Appendix 9: Summary feedback from patient events and stakeholders and draft CCG response

General feedback

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

Oxford City locality response to patient feedback

Key Themes	Summary of issues	CCG response
Support areas of deprivation	• Will resource allocation follow deprivation, therefore innovations in health teams. Can work to local need. • Allocate resources - based on deprivation so people can see. • Deprivation pockets - if tell them to go elsewhere they can be setting up additional problems - must be careful. If from deprived community may be an education issue.	Most 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. Health inequalities and deprivation is a key factor in determining how this funding is allocated. In addition, a number of specific projects aim to tackle deprivation and unmet health and wellbeing needs, including the introduction of a social prescription model in practices and other community settings. Examples also include the Barton healthy new town initiative and the expansion of the deprivation locally commissioned services which currently includes safeguarding and use of language line (our interpreting service). We have used the Joint Strategic Needs Assessment (JSNA) to identify needs in plans and will continue to look at how deprivation is affecting health.
Funding concerns	• Why are public health budgets slashed? • Fund them properly (and in line with need not geography) • Inequality of funding • Place based funding in Oxfordshire (nationally underfunded) • How can we shift from specialist care budgets which are over-funded	Public Health budgets reside at the local authority. We recognise however that more needs to be done on prevention. Implementation of the plans will require investment either through core funding or through release of funding in secondary care over time. This requires a step change in the model of primary care and services that are better joined up to keep people out of secondary care. Shifting funds from acute (and specialist) to community care is difficult due to the nature of national funding flows. We are redesigning pathways to get patients the support from the right person. Social prescribing is a good example of this.
Recruitment	• Young medical students are being put off becoming GPs • Scope for different models of employment - flexible employment - Oxford weighting • 111 don't have staff either and tell patients to call back • Increase attractiveness of GP/community work	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 • increasing capacity in primary care; • upskilling existing staff; and • bringing in and expanding new roles.
Work differently	• Neighbourhood teams and practices working together • Pharmacy nurses who can prescribe - extended hours (surgery just started doing) • More social prescribing - CAB/MIND • Use other staff eg nurse practitioners can advise on the smaller health problems • Changing patient expectations/nurses are not second best • Social care experts - not in a bed - direct elsewhere	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 clinical pharmacists and social prescribers. We will aim to increase effective contributions from: • Extended trained health care assistants • Advanced Nurse Practitioners • Clinical pharmacists • Paramedics • Practice based Mental Health workers • Social prescribers and other staff appropriate to the demographics of the practice.

Prevention	• School health nurses very important for prevention and to ensure mental health and other issues addressed early • Health education - schools should be starting to educate children, education and money are main drivers for prevention • GP practices to include things like pilates/prevention	School nursing is commissioned via the Local Authority. As we join our plans better with Local Authority planning we intend to place greater integration and focus on prevention. This needs further development in future plans as our vision for integration develops through the Health and Wellbeing Board. 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. In addition, the social prescription model 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.
Concerns for vulnerable patients	• Frailty - essential that local services are available for people who are frail regardless of age. • Have someone linked to the practice who links to the area looking after elderly people • Continuity of care for elderly is an issue particularly for ongoing illness, repeating prescriptions is an issue • Specialists - more for vulnerable children and safeguarding	As a result of the planning process, the CCG is working with partners to develop a frailty pathway that provides appropriate services available to assess patients at home, access to rapid diagnostics in an appropriate place to reduce admission and support for the frail and vulnerable at home for transient illnesses. The aim is to keep patients out of hospital or, if they must be admitted, to ensure that they are discharged appropriately and with support for as long as is necessary.
Services for mental health	• Appointments for mental health - need to be seen then, not wait. • Possible hub for wellbeing - for people to go to and talk about it. Mental health is such a wide range - severe to minor/access to mental health - develop support network • Support for mental health across age range in the hubs • Waiting times for mental health support/quicker - people go back to GPs - not necessarily right place to go	Mental health services is a key priority for the City locality plan with a high prevalence of patients with severe and enduring mental illness, depression and other common complex mental health problems. As part of the plan, the CCG is developing a programme of enhanced care for people with mental health conditions, staffed with multidisciplinary teams working in partnership with neighbourhoods of local practices to address identified needs and provide mental health support. This may include screening, outreach, and assessment of needs, advice, signposting and access to therapies and support of primary care workforce. We need to consider how we enhance this support across the county but for this need a long term funding source. This is under consideration.
Access and transport issues	• Transport and access is a huge issue- bus services are a main issue as parking is horrid. • Ensure transport is available for patients to travel e.g. local people who can help transport	This level of detail has not been possible in the first plans – however it is acknowledged as being a very important consideration. We will need future plans to evidence close working with Districts and City Councils to understand how patients can easily access services. The CCG will consider transport and infrastructure in deciding future primary care estates and in bringing services out of the hospital closer to people's home, working with local councils. The process for agreeing this will be clarified in the next draft of the plans.

