North Oxfordshire Locality Plan Refresh 2019

NHS
Oxfordshire
Clinical Commissioning Group

This refresh presents the summary and actions from the 2018 plan and updates the actions for 2019 progress and next steps (overleaf).

Executive Summary

Locality Overview:
The North Oxfordshire locality has a registered patient population of approx. 114,000 served by 12 GP practices. The North locality has some of the most deprived areas in Oxfordshire, centred in Banbury.

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

What is working well:

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

Key locality challenges:

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

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

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

Key priorities for the North Oxfordshire locality:

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

Proposed solutions (2018)	Delivery scope (2018)	Benefits (2018)	Implementation steps (2018)	Progress to Jan 2019	Next steps April 2019 on
Clinical pharmacist support in practices	5 NOLG practices (Chipping Norton, Hightown, Horsefair, West Bar, Woodlands) currently employ clinical pharmacists in practice, which has been very effective. This would be rolled out to all NOLG practices and supported both with funds and potentially supervision from the OCCG Medicines Management team.	Clinical pharmacists in practice have been shown both nationally and in NOLG to be able to take on previously GP-only tasks, and also improve quality and safety of patient care and practice processes.	1) Agree funding 2) Set out scope of work for pharmacists and employment model 3) Recruit	Locality Pharmacist employed July 2018	Additional roles funding will be available via Primary Care Networks PCNs) during 2019-20
Mental health worker support in practices	The rural cluster of four NOLG practices (Bloxham, Chipping Norton, Deddington, Wychwood) currently employs two mental health workers across those practices. This has been successful and could be extended to all NOLG practices, initially on a non-recurrent basis, and may become recurrent depending on need and alignment with the wider Mental Health Forward View.	These mental health workers would be able to see patients with medically unexplained symptoms, mental illness, and other patients whose complex mixed physical and mental symptoms are challenging in primary care, freeing up GP time and providing better and more appropriate care for those patients.	1) Agree funding 2) Set out scope of work for pharmacists and employment model 3) Recruit	Locality mental health worker employed November 2018	Consider expansion if funding available, or move to practice-based service. PCNs to review impact and consider funding options.
Coordinated public relations campaign for Banbury-focused recruitment	Recruitment to almost every role in health and social care in north Oxfordshire has been challenging in the last few years. A coordinated public relations campaign with OUHFT, OHFT, Cherwell DC, Banbury TC, OCC, and the local chamber of commerce is proposed.	The introduction of a positive and coordinated campaign would improve morale among both staff and confidence among the population locally, and would aim to improve recruitment across the locality.	External support could enhance deliverability.	Proposals for new roles linked to Integrated Front Door	Assess impact and requirements of PCN changes
Continuation and expansion of primary care visiting service	Continuation of locality-based home visiting service to provide clinical assessment and treatment in the working day in addition to planned GP home visits and EOL care.	Prompt access to care for acutely ill frail, elderly or housebound patients or those at risk of deterioration or admission thereby reducing unplanned admissions. Supports best use of GP time (to see as many patients as possible) and free up GP capacity.	PML to recruit additional staff to start from 2018/19	6% more appointments available 2018-19. Profiled to match seasonal demand.	Subject to PCN development
Coordinated care home support from practices	The NOLG practices would continue and finish the process of ensuring that all care homes in north Oxfordshire are covered by a single practice responsible for regular	Patient care would be much better coordinated for those care homes, who also have among the highest rates of urgent admission and	To agree with PML process for managing care homes not currently managed by	All care homes allocated to individual practices and now all signed up to	Subject to review of care home support and future PCN contract.

