Intranet: South West Locality

Oxfordshire
Clinical Commissioning Group

MINUTES:

TITLE: South West Locality Executive meeting

Held on: 18th October, 2016

Present:	Practice	Representative
Y Y	**Abingdon Surgery**	Flynn Reid (PM) Charlotte Treacy (GP)
Y Y	**Berinsfield Health Centre**	Julie Anderson (Chair) Jonathan Crawshaw (GP)
	Clifton Hampden Surgery	Richard Lynch-Blosse (GP)
Apols Y	**Church Street Practice**	Kate Blowfield (PM) Matthew Gaw (GP)
Y Apols Y	**Didcot Health Centre**	Jackie Mercer (PM) Mark Olavesen (GP) Alexa Slade
Y Y	**Long Furlong Medical Centre**	Nick Elwig (GP) Diana Donald (PM)
Y Y	**Marcham Road Surgery**	Rose Moore (PM) Jacqueline Bryant (GP)
Y Y	**Malthouse Surgery**	David Ridgway (PM) Laura Singer (GP)
	Newbury Street Practice	Patricia Heavens (GP)
 Y	**Oak Tree Health Centre**	David Ellis (GP) David Corps (GP)
Y Y	**White Horse Surgery**	Jo Morgan (PM) Jane Braddy (GP)
Y Y Y	**Woodlands Medical Centre**	Ann Sadler (PM) Helen Miles (GP) Ronan Llyr (Med student)
In attendance:	**OCCG**	Duncan Smith, OCCG Non Exec Director Sula Wiltshire, Director of Quality/Lead Nurse Julie-Anne Howe (interim LCD + notes) Justina Zurauskaite – apols

		Zoe Kaveney, Project Manager, Planned Care
	SWOLF / Patient Rep MRHC	Alison Langton
	Other Guests	-

1.	**Welcome and apologies** **Declarations of interest**	**Action**
	The Chair – Julie Anderson (JA) - welcomed everyone to South West Oxfordshire Locality (SWOL) meeting. Apologies as above. **Matters arising:** Jane Braddy was welcomed to the group from WHMP, replacing Gavin Bartholomew. Gavin has formally stepped down from his Primary Care development role in the CCG so ending a long involvement local health service management that goes back many years. GB was again formally thanked by the Chair and group, for his contribution and valuable input both to SWOL and OCCG over the years. OptimiseRx – one month on practices are finding this system useful. Details of how to report feedback on trial will come out shortly from Ross Burton, Medicines Management Team, and final collated report will come out in due course. Noted clunky system re medications having to be changed in EMIS, and OptimiseRx – needs live editing to improve usability. JAH to feed back to MMT.	**JAH**
2.	**Minutes of the Last Meeting – 21st June, 2016**	
	The minutes of the previous meeting on 20th September 2016 were agreed.	
3.	**SWOLG – Deputy LCD Post**	
	Deputy LCD role - JA was pleased to announce that Jonathan Crawshaw had submitted and Expression of Interest (EoI) in the deputy role. JAH outlined the process which would now follow, explaining she would shortly send the EoI to all SW practices to discuss in-house, and return to the November meeting to vote on appointment. JAH would then support JC through this process, with an anticipated start date of January 2017. **LCD role** - JA reiterated that practices did need to be discussing succession planning for her post (May 2016) within their practices, and Expressions of Interest would be invited in the New year. JA was happy to informally discuss what is involved with any interested parties.	**JAH** **ALL practices**

4.	OCCG Update	
	Latest information about Oxfordshire transformation programme : http://www.oxonhealthcaretransformation.nhs.uk/ JA updated the group and gave a presentation, here:  paper 3a - Update for SWOL Oct 16.ppt **GP AF progress** - Abington Federation - DR advised had all practices signed up to meet the criteria and a plan was in place. ValeMed are currently seeking an agreement, with Didcot being very instrumental, and meeting shortly to consider IT issues. An IT solution is being investigated by both to aid joint working across practices; EMIS Clinical Viewer could be activated. Issues of holiday and sickness cover to ensure a consistent service is delivered are being resolved. The movement of 30 mins per 000 population to 45 mins is expected over the next 18 months as population changes and weightings become more defined. **Sustainability & Transformation Fund** – (the £4) – existing plans had been approved and a model for disseminating the funding was being worked up. Following this, the following matters were raised from members present: 1) Concern was expressed that the federations had felt pushed into signing the " letter of intent" and why they were not aware of the background to this, JA explained there had been an invitation from CO of OCCG (David Smith) to providers including federations to form a Joint Venture alliance. This was mainly to ensure OUH and OH worked together to resolve the impending financial imbalance in the health system and to ensure primary care played an integral part in these new ways of working. Federations act as representatives of primary care providers whilst the OCCG held a commissioner role. SWOL practices are members of both OCCG and federations. SWOL GPs were advised to ensure their federations were keeping them informed of developments and JA offered to circulate the correspondence from the local federations and OCCG on this matter. DR confirmed that the alliance working between PML / OHFT / OUHT had done lots of preliminary work on joint ventures over the past year. He noted the PML scope was wider across the county, and that SW, although substantial in size did not seem well represented.	JA

