non-clinical staff
 - proposals to reduce waiting times for routine appointments through expansion of the urgent access hubs and making more use of the emergency multidisciplinary unit in Witney.
 - A full summary of themes identified through engagement is included in Appendix 1. This includes comments from the patient forum, the meetings with patients of former Deer Park surgery, the workshops in Witney and Carterton, written feedback and other contacts.
 - If any proposals require significant changes that could adversely impact patients a more formal consultation will be undertaken for the specific service area.

Key messages:

The West Oxfordshire locality based primary care plan builds on the principles identified by the Oxfordshire Primary Care framework to create a 5 to 10 year strategy for the locality.

The plan has received significant input from clinicians, patients and other stakeholders to ensure future health services best reflect our local community.



Part B: The demographics of the West Oxfordshire locality population

1. Summary

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



1.1. Population

- The registered patient population at 1 January 2018 was 81,638¹.
- The locality is contained entirely within the West Oxfordshire District Council area. It is made up of market towns and villages. Witney is the main urban area (over 27,000 people), and Carterton the second largest town (16,000 people). Other settlements are much smaller.
- West Oxfordshire is the most rural district in the county – more than half the residents live in an area classified as rural.
- Known transport issues for village residents are made greater by recent reductions in rural bus services. Bampton and other villages are significantly affected. Carterton is currently well-connected by bus to Witney and onwards to Oxford.
- Public transport access to Oxford hospitals are more challenging especially for patients and carers with limited mobility. Long journey times and the costs and difficulty of parking are a major public concern.
- There is a significant armed services population associated with RAF Brize Norton, with approximately 1,000 civilians registered with the base medical practice in addition to service personnel. Health services for service personnel are commissioned by NHS England.

1.2 Age

Patients registered with West Oxfordshire practices are older than average, as indicated in table 2 and figure 2.

ONS estimates from 2015 indicate that the total estimated population in wards covered by the West OCCG locality as of mid-2015 was 81,500 residents of which 2,200 were aged 85 or over with the ward of Burford having a significantly higher proportion of the population aged 85+ (6%). In the 5 year period between 2017 and 2022, the age group with the highest

Area	% of population	
	aged over 65	aged over 85
Rural West	19.3%	2.7%
Witney & East	20.8%	3.2%
West Locality	20.2%	3.0%
Oxfordshire CCG	16.7%	2.4%

Table 2: % of patients aged 65+ and 85+ (source: NHS Digital, January 2018)

¹ Data from NHS Digital January 2018: <http://content.digital.nhs.uk/gppatientsregistered>

growth in all districts and Oxfordshire County is expected to be aged 75 to 84 (+23% in Oxfordshire and +27% in the district of West Oxfordshire).²

Figure 2: Age distribution of population registered in West Oxfordshire practices and all Oxfordshire practices (data from NHS Digital January 2018)

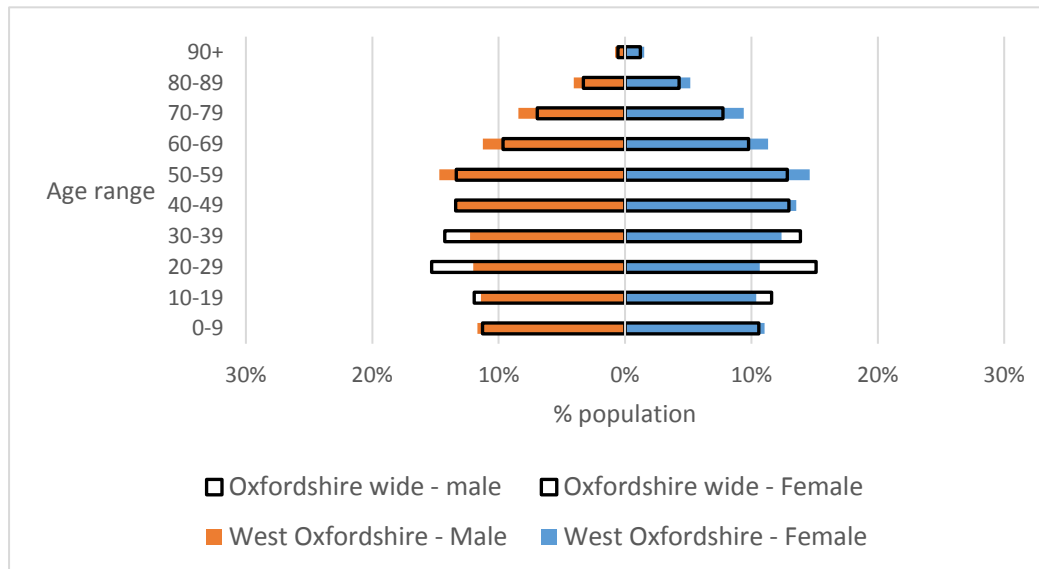
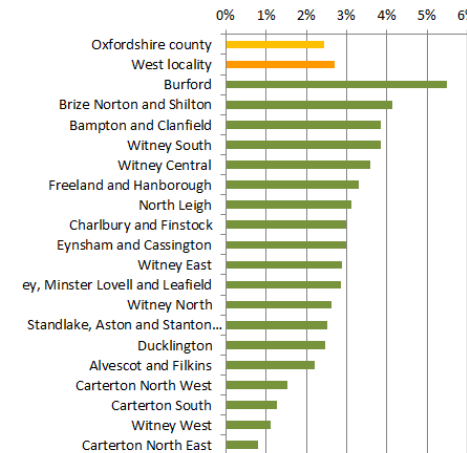


Figure 3: Wards: % of people aged 85+ (ONS 2015)



1.3 Care home population

- As of June 2017 there was a total of 18 care homes with 647 care home beds in wards in the West locality.
- The ward with the greatest number of care home beds was Witney East.

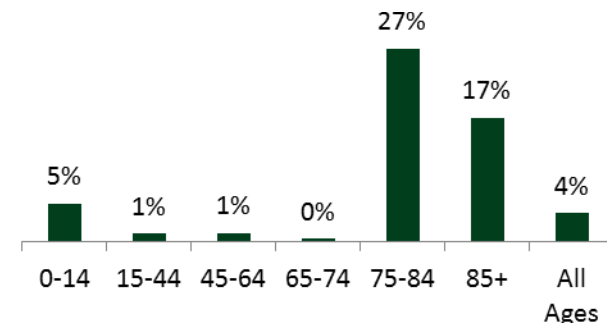


Figure 4: Growth in population of West Oxfordshire district in the next 5 years (ONS 2015)

² Source: 2014 ONS estimates. Housing projections set out below indicate that growth in the younger age groups is expected to significantly exceed ONS estimates.

1.4 Housing growth

ONS population projections do not take into account the significant housing growth expected in Oxfordshire over the coming years. Based on district council data collated for the Oxfordshire Infrastructure Strategy³, there are 3,600 dwellings expected in the locality over the next 5 years and over 8,000 in the next 10 years. At an average rate of 2.4 occupants per dwelling, estimated occupancy for these new homes is 8,700 in 5 years and nearly 20,000 in 10 years as shown in table 3. Most development will be in the Witney, Carterton and Eynsham areas. This includes two schemes with capacity for over 500 homes in West Oxfordshire with planning permission, in North Curbridge (West Witney) and on land at east Carterton.

	Housing growth – 5 years						Population Growth 5 years	Housing Growth – 10 years						Population growth 10 years
	2017/18	2018/19	2019/20	2020/21	2021/22	5 yr Total	5yr Total	2022/23	2023/24	2024/25	2025/26	2026/27	10 yr Total	10 yr Total
Rural West Cluster	167	328	405	314	264	1,478	3,547	255	245	225	105	80	2,388	5,731
Witney and East Cluster	115	254	496	473	789	2,127	5,105	735	777	730	645	620	5,634	13,522
Total West Oxfordshire	282	582	901	787	1,053	3,605	8,652	990	1,022	955	750	700	8,022	19,253

Table 3: Housing growth in West Oxfordshire locality to 2026/27

³ The Oxfordshire Infrastructure Strategy is published by the Oxfordshire Growth Board at: <https://www.oxfordshire.gov.uk/cms/content/oxfordshire-growth-board>. The West Oxfordshire District Local Plan 2031 is currently at examination: <http://www.westoxon.gov.uk/localplan2031#>

1.5 The health of our community in West Oxfordshire locality

Health outcomes are generally better than average in the West Oxfordshire locality. A summary of West Oxfordshire's health needs analysis for the locality (June 2016)⁴ is as follows:

- Although the rates of poverty affecting children and older people in the West locality were lower than the OCCG average and national average, deprivation data shows there were areas of Witney that had the highest rates of poverty affecting children and older people.
- The following health outcomes were higher than the OCCG average:
 - Deaths from All Causes under 75 years
 - Alcohol related hospital admissions
- The Freeland & Hanborough ward had a higher death rate from stroke than predicted by the age of the local population, but outcome may have been influenced by the 65 care home beds within Freeland and Hanborough ward.
- The Witney South ward had a standardised admission ratio for intentional self harm above the England average.
- West Oxfordshire locality patients have a slightly higher prevalence of long term conditions than average, which reflects the higher age of the population (table 4). Practices manage chronic diseases of their patients extremely well, with QOF achievement (quality measure of managing long term conditions) near 100%.