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	care and staff support in those homes. The care homes would also have HSCN digital support and EMIS access, allowing on-site GP record access and updating for care home staff and visiting clinicians.	stroke incidence in the county. This would not just be in better access to GP care, but also would support better care by DNs, care home support staff, and paramedics now able to access GP records for those patients.	single practice. CSU to manage implementation steps for digital support.	Proactive Medical Care Locally Commissioned Service.	
EMIS Clinical Services interoperability	Currently the EMIS Clinical Services module makes it possible for all NOLG practices to share their GP records with the NAH and with each other in GPAF services. This would be extended to community and mental health services in north Oxfordshire, starting with community nursing teams (including specialist community nurses).	Full sharing of the EMIS GP record with colleagues in community and mental health services would make care of patients across those services better informed and coordinated, removing the need for regular and unreliable telephone and letter contacts for information.	CSU to manage implementation steps for digital support	See Local Health & Care Record Exemplar (LHCRE) programme	Subject to LHCRE milestones
Increased and more reliable access for patients in Banbury	Well-resourced and reliable neighbourhood access hub in Banbury. Additional hub appointments	Practices better able to plan their rotas and own GP provision. Clearer access for patients and confidence that they can get an appointment. More reliable care.	1) Assess scope of centre within current contracts 2) Model capacity requirements 3) Confirm site 4) Agree new contract model, patient flows and infrastructure 5) Set up	Integrated Front Door (IFD) project has introduced streaming to GPs at Horton A&E	IFD proposes fully integrated model to stream patients attending A&E to hospital or primary care as needed.
Social prescribing extension and support	Currently, the social prescribing project supported by Cherwell DC is available to the six Banbury practices and mainly offers self-care and advice signposting to some patients. The proposal is to expand the project with OCCG funding both in Banbury and to the rest of north Oxfordshire. The rural cluster practices have recently made proposals for projects to deliver: Proactive Care for the frail elderly and Housebound Populations, and Integrated Social Prescribing and Self-management hubs.	The wide and coordinated availability of social prescribing to patients across north Oxfordshire would be of great benefit in directing patients to the most appropriate resources including self-care advice, financial and social support and advice, and other resources from third sector organisations.	1) Agree funding and resources available in other sectors (financial and people) 2) Determine cohorts of patients 3) Agree siting and employment 4) Agree how to structure scheme and socialise	Citizens Advice leading funded project. Available to all practices by June 2019	Additional roles funding will be available via PCNs during 2019-20

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	These will be subject to further discussion and development with the locality.				
Rural cluster – services appropriate to local needs delivered through the practices	Integrated community nursing (services) pilot which includes the more proactive management of housebound / frail. Practices to provide neighbourhood based step up / step down care for frail / elderly patients who have acutely deteriorated, overseen by a neighbourhood matron working alongside the duty teams in the practices within the neighbourhood. Implementation of this workstream is dependent on the wider Oxfordshire wide frailty pathway which is being developed and will be rolled out in 2018/19.	Expected outcomes from this approach would be: • Reduction in the number of reactive home visits • Reduction of hospital admissions • Reduction in falls • Improved wellbeing and reduced social isolation	1) Agree funding and resources available in other sectors (financial and people) 2) Determine cohorts of patients 3) Agree employment model, commence training and implement	MDT meetings set up to review patients in pilot practices	Development linked to Oxon frailty pathway
Estates prioritisation	New housing developments, in particular around Banbury, Chipping Norton and Heyford Park is likely to require additional primary care infrastructure. Options appraisals will need to consider accessibility, capacity and expected utilisation and how best to provide services. In addition, current estates needs to be reviewed to support organic growth and to allow delivery of different models of care.	Fit for purpose and efficiently resourced estates that provides appropriate and accessible primary care and out of hospital care.	CCG-led working with district councils and private developers	Regular contact with District Council planning department.	Options appraisal for Banbury during 2019.
Address inequalities in the deprived Super Output Areas in Banbury, through the Brighter Futures in Banbury Programme	The actions for the health and wellbeing theme of the programme for 2018-19 will focus on: 1. supporting local primary schools to increase their physical activity offer, specifically through the Walk Once a Week initiative; 2. facilitate dementia friendly communities through training; 3. provide a framework for local businesses to adopt healthy workplace actions and initiatives.	• Embedding physical activity as part of the school ethos, to support pupils and their families to adopt healthy habits. • Providing training to local stakeholders to be able to support people in the community with early stage dementia. • Supporting workplaces to consider the wellbeing of their employees.	Joint working with Cherwell District Council (CDC), through CCG staff member as Health & Wellbeing Theme Lead	i) 4 primary schools engaged ii) Training delivered (5 sessions) iii) Framework not yet taken forward. iv) Healthy cooking skills project in addition	i) Ongoing ii) Further sessions planned iii) Cherwell DC plan district wide approach when PHE framework available iv) Focus on holiday hunger