Oxfordshire
Clinical Commissioning Group

North Oxfordshire Locality Meeting

Date of Meeting: 19 March 2019					**Item No:** 5	
Title of Paper: **Locality plan refresh 2019**						
Is this paper for	**Discussion**		**Decision**	✓	**Information**	

We shared proposals to update and refresh the locality plan (published January 2018) with the North locality meeting on 26 February 2019. The aim is to briefly update the locality plan in advance of the changes associated with primary care network development. We do not therefore anticipate new priorities or work streams in the scope of this update.

The 26 February meeting highlighted misleading wording describing the visiting service (amended) and asked about Integrated Front Door progress (added).

The attached update is a revised draft to be considered for publication in early April 2019. Potential sources of change are:

- Data awaited from PML on NOxMed services
- Comments being sought from the locality patient forum –next steering group meeting on 2 April 2019.
- Comments and suggestions from the North locality meeting on 19 March 2019

Action Required:

Review this draft and provide comments at the North locality meeting or to fergus.campbell@nhs.net by 26 March 2019.

Author:	Fergus Campbell	**Clinical Lead:**	Dr Shelley Hayles

North locality plan – draft review of workstreams Jan 2019

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	Pharmacist in place Employed (date and FTE - PML)	Additional roles funding will be available via 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	Employed (date and FTE - PML)	Consider expansion if funding available, or move to practice-based service
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	PML to recruit additional staff to start from 2018/19	Awaiting data from PML	Subject to PCN development

North locality plan – draft review of workstreams Jan 2019

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		unplanned admissions. Supports best use of GP time (to see as many patients as possible) and free up GP capacity.			
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 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.	Patient care would be much better coordinated for those care homes, who also have among the highest rates of urgent admission and 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.	To agree with PML process for managing care homes not currently managed by single practice. CSU to manage implementation steps for digital support.	All care homes allocated to individual practices and now all signed up to Proactive Medical Care LCS.	Subject to review of care home support and new national contract.
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	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.

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			infrastructure 5) Set up		
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. These will be subject to further discussion and development with the locality.	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, piloted at Deddington from Jan 2019	Available to all practices by June 2019. Additional roles funding will be available via PCNs during 2019-20
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	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.

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	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 the delivery of different models of care.				
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) X primary schools engaged ii) Training delivered (5 sessions) iii) Framework not yet taken forward. iv) Healthy cooking skills project in addition	i) ? ii) Further sessions planned iii) Cherwell DC plan district wide approach when PHE framework available iv) Continue – focus on holiday hunger