Table 4: Disease and LTC Prevalence QOF data 2016/17

	2015/2016 Disease and LTC prevalence QOF data 2016/17 (%)					
	Atrial Fibrillation	Hypertension	Dementia	Depression	Asthma	COPD
Rural West	2.1%	13.4%	0.7%	8.3%	6.4%	1.5%
Witney & East	2.2%	16.0%	1.1%	6.7%	6.7%	1.4%
Oxfordshire	2.2%	15.0%	0.9%	7.3%	6.6%	1.4%
England	1.7%	12.1%	0.7%	7.7%	5.7%	1.4%

Key messages:

Health outcomes are generally better than average in the West Oxfordshire locality. Patients in West Oxfordshire are older than average and the age group with the highest growth is expected to be aged 75 to 84.

In addition there is significant housing growth in Witney, Carterton and Eynsham which will have an impact on the use of services.



⁴ Source: Public Health England Public Outcomes Framework unless otherwise specified

Part C: How our population in West Oxfordshire accesses services

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



- 6 practices have above average GP-referred first outpatient appointments compared to the OCCG average (figure 5). This means the locality average is slightly above the OCCG average. However, the email service to secondary care consultants is used a lot in West (with significant variation across practices). There is some evidence that it can reduce referrals and this is recognised by GPs.
- Half the practices show a higher usage than OCCG average for out of hours (OOH) GP services and overall OOH use is slightly above the OCCG average.
- Use of A&E activity in West Oxfordshire is much lower than the CCG average (figure 6). This is associated with successful earlier campaigns to direct patients to the MIU as a better and more cost effective alternative to A&E and effective signposting in primary care.
- Urgent care emergency admissions are just below OCCG average.

Figure 5: GP-referred first outpatient appointments among practices in West locality and Oxfordshire average, standardised rate per 1,000
Source: SUS data March 2017

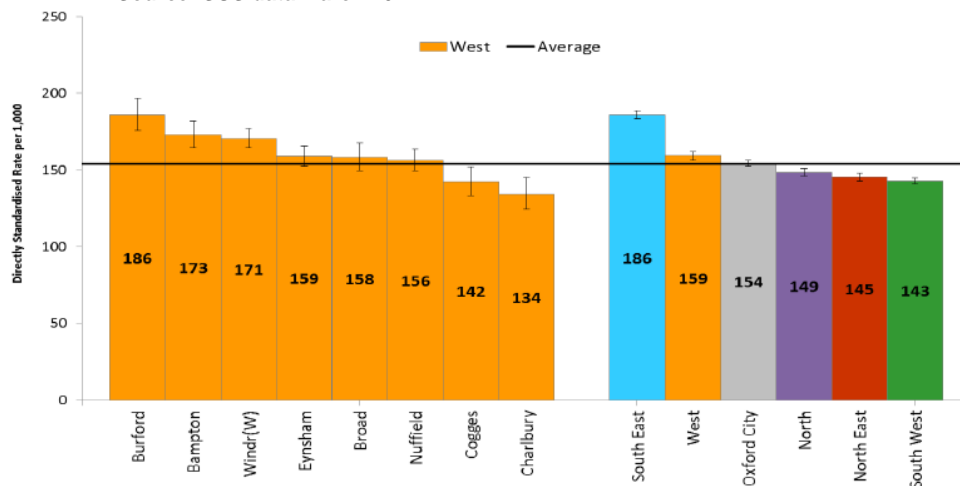
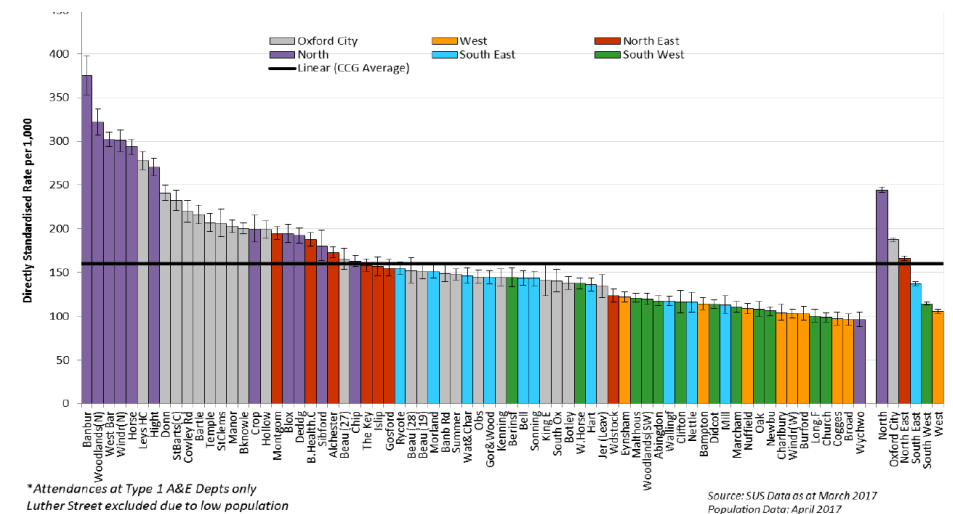


Figure 6: A&E attendance across Oxfordshire, rate per 1,000 2016/17
Source: SUS data March 2017



1. Overview of Primary and Community Care

The West locality has 8 GP practices, working in two clusters, offering primary care from 10 locations.

1.1 Access to primary care in West Oxfordshire Locality

Core primary care services are delivered Monday-Friday from 0800-1830 hrs by all practices in the locality. Feedback from the GP Patient Survey and the process of patient engagement to support the development of this plan indicate a high level of satisfaction with primary care services. Patients commented that services are responsive and provide excellent continuity of care.

In common with national trends, the average number of appointments per year is consistently increasing, putting pressure on the capacity to meet demand⁵. GP Federations provide additional GP and nurse appointments outside of normal practice opening hours, which are funded by the GP Access Fund scheme. These appointments are pre-bookable and are intended to provide routine appointments to those patients for whom normal practice opening hours are not convenient. This service is delivered in rotation from practice sites and appointments are available from 6:30-8pm Monday-Friday. These additional hubs are popular with patients and GPs in West Oxfordshire. There is also availability for several hours on a Saturday. Sunday appointments are provided by a hub in Banbury but are open to West Oxfordshire patients. The appointments are available to patients registered at any practice in the federation, regardless of the location of the clinic. There is currently little demand for routine weekend appointments but there is a national requirement to deliver them.

Table 5: Practices and branch surgeries in the West Oxfordshire Locality

#	Neighbourhood /Practice	List Size (1 st Jan 2018)
Rural west cluster		30,864
1, 1a	Bampton Surgery and Carterton Health Centre (branch)	8,474
2	Broadshires Health Centre	10,476
3, 3a	Burford Surgery and Carterton Health Centre (branch)	6,542
4	The Charlbury Medical Centre	5,372
Witney & East cluster		50,774
5	Cogges Surgery	7,657
6	Eynsham Medical Group and Long Hanborough Surgery	13,916
7	Nuffield Health Centre	12,037
8	Windrush Medical Practice	17,164
West Oxfordshire Locality Total		81,638

Figure 7: Map of practices in West Oxfordshire locality



⁵ Trends in consultation rates in general practice: <http://digital.nhs.uk/catalogue/PUB01077>

1.2 Primary care in care homes

For patients in care homes, the CCG commissions an enhanced service for Proactive Care Home Support from primary care. This is an optional scheme which involves a practice forging a closer working relationship with one or more care homes, and providing GP services to the majority of the residents in these homes. Almost all care homes in the West Locality are covered either by the CCG scheme or a separate arrangement and it is a priority for the Locality in the next year for all patients in care homes to have proactive care and support.

1.3 Out of hours

Outside normal practice opening hours, all patients have access to GPs and nurses working in the Out of Hours Urgent Care Service. Oxford Health NHS Foundation Trust holds the contract for delivery of this service and the service is delivered from the Witney Hospital site. Appointments are accessed via the NHS 111 service, and cannot be booked in advance or for routine problems.

1.4 Urgent Care

1.4.1 Minor Injuries Unit (MIU)

The MIU is a nurse-led service delivered from Witney Community Hospital from 10:00 to 22:30 Monday to Sunday. It is a walk-in service (meaning patients do not need to be referred). It also provides access to x-rays from 10:00 to 19:30 both to MIU patients as well as to patients referred directly by their GP.

1.4.2 Urgent Access Hubs

The GP federation, PML, provides additional urgent same-day GP and nurse appointments at a 'hub' based at the Windrush Health Centre in Witney. There are also routine pre-bookable physiotherapist appointments for assessment of musculoskeletal problems. The patient must be registered at any practice in the federation and the appointments can only be accessed through their practice (it is not a walk-in service). It is open from 9:00 to 18:00 Monday to Friday and funded through a national initiative and the GP Access scheme.

This service increases the capacity of primary care to manage urgent non-housebound patients. It is suitable for patients who require same-day attention but where continuity of care by their own GP on that particular occasion is not paramount to their effective management. This service increases access for urgent patients, whilst also freeing up additional time in practices for GPs to spend with complex patients where continuity of care is important.

Urgent access hubs are popular with both patients and GPs. Capacity is, however, limited and an increase in appointment availability would be beneficial to match demand. In addition, as the hub is located in Witney, it is predominantly used by those practices based in and around

Witney whilst more rural practices (particularly Burford, Charlbury and Bampton) use it less frequently. This rural cluster is interested in developing a second hub in Carterton. This would be closer to their patients and offer equity of urgent access, in line with the Witney practices.