North locality response to patient feedback

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

Use of technology	• Far better use of technology, skype, proactive email messaging to patients • Lack of trust on online systems • User friendly websites • All social media sites • Link back office IT	Greater use of technology will be a key enabler in connecting primary care with others, for patients to manage their own conditions and for the provision of timely advice. This is included in the plan, with clear timelines set out in the countywide plan to be published alongside the 6 locality plans in January 2018.
Recruitment	• What is being done to pull back GPs who have left the profession • How much of a recruitment issue? Facts/figures. Need to know scale of problem • More recruitment and invest in recruitment • What is OCCG doing to advocate and get Government to address GP recruitment?	The number of GPs in the locality and the future required workforce under the current model of care is set out in the locality plan. Future sustainability of primary care is dependent on introducing a wider mix of skills into general practice, and the North locality is leading the way in this, with many practices already employing, for example, clinical pharmacists or MSK practitioners. This will be supported by a countywide plan to recruit and retain GPs in Oxfordshire and the North locality.
Gaps in children's services	• No mention about children's services • Problems with fragmentation in children's services	The Oxfordshire Primary Care Framework confirms the important role of primary care services for the health of children and these are considered within the localities. The CCG will consider how these can be referenced more clearly. Examples include: • Support families and children especially those on with a child protection plan • Support for children's mental health • Increased access for children in primary care after school, during which time there is a higher than average level of attendance at A&E It is acknowledged that we need to build more into the plan around children services and this will be included in future versions.
Walk-in/urgent appointments	• Some practices have walk-in in the morning. Very booked appointments and disruption. • Need EMU at the Horton and a walk-in service • World wants walk-in. Employer issue re sit in waiting room half day and lose pay • More walk in to take the pressure off A&E. Also central as each practice can't offer this. • Walk-in system works well on a Monday at West Bar	The CCG recognises that practices have different appointment systems that work well according to patient preferences and they should work with PPGs to ensure that these are appropriate. The next iteration of the plans will confirm that the CCG is working towards an Oxfordshire wide standard, so patients can have access to urgent appointments when clinically necessary, regardless of how practices manage their appointment systems. We need our plan to simplify access routes for patients, offer choices of online or a range of alternatives to seeing a GP such as self referrals to Physiotherapists. Clearer and wider access routes would be a preference to blanket walk-in to primary care.
Continuity of care	• If ongoing health issues then want continuity • Continuity for diabetes needed • Patients want continuity of care by the appropriate specialist • Concerns over the waiting times for routine appointments	The plan recognises that different dimensions of access are valued differently by different people, depending on their need, age and working circumstances. Introducing a wider 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.
Heyford Park	• Need to create a new primary care centre at Heyford Park with reasonable car parking	There are ambitious plans for housing growth in Oxfordshire to deliver 100,000 homes by 2031 and we recognise that Upper Heyford is one of the largest single sites in Oxfordshire for new homes.

