West Locality Plan summary refresh 2019

NHS
Oxfordshire
Clinical Commissioning Group

West Oxfordshire Locality Plan Summary

Locality overview:

West Oxfordshire Locality is home to a registered patient population of 82,730 (January 2019). The locality is made up of market towns and villages. Witney is the main urban area (over 27,000 people), and Carterton the second largest town (16,000 people). West Oxfordshire is the most rural district in the county and residents are older than average. This creates specific challenges around transport links and access.

What is working well:

- Extended access hubs in Witney
- Use of broader skill mix, including emergency care practitioners and pharmacists
- Activity-led website signposting patients in Windrush
- Optimised reception rostering to improve retention recruitment
- Longer appointments in some practices

Key locality challenges:

- Estates that can match the pace of their growing population, in particular Witney, Carterton and Eynsham
- Parts of the locality have a significantly older population, which causes challenges for access to services
- Recruiting enough staff for the growing ageing population

Key Priorities for the West Oxfordshire Locality

The locality identified 4 key priorities for the locality and 13 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 West Oxfordshire. Primary care networks (from July 2019) will be crucial to the next steps.

		Priorities			
#	**Workstreams**	Meet the healthcare needs of the ageing population in the locality	Ensuring safe and sustainable primary care that delivers high quality services	Improving prevention services	Planned care closer to home
1	Maximise benefits of Emergency Multidisciplinary Unit	■	■		
2	Community gerontologist or interface physician for complex multi-morbidity patients in care homes and assisted living	■	■		
3	Locality diabetes service, and extend to other conditions, such as heart failure and COPD			■	■
4	Increased primary care visiting service	■	■		
5	Same-day care services in Witney and Carterton with increased capacity		■		
6	Urgent Treatment Centre in Witney, integrating current services		■		■
7	Wider primary care clinical skill mix delivered through practice-based and cluster services to supplement existing GP and practice nurse staffing	■	■		
8	Practice based mental health practitioners for rural West	■	■	■	
9	Enhanced signposting role for receptionists and development of practice websites for signposting	■	■	■	
10	Development of practice website		■	■	
11	Development of social prescribing model		■	■	
12	Shared back office services		■		
13	Estates prioritisation	■	■		

Proposed solutions (2018)	Delivery scope (2018)	Benefits (2018)	Progress Jan 2019	Potential actions 2019
Maximise benefits of EMU	Build on the current EMU model to ensure that primary care and other community services are making most efficient use of this resource.	- Prevention or early identification of health or social crises and to forward plan. - Reduce emergency admissions	EMU outreach model discussed with locality Sept 18 and implemented by Oxford Health FT.	Review outreach and usage data Consider future working with primary care networks (PCN).
Community gerontologist or interface physician for complex multi-morbid patients	Develop a plan for virtual ward rounds of identified frail or medically unstable patients. This could include input from a gerontologist or interface medic, physician, social worker, nurse and GP. Weekly community pre-bookable gerontologist clinic to review the most medically complex or frail elderly, as requested by their GP.	Closer working with community services including district nursing and Hospital at Home. - Greater support to high-need patients following hospital discharge.	OCC/OCCG review of care home support started 2018	Propose future approach in light of review and future GP contract – specification.
Locality diabetes service, and extend to other conditions, such as heart failure and COPD	Integrated care between primary, community & secondary care with locality based diabetes clinical boards following success of pilot in North East Oxfordshire; roll out to West Oxfordshire.	Consistent service across the locality. Supports bringing care closer to home.	Diabetes LCS fully in place including joint planning with secondary care.	PCNs consider models of care for other conditions.
Expansion of primary care visiting service	Increase the capacity of the visiting service Palliative care training Continuing the care homes support in its present form – to discuss	Supports primary care sustainability, allows assessment of frail elderly patients earlier in the day, supporting early assessment in an ambulatory care centre supporting care at home. Can help support care at home for frail elderly	28 % additional visit capacity from April 2018. Capacity profiled to match seasonal pressures	Closer working with other services visiting patients' homes.
Same-day care services in Witney and Carterton with increased capacity	- Integrated pathway for patients who need a same-day clinical response. - All services based on use of EMIS patient record - Common policies and practices across the cluster. - Consider integration of service with out of hours GP service and Minor Injuries Unit - Consider mix of pre-booked appointments and walk-in access.	- An agreed definition of urgent / same-day care across the locality. - Consistent level of care across same day care services; avoiding gaps, duplications and hand-offs. - Efficient use of clinical workforce. - Wider range of services provided for patients: GP, nurse, mental health worker and others including potentially pharmacy and physiotherapy.	Physiotherapist appointments available at hub 11% additional appointment capacity from April 2018.	PCNs review need and propose future models.