1.4.3 Primary Care Visiting Service (PCVS)

The Primary Care Visiting Service is led by Emergency Care Practitioners (ECPs). They visit acutely unwell housebound patients at the request of the patient's GP. This service runs in-hours from Monday to Friday and increases the capacity of primary care to manage urgent housebound patients. Capacity is currently 5 WTEs shared across 3 of the CCG localities (West, North and North East). Increased capacity will be required to match the demand from an increasing elderly and housebound population.

1.4.4 Emergency Multidisciplinary Unit (EMU) in Witney

The Witney EMU is a great asset to the current local services and has been well received by both patients and the locality GPs. Local GPs and other community services can refer adults who are acutely unwell who require investigation and treatment but are unlikely to need overnight admission. In this way, it provides a less acute medical setting than the hospital and is closer to home. Oxford Health NHS Foundation Trust holds the contract and the unit is staffed by both physicians and nurses.

1.4.5 Future plans for urgent care

As part of the Urgent and Emergency Care Review, NHS England intends to establish commonality in the specification for urgent care through urgent treatment centres (UTCs) by December 2019.⁶ There are multiple urgent care services based in Witney and a wide range of discrete primary, community and secondary care health services already available on the "health campus" formed by Witney Community Hospital and Windrush Health Centre. However, there is currently little integration. Looking towards an Urgent Treatment Centre (UTC) model which coordinates these services may facilitate sharing of staff, buildings and resources and may also allow for a more streamlined, more efficient, and less confusing service.

1.5 Community elective services

Community health services on the Witney Community Hospital and Windrush Health Centre "health campus" include:

- Community hospital including therapies and in-patient care
- Range of outpatient clinics

⁶ <https://www.england.nhs.uk/urgent-emergency-care/urgent-treatment-centres>

- Endoscopy (independent provider)
- Podiatry clinic
- Sexual health clinics
- Independent audiology clinics
- GP out of hours service base
- Bladder & bowel service
- Community ultrasound
- Community midwife clinics.

The MSK Assessment, Triage and Treatment (MATT) service is provided from the former Deer Park Medical Centre building on the west side of Witney, by an independent provider, Healthshare. District nurses are mostly based at the hub offices on the edge of Witney, with some health visitor teams working across the area and based at Cogges Surgery and Carterton Health Centre.

Service	Hours M-F	Hours w/e	Staff	Referral
Minor injuries unit	1000-2230 ⁷	1000-2230 ²	Nurse/HCA	Self
GP Access Fund Hub	9 hrs / week	Sat am	GPs, ANP	Practice
GP Access Fund practice	1830-2000	-	GP & Nurse	Practice
Primary Care Visiting service	0800-1800	-	ECPs, ANPs	Practice
Out of hours GP service	1830-0800	24 hours	GPs	NHS 111
EMU	0800-2000	1000-1630 ⁸	Medic ⁹ , Nurses	Clinician
District nursing hub	0800-1630	0800-1630	Nurses	Practice, self
Hospital at Home	0800-2200	0800-2200	Nurses, ECPs, APs	Clinician

Table 6: Summary of primary care services in West Oxfordshire locality

⁷ X-ray available 1000-1930 only

⁸ Not available at Witney for last 18 months

⁹ "Interface medic" – experienced gerontologist or GP with special interest

Focus on primary care in Witney

Witney is the largest town in the West Oxfordshire locality. It has a population of approximately 28,000 and is served by 3 practices located in the town following the closure of Deer Park Medical Practice earlier this year (see appendix 3 for more detail) – Nuffield Surgery and Windrush Medical Practice in the town centre and Cogges Surgery in East Witney. Windrush Health Centre is part of a “health campus” on the same site as Witney Community Hospital. A full list of services provided at Witney Community Hospital is provided on pages 17-18.

Practices in Oxfordshire have been working together to provide pre-bookable and same day, evening and weekend appointments within general practice since 2015, strengthening the support available for those with the most complex needs and introducing new ways of accessing services. This service is delivered from 6:30-8pm Monday-Friday at practices across West Oxfordshire and on Saturday at Windrush Health Centre. The CCG also commissioned over 1,000 additional appointments per month for patients in West Oxfordshire to be delivered during core GP hours by GPs, advanced nurse practitioners and physiotherapists – these are all provided at Windrush Health Centre and are available to all patients registered in West Oxfordshire practices. The weekday services have received positive feedback from patients. The locality plan for West Oxfordshire indicates an intention to increase capacity in the locality – with options for locations to be considered by practices to ensure maximum utilisation. In addition, an Urgent Treatment Centre model on the site of the current Minor Injuries Unit at the Community Hospital, if it meets the appraisal process to be carried out by March 2018, will ensure a consistent route to access urgent appointments, over time to be booked through NHS 111 and GPs.

The West Oxfordshire Local Plan 2031* identifies Witney as a key area for future development with an identified housing need of 4,400 homes to 2031 shown in figure 7. This includes:

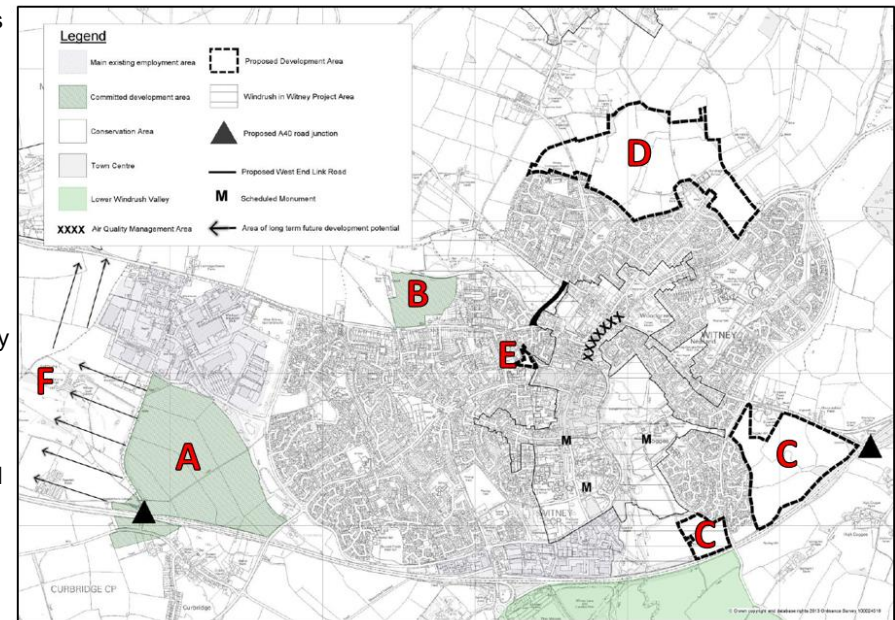
- Confirmed developments in West Witney of 1,000 dwellings (A) and in Burford Road of 260 dwellings (B)
- Strategic Development Areas on the eastern side of Witney of around 450 dwellings (C) and to the north of Witney of around 1,400 dwellings (D)
- Non-strategic housing allocations on Woodford Way Car Park of 50 dwellings (E) and on land west of Minster Lovell of 85 dwellings (to the North West of the map).

Land to the west of Down’s Road (F) has additionally been identified as an ‘area of future long-term development potential’ to include consideration of opportunities for new housing and employment to meet identified development needs beyond 2031.

Future primary care infrastructure in Witney will need to respond in a timely and appropriate way to future housing growth. The Cogges Surgery has recently received funding from NHS England’s Estates and Technology Transformation Fund to improve clinical capacity. In the longer term, Nuffield Health Centre has indicated its intention to relocate and expand capacity and Cogges Surgery will consider increasing capacity further with the possible need to relocate. This will ensure that patients from a much wider area will be able to access primary care services at the surgery. The future location of the surgery will be subject to an options appraisal which will include considerations regarding accessibility, capacity and expected utilisation, and will be subject to consultation with its registered patients. An options appraisal will also be completed on how best to provide services.

*To read the West Oxfordshire Local Plan 2031 visit West Oxfordshire District Council website: <https://www.westoxon.gov.uk/media/1037296/Local-plan-2011-2031.pdf>

Figure 7: Witney sub area strategy (planned housing growth to 2031)



2. Primary care workforce

2.1 General practitioners

Practices responded to a survey in September 2017 regarding capacity details, gaps in current staffing and known/planned for retirements. Table 7 indicates the number of sessions currently delivered, the future number of sessions required and the number of GPs required to continue delivering the same level of service. Future projections do not account for the number of GPs that are expected to retire in the next 5-10 years, although it is expected that up to 30% of the current workforce will retire in the next 3 years.

Future numbers of GPs is likely to be impacted by:

- Intentions across Oxfordshire to move to longer 15 minute appointments for patients with greater needs
- Potential changes in skillmix and a greater role for signposting and community champions to support patients in managing their long term conditions.

Table 7: GP workforce in North Oxfordshire locality

Locality	Current number of sessions delivered*	Number of sessions required in the future		Number of additional GPs required (FTE) – assumes 8 sessions per week	
		5 years**	10 years**	5 years*	10 years**
Rural West	134	150	159	2.2	3.5
Witney & East	204.25	225	258	2.8	7.5
West Locality	338.25	374	417	5.0	11.0

* Data from workforce survey; **Data calculated from housing projections (table 3 above)

2.2 Other primary care workforce

In terms of other general practice in the locality, table 8 indicates current sessions offered by treatment room nurses, advanced nurse practitioners, healthcare assistants and phlebotomists taken from the workforce survey. Plans for future recruitment of staff are unlikely to meet future demands from population growth.