		Future primary care infrastructure in the area will need to respond in a timely and appropriate way to future housing growth. Any future primary care infrastructure in Upper Heyford, whether as a new surgery or as a branch site of an existing surgery, will be subject to an options appraisal which will include considerations regarding accessibility, capacity, expected utilisation and financial viability. An options appraisal will also be completed on how best to provide services. The process for this has been made explicit in the revised draft of the plan.
Future of the community hospital in Chipping Norton	• Local services in the community hospital should be at least maintained, in particular: o First Aid Unit – frequent mentions of its local importance o Specialist Outpatient appointments and X-ray o Ultrasound suggested as an additional service	We recognise local services are valued. We will continually review how we achieve local access and make best use of clinical resources.

North East locality response to patient feedback

Key Themes	Summary of issues	CCG response
Continuity of care	• Older people like to see the same GP • Long term conditions need continuity of care • Don't care who I see as long as I get sorted • Two types of patient care demand - access without continuity and also continuity first	The plan recognises that different dimensions of access are valued differently by different people, depending on their need, age and working circumstances. Introducing a wider skill mix in practices and increasing overflow appointments for patients who prefer rapid access over continuity enables GPs to concentrate resources on seeing patients who require a higher level of continuity of care and to be seen by the same GP where possible.
Access to GP appointments	• Extended access/hours services needs to be advertised more • Patients need more information around waits and how to access services such as the Hub • Good triage model is important • Issue of confidentiality around receptionist triage • Train receptionist to be professional – will be better accepted by patients • Feel OK about seeing other people other than GP • Possibility of using the most efficient /appropriate member of staff • Early visiting service a 'brilliant idea'	NHS England has made funding available for training in active signposting, so they can be skilled and confident in sensitively ascertaining the nature of the patient's need and exploring with them safe and appropriate options. Oxfordshire Training Network is delivering the training by March 2018. Extended access appointments were advertised in the summer 2017 in the local press and are now advertised through practices. Utilisation of available appointments has increased substantially to around 85% of additionally commissioned appointments and we will work with the practices to ensure that patients are made aware of the services and encouraged to make use of them as an alternative means of fast, convenient access. This plan makes more appointments available and will ensure that patients know about them.
Structure of GP services	• Local practices are expected to implement national initiatives without resources which increases pressure • Work as individual practices but in a loose grouping • Working well together enables services to share specialists and expertise • Branch surgeries are good for access • When surgeries merge have to pay attention to integration of systems • We don't want to lose the good things • Share best practice	GP practices in NE Oxfordshire are now working in neighbourhoods and members of a federation of practices (ONEMED). This approach has a number of benefits, including: - Faster access to appointments at evening and weekends at neighbouring practices - Economies of scale for practices to increase their purchasing power - Greater resilience through sharing functions and creating a pooled resource of staff - Opportunities for staff to be involved in wider projects However, we recognise that successful primary care should retain the 'localness' that means that GPs know their patients' needs. Future development of primary care and the location of practices will need to balance the need to harness the benefits of working and scale with the importance of ease of access for patients. Development of technological solutions will play a key role here.
IT/information	• Access and use of online services to save time • Text/email should be a two way dialogue • Email are not read by practice • Challenge of branch surgeries in rural locations - could benefit from technology access	Greater use of technology will be a key enabler in connecting primary care with others, for patients to manage their own conditions and for the provision of timely advice. This is included in the plan, with clear timelines set out in the countywide plan to be published alongside the 6 locality plans in January 2018.
Transport	• No bus service so no point in	This level of detail has not been possible in the first plans –

