NHS
Oxfordshire
Clinical Commissioning Group

West Oxfordshire Locality Group

Note of Meeting 13 July 2017

Chair: Dr Miles Carter

Attendance

Practice	**Clinical Representative**	**Practice Manager**
Bampton	Dr Nick Ward	Sara Ward
Broadshires	Dr Anna Smith	
Burford	Dr Simon Albert	Apologies
Charlbury	Apologies	
Cogges	Apologies	Chris Wilkinson
Eynsham		Teresa Young
Nuffield	Apologies	Catherine Simonini
Windrush	Dr Nick Thomas	Morag Keen

Clinical Director	Apologies	Dr Kiren Collison
Public Forum	Graham Shelton	Madeleine Radburn
West Oxfordshire DC	Jacqueline Boehr	
PML (for WestMED)	Laura Spurs	
OCCG	Sula Wiltshire, Julie Dandridge, Fergus Campbell, Janet Garrison	
Facilitator	Judy Oliver	

		Action
1.	**Apologies & Declarations of Interest** i. Welcome: • Sula Wiltshire (OCCG Quality Director) • Janet Garrison (Practice Nurse Locality Lead) this new role noted and welcomed. Janet will contact practices about support for their nurses. • Judy Oliver (independent facilitator) • Jacqueline Boehr new Healthy Communities Officer, West Oxfordshire District Council ii. Apologies: Dr Helen Bayliss, Dr Gareth Evans, Dr Brian Green, Debra Barnes iii. Update declarations of interest – none reported. FC following up gaps in the locality Register of Interest	JG FC
2.	**Transformation Phase 1 consultation report** Ally Green (OCCG Head of Communications & Engagement) presented the key points of the circulated report. WOLG noted the: • scope of the consultation • The level of participation	

	• the issues raised by participants • additional work to inform the Board decision on 10 August • plans looking ahead to phase 2 engagement	
3.	**West Primary Care plan workshop** In a brief introductory discussion: • MC highlighted the opportunity to add more into the plan in relation to local need. • GS noted the views of the patient group, included in Part H of the plan, and particularly suggested prevention as an extra focus. • KC flagged need for focus on infrastructure and a frail elderly focus eg nursing homes eg gerontologists in Reading, or case manager model. An independent facilitator, Judi Oliver, led a workshop based on discussions in pairs and 4 small groups of key questions in the current draft plan. It also briefly addressed the need Judi's notes of the workshop attached as an appendix including: • Summary of priorities • Examples of relevant developments elsewhere in the country • questions asked • recorded notes of discussions (shown in the question boxes) FC to work with the locality leadership, volunteers from the membership and consultants appointed by OCCG to develop the plan further and bring back to WOLG in September.	FC
4.	**Flu immunisation - increased take-up** Catherine Simonini shared The Nuffield practice's approaches to maximising take-up of flu immunisation for all practices to consider • Send repeated texts to all with mobile phone – the practice doesn't send letters • Publicity through posters, reception screen, message on check-in, prescriptions • reception check flu imms status when patients call in and prompt for appointment. • Follow up all eligible by telephone (many staff involved). • Added Saturday clinics this year • Note new comms challenge for obese patients – note QOF overlap.	PMs
5.	**Minutes of 08.06.17 & matters arising** • **GP Access Fund criteria** - JD confirmed that future requirements did not necessarily mean that all clinics must be GP staffed. • **Windrush website** - MK awaiting Footfall response on anticipated patient take-up • **Primary care plan options** LS doing further work on the service options in relation to district nursing and links with MIU and out of hours GP. • **SCAN pilot** - Note Zoe Kaveney has sent practices the list of suggested (but not mandatory) blood tests for these suspected cancer referrals.	MK LS

6.	**AOB**
	• **Deer Park**. IRP report now available following referral by HOSC to Secretary of State in March 2017 – FC to send round the link to the Independent Review Panel recommendations.
	  ○ GS suggested OCCG conduct properly balanced survey of populations health needs as part of the primary care plan for Witney proposed by IRP.
	  ○ JD noted recent HealthWatch Oxfordshire survey and that OCCG keen to look wider than Witney.
	• **Future WOLG** Note no August meeting
		JD

Items anticipated on the 14 September 2017 agenda:

- Locality primary care plan – further development
- Use of primary care data / risk stratification
- New MSK service

Dates of future WOLG Meetings

Date	Time	Venue
**** August 2017 meeting cancelled ******	1315-1515	Windrush Health Centre
14 September 2017		
12 October 2017		
9 November 2017		
14 December 2017		
11 January 2018		
8 February 2018		
8 March 2018		

Notes from the WOLG Planning Workshop held on 13 July 2017 at Windrush Health Centre

Attendees: see separate list **Facilitator: Judy Oliver**

OUR SHARED GOALS

1. **Shared patient record accessible to all local services when needed to enable joined-up high quality care.**

QUESTIONS:
Clear locality agreement on this point so no further question at this stage.