Table 8: Non-GP practice workforce in West Oxfordshire (current and plans to recruit)

Locality	Treatment room nurse sessions		Advanced Nurse Practitioners		Health Care Assistant		Phlebotomist	
	Currently	Plans to recruit additional staff (3 years)	Currently	Plans to recruit additional staff (3 years)	Currently	Plans to recruit additional staff (3 years)	Currently	Plans to recruit additional staff (3 years)
Rural West	53.5	2	1	2	9	1	23	0
Witney & East	70.9	8	6	0	11	0	19	0
West Locality	124.4	10	7	2	20	1	42	0

As indicated in tables 8 and 9, practices in West Oxfordshire have not yet begun to employ a broader skillmix to deliver primary care in the future, with the exception of 2 practices that employ advanced nurse practitioners. There is some interest in employing pharmacists, mental health practitioners; practices have expressed concern about indemnity and employment models as a barrier to working across practices.

Table 9: Practice intentions to employ or share clinical staff (ANPs, ECPs, APs, PAs)

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
Rural West	0	3	1	1	0	0	3	1	0	0	0	3	0	0	0	0	4	0	0	0
Witney & East	0	1	1	1	1	0	0	2	0	1	0	1	1	0	1	0	1	1	0	1
West Locality	0	4	2	2	1	0	3	3	0	1	0	4	1	0	1	0	5	1	0	1

Table 10: Practice intentions to employ or share clinical staff (pharmacists, physiotherapists, phlebotomists, mental health practitioners)

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
Rural West	0	4	0	0	0	0	3	1	0	0	0	4	0	1	0	0	3	1	0	0
Witney & East	3	0	0	0	2	0	1	1	0	1	0	1	0	1	0	1	0	1	0	2
West Locality	3	4	0	0	2	0	4	2	0	1	0	5	0	2	0	1	3	2	0	2

Key messages:

There is currently good access to primary and urgent care in West Oxfordshire. It is intended to increase urgent access through the hubs, particularly in the rural West and to develop an urgent treatment centre in Witney with better integration of services.

There is significant growth in West Oxfordshire which will have an impact on primary care services and future workforce. Growth projections suggest that a further 11 GPs (FTE) will need to be recruited to meet demand in the next 10 years (this does not account for retirements). Practices will therefore need to consider employing a broader skillmix to ensure a more sustainable workforce for the future.



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

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



Priority 1 – Meet the healthcare needs of the ageing population in the locality

Background

West Oxfordshire has among the oldest population in Oxfordshire, which is set to grow rapidly in the coming years. As the older population increases, so will the population living in nursing and residential homes.

Objectives:

- Prevention of, and early identification of, health and social care crises in frail adults, both at home and in care homes.
- Care of frail adults in the least acute setting which is appropriate to their needs.
- Move more acute services from the John Radcliffe Hospital to EMU and community settings in the locality.
- Support the needs of housebound patients or those living in assisted living accommodation.

Plans:

- a) Build on the current EMU model: The Witney EMU is a great asset to the current local services. Local GPs and other community services can refer adults who are acutely unwell who require investigation and treatment but are unlikely to need overnight admission. In this way it provides a less acute medical setting than the hospital and is closer to home. We plan to meet clinicians from Witney EMU to explore the factors currently limiting their capacity and ensure that primary care and other community services are making most efficient use of this resource.

- b) Virtual ward rounds: We will work with EMU to develop a plan for virtual ward rounds of identified frail or medically unstable patients. This would aim for prevention or early identification of health or social crises and to forward plan. This could include input from a gerontologist or interface physician, social worker, nurse and GP.
- c) A weekly community pre-bookable gerontologist clinic to review the most medically complex or frail elderly, as requested by their GP. We plan to work with EMU to develop a plan that uses EMU as a base and will allow sharing of resources, staff and space. A business case will need to be developed.
- d) Care/nursing homes: Some local practices welcome a plan for a gerontologist or interface physician to manage their care home patients. This could be an extension of the current hospital outreach programme and involve both virtual and real ward rounds. This would allow preventative measures for keeping patients well, early identification and management of physical or mental health deteriorations and greater support to care home staff by having a direct link with medical support. In turn, these measures may reduce inappropriate acute hospital admissions and keep patients closer to home. As some practices are keen to continue to manage their care home patients themselves this would be an optional service. The patient would remain on the practice list. A business case will need to be developed.
- e) Increasing the capacity of the primary care visiting services: Emergency care practitioners visit acutely unwell housebound patients at the request of the patient's GP. This service increases the capacity of primary care to manage housebound patients with medically urgent conditions. However, capacity is currently limited to 5 practitioners across 3 localities. Increased capacity will be required to match the demand from an increasing elderly population.

Plans for other services set out in subsequent priorities, in particular social prescribing and urgent access hubs, will also support care for the older population.

Priority 2 – Ensuring safe and sustainable primary care that delivers high quality services

Background

The traditional primary care model has worked well over the years. However, the demand for primary care services is increasing: patients are visiting their GP more frequently each year and, as set out in table 2, the number of patients in West Oxfordshire is increasing, with 20,000 more patients expected over the next 10 years (and the 5,000 additional patients in Witney and the East of the locality over the next 5 years). A future model of primary care will rely on adequate workforce, building space and resources.

It is predicted nationally that 30% of GPs are planning to retire in the next 5 years. For the rural cluster of West Oxfordshire, this figure may be even higher, with 43% of GPs aged over 55¹⁰. With the challenges around GP recruitment, limited practice space and resources not keeping pace with soaring demand, we recognise that the traditional model needs adaptation. Without this, primary care will not be sustainable longer term.

Objectives

- Sharing of resources, staff and knowledge across practices
- Streaming of patients to the most appropriate service to meet their needs
- Boosting the primary care workforce, both GPs and other healthcare professionals
- Optimising space within practices and expanding buildings to manage the population growth
- Patient education about the services available and that a GP will not always be the first or only port of call.

Plans

a) Increasing the capacity of the urgent access hubs: Different dimensions of access are valued differently, with some people preferring rapid access to any clinician and some requiring continuity of care with the same clinician. Increasing the capacity of the urgent access hubs will provide additional same day access. This is particularly beneficial for patients of working age and for children who, except in specific circumstances, do not need to see the same GP each time for episodic conditions. In turn, this releases GP time in practices to reduce the demand on waiting times for routine appointments and devote more time to those requiring longer appointments and greater continuity of care. However, capacity is currently limited and an increase in appointment availability would be beneficial to match demand. There is also an issue of inequity of use of the urgent access hub. As it is located in Witney, it is predominantly used by those practices based in and around Witney,

¹⁰ General and Personal Medical Services, England High-Level March 2017, Provisional Experimental statistics, NHS Digital

while more rural practices (particularly Burford, Charlbury and Bampton) use it less frequently. If a hub were to be located closer, the rural cluster practices have stated that they would use it more. Therefore, they propose that we plan for a second hub in Carterton. with the number of appointments for core general practices increasing each year.

b) Workforce: All practices are potentially vulnerable because of difficulty recruiting staff, a high proportion of retirements in the next few years and increasing list size. The roles of allied health professionals need to be developed in order to support the GP workforce. The workforce model will be based on GP-led multi-disciplinary teams and include nurses, healthcare assistants, physiotherapists, clinical pharmacists and mental health workers. The allied health professionals will work either at practice level or at neighbourhood level depending on local need. The WestMed urgent access hubs and the primary care visiting services are successful examples of this at federation level.

The locality is currently testing a model of employing a pharmacist and potentially a pharmacy technician to work across the whole locality. Clinical pharmacists can have a valuable role in general practice. In addition to freeing GP time, benefits include timely medication changes following discharge from hospital, safer prescribing across the locality and potentially suggesting medication changes more quickly than individual GPs.

Training of allied health professionals to increase their skills will be needed. This may include upskilling of healthcare assistants to perform duties traditionally performed by practice nurses, such as wound care or ECGs, or it may include training in nurse prescribing. The CCG's practice nurse educational coordinator will help practices across the locality to find appropriate training and mentoring for HCAs wanting to develop new skills. This training could be delivered at neighbourhood to locality level. Practices may also be able to provide some training "in house".

Development of portfolio roles for GPs. This may include a post rotating between a practice (or a set of practices), the urgent access hub, interface medicine or GP-specialist clinic (for example, the GP-cardiologist clinic). These posts will be developed at federation level according to local need and then advertised to all GPs, but with a particular focus on GP trainees and newly qualified GPs.

Workforce development is a priority across Oxfordshire. More detail on CCG wide support is provided in part E.

c) Estates development and infrastructure

Investment in GP practices to increase capacity for the rising population will be required and practices may consider merges where this makes sense logistically and financially. Current use of space, such as the community hospital, Deer Park site and Windrush Health Centre, needs to be reviewed to optimise space usage and boost joint working, for example, by co-locating urgent services on one site. Further intentions on estates prioritisation to support the plans is provided in part E.

d) Involvement of patients: engagement with practice PPGs as well as the locality forum to:

- publicise important health messages
- publicise the range of services available to patients and what the most appropriate setting is for their need e.g. MIU, pharmacist, minor eye conditions service (MECs).
- share the pressures faced by the local NHS
- Educate and manage patient expectation around a changing healthcare model. This may include seeing a nurse or being referred to the urgent access hub when they may have traditionally seen their own GP.

e) Development of practice websites: Windrush Medical Practice website is already an excellent example of enhancing signposting of information to patients, improving access as well as being an effective way of streaming the requests to the most appropriate person within the practice. Other practices are keen to learn from their experiences. Investment will be needed to set up the sites. NHS England is supplementing this through providing training for receptionists to become skilled and confident in sensitively ascertaining the nature of the patient's need and exploring with them safe and appropriate options. This is being delivered locally through the Oxfordshire Training Network. These initiatives have also been shown to reduce demand on services and decrease waiting times for appointments.