	choose and book • If I couldn't drive I couldn't get to Horton General Hospital because there is no bus service • Early visiting services is a good idea if you can't drive to the GP surgery • Out of hours service difficult to get to without using taxi • Parking is limited at Deddington, Woodstock and Bicester practices which causes problems as direct public transport links are not good	however it is acknowledged as being a very important consideration. We will need future plans to evidence close working with District Councils to understand how patients can easily access services. The CCG recognises that public transport links are a vital component of access, in particular if there are models involving neighbourhood hubs and the withdrawal of bus services can have a negative effect on access. The CCG will consider transport and infrastructure in designing its model of care and in deciding future primary care estates. The CCG will consider transport and infrastructure in deciding future primary care estates.
Bicester Community Hospital	• Under-use • Could become a Minor Injuries Unit • Does have beds but not clear what's happening there • NHS doesn't advertise itself very well • Needs to be a bigger hub	Community hospitals will be considered in the Oxfordshire Transformation Programme. The plan for North East Oxfordshire recommends better use of the space at Bicester Community hospital, including through the provision of ambulatory care facilities and a service model that reduces reliance on A&E.
Did not attend	• Everyone should pay £10 per appointment to GP, then if you attend you get it back • Campaign for early appointments might help to fill gaps left by DNAs	The NHS constitution confirms that the NHS services are free of charge, except in limited circumstances. Any changes to the payment for services need to be agreed by Parliament.
Pharmacy/ prescriptions	• Why do I have to go through a GP to get low level medication? A pharmacist should deal with it • Better use of health workers to deal with repeat prescriptions • Do have services in rural practices to dispense directly to homes	Pharmacists have an important role in the management of patients conditions and enabling GPs to focus their skills where needed. The next draft of plans confirm how we will achieve through: • non-recurrent funding to support clinical pharmacists to work in general practice • Provision of a minor ailments scheme in more deprived areas of the county to enable people with minor health conditions to access medicines and advice they would otherwise visit their doctor for.
Heyford Park	• Need to create a new primary care centre at Heyford Park with reasonable car parking	There are ambitious plans for housing growth in Oxfordshire to deliver 100,000 homes by 2031 and we recognise that Upper Heyford is one of the large single sites in Oxfordshire for new homes. Future primary care infrastructure in the area will need to respond in a timely and appropriate way to future housing growth. Any future primary care infrastructure in Upper Heyford, whether as a new surgery or as a branch site of an existing surgery, will be subject to an options appraisal which will include considerations regarding accessibility, capacity, expected utilisation and financial viability. As a first stage, the CCG is currently scoping the feasibility of current providers delivering services for Heyford Park residents in Heyford Park or through existing services. The process for this has been made explicit in the revised draft of the plan.
Vulnerable Groups	• Concern about whether the plans had enough in place for younger people and for people with LD and MH difficulties • Concerns around the pockets of	Mental health services is a key priority for the locality plan and this will be strengthened in the next version. As part of the plan, the CCG is developing a programme of care for people with mental health conditions in partnership with neighbourhoods of local practices to address identified needs and provide mental health

	deprivation in the North East which came out of the Bicester JSNA profile	support. This may include screening, outreach, assessment of needs, advice, signposting and access to therapies and support of primary care workforce. Some additional funding that was secured through the Prime Minister's Challenge Fund and the subsequent GP Forward View has been invested recurrently in general practice and will continue to be invested as part of the local plans. Health inequalities and deprivation is a key factor in determining how this funding is allocated. In addition, a number of specific projects aim to tackle deprivation and unmet health and wellbeing needs, including the introduction of a social prescription model in practices and other community settings. These will be included in the plan going forward.

