

Locality Proposal for Implementation of New Models of Care Closer to Home

Proposal Name	Witney Multispecialty Community Provider		
Name of Initiator	Stephen Smith		
Organisation	WestMed (PML)		
Key Partners	PML, OUHT, OHFT, OCC, OCCG, SCAS, ?AHSN		
Locality	Witney		
Contact Details	Telephone	01993 702911	
	Email	stephen.smith@nhs.net	
Date of Submission	15 December 2015		
What Area of the Care Closer to Home Strategy Does the Project Relate to?			
It incorporates all 6 of the Improvement Interventions			
Expected Start Date	15/12/15	Expected End Date	DD/MM/YYYY
Proposal(s)			
<p>The PMCF pilot in West Oxfordshire has developed systems to improve access for “urgent” problems and given time to provide continuity for the complex patients. It has established the infrastructure to allow the establishment of a Multispecialty Community Provider which will work collaboratively and integratively with partner organisations to allow care to be provided closer to people’s homes. It will improve quality, improve efficiency, improve access, manage demand and be patient-centred.</p> <p>AIMS:</p> <ol style="list-style-type: none"> 1. To stratify the care different groups of patients and 2. To redesign services around peoples’ needs which will: <ol style="list-style-type: none"> a. improve access to care b. bring care closer to their home c. be based on the individual and population’s needs d. be of higher quality e. be more proactive f. more holistic (in addressing physical, mental and social care needs) g. more efficient and integrated h. better manage demand <p>COHORT:</p> <ol style="list-style-type: none"> 1. Patients and carers who require “urgent” same day care 2. Patients and carers who require ongoing care either through their GP surgery or through associated community based services 3. Patients who are in the “top 2%” of NHS expenditure (aka Very High Intensity Users VHIU) 			

whose care may not be adequately coordinated or not delivered in a patient focused way.

4. Patients who currently have to go to hospital for care but that could have this provided closer to their home
5. People in Care and Nursing Homes

NEW WAY OF WORKING

1. Greater integration
2. Greater collaboration
3. Skill mix – new roles and everyone working to the top of their grade
4. Greater focus on triage/care navigation so the person gets to the right place, to see the right person in the right timescale.
5. Shared ownership of problems affecting the NHS and Social Care systems locally

PROPOSED MODEL

1. Enhanced GP Surgery based care

- a. Greater training in and use of clinical and non-clinical triage
- b. Longer GP appointments
- c. Reducing GP initiated follow up appointments (either by using other clinicians and/or other modes of follow up)
- d. Up skilling workforce
- e. Increasing efficiency
- f. Following up more patients from secondary care
- g. GPs focus on what only they can do and other work delegated to team
- h. Increased capacity to do this by...

2. Setting up a Multi-specialty Community Provider model to provide an Urgent Care Hub and a Complex Routine Care Hub

a). Urgent Care Hub

- Piloted in Witney and then potentially satellite locations(s)
- Co-locating the range of staff involved in providing Urgent Care (including PMCF Hub, EMU, MIU, Early Visiting Service, ILT/ DNs, H@H, Mental Health Crisis Team, Community Midwife, Social Worker, Carers, Diagnostic Physiotherapy, Palliative Care, Out Of Hours, SCAS. Some of these will be actual and some virtual e.g. DN could be contacted to come and see a patient at the Hub).
- Access to hub through GP Surgery based triage so aim to see the correct professional first time (avoiding duplication and time wasted on referrals) and manage demand
- Transport for patients to be brought to the hub where necessary
- Use shared electronic record
- Able to follow up certain patients e.g. via a Virtual Ward
- Shared learning and better communication between staff
- Shared ownership of outcomes
- Fostering team work and “can do” attitude
- Ability to flex with surges in demand (“Winter Pressures”)
- Alliance with OUHT and OHFT and ?OCC
- Coordinated by “MCP Back Office”

b). Complex Routine Care Hub

Three elements

1. Complex Patient Care

- a. Case Finding of VIHU across a population/locality
- b. Proactive Care Planning
- c. Patient education and shared decision making (?Patient held budgets)

- d. Case Management which may involve
 - MDT assessments and management
 - Admission to Virtual Ward
 - “Intensivist” e.g. GPwSI Complex Care
 - GPwSI Care Home
 - Longer GP appointments
2. Outpatient and Specialist Care in the Community
 - a. Office based specialist nurses
 - b. GPwSI
 - c. Shared outreach clinics
 - d. Oxford Eye Care model extended
 - e. Virtual Consultations e.g. Skype Dermatology Clinic and greater use of email between professionals for advice etc..
 - f. Consultant led education
 - g. Community based Chemotherapy
3. Greater access to diagnostics
 - a. Locally based – extend scope and utilization
 - b. Direct access – e.g. CT Head

Coordinated by “MCP Back Office” which addresses:

4. Contracts
5. Recruitment
6. Governance
7. Data analysis and audit
8. Unified and simplified claims processes
9. Training – e.g. triage, risk management, complex care, care home staff
10. Research
11. 7day working could be delivered through the MCP model

It will require new roles to be created/evolved:

- Diagnostic Physiotherapist - as first point of contact for MSK problems – e.g. surgery can triage patient with acute back pain to Physio rather than GP. Physio would then refer on if needed ongoing treatment to Treatment Physiotherapy team.
- Physicians Associate – to act as GPs House Officer – follow up patients, paper work etc.
- Clinical Pharmacists – for Minor Ailments and specific medications advice
- GPwSI Complex Care – an expert on patients with multiple medical, psychological and social problems and how their needs can be better met and in a more holistic way. . Would address inappropriate users of the services .Would act as the “Intensivist” role monitoring and coordinating the care for the “top 2%” VIHU. Would educate GPs and other clinicians on recognising, managing and (potentially) preventing complex care. Would link with other agencies and voluntary sector.
- GPwSI Care Home – an expert in the needs of patients in residential and nursing care. Would proactively manage them using telemedicine and biometrics were relevant. Would conduct actual or virtual ward rounds. Would ensure good care plans are in place. Would educate staff.
- Office Based DNs – DNs role could be divided in to urgent and elective work and where the patient can come to a surgery, the DN could provide care rather than in patient home (which saves travelling time). Their role with Practice Nurses could merge and benefit from mutual learning and better access to GPs and practice staff.