Priority 3 – Improving prevention

Background

A central tenet of the GPFV is commitment to more initiatives around preventative care. Clear signposting and increased access to self-care information and resources can empower patients to play a more pro-active role in their healthcare. The benefits of this are that patients are less reliant on acute services and feel confident using services such as pharmacies to control their symptoms where appropriate. A Kings Fund report identifying priority areas for Clinical Commissioning Groups states that expenditure on prevention is 'an excellent use of resources'. In a review of more than 250 studies published on prevention in 2008, nearly 80% were within the National Institute for Health and Care Excellence's threshold for cost effectiveness¹¹.

There is good evidence that social isolation impacts on people's health and also uses up a huge amount of scarce GP time. In addition, many patients with chronic diseases need extra support with their management and this can often be provided by trained volunteer peers, rather than healthcare professionals. Many patients with chronic diseases will also suffer social isolation due to the real, or perceived, effects of their illness. For this reason, combining self-management and social prescribing hubs makes good economic sense, as there will be some overlap of skills and resources.

Objectives

- Development of social prescribing and health and wellbeing model: System wide approaches to health promotion recognise that individual behavioural change is sustained through social influences of family, friends, school and work colleagues, which primary care is well placed to support through practice-held registered lists of all patients. There are numerous successful examples of social prescribing schemes across the country that are often run in conjunction with third sector organisations, and in West Oxfordshire there are many associations run by community groups including volunteering, arts activities and social groups that help people live healthier lives.

We will harness the enthusiasm of these community-led examples in West Oxfordshire to promote healthier lifestyles and make healthy living the norm. This includes:

¹¹ <http://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners>

- Partnering with local organisations and established groups to create better connected communities and to ensure any social prescribing schemes that can link patients in primary care with non-medical sources of support are embedded in the community,
 - Considering ways to work with schools, nurseries, colleges and families to get young people to be more active and increase their physical and mental wellbeing, and
 - Developing a proactive physical activity referral scheme(s) in partnership with West Oxfordshire DC and integrated with other health prevention activity. The scheme would target people before they develop a long term condition, people identified at risk of developing such a condition, as well as patients already identified on chronic disease registers.
- Enhanced signposting role for receptionists: As part of the General Practice Forward View, CCGs have been allocated funding to support practices to train reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence. This provides patients with a first point of contact which directs them to the most appropriate source of help. Receptionists acting as care navigators can ensure the patient is booked with the right person first time.
 - Making Every Contact Count: 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 4 – Planned care closer to home

Background

We are integrating care between primary, community & secondary care for patients with diabetes enabling patient empowerment and self-management with a focus on population health outcomes. Pilots have commenced in the North East locality with practice diabetes multi-disciplinary team meetings and in the next year it is planned to have an alliance contract between the GP federation Oxford University Hospitals NHS Foundation Trust, and Oxford Health NHS Foundation Trust to deliver an integrated diabetes service co-ordinated by a locality clinical board with an outcomes based contract and resources and responsibility share between the alliance parties. Effective use of ICT and data sharing for a diabetes dashboard, screen sharing between primary and secondary care - enabling joint consultations and earlier specialist intervention – will be integral to the success of the project.

As part of the planned care programme, there are now musculoskeletal hubs running across the county, with a bladder and bowel service and a local optometrists offering a minor eye condition service. This improves care closer to home and promotes prevention.

Objectives

Following the success of the local diabetes pilot in the North East, we plan to introduce this into the West locality. If successful, we will build on the model to bring chronic disease management closer to home, extending to other conditions, including cardiology and COPD.

Planning for the future

In response to the key objectives outlined in each of the priorities, we have recommended 13 workstreams. Each workstream responds to the challenges of at least one priority. The chart below indicates how each initiative aligns to the different priorities.

#	Workstreams	Priorities			
		Meet the healthcare needs of the ageing population in the locality	Ensuring safe and sustainable primary care that delivers high quality services	Improving prevention services	Planned care closer to home
1	Maximise benefits of Emergency Multidisciplinary Unit				
2	Community gerontologist or interface physician for complex multi-morbidity patients in care homes and assisted living				
3	Locality diabetes service, and extend to other conditions, such as heart failure and COPD				
4	Increased primary care visiting service				
5	Same-day care services in Witney and Carterton with increased capacity				
6	Urgent Treatment Centre in Witney, integrating current services				
7	Wider primary care clinical skill mix delivered through practice-based and cluster services to supplement existing GP and practice nurse staffing				
8	Practice based mental health practitioners for rural West				
9	Enhanced signposting role for receptionists and development of practice websites for signposting				
10	Development of practice website				
11	Development of social prescribing model				
12	Shared back office services				
13	Estates prioritisation				

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

Proposed solutions	Delivery scope	Benefits	Implementation steps	Duration	Priority level 1 = immediate 2 = 2 nd tier
Maximise benefits of EMU	Build on the current EMU model to ensure that primary care and other community services are making most efficient use of this resource.	<ul style="list-style-type: none"> - Prevention or early identification of health or social crises and to forward plan. - Reduce emergency admissions 	Work with OH to assess number of sessions required and amend contract	Ongoing	1
Community gerontologist or interface physician for complex multi-morbid patients	<p>Develop a plan for virtual ward rounds of identified frail or medically unstable patients. This could include input from a gerontologist or interface medic, physician, social worker, nurse and GP.</p> <p>Weekly community pre-bookable gerontologist clinic to review the most medically complex or frail elderly, as requested by their GP.</p>	<p>Closer working with community services including district nursing and Hospital at Home.</p> <ul style="list-style-type: none"> - Greater support to high-need patients following hospital discharge. 	Development of proposal and business case	Ongoing	1
Locality diabetes service, and extend to other conditions, such as heart failure and COPD	Integrated care between primary, community & secondary care with locality based diabetes clinical boards following success of pilot in North East Oxfordshire; roll out to West Oxfordshire.	Consistent service across the locality. Supports bringing care closer to home.	To be agreed with planned care team	2 years	1
Expansion of primary care visiting service	<p>Increase the capacity of the visiting service</p> <p>Palliative care training</p> <p>Continuing the care homes support in its present form – to discuss</p>	<p>Supports primary care sustainability, allows assessment of frail elderly patients earlier in the day, supporting early assessment in an ambulatory care centre supporting care at home.</p> <p>Can help support care at home for frail elderly</p>	To recruit additional emergency care practitioners from current provider	5 years	1
Same-day care services in Witney and Carterton with increased capacity	<ul style="list-style-type: none"> - Integrated pathway for patients who need a same-day clinical response. - All services based on use of EMIS patient record - Common policies and practices across the cluster. - Consider integration of service with out of hours GP service and Minor Injuries Unit - Consider mix of pre-booked appointments and walk-in access. - Consider links between primary care visiting service and community services such as Hospital at Home and District Nursing Urgent Hub. 	<ul style="list-style-type: none"> - An agreed definition of urgent / same-day care across the locality. - Consistent level of care across same day care services; avoiding gaps, duplications and hand-offs. - Efficient use of clinical workforce. - Wider range of services provided for patients: GP, nurse, mental health worker and others including potentially pharmacy and physiotherapy. - Increased same-day capacity for local patients within existing resources of clinical staff and funding e.g. by focusing on Advanced Nurse Practitioners (prescribing) 	To agree with federation	Ongoing	2

		offering a minor ailments service, with GP oversight (may be remote).			
UTC in Witney	Develop MIU to have full UTC capabilities, including: Access 12 hours a day GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics Consistent route to access urgent appointments, including booked through NHS 111, ambulance services and general practice with a walk-in access option retained. Integration over time with other urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.	Clarity for patients on urgent access Reduced attendance at, and conveyance to, A&E Improved patient convenience Sharing of staff, buildings, records and resources and may allow for a more streamlined, more efficient and less confusing service.	To confirm with provider capacity and utilisation	By December 2019	2
Wider primary care clinical skill mix delivered through practice-based and cluster services to supplement existing GP and practice nurse staffing	- Pharmacists (practice/cluster or locality level). - Diagnostic physiotherapy (note self-referral to MSK Assessment & Treatment Service expected from April 2018). - Physician associates, social community nurses. - Other clinical roles (NB OCCG sourcing further evidence-based guidance).	- Improved range of services offered to patients. - Reduced pressure on GP capacity, freeing up time for 15 minute appointments with complex patients. - Alleviates pressure on recruitment of GPs.	1) Agree funding 2) Set out scope of work for pharmacists and employment model 3) Recruit	1 year	2
Practice based: Mental health practitioners	- Mental health practitioners in the rural West area learning from the Chipping Norton rural cluster model.	These mental health workers would be able to see patients with medically unexplained symptoms, severe 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 mental health worker and employment model 3) Recruit	Non-recurrent initially	2
Enhanced signposting role for receptionists	- Enhanced signposting role for reception/admin teams (including face to face, telephone, other)	- Improved access to service information for patients. - Effective integration of care; greater collaboration between services and joined up care around the patient. - Reduced demand on core primary care services by shifting patient care demands to other providers/ third sector.	Training in place	Initial training	1
Development of practice websites	Following success of Windrush practice website that provides enhanced signposting information, support other practices that wish to adopt similar model.	- Enhanced information to patients and education (including work in schools). - Improved access to service information for patients.	To confirm with provider	Ongoing	2