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	- Consider links between primary care visiting service and community services such as Hospital at Home and District Nursing Urgent Hub.	- Increased 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).		
Urgent Treatment Centre (UTC) in Witney	Develop MIU to have full UTC capabilities, including: Access 12 hours a day GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics Consistent route to access urgent appointments, including booked through NHS 111, ambulance services and general practice with a walk-in access option retained. Integration over time with other urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.	Clarity for patients on urgent access Reduced attendance at, and conveyance to, A&E Improved patient convenience Sharing of staff, buildings, records and resources and may allow for a more streamlined, more efficient and less confusing service.	Oxfordshire campaign to maximise Minor Injuries Unit use Jan 2019.	Review national requirements and local need to ensure best use of urgent care resources. NHS England to do extended access review.
Wider primary care clinical skill mix delivered through practice-based and cluster services to supplement existing GP and practice nurse staffing	- Pharmacists (practice/cluster or locality level). - Diagnostic physiotherapy (note self-referral to MSK Assessment & Treatment Service expected from April 2018). - Physician associates, social community nurses. - Other clinical roles (NB OCCG sourcing further evidence-based guidance).	- Improved range of services offered to patients. - Reduced pressure on GP capacity, freeing up time for 15 minute appointments with complex patients. - Alleviates pressure on recruitment of GPs.	Locality clinical pharmacist appointed October 2018.	PCNs funded to employ clinical pharmacist-from 2019-20.
Practice based: Mental health practitioners	- Mental health practitioners in the rural West area learning from the Chipping Norton rural cluster model.	These mental health workers would be able to see patients with medically unexplained symptoms, severe 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.	Locality allocated the funding to pharmacist team (above).	Evaluate North scheme as option for PCN resources.

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Enhanced signposting role for receptionists	- Enhanced signposting role for reception/admin teams (including face to face, telephone, other)	- Improved access to service information for patients. - Effective integration of care; greater collaboration between services and joined up care around the patient. - Reduced demand on core primary care services by shifting patient care demands to other providers/ third sector.	4/8 practices accessed training in 2018.	Assess need for further training. Develop interaction with social prescribing and other new services.
Development of practice websites	Following success of Windrush practice website that provides enhanced signposting information, support other practices that wish to adopt similar model.	- Enhanced information to patients and education (including work in schools). - Improved access to service information for patients.	Practices currently commission websites independently	Consider options in the light of PCN development and social prescribing.
Development of social prescribing model and prevention for children and young people	Social prescribing scheme for patients referred by GP to a Wellbeing adviser and onto community services. People will be encouraged to get involved in activities that match their needs – they may promote physical exercise or social integration. A secondary aim includes community activation – helping people live healthier lives with the support of community associations, schools and employers.	Reduced pressure on GP appointments Reduced obesity and social isolation; more sustainable use of primary care	Citizens Advice piloted service from Jan 2019, and available in all practices from June 2019.	Work with Citizens Advice to fully implement Community Connect across locality by June 2019 and meet future PCN requirements
Shared back office services	- Shared back-office functions. - Support with policies, recruitment and payroll	- Better use of practice resources of space and staff by sharing back office resource.	Rural West practices discussed shared business continuity	Federation/PCNs review opportunities and options.
Estates	Investment in GP practices to expand/increase capacity for rising population. Practices might consider mergers where it makes sense for logistical and financial reasons. Particularly large growth is expected in Witney, Carterton and Eynsham.	Sustaining Primary Care and meeting the needs of a growing population. Continue to provide care closer to home	OCCG has met with West Oxfordshire District Council, and major scheme developers to seek infrastructure funding.	Assess impact of PCN development on estates needs and opportunities. Develop plans for Witney and Carterton.

Proposed solutions (2018)	Delivery scope (2018)	Benefits (2018)	Progress Jan 2019	Potential actions 2019
	Review use of space in Windrush Health Centre and Witney Community Hospital to boost joint-working and maximise use of this health campus. Identify needs and opportunities for primary care infrastructure growth to meet future requirements Carterton: identify suitable infrastructure to meet forecast population growth and any additional local services for the cluster. Work with developers and the district council to ensure infrastructure across new and existing sites, including Deer Park, meets future growth and is accessible.		OCCG and Nuffield engaged in Witney One Public Estate project – awaiting feasibility studies.	Options appraisal for Eynsham.

This refresh is based on the plan and summary issued in 2018. Statistics updated in the executive summary. 2019 progress and next steps columns added to the 2018 action plan above.

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