2. **Improved locality-wide signposting to help patients go directly to the appropriate services to include better website facilities, social prescribing scheme and enhanced signposting role for Practice Receptionists/Administrators**

Notes: Examples of good practice elsewhere:

- West Norfolk Alliance of NHS, local government and third sector has developed a website known as LILY (Living Independently in LYnn) which the public can access to find and contact the services they need. The local District Council has played a key role in this and hosts the website.
- Non-clinical co-ordinators have been employed across groups of practices e.g. Kent, Bromley By Bow to develop a local Directory of Services (which lists local groups and recognises what capacity they have to help). All practice staff are able to refer vulnerable patients to the Co-ordinator who meets with them and their families/carers to assess situation and resolve difficulties so patient is stabilised. In BbB, they plan to train members of the community to be social prescribers. Also, receptionist re-named Patient assistants and waiting room is re-designed like “Apple Store” to proactively work with patients.
- In the Kent example, Co-ordinator, non-clinical but highly knowledgeable about how local government/NHS operates, ran “virtual ward” of up to 100 people across three practices i.e. the equivalent of a “cluster”. Any member of practice staff could refer patients (of any age) considered to be vulnerable. Cases worked through by Multi-disciplinary team working across the 3 practices.
- It makes sense to ensure that there is a link between the local Directory of Services used by Practices and the one used by NHS 111.
- Practices in Suffolk run open days for patients which combine opportunity to find out what other services and groups are available in the community and get their flu jabs at the same time.

QUESTIONS:

If we knew our signposting system can really help patients to find the service they need, how would it work in practice?

A combination of self-help options e.g. super app, website and designated points of contact e.g. single point of contact for vulnerable, receptionists knowledgeable about local services and trained as “patient assistants” to provide close support, signpost patients to the service they need.

System must be trusted and give people confidence they will get help when they need it. People well trained. Patients empowered to do things for themselves and can self-refer.

What would be in place at the level of our practices? Our cluster? Our locality?

Practice(“ticket”) – Patient able to access signposting simply and quickly via telephone/answerphone message, live chat on-line via website or face to face at the Practice. Social prescribing based on community/village involving local people. Access to Pharmacist to support self-help.

Cluster (“Station”) –Common themes could be identified here. Key to the future.

Where resources could be shared.

Locality or County Level (“Railtrack”): Design starts here, gathering information about services available and communicating it in clear language/terminology and co-producing and maintaining Directory of Services/Website/App in consultation with patient representatives.

Telephone advice e.g. via 111 service

Proactive public education about prevention led by County Council e.g. schools and via public information channels, social media. National initiatives wherever possible e.g. Public Health England.

What action is needed to progress this?

Explore with West Oxfordshire District Council what help they can give to this.

CCG to pull together comprehensive Directory of Services for locality, involving District Council, accessible by the public via website and app, and keep this up-to-date.

Investigate what scope there is for 111 service to support this.

Virtual task Force: Madeleine Radburn, Catheine Simonini, Laura Spurs, Jacqueline Boehr

3. **Integrated urgent primary care service to offer:**
   - Seamless service to patients who need a same-day clinical response
   - Service in Witney and Carterton
   - Locality or cluster level clinical triage of patients where appropriate, using ICT to maximise efficiency - all services based on use of EMIS patient record
   - Greater same-day capacity for local patients within existing resources of clinical staff and funding e.g. by focusing on Advanced Nurse Practitioners (prescribing) offering a minor ailments service, with GP oversight (may be remote)
   - Consider integration of service with out of hours GP service and Minor injuries unit (this would imply 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

     Examples elsewhere:
   - Development of Multi-disciplinary Clinical assessment Service in Norfolk provided by Integrated Care 24.
   - Access to urgent mental health support via 111 in Cambridgeshire and Peterborough – directs patient to clinical help quickly.
   - Urgent care service needs to be thought about on a 24/7 basis so Primary care needs to liaise with 111 (SCAS) and Out of Hours(Oxford Health)
   -

QUESTION

If we knew we can provide truly integrated Urgent Care to our patients, how would it work in practice?

