**Robert Courts MP response to Locality Place Based Primary Care Plan: North East Locality**

1. *Background and overview North East Oxfordshire primary care use and outcomes*
   1. In this locality, the Woodstock Surgery falls within my constituency, and so I shall focus on the impact that these proposals will have on this particular practice.
   2. The CCG states that its key priorities are to: the sustainability of primary care; increased capacity in primary care to meet housing and population growth; new models of clinical care and long term conditions management; new models for Urgent Care, particularly frail elderly patients; increase self-care and promotion of health and wellbeing. This will be delivered through 10 work streams.
   3. Although these priorities may be right for Bicester, Woodstock has a differing demographic, being the oldest part of the locality, with 4.4% over 85 (compared to the locality average of 2.3%).
   4. Bicester is rapidly expanding, with an influx of families with young children. With a greater population of working age, the demand for services such as Out of Hours GP appointments is the highest in the North East compared with all other localities, where as in Woodstock it is well below average. Woodstock clearly has differing demands to the rest of the locality, and I feel it would be better served in the West, as it bears a strong resemblance in usage and demographics to other practices, such as the Eynsham Medical Group which is similar in size and accessibility to both the John Radcliffe and community hospitals.
2. *Workforce* 
   1. As outlined in the plan, Oxfordshire is facing recruitment issues, particularly in rural areas, in part due to the high cost of living. There is a shortage of healthcare professionals, and although there has been a significant increase in the number of GPs in training in recent years, this will of course take years to have an effect on recruitment.
   2. I agree with the CCG’s plans to make the current workforce more efficient by freeing up GP time through upskilling existing staff and by bringing in and expanding new roles. This is tied to the plan’s proposals to enhance the signposting role for receptionists and bring in a wider range of staff with a different skill mix to supplement existing GP and practice nurse staffing.
   3. Key to these proposals is creating other ways for patients to access treatment and advice away from their GP, through Primary Care Urgent Access hubs, and removing the need for a hospital visit. In order to realise these aims, staff upskilling is essential.
   4. There are other measures that I suggest the CCG consider. Firstly, further public explanation to help patients understand why care might be provided by someone other than their GP, ensuring the public are comfortable with receptionists having a greater role to play and consequently access to more information. A way to promote this is by launching a campaign to publicise the roles and skills of staff in practice. This could follow a ‘*your journey through the practice*’ flowchart, explaining that as first contact, receptionists need to determine who is best to treat each patient. It is essential that receptionists are properly supported as they are learning these new skills.
   5. I support plans to share back office services, including sharing staff across practices, to ensure better use of resources. I urge the CCG to discuss these measures with WODC who have made impressive savings through these changes, by avoiding duplication and having a small pool of very well trained administrative staff.
   6. I would suggest overall that close and continued co-operation with district councils, OCC and other public bodies is carried out at all times: they are closest to the people that they represent and understand the needs and requirements of local communities. The challenges faced by healthcare and caused by many and varied factors, and it therefore follows that the solutions will be multi-faceted, with contributions to be made from many local stakeholders.
   7. The CCG also needs to recognize the differing demands for GPs in more urban practices in Bicester and rural practices like Woodstock. The issues with recruitment, such as the cost of living, is greatly exacerbated in a rural practice.
   8. To increase training capacity and encourage GPs to remain in the area where they have trained, I suggest that the CCG should offer rotations throughout the locality, or the wider county area, when training so that GPs have varied training and gain understanding of the different demands of different practices.
3. *Estates*
   1. Particularly with the projected growth in North East Oxfordshire, it should be expected that many of the practices will reach issues with capacity. It is extremely important that the CCG engages with planning authorities in order to understand where and when developments are planned to take place, as well as work to understand how new sites can be incorporated into planning applications in order to support a growing population.
   2. I understand that some GPs have concerns that the provision for healthcare facilities in many planning applications are insufficient, perhaps being too small and unfit for purpose. I urge the CCG to work with WODC and Cherwell District Council to make clear the specifications it requires, so that healthcare services can grow with North East Oxfordshire. A key way of ensuring this is through the CCG working with the Oxfordshire Growth Board, WODC’s Cabinet and Economic & Social Scrutiny Committee.
   3. I am particularly concerned about the Woodstock Surgery, which is already reaching capacity and the facility is in need of regeneration. In the plan, Woodstock is set to require a tripling of its size in meters squared in order to accommodate population needs in 10 years time, yet there is no solution to this problem here. I therefore again urge with the CCG to work with WODC to verify a suitable site in upcoming developments in the area for a relocated practice. It is not suitable for this practice be absorbed into others in the plan as Woodstock is serving a population with different demands. I would be grateful if the CCG can contact me about how to find a solution to this.
4. *Digital*
   1. Pivotal to achieving the overall vision of these plans is for patients to be able to easily access different parts of the primary care system in Oxfordshire and for whoever is dealing with the patient to be able to do so smoothly, without the patient having to explain potentially complex long-standing conditions. If this is not smooth, patients will be put off meeting with alternative healthcare professionals and go back to having GP appointments as their first port of call.
   2. The way to achieve this is by all local services being able to access patient records. This not only creates a better experience for the patients, but will also ensure that GPs can be kept updated with a patient’s recent discussions with others, for example the mental health team, without the patient having to feedback. This would lead to more streamlined and effective care. However, patient records confidentiality is of the upmost importance: access must remain strictly with healthcare professionals.
   3. In particular, many care home residents have complex health needs and will be regularly treated by a wide range of healthcare professionals at the home, by their GP and visiting clinicians. It is therefore essential that all involved in managing a patient are able to access the same up to date records for the best treatment plan.
   4. The use of clear signposting on practices’ websites is crucial. A first post of call for many patients is to seek advice about whether they need to book an appointment by consulting their practice’s website.
   5. More broadly, I would like to see a greater role in the use of technology in the provision of primary healthcare. The first is in the booking of appointments, where some practices have rolled out a scheme, but progress is slow. The second is in the provision of care in a primary context: simple queries might be better dealt with by a five minute Skype call - provided the vulnerable are protected and this complements rather than replaces traditional appointments - than by a face-to-face appointment. Commercial providers are exploring this idea: perhaps there might also be a place for this within the umbrella of the NHS?
5. *Funding*
   1. This plan does not include any detailed costings about precisely how much these changes will cost and the projected savings made by efficiencies such as pooling back office services.
   2. The plan states that it will require investment either through core funding or through release of funding in secondary care over time. A projected costs plan should have been included in the plan, to understand where this funding will come from, and to understand why funding in secondary care will be released over time, and if this is due to a cut in services elsewhere.
6. *Outline mobilisation plan*
   1. Although I appreciate the desire of the CCG to implement these changes as soon as possible for the benefit of patients, I would appreciate greater clarification of the proposed timelines. As the results of this consultation will be published on 31st January 2018, presumably alongside a revised final plan, this is already a long way into 17/18 Q4. More details about implementation would be appreciated, especially if they are public facing, in order to properly inform patients in advance of any changes. I would emphasise that sudden changes, brought in without notice and without even informal consultation with elected representatives, local bodies or patient groups, ought not to be entertained.

**Robert Courts MP**

**15th December 2017**