	Duncan Smith advised OCCG was very pleased with the joint working to date but recognised there was some way to go. The youth and size of Federations was an issue as they tried to support practices with clear communications, risks to employment, and no funding on their balance sheets. This at times inhibited their ability to deliver their ambitions. 2) Clarification was sought on why funding was so short term, especially with the OCCG Director of Finance reporting the CCG was on target to deliver a balanced budget. It was explained this masked an underlying £30 million deficit which would become larger in the forthcoming financial years as the growth in the CCG budget would barely keep pace with demographic growth. 3) Concerns were expressed around uncertainty on options detail in STP plans, public disquiet and seeing changes as cuts, plans actually releasing any savings, a provider alliance simply strengthening secondary care to keep potential savings, and the need for the primary care element of the STP model needing more clarity. Practices felt that with the pressures they were currently under the OCCG needed to be supporting them more, to avoid GP contracts ending. **Savings Taskforce** – JA explained the purpose of this newly established group, how it aimed to work and provided a briefing, here:  paper 3b - Briefing for Localities Savings Practices were encouraged to put forward ideas and suggestions on areas which they felt could generate savings. **Enhanced Minor Surgery Scheme** – JA reminded practices to have a GP and PM to attend 15.11.16 extended meeting (to 4pm) to establish what was required for set up of this scheme. JA agreed to circulate the specification. Note: for Primary Care LIS purposes, time spent here will count as covering the August meeting which did not take place. **Science Vale & population growth –** The latest meeting of the Science Vale Project Group had been cancelled due to the uncertainty over STP making it difficult to progress. However the new practice is west Didcot was still planned, discussions with council planners to identify suitable sites have started and OCCG was still monitoring populations / list sizes / and pressures. These meetings would continue in virtual form to ensure progress is maintained.	All JA **All diary date**

5.	**Sustainability & Transformation Plan update**	
	A presentation was given on the current STP position – seen here:  paper 4 - Health and care transformation ir JA, Sula Wiltshire, and Duncan Smith led a discussion on Transformation, with an exercise undertaken seeking ideas on "What would you want to see locally for patients which would make a difference for SWOLG (within constrained)?". Ideas included: • GP access to diagnostic unit was key, including CT scan, as there was a firm belief this access would reduce referrals. • EMU with capacity to meet demand + transport + early visiting service. • If GPs are working 7 dpw, then other supporting services needed to match that to maintain efficiency (e.g. bloods etc). • EMIS system common to all providers with patient access. • Re-setting patient expectations on what is achievable and affordable. Use model of Red/Black drugs to GPs can clearly say what is a savings rather than clinical issue to patients in an open honest way. • Transparency across all practices so patients modify behaviours and expectations and don't try to 'play' practise off against each other. • Primary Care holding a block contract with uplift so can afford more admin to support patient and practice functions. • Five years of protected services. • Bin Casenotes and all have access to results on ICE – both primary and secondary care viewing results both ways and across practices especially if sharing patients (Bucks can already do this so why not OCCG?) • All practices using OUHT PALs for secondary care patient appointment / waits / test issues (varies currently) – will encourage OUHT to up their game for patients. • More integration of primary care and community care services. • Break out of the Block Contract model as it restricts change and just encourages funding into secondary care a year later, with uplift. • OCCG to support more GPwSI model working – others can do it without the restrictions OCCG have, why is that? • Premises fit for increased working to support population growth (e.g. Didcot sites for health campus need to progress faster). • Practices working to a recognised safe level of appointments per WTE and alternative options put in place. • Centralising some secondary services across local practices to share expertise, e.g. insulin conversion, gynae coils etc.	

	• Increased need for Mental Health provision for complex needs patients. • Transport is a huge issue with rural localities, patients default to hospital as they can't get to Abingdon or Witney. • Improving DN support (Integrated Locality Team availability). • OUHT staff being informed of actual costs, and drug costs, so they acted responsibly within a system of restrained costs. Perhaps tick boxes within specialties of what drugs can be given to match primary care availability? • Having a rota of GPs attending secondary care meetings instead of the LIS meetings, to broaden understanding of the wider issues. • All health and social care providers were involved in discussions and planning around the STP, as well as LMC. • The term Neighbourhoods was explained as groupings of approximately 30-50,000 patients – our proposed model is 1) Abingdon (though > 50,000), 2) Didcot and 3) Wantage + Faringdon – did that seem correct for patient access? Community Hubs would exist, would a health care campus in Didcot, with increased diagnostics be right for SWOLG? • Issues were raised around the need to count unmet need, e.g. Abingdon EMU turning patients away at 10.30am due to capacity issues around staffing, transport etc. This in turn means GPs stop trying to use it due to the time it takes to then be rejected. • Noted Abingdon EMU can't work without access to beds, and good social care links. • The pressures within primary care were acknowledged, and a question on how others are managing in CCGs elsewhere with innovation. • ZK raised the need for CCG Planned Care to increase awareness of their current projects, which did include a number of the improvements being sought by practices. There was a trade-off between capacity to do projects, a shared risk attitude, patient access issues, sensible funding and an assured quality of service. • Delayed Transfer of Care beds from OUHT to local care homes was aired, with recognition that locally homes were extremely expensive, and this may be inhibiting the current local provision of step down beds. However it was felt more effort should be made to secure places locally for patients, particularly with the population growth and service equity. • OCCG has longer patient lengths of stay in IP beds compared to national data – why is that, are risk thresholds lower? • Community hospital beds are more expensive than acute beds	

	(economies of scale re staffing ratios and fixed / premises costs etc). Should rehab be done elsewhere to shift funding?	
9.	**Any Other Business**	
	• NHSe funding for practice training in Five Year Forward View – where is this money and how is it being used? Need for receptionist training. Think is £25k per CCG from October. •	
10.	**Date of Next Meeting**	
	15th November 2016 **13:00-14.30 main meeting** **14.30 – 16.00 extended meeting re Enhanced Minor Surgery** **Didcot Civic Hall**	