Development of social prescribing model and prevention for children and young people	<p>Social prescribing scheme for patients referred by GP to a Wellbeing adviser and onto community services. People will be encouraged to get involved in activities that match their needs – they may promote physical exercise or social integration.</p> <p>A secondary aim includes community activation – helping people live healthier lives with the support of community associations, schools and employers.</p>	<p>Reduced pressure on GP appointments</p> <p>Reduced obesity and social isolation; more sustainable use of primary care</p>	<p>Agree scheme with West Oxfordshire District Council</p>	<p>July – Sept 2018: soft launch Oct 2018 onwards: service fully operational Sept 2019: review to assess impact</p>	<p>2</p>
Shared back office services	<p>- Shared back-office functions.</p> <p>- Support with policies, recruitment and payroll</p>	<p>- Better use of practice resources of space and staff by sharing back office resource.</p>	<p>1) Scope programme 2) Recruit resources</p>	<p>1 year</p>	<p>1</p>
Estates	<p>Investment in GP practices to expand/increase capacity for rising population.</p> <p>Practices might consider mergers where it makes sense for logistical and financial reasons. Particularly large growth is expected in Witney, Carterton and Eynsham.</p> <p>Review use of space in Windrush Health Centre and Witney Community Hospital to boost joint-working and maximise use of this health campus.</p> <p>Identify needs and opportunities for primary care infrastructure growth to meet future requirements</p> <p>Carterton: identify suitable infrastructure to meet forecast population growth and any additional local services for the cluster.</p> <p>Work with developers and the district council to ensure infrastructure across new and existing sites, including Deer Park, meets future growth and is accessible.</p>	<p>Sustaining Primary Care and meeting the needs of a growing population.</p> <p>Continue to provide care closer to home</p>	<p>1) Options Appraisal 2) Implementation in line with CCG priorities</p>	<p>Continuous</p>	<p>1</p>

Key messages:

West locality priorities:

1. Meet the healthcare needs of the ageing population in the locality
2. Ensuring safe and sustainable primary care that delivers high quality services
3. Improving prevention services
4. Planned care closer to home

The 13 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 West. A key aim across all enablers is to strengthen practice sustainability.

1. Workforce:

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

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

This includes concrete working with partners to:

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

- Develop a standardised approach to the development and training of healthcare assistants
- Increase community-based academic activity.

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

Effective workforce planning requires:

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

The CCG will provide support at locality level for practices to model and plan the workforce appropriate for populations of 30-50,000. This may include sharing staff across practices as set out in priority 2 above or providing support for mergers, where requested by practices, to provide a greater level of sustainability.

2. Estates

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

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

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

In the West locality key estates priorities include:

- Review use of space in Windrush Health Centre and Witney Community Hospital to boost joint-working and maximise use of this health campus. Looking towards an Urgent Treatment Centre (UTC) type model which coordinates these services may facilitate sharing of staff, buildings, records and resources and may allow for a more streamlined, more efficient and less confusing service.
- Identify needs and opportunities for primary care infrastructure growth to meet future requirements. Specifically this includes:
 - Replacement of Long Hanborough Surgery (project agreed following developer agreement)
 - Minor improvement to clinical capacity of Cogges Surgery in Witney (ETTF funding allocated)
 - Expansion of Eynsham Medical Centre
 - Expansion of Broadshires Health Centre or redevelopment of Carterton Health Centre
 - Expansion and relocation of Nuffield Health Centre and / or Cogges Surgery within Witney, including development of criteria for the options appraisal, identification of appropriate sites and consultation with current patients.

3. Digital

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

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

Key digital priorities for the West locality include:

- Shared patient record accessible to all local services. 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 status quo 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.
- Access for care homes. All care homes 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.
- Use of websites and directory of services for signposting, such as the excellent example at Windrush Medical Practice.
- Use of ICT to maximise efficiency of clinical triage.

4. Funding

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

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

The CCG will support future investment in workstreams that are intended to deliver savings elsewhere in the system subject to a robust business case. This will provide a significant step forward in delivering accountable care, in which resources are allocated according to the

needs of the population of Oxfordshire and in which partners in the health and social care system share financial and clinical accountability to deliver better outcomes.

Oxfordshire CCG has responsibility for the review, planning and procurement of primary care services in Oxfordshire, under delegated authority from NHS England. The Oxfordshire Primary Care Commissioning Committee (OPCCC) carries out these functions and is chaired by a lay member¹². 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 11 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.

Table 11: 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

¹² The papers and minutes of the OPCCC are available at: [http://www.oxfordshireccg.nhs.uk/oxfordshire-primary-care-commissioning-committee-\(opccc\)-meetings](http://www.oxfordshireccg.nhs.uk/oxfordshire-primary-care-commissioning-committee-(opccc)-meetings)

5. Outline mobilisation plan

See following page.

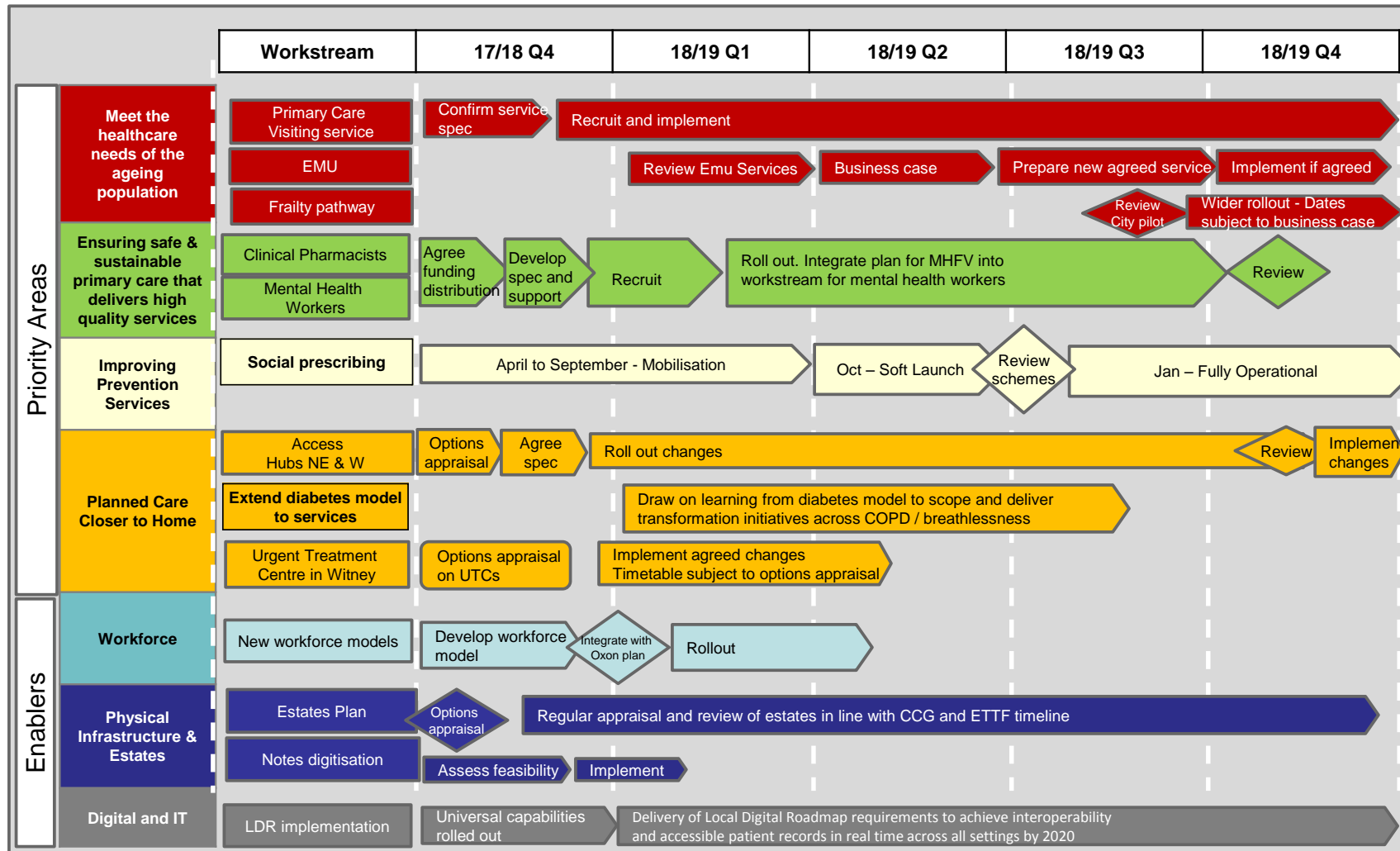
Key messages:

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

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



Outline mobilisation plan



Appendix 1: Patient and Public engagement and involvement

Public & Patient Partnership West Oxfordshire (PPPWO) steering group - Discussion of WOLG primary care priorities

Fergus Campbell (Locality Coordinator) attended the PPPWO steering group meeting on 13 June 2017 to discuss the West Oxfordshire Locality Group draft priorities for primary care (version 2). He had circulated these to all members following the WOLG meeting on 8 June

The PPPWO meeting suggested the following:

- Meeting the needs of the growing and ageing population should be a very high priority
- GPs having access to faster and more accessible diagnostics closer to home for the patient (avoiding journeys to Oxford hospitals)
- Explicit focus on reduced time to access routine appointments
- Add a focus on prevention and public health improvement
- More clearly addressing the needs of isolated rural populations
- Expand the scope of integrated working to reference ambulance services, social care and voluntary sector.