South East locality response to patient feedback

Key Themes	Summary of issues	CCG response
Continuity of Care	• Continuity of care a big concern for patients and not having this is counterproductive overall. It is important to see the same GP for people with long-term conditions important to see same GP if possible. • Over 75's have named GP / some patients can only see own GP rarely. Potentially it is about speed for kids - elderly want continuity • Choice re see own GP or other	The plan recognises that different dimensions of access are valued differently by different people, depending on their need, age and working circumstances. Practices in the South East rotate extended access, which enables rapid access at the surgery for patients who need this and enables GPs to concentrate more resources on seeing patients who require a higher level of continuity of care and to be seen by the same GP where possible. It is our intention to maximise continuity where needed and we are supporting primary care to free the urgent care slots to do this.
Ambulatory Care/Rapid Access Care Unit (RACU).	• RACU is good, near practices can access. Is it possible to expand the service and, if so, how would this work? • There are good examples of care in the RACU in Henley and the similar unit in Thame (frailty assessment unit) • Was agreed that there needed to be some sort of ambulatory unit in or close to Wallingford as North and South of the locality were supported • Recognition that people did not want to give up their community beds but that the RACU model did seem to be working and the community were happy with it.	The Rapid Access Care Unity (RACU) in Henley provides quick access for frail elderly patients in the south of the locality and we will consider ways to increase capacity here. In addition, we will work with the community and assessment treatment service in Thame to expand capacity so patients in Chalgrove & Watlington, Wallingford and Wheatley can be cared for in their homes and fewer will be inappropriately transferred into the acute setting.
Care Homes	• Less care homes in Henley, putting a strain on GP times - need more young families • Care home initiative good but also need to include end of life patients who want to stay at home therefore their specialist needs have to be addressed. They also need to fit into the model. They also need to have choice. • Care home initiative - done by partners, affects local service. Could this be done by locums?	There is a large number of care homes in the locality and we are working with planners to consider the impact on the provision of primary care as the number continues to grow. End of life care has to be of high quality with clear communication between clinicians and their patients and carers. A Digital Proactive Care Plan (dPCP) has been produced to ensure we reflect the needs and wishes of patients. More information on the care home initiative and end of life care will be provided in the next draft as the proposal is developed. We have a scheme to fund practices who support care homes and this is being further developed to be more flexible
Structure of GP services	• Henley practices working together - what level of collaboration is there? Not all practices/GPs in the area work effectively together • Locums do not always understand patient needs, which means we need to come back twice • It is essential for GPs to get to know their patients • Part-time GPs is this realistic? • Centralising services doesn't always work • NHS 111 should be abolished - money to GPs, to respond to	The South East locality covers a large geographical area which brings challenges to further integration. However, the practices do already work in a federation for the purposes of extended access appointments and are considering other opportunities for future collaboration, for example sharing staff. The traditional model of general practice continues to be popular among patients and GPs are among the most trusted profession. However, changing working patterns and concerns around burnout mean that the model has to adapt to ensure future resilience, for example through greater collaboration, making better use of other clinical professions and harnessing the benefits of IT.

	needs, employing additional GPs to do that • Practice nurse tasks - some devolved to health • Receptionists triage - didn't like - can be both ways	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.
Waiting Times	• Waiting times for appointments needs to be improved • Seeing your named GP earlier than 3-5 weeks later • Seen on day access vs own doctor - won't build up relationships • Tried so hard appointments on the day - but if not needed on that day feel guilty to pick a much needed appointment. Online = 28 days / needs triage re on today eg = phone discussion by GP. Some practices do. Patients to understand this	Practices in the locality have signed up to a commitment to see any patient with an urgent health care need on the same day and to be able to offer a routine appointment within a week, although not necessarily with a clinician of the patients' choice. Practices have achieved this either through operating a triage system, training their nurses to be nurse practitioners to see minor illness or employing more salaried doctor sessions. We are working with practices that report concerns about seeing a GP of the patient's choice by, for example, having a well-advertised 'buddy' system with another GP or their registrar if that GP is a trainer.
Integration	• Integration with Bucks and Berks • More sharing of staff across organisations to meet the needs of the patients • There needed to be more joined up thinking across the SE and especially across borders as many patients live on the borders • Linking GPs better into the depth of NHS services • GPs and other providers (mental health) working across practices – liked	Some district nursing is provided by the Buckinghamshire community team, where there are good links. There is room for improvement on engagement/integration with social care and better integration between social care and the primary care team is a key focus of the plan. Records sharing is an essential component of good joined-up care delivered across organisations and there is a programme for records to be interoperable across primary care, community and mental health services and secondary care.
IT	• Should use Skype or facetime to give more appointments • Ageing population - IT a problem (not all have mastered) • What IT do older people use / feel comfortable with? • Some older people are fine with IT • Sharing of patient records - cross border comms • IT up to date - Dr had old DELL / nothing countywide central hardware. Systems all fall over sometimes. • Monitor in home re falls and if no main carer - sensory technology eg buttons to press (eg soles shoe - door frame where frequently walk eg loo and not back to bedroom in middle night) Call made helps admission avoidance • More technology to support better working and patient access as well as record sharing • Sonning Common info useful to spread about. Helps even if only tells Sonning Common own patients. Vehicle used to	Feedback from patient forums is that the model of face to face and telephone consultations works well in the South East locality. Email and Skype consultations may be appropriate in some cases; however, there may be scope for a Skype consultation service provided by the federation / locality. OCCG is considering developing an online consultation tool that may help provide patients with an effective way of engagement with primary care resources. Patients should be strongly encouraged to use the current online services, in particular, access to their medical records providing them with rapid access to test results. Access to patient medical records will also allow patients to share their medical details with other NHS providers outside Oxfordshire who are not able to access patient records directly. The ideas from Sonning Common are very helpful and will be further explored and considered for roll out across the locality.

