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Locality Proposal for Implementation

of New Models of Care Closer to Home

Proposal Name	PML Multispecialty Community Provider			
Name of Initiator	Toby Quartley			
Organisation	ONEMed (PML)			
Key Partners	PML, OUHT, OHFT, OCC, OCCG, SCAS,?AHSN			
Locality	North East Oxfordshire			
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Date of Submission	20 January 2016			
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	26/1/16		Expected End Date	DD/MM/YYYY (TBC)
Proposal(s)				

PML's PMCF pilot in North East Oxfordshire has developed systems to improve access for "urgent" problems and gives time to local Practices to improve continuity for their complex patients. It has established the infrastructure to allow the establishment of a Multispecialty Community Provider that will include the Practices within ONEMed (PML) which will work collaboratively and integrate effectively 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.

AIMS:

1. To stratify the care for different groups of patients
2. To redesign services around people's needs which will:
    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. be more holistic (in addressing physical, mental and social care needs)
    g. be more efficient and integrated
    h. better manage demand

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COHORT:

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 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. Share responsibility in the management of patients closer to home, with secondary care specialists, e.g. i) Gerontology and adults with complex co-morbidity, ii) Diabetes, iii) ENT
   g. GPs focus on what only they can do and delegate other work to team members
   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 Bicester and then potentially satellite locations(s)
- Co-locating the range of staff involved in providing Urgent Care 8am – 8pm/7days system (including transforming the PMCF Hub and GP Out Of Hours service and Early Visiting Service alongside with Rapid Access to Gerontology, MIU, ILT/ DNs, H@H, Mental Health Crisis Team, Community Midwife, Social Worker, Carers, Diagnostic Physiotherapy, Palliative Care, 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 and intravenous therapy
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:

- Contracts
- Recruitment
- Governance
- Data analysis and audit
- Unified and simplified claims processes
- Training – e.g. triage, risk management, complex care, care home staff
- Research
- 7day working delivered through the MCP model

<u>It will require new roles to be created/evolved:</u>

- 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 General Practice 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 care episodes of clinical decline. Would link with other agencies and voluntary sector.

- GPwSI Care Home within a MDT providing expert advice in the needs of patients in residential and nursing care. Would proactively manage patients 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.

<u>It will require new systems to be set up:</u>

- Virtual Ward Round
- Greater IT integration
- Back Office development
- Data and Audit management- population mapping, claims processes
- 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

<u>It will require new ways of thinking:</u>

- 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 is required (and from which organisations) to deliver the proposal:

- OCCG
  - Funding to work up proposals and new models
  - Commissioning (and adequately funding) the transfer of work
- Cross-organisation support via Transformation Board
- Close working between providers within the PML GP Federation, other local federations (OxFed, Abingdon Federation and SEOX) as well as other providers (OUHFT, OHFT, OCC, SCAS etc.)
- LMC to help with grassroots engagement in general practice
- 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 outpatient appointments – new and follow up
- More patients dying in their chosen place

Improved quality of care so:

- Fewer Datix submissions over communication problems or inappropriate transfer of work
- Improved patient satisfaction (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 satisfaction surveys
- Easier recruitment
- Better retention esp. GP registrars remaining in Oxon

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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: • Transformation Board • ONEMed (PML) Steering Group and then • Federation workshops • OHFT/OUHT/OCC/SCAS/AHSN/Alliance • LMC • NHS England • OCCG • NHS111	 26/1/16 12/1/16 3/2/16 & 2/3/16 9/12/15 4/2/16 19/1/16 January TBC TBA	
Public engagement • Local Patient Forum • ?HOSC • Communications team	TBA – Jan or Feb	
Political engagement (meet with DC)	Jan/Feb	
Premises audit	Jan 2015	Feb 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. Bicester-centric model may be an issue for non-Bicester practices until a Kidlington satellite site is available for expansion. – *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 are viable.*

- Protectionism. *Convincing organizations of the need and benefit of changing*

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- 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) as exampled by 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 directing of patients and to manage demand.*
- Inadequate premises including current configuration. *Audit of occupancy of existing premises and scope to expand.*
- Patient acceptance. *Strong narrative that it's all about improving services for them and with their needs at the centre.*