The meeting also discussed that:

- As patients we recognize that things need to change and understand the need to use non-GP clinical staff for many routine things
- equipping GPs to manage mental illness in the community more effectively. This is especially important in those with serious mental illness who fall outside the community-based psychological support services.

Key themes from the meetings with former patients of Deer Park Medical Practice (see appendix 3 for more detail regarding the practice):

- Queries and reminders that the IRP advice was to not preclude having a GP practice in Deer Park Medical Centre (DPMC)
- Lack of confidence that OCCG is following the IRP advice
- Concerns from previous DPMC patients about waiting times at their new practices and difficulties with online appointment availability and impact of closing Deer Park has had on this
- When looking at expansion of primary care / new premises will the DPMC building be considered?
- Concern raised that the IRP response was focussed on Witney and surrounds but the CCG plans address wider West Oxon issues
- Concern raised that there needs to be more engagement in the development of the Locality plan

- Proposal for services to be re-opened at Deer Park or somewhere in West Oxfordshire - more doctors to allow more appointments available The hub appointments not sufficient for population
- Recognise there is a conflict of interest with GP practices; APMS contracts are different and challenges of recruiting GPs are not as big.

Key themes from the patient engagement: November – December 2017

A period of engagement was undertaken between 3 November 2017 and 3 December 2017 for each of the locality plans. The plans were presented and discussed at a series of public workshops around Oxfordshire, and discussed at various stakeholder meetings including Witney on 1 November 2017 and Carterton on 8 November 2017. An online/paper survey was available on OCCG's engagement website - Talking Health. People also had the opportunity to give direct feedback via email, letter, phone, or freepost. Following this period of engagement the draft plans were published and were available for further comment until 17 December 2017.

In the West Oxfordshire locality, 51 people registered and followed this engagement activity on Talking Health. Of these 51 people, 21 people then responded to the survey. In addition, the CCG received responses relevant to the West Oxfordshire locality from:

- Keep our NHS Public
- Robert Courts MP
- Windrush Practice Patient and Participation group
- Several members of the public.

Although respondents agreed with our proposals and approach, there is continued concern in West Oxfordshire about the closure of Deer Park Medical practice and the lack of engagement from the CCG on the future of primary care services in Witney, specifically relating to Deer Park and the future of the premises. People are aware of the challenges facing primary care and the increased housing growth planned for the area. People are concerned about waiting times for non-urgent appointments, reception staff triaging patients and if there is a risk in using less qualified staff instead of GPs for some work.

However, in general people were positive about their practices, and appear to have a sympathetic understanding of the pressures facing GPs in primary care. The wider issues that were identified related to GP recruitment, lack of funding of the NHS, closer working with local authorities around planning and housing developments and improving infrastructure. Concern was raised about the rurality of the locality and lack of public transport. Communication between health professionals and different NHS organisations could be improved, using better technology. For those that were involved in this engagement, they wanted to know how the plans would be funded and how the plans would be

implemented. Specifically raising concerns around the recruitment and retention of staff and the impact that this would have on the development of services. Some of the themes included:

- Improve staff training
- Local Authorities should provide infrastructure
- Increase the opening hours of the Witney MIU to reduce pressure on primary care
- Re-instate Deer Park practice
- Make hospital service local
- Triage minor illness using nurses
- Improve communication between health professionals
- Reduce the number of referrals to Oxford
- Evaluate the services you have already.

This feedback, together with the feedback from the stakeholder events and the meetings with stakeholders set out on page 8 has been incorporated into the revised plan. A summary of the responses is set out below:

Key Themes	Summary of issues	CCG response
Readability	<ul style="list-style-type: none"> • The plans are long • How do we know how to navigate the plans? 	<p>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.</p> <p>The CCG will consider other comments relating to readability in future versions of the plans.</p>
Relationship between the plans and BOB STP and Accountable Care Systems	<ul style="list-style-type: none"> • 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 	<p>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.</p> <p>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</p>

		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	<ul style="list-style-type: none"> • There is no indication of how much the plans cost • Is there enough funding for the recommendations in the plans to be implemented? • To what extent is the feasibility of the plans unknown / unlikely? 	<p>The funding consequences of the first year of the plans is now included in part E. 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.</p> <p>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.</p>
Phase two STP transformation programme	<ul style="list-style-type: none"> • Why are you producing the plans now when the consultation on phase 2 of the STP transformation programme has not yet started? 	<p>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.</p>
West Oxfordshire locality boundaries	<ul style="list-style-type: none"> • As the locality does not align with the district council it is not possible to see whether the plan is relevant to all patients in West Oxfordshire 	<p>The West Oxfordshire locality (WOLG) is contained entirely within the West Oxfordshire District Council area. However, localities do not map with constituency or district council boundaries. This is because Oxfordshire CCG's localities reflect patient flow and long standing working relationships of GP practices that pre-date the formation of OCCG in 2013. A number of services are arranged around or report on the basis of these well-established boundaries. This also aligns with the National Association of Primary Care recommendation of designing services at a population level of around 30-50,000 patients. This enables a robust, high quality of services that remain local to patient need. Plans that relate to patients in other parts of West Oxfordshire council are set out on page 6.</p>
Population growth/housing development	<ul style="list-style-type: none"> • OCCG must cooperate more with the councils to get funding for health infrastructure • Work with developers • Need to be planning ahead 	<p>We are working closer with planning authorities at West Oxfordshire District Council to secure land and financial contributions to assist with estates growth across the locality and linking in with all local Neighbourhood Development Plans (NDP) to ensure Primary Care Services are on the agenda for planning decisions.</p>

		<p>Future primary care infrastructure in the area will need to respond in a timely and appropriate way to future housing growth. Any decision will be subject to consultation with local patients. An options appraisal will also be completed on how best to provide services.</p>
Access to GP appointments	<ul style="list-style-type: none"> • Not acceptable to wait two - three weeks • Poor experience – had to go home to phone for an appointment even though I was already at the surgery • Appointments – some practices have a phone-back system which works well • Want continuity of care but difficult to get appointment with named GP • Important for people with LTC to see own GP who knows you well • Phoned 111 and saw doctor in Witney, experience very good • Early visiting service works well 	<p>The plan recognises that different dimensions of access are valued differently by different people, depending on their need, age and working circumstances. Introducing a wider skill mix in practices and increasing overflow appointments for patients who prefer rapid access over continuity enables GPs to concentrate resources on seeing patients who require a higher level of continuity of care and to be seen by the same GP where possible. Our plans look at how this may be done.</p> <p>Additional appointments have been introduced in the locality at evenings and weekends and also during the day at hubs in the county. Due to the success of these appointments, more will be introduced during the year, ensuring patients will have rapid access to appointments and enable patients who prefer continuity of care to see their own GP.</p>
Access to other clinicians/ pharmacists	<ul style="list-style-type: none"> • Should be able to book to see a nurse , not just GP • Pharmacies could be used more as a first point of contact • Pharmacists have skills but not authority to prescribe? • More use of triage • More training of receptionists • May not need to see a GP – other professionals could be first point of contact e.g. physio 	<p>Future sustainability of primary care will be dependent on increasing the contributions from a wider range of staff than the traditional model of GPs and practice nurses. Some practices are already seeing the benefits of employing, for example advanced nurse practitioners and social prescribers. Pharmacists can play a valuable role in general practice, including managing adherence to medicines and holding clinics for patients with specific long term conditions; some are also registered prescribers. We aim to support these other health care professionals have the right skills such as the ability to prescribe (which is permitted for some allied health professionals).</p> <p>NHS England has made funding available for training in active signposting so receptionists 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.</p>
Recruitment/ retention of staff	<ul style="list-style-type: none"> • Shortage of clinical workers is a problem for the proposals • Provide affordable accommodation to help recruit more GPs • Recruitment vital to sustain services • Important for patients to raise funding/investment in GP services issues with their MPs • Upskilling workforce 	<p>The CCG agrees that there is increasing pressure on the GP workforce through changes in working patterns and an ageing workforce. NHS England is working with partners to increase medical school places, recruit from overseas and offer incentives for returning GPs. The CCG is also developing a countywide workforce plan with the aim of</p> <ul style="list-style-type: none"> • increasing capacity in primary care; • upskilling existing staff; and • bringing in and expanding new roles.