	communicate / email and online get more info than if not. Tec savvy benefits more. Sonning Common 24% on email • IT - some practices reluctant to use emails. Could this be used for simple medical queries? Have national policy setting out what can be done by email	
Health Promotion	• Prevention - eg obesity - healthy eating • More prevention info on basic biology / kids to understand to manage self-care and go for advice. NOT GP. • Monthly short para from a GP on key messages eg flu jab records • Ideas: keep people out of surgery = early warning indicators eg. UTI's in place and contact GPs when concerns • Prevention - eg obesity - healthy eating	We agree that initiatives around preventative care are essential to a healthy population in the South East locality and we are committed to working with partners to achieve this, including consideration of the options presented. This also involves clear signposting and increased access to self-care We will pilot a social prescribing programme that best serves the patient profile of South East Oxfordshire to help give advice, direct patients to appropriate services and empower patients with the confidence and information to look after themselves.
Information/Communication	• Information needs to be on website • Newsletters / emails • Signposting to other services • Using local communication channels - insert sheets of magazines, newsletters, etc • Directory of services - voluntary / other support organisations • GPs and other providers (mental health) working across practices – liked • Reaching older patients who may not come into the surgery	As part of the active signposting initiative we will develop a directory of services for staff and patients. Practices and patient groups will hold lists of the different services available to patients, and this information will be held/led by receptionists. In addition, the pilot social prescribing programme, described above, will consider how to signpost patients to other organisations and reach out to patients who may not access the surgery.

South West locality response to patient feedback

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

	• There are patients who want convenience and not bother about continuity and the others that want continuity - challenge to balance it out • Elderly patients need personal contact over the telephone, they do not all have mobiles/computers • Essential for patients to see the correct specialist	continuity of care and to be seen by the same GP where possible.
Secondary Care	• Speed up communication especially with secondary care letter communication between primary care and secondary poor - impacts on GP ability to help patients - no communication	The CCG recognises that communications between different healthcare professionals is essential in providing good integrated care. Records sharing for cross-organisational care, in particular between primary care, community and mental health services and secondary care is a key focus across the county to deliver more joined-up care.
Pharmacy/Prescriptions	• Make sure patients get an email to say prescription is in at BOOTS! • Dispensing practice - can email repeat prescription	The CCG will share this feedback with practices to ensure this works effectively.
IT/Information	• Simple email route for non-sensitive information • Patient records are electronic, older ones kept on paper • Better use of IT, i.e. send an email instead of a letter to patients	The success of the plan will depend on maximising the use of technology available; empowering patients and ensuring there is interoperability between systems and across providers. This will be set out in more detail in the Countywide plan to be published alongside the locality plans.
Housing	• Growth will come from housing • Developer could blackmail councils? - Idea of what stages development are? What funding has been given? What land has been put aside? • Wantage issue relates to package - housing, schools, transport • Abingdon, 15000 houses which practices will absorb population • In Didcot there is a large housing growth so the infrastructure has to be addressed	There are large-scale planned increases in housing across the South West locality and a coordinated and strategic estates approach is required so that primary care capacity can meet the demand of the future population. We are working with planning authorities at South Oxfordshire District Council and Vale of White Horse District Council to secure land and financial contributions to assist with estates growth across the locality and linking in with all local Neighbourhood Development Plans (NDP) to ensure Primary Care Services are on the agenda for planning decisions. This forms a key part of the plan for the SW locality. In Didcot we are considering our options of commissioning a new practice or expanding a local practice.
DNAs	• DNA's stats work well • DNA's could be improved • Why are people not charged if they DNA for their GP appointments?	NHS England and the CCG is working with practices to maximise the use of appointment slots and improve continuity by reducing DNAs. Changes may include redesigning the appointment system, encouraging patients to write appointment cards themselves, issuing appointment reminders by text message, and making it quick for patients to cancel or rearrange an appointment. The NHS constitution confirms that the NHS