- Office Based Specialist Nurses – as above. Much more efficient to be seeing 12 patients in a session in a surgery setting than only 4 in the patient home.
- Care Navigators – potentially training and/or new roles to help patients through the myriad of services available both NHS, Social and Healthcare and Voluntary.

It will require new systems to be set up:

Virtual Ward Round
 Greater IT integration
 Back Office development
 Data and Audit management- population mapping, claims processes
 Triage training
 New modes of consulting email, Skype, telephone etc.
 Transport for patients to hubs to avoid time consuming home visiting
 Mature systems for feedback and quality improvement
 Closer integration of teams
 Training and education – especially on triage and care navigation
 Staff rotation
 Clinical risk management

It will require new ways of thinking:

Shared vision, ownership and support across partner organisations
 Closer working relationships
 Strong clinical leadership
 Letting go of some work and delegating to others
 Element of risk taking
 Given financial and workforce constraints, we need to make better use of our workforce and reduce inefficiencies by avoiding duplication and better integration.

Resources/Support required

Explain at a high level what support (and from which organisations) is required to deliver the proposal

- OCCG
 - Funding to work up proposals and new models
 - Commissioning (and adequately funding) the transfer of work
 - To act on behalf of Deer Park Medical Centre (currently Deer Park Medical Centre in Witney is run by Virgin Care Coventry and is not part of WestMed/PML)
- Cross-organisation support via Transformation Board
- Close working between providers - WestMed (PML), OUHFT, OHFT, OCC, SCAS
- LMC to help with grassroots engagement
- NHS England -contracts
- Premises development – including identifying the correct services in the correct locations
- NHS 111 – to ensure that patients dispositions are more appropriate

Desired Outcomes / Proposed Benefits

What will be different as a result of this project and how will this be measured?

More patients managed in or close to their own home so:

- Fewer admissions to hospital esp. A+E and Emergency admissions
- Fewer DTOCs
- Fewer patients outpatient appointments – new and follow up
- More patients dying in their chose place

Improved quality of care so:

- Fewer Datix submissions over communication problems or inappropriate transfer of work
- Patient satisfaction survey.
- Increase in number and utilization of proactive Care Plans

Improved access to care so:

- Shorter GP waiting times
- Improved A+E 4hour waiting target
- Improved SCAS response targets

Improved morale and reduced stress:

- Staff surveys
- Easier recruitment
- Better retention esp. GP Registrars remaining in Oxon.

Better demand management

- Fewer inappropriate referrals/admissions/presentations
- Fewer GP urgent home visits including to care homes

Milestones

List the top 5 milestones required to deliver this project

Milestone	Start date	End date
Stakeholder engagement: <ul style="list-style-type: none"> • Transformation Board • WestMed (PML) Steering Group and then • West Practices – including Deer Park • OHFT/OUHT/OCC/SCAS/AHSN/Alliance • LMC • NHS England • OCCG • NHS111 	15/12/15 16/12/15 18 or 20/1/16 ?9/12/15 4/2/16 19/1/16 9/12/15 TBA	
Public engagement <ul style="list-style-type: none"> • Local Patient Forum • ?HOSC • Comms team 	TBA – Jan or Feb	
Political engagement (meet with DC)	Jan/Feb	
Premises audit	Dec 2015	Jan 2016

Funding streams

- To work up proposal fully
- To fund premises development
- To pump prime service
- To transfer funds

Risks

What are the main risks to the delivery of the project and what mitigating actions are required

- Work force - availability and skill mix. *Training up existing staff; retention through career development and staff rotation; re-employment in new roles; cross agency working; recruitment drives e.g. Physician Associate & Clinical Pharmacist training programmes.*
- GP disengagement due to change fatigue, financial risk esp. over OBC and GMS contract. Witney centric model may be an issue for the village practices. – *Clinical leadership and “what’s in it for me and my patients and why should I change”. Also addressing concerns over funding and future of GMS contract. Whether “satellite” locations could/should be explored for the villages.*
- Protectionism – *convincing organizations of the need and benefit of changing*
- Destabilising other parts of the NHS – *collaborative working and senior level involvement. Redeployment vs unemployment.*
- Inadequate funding – *needs up front monies (could come from PMS premium) and commitment from OCCG to adequately fund the shift of activity.*
- IG – *public engagement*
- Contracting - *if this is to be Outcomes Based, how to share risk across organisations (especially practices/federations) qv OUHT/OHFT Alliance.*
- NHS 111 – *current algorithms will not be suitable and need to include new models of care and not stoke inappropriate demand. GP Surgery triage essential to ensure appropriate to direct patients and manage demand.*
- Inadequate premises including current configuration – *audit of occupancy of existing premises and scope to expand.*
- Patient acceptance – *strong narrative that’s it’s all about improving services for them and with their needs at the centre.*
- Deer Park Medical Centre – *discussions at local (GP to GP) level and at higher level between Virgin Care, PML and OCCG.*