IT	<ul style="list-style-type: none"> • Patients' notes: not everyone can see them, would assist continuity • Electronic conversations – better use of email and website communications • Don't assume everyone has internet or mobile access. Need paper versions of information • Online booking/ access to notes / prescriptions is good • Integration of IT systems to encourage more use of computers • Potential for skype consultations 	<p>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.</p> <p>Making the most of opportunities for greater use to technology are intended to enable the CCG to provide care to different patients in different ways. Practices will need to work with their patients and patient participation groups to ensure that all patients have the same chance to contact their practices, whichever mode of access they choose.</p> <p>We will introduce the online consultation initiative across Oxfordshire practices in three phases which will allow patients to be signposted to the most appropriate service.</p>
Prevention/social prescribing	<ul style="list-style-type: none"> • Not enough emphasis on keeping well • More education in schools about staying healthy • Need to focus on younger generation • Invest time with young people • Social prescribing is a good idea e.g. walking groups • Age UK offers exercise to prevent falls • Paid person to be a befriender or supporter for social prescribing • Keep older people active • It is important to build on the examples already in place in West Oxfordshire 	<p>There are some excellent examples from across the county of working with schools to promote healthy lifestyles and increase health literacy, which we will aim to build on. As part of the plans, we are piloting a social prescription model, which will enable clinicians to refer for non-medical issues such as isolation and financial advice that can have an impact on people's wider health and wellbeing needs and we will work with patients and their carers to consider the most appropriate model for patients in the West locality, including the suggestions provided as part of the consultation..</p>
Witney Community Hospital	<ul style="list-style-type: none"> • EMU works well • Better use of Witney hospital – gerontologist used to be based there – why was this stopped • Maintain and expand Witney Hospital ; expand the MIU so it can stay open longer and increase capacity 	<p>The Witney EMU is a great asset to the current local services and is popular among patients and practices. We will work with clinicians from Witney EMU to explore the factors currently limiting their capacity and ensure that primary care and other community services are making most efficient use of this resource. We will also work with the providers to consider how to build on this, for example developing a plan for virtual ward rounds of identified frail or medically unstable patients or a weekly community pre-bookable gerontologist clinic to review the most medically complex or frail elderly.</p>
Mental Health	<ul style="list-style-type: none"> • Not enough support for young people • School counsellors have long waiting lists • A mental health nurse should be attached to each practice • Need to look at self harm rate in south Witney which is above average • People with mental health issues need more support 	<p>Mental health services are a key priority across the county, and we recognise that there are pockets across the West locality that have a high prevalence of patients with severe and enduring mental illness, depression and other common complex mental health problems. We are considering a programme of enhanced support for mental health workers in practice, which may include link workers, based in neighbourhoods who have a track record in mental health and knowledge of the services available in the wider</p>

		<p>community and who can address identified needs and provide mental health support. Further details will be provided in the next iteration of the plan.</p> <p>We acknowledge that we need to give more focus on children and this will be included in later versions of the plan.</p>
Communication	<ul style="list-style-type: none"> • Better communications between OUH FT, GP Surgery, patients at pharmacist without discharge summary • Language about the elderly - it's not our fault • Website improvement and communication 	<p>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.</p> <p>There are excellent examples in the locality of websites that provide enhanced signposting information, such as that of the Windrush practice. We will aim to support other practices that wish to adopt similar model.</p>
Link to Adult social care	<ul style="list-style-type: none"> • How do the plans sit in relation to adult social care? • Needs to be good integration between different care providers in social care and primary care 	<p>There are some challenges working with social care and better integration between social care and the primary care team are a key focus of the plan. Records sharing is an essential component of good joined-up care delivered across organisations and there is a programme for records to be interoperable across primary care, community and mental health services and secondary care.</p>

Appendix 2: Examples of what is working well in West Oxfordshire

What is working well:

- Range of services available close together in Witney including EMU and MIU
- Primary Care Visiting Service – valued by patients and clinicians, and is very effective in identifying patients who would benefit from EMU.
- Neighbourhood Access Hub has provided helpful extra capacity, and the recent addition of a physiotherapist has been very successful and popular in meeting patient need.

At practice level, highlights include:

- 2 practices have successfully introduced 15 minute appointments (Burford, Windrush)
- Windrush Medical Practice has developed a new signposting website with its patient group and including an e-consultation option
- Clinical pharmacists starting at Eynsham and Windrush following successful bid to NHS England
- Well-developed recall approach for patients with long term conditions at Burford.

Appendix 3: Deer Park Medical Practice & Independent Reconfiguration Panel Advice

Following an unsuccessful procurement process, Deer Park Medical Practice in Witney closed on 31 March 2017. Its patient list was dispersed to surrounding practices. OCCG worked with the GP practice and its 4,399 patients to ensure that the list dispersal was managed in a safe and orderly way. OCCG also worked with the other practices in Witney to help minimise any impact on their services as Deer Park closed. This included extra investment over the transition period to support practices registering large numbers of patients and to fund additional appointments in the local GP access hub.

In December 2016 a member of Deer Park Medical Practice Patient Participation Group requested a judicial review on the decision to close services at Deer Park Medical Centre. The judge hearing the case in February 2017 refused permission to bring a judicial review, however the Oxfordshire Health Overview and Scrutiny Committee referred the matter to the Secretary of State (SoS) for Health on the grounds that the closure was a substantive change in service. In March 2017 the referral was passed to the Independent Reconfiguration Panel (IRP) for initial assessment in line with the protocol for handling contested proposals for the reconfiguration of NHS services.

The IRP concluded that the referral was not suitable for a full review¹³ because further local action by the NHS with the HOSC could address the issues raised. The SoS responded to HOSC on 3 July 2017 with a copy of the IRP review confirming he had accepted their recommendations in full. This letter was shared with the OCCG by HOSC.

On 25 July 2017 NHS England (NHSE) wrote to the CCG confirming their expectations that OCCG would address the recommendations from the IRP and in particular:

1. The CCG must continue actively to pursue the objective that all former DPMC patients are registered as soon as possible.
2. The CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. At the heart of this must be the engagement of the public and patients in assessing current and future health needs, understanding what the options are for meeting their needs and co-producing the solutions. This work should seek to produce a strategic vision for future primary care provision in line with national and regional aims and should not preclude the possibility of providing services from the Deer Park Medical Centre in the future. *(NHSE added that this needs to be linked to, and integrated with, the wider OCCG and Sustainability & Transformation Programme plans for the whole of Oxfordshire).*

OCCG had already written to Deer Park Medical Centre patients advising them of the closure and alternative practices in their local area. In response to the IRP's recommendations OCCG has continued to encourage patients who had not yet registered with another practice to do so.

¹³ IRP initial review is available at: <https://www.gov.uk/government/publications/irp-deer-park-medical-centre-witney-initial-assessment>

In total four letters have been sent to patients who remain on the Deer Park patient register with advice about how to register with another practice and the importance of doing so. Telephone advice and help has also been made available and information has been shared widely with the local media, Healthwatch, local GP practices and their PPGs and on the CCG website. On 18 January 2018, there were 285 Deer Park Medical Centre patients who had not yet registered elsewhere.

As outlined in this locality plan, along with GP colleagues, OCCG have developed a Primary Care Framework to provide strategic direction for a sustainable GP service in Oxfordshire. As the IRP recommendations were published, work was already underway to develop a locality place based plan for West Oxfordshire; patient and stakeholder engagement and involvement is an integral part of this process and the developing plan is being tested with the public, PPGs, local councillors and wider stakeholders. The development of this plan incorporates the IRP recommendations; engagement activity with the local community is outlined in appendix 1 above. Whilst the plan will be published as a first version in January 2018, the process of engagement on the long term future of primary care in the West locality is iterative and will continue as primary care starts to address in more detail long term sustainability of premises, practice size and workforce.

Appendix 4: References

1. [Oxfordshire CCG Primary Care Framework](#), Oxfordshire CCG, March 2017
2. [GP Forward View](#), NHS England, April 2016
3. [Transforming our health care system](#), Kings Fund, March 2011
4. [Berkshire, Oxfordshire and Buckinghamshire \(BOB\) Sustainability and Transformation Plan](#), October 2016
5. [Patients registered at GP practices by age and gender](#), NHS Digital, updated quarterly
6. [Oxfordshire Joint Strategic Needs Assessment](#), March 2017
7. [Oxfordshire Growth Board](#), including the Oxfordshire Infrastructure Strategy (OxIS) and the Oxfordshire Strategic Housing Market Assessment
8. [West Oxfordshire Local Plan 2031](#), on West Oxfordshire District Council website
9. [QOF](#), 2016/2017

Appendix 5: Glossary of Abbreviations

A&E	Accident and emergency department in hospital that deals with life threatening emergencies. In Oxfordshire, these are sited at the John Radcliffe in Oxford city, the Horton General Hospital in Banbury. Patients in Oxfordshire also attend the Royal Berkshire Hospital in Reading and the Great Western Hospital in Swindon.
BOB STP	The Sustainability and Transformation Partnership for Buckinghamshire, Oxfordshire and Berkshire West NHS and local councils have formed partnerships in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations.
CCG	Clinical Commissioning Group Clinical Commissioning Groups commission most of the hospital and community NHS services in the local areas for which they are responsible. Oxfordshire CCG also has delegated responsibility from NHS England for commissioning primary care services.
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.
EMU	Emergency Multidisciplinary Unit
EOL	End of Life
ETTF	NHS England's Estates and Technology Transformation Fund A multi-million pound investment (revenue and capital funding) in general practice. CCG's bid on an annual basis for capital funding from the scheme.
GP	General Practitioner
GPAF	General Practice Access Fund
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
HSCN	Health and Social Care Network
HOSC	Oxfordshire Health Overview and Scrutiny Committee
ILT	Integrated Locality Team
IRP	Independent Reconfiguration Panel The Independent Reconfiguration Panel is the independent expert on NHS service change. IRP is an advisory non-departmental public body, sponsored by the Department of Health.
ISTC	Independent Sector Treatment Centre
MIU	Minor Injuries Unit
MSK	Musculoskeletal
NAH	Neighbourhood Access Hubs
WOLG	West Oxfordshire Locality Group
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
SoS	Secretary of State for Health
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