		services are free of charge, except in limited circumstances. Any changes to the payment for services need to be agreed by Parliament.
Health Promotion	• What plans do you have for engaging more with the public - to treat themselves first when they can, seek advice from a pharmacist, etc. and not just thing about going to see their GP? • Increase social prescribing • Need more communication/leaflets to help inform patients of signs to look out for as they get older	There are some excellent examples from across the county of working with schools to promote healthy lifestyles and increase health literacy, which we will aim to build on. We agree that initiatives around preventative care are essential to a healthy population and we are committed to working with partners to achieve this. This also includes signposting to relevant services and increased use of pharmacists to provide appropriate care for a range of conditions and release the pressure on GPs.
Confidence in CCG	• Forward planning has to come first with the business case • Difficult to disagree with priorities - issue is how are you going to do it? • Is anyone in CCG in charge of making this happen? Limited levers to fix problem. • How soon is it likely to happen? • No confidence that it will be delivered	It will be important to maintain momentum and coherence on the delivery of the plans while there is engagement and enthusiasm across the system so that the plans can start to deliver benefits as soon as possible and be delivered in a planned way. Some aspects of the plans are already being implemented, where funding for primary care has been made available or if no funding is required. Future investment will be subject to a business case. As the plans are iterative, there will be opportunities for patients and the public to track the benefits and hold the CCG to account for delivery of the plans. The CCG has developed these plans to set out what change is needed. This has not previously been done. We have set aside some resources to deliver and also have detailed implementation plans which will be reviewed in the Oxfordshire Primary care commissioning Committee (OPCCC). The CCG has taken some important new steps and is working more closely with District and City Councils.

West Oxfordshire locality response to patient feedback

Key Themes	Summary of issues	CCG Response
Population growth/housing development	• OCCG must cooperate more with the councils to get funding for health infrastructure • Work with developers • Need to be planning ahead	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. 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.
Access to GP appointments	• 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	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. 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.
Access to other clinicians/ pharmacists	• 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	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). 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.

Recruitment/ retention of staff	• 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	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 • increasing capacity in primary care; • upskilling existing staff; and • bringing in and expanding new roles.
IT	• 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	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. 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. 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.
Prevention/social prescribing	• 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	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. We have bid for some national funding together with Cherwell and West Oxfordshire District Councils and should find out if we are successful in January 2018.
Witney Community Hospital	• 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	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.
Mental Health	• 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	Mental health services is 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 community and who can address identified needs and provide mental health support. Further details will be provided in the next iteration of the plan. We acknowledge that we need to give more focus on children and this will be included in later versions of the plan.
Communication	• Better communications between OUH, GP Surgery, patients at pharmacist without discharge summary. • Language about the elderly - it's not our fault • Website improvement and communication.	The CCG recognises that communications between different healthcare professionals is essential in providing good integrated care. Records sharing for cross-organisational care, in particular between primary care, community and mental health services and secondary care is a key focus across the county to deliver more joined-up care. 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.
Link to Adult social care	• 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	There are some challenges 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.