Cluster Level: Patients requiring urgent care/non-clinical help would be triaged before they get to Practice e.g. via 111 and Hubs within each cluster (across the whole locality) where care will be responsive and consistent, run by multi-disciplinary primary care teams e.g. nurses, physio, mental health, pharmacists, children e.g. Bradwell Clinic 4-6 – links with MIU and Walk-In Centres. Easy access, good transport links. Signposting facility via website. Every interaction with patients is used as an opportunity for health education/prevention/manage expectations, building and sustainable patients' personal responsibility for health.

Practices within the cluster to adopt common practices and policies so care is delivered consistently

Locality Level:"Medically urgent" clearly defined and promoted so patients know how to use the service appropriately e.g. MECC – Make Every Contact Count.

What action is needed to progress this?

Produce clear definition of urgent care which is used and promoted across the locality.

Practices in clusters to start sharing practices/policies to develop consistent approaches across clusters.

Introduce skill mix in same day urgent care service.

Develop Mental Health role in primary care.

Train receptionists as Patient Advisors.

Develop means to educate public so that patients understand.

4. **Wider primary care clinical skill mix delivered through practice-based and cluster services to supplement existing GP and practice nurse staffing. These would include:**
    - Pharmacists
    - Mental health practitioners
    - Diagnostic physiotherapy (note self-referral to MSK Assessment & Treatment Service expected after October 2017)
    - Advance nurse practitioners (prescribing)
    - Other clinical roles (please identify)

QUESTION 4

If we knew that practices would have access to a wider mix of health professionals to supplement their services, how would this work in practice? At what level would we want the services to operate:

Pharmacists:To operate in practices but organised across cluster – medicines management, hospital discharge changes, changes in MEDs, health promotion, support for minor illness (greater risk/indemnity issue could cause higher costs), urgent repeat prescriptions

Mental health practitioners – operate across cluster based at hub – 7 days a week

Diagnostic Physiotherapy – 5 days a week service to operate at cluster level

Advanced Nurse Practitioners: At practice level, they will support long-term need. Service would operate at a cluster level, enabling same day access appointments (hub), EVS instruction (Triage|), Medical Reviews, Referral to Social care, EMU, etc

Physician Associates: at Locality level (employed by Federation) – review potential problem of indemnity costs

Social Community Nurses: to support high demand patients

Care Home Specialists e.g. gerontologists to remove responsibility from primary care.

What else could be done?

Patient Participation Groups could be organised at cluster and locality level as well.

Flu jabs and Care Home support/visiting service to be organised at Locality level.

5. **We have the capacity to meet the needs of our growing and ageing population:**

   - Plan for population growth associated with large-scale house building in Witney, Carterton and Eynsham including seeking capital funding from developers
   - capacity and services able to support more high-need patients
   - closer working with community services including district nursing and Hospital at Home
   - build on primary care visiting service

   Notes: Examples might include:

   Birmingham – Modality Partnership is working on a project to enable all telephone calls in practices to be handled and appointment bookings made by a central call centre (which could be provided by 111 provider already in place)

   Northamptonshire Council, Community/Mental Health Trust and University have set up a social enterprise – First for Wellbeing which enables public access or referrals to helpful information to prevent ill health.

   Bromley by Bow use the clinical data collected across practices to identify those groups of people who take up most of the practices' time. They then form Multi-disciplinary groups to design proactive pathways of care to better manage these groups of patients.

   Sue Crossman, previously Accountable Officer for West Norfolk has developed an innovative approach to Continuing Healthcare which improves the patient's and the families' experience and saves money for both social care and NHS.

   Look at model developed by Stowhealth, rated "outstanding" by CQC – also could look at leadership development programmes for GPs, Practice Nurses and Practice Managers. The latter produced an analysis of areas which could be streamlined and run more effectively through collaboration between practices.

QUESTION

What else could we do to help ensure we have sufficient capacity to cope with the demands of a growing and ageing population?

Provide greater support to patients when they are discharged.

Do more on developing IT infrastructure to enable greater integration especially between NHS and social care but also between different parts of the service.

Investigate the Model of Nursing/Care Home support developed in Windsor, Ascot and Maidenhead to see how this could be adapted here.

Improve transport links

Centralise back office functions across practices e.g. training, CQC