NHS
Oxfordshire
Clinical Commissioning Group

North Oxfordshire Locality partnership

Notes of Meeting: Tuesday 21 August 2018 1.30 – 3.30 pm

Chair: Vanessa Newman (Wychwood Surgery)

Practice	**GP representative**	**Practice Manager**
Banbury HC	Dr Marlett Smit	Tony Summersgill
Bloxham	Apologies	Apologies
Chipping Norton HC	Dr Neil Fisher	Chris Bean, Monica Reid-Thomas (work experience)
Cropredy	Apologies	Andrea Kirtland
Deddington	Dr Martyn Chambers	
Hightown	Dr Louise Cornwall	Di Stringer
Horsefair		
Sibford	Dr David Spackman	
West Bar	Dr Stephen Haynes (StH)	Apologies
Windrush	Dr Simon Bentley	
Woodlands	Dr Shishir Kumar	Apologies
Wychwood	Dr Katy Walsh	Vanessa Newman

Other attendees		
Lay members	Anita Higham	Chris Ringwood
Cherwell DC		
NOLG Clinical Directors	Dr Shelley Hayles (ShH)	Dr Neil Fisher
OCCG	Diane Hedges, Jo Cogswell, Julie Dandridge, Fergus Campbell	
PML / NOxMed	Laura Spurs	

		Actions
1.	**Apologies & Declarations of Interest** VN noted the simplified agenda as circulated by e-mail with focus on Integrated Front Door discussion. **i. Apologies:** Deb Chronicle, Barry Tucker, Helen Murphy, Cath Rose, Fiona Jefferies**,** **ii. Update declarations of interest** None additional **iii. Conflicts of interest pertaining to agenda items** Noted that as primary care providers and federation members many present have a conflict of interest **iv. Anita Higham's role on OUHFT Council of Governors noted.**	
2.	**Integrated Front Door - North urgent care. Discussion with members only.** NF summarised the background to the proposals: • System not as good as it might be – i.e. separate elements of urgent/same-day care not always used efficiently.	

- Desire to group same-day resources on single Banbury site
- Decision needed about where in the system the hub resources should be used.
- Need to get flow of patients right i.e. avoid perverse outcome. Different rates of attendance. However - lack of primary care workload/patient flow data.

JC confirmed the overall aim was to make elements of the urgent care system work better together and avoid unintended consequences.

Individual practices each given opportunity to raise concerns and questions:

- SK Woodlands - will there be a financial consequence for practices with high urgent care activity transferring to a new arrangement?
- StH West Bar:
  - A&E tend to get the focus of attention at national level
  - need to check indemnity for GPs when patients are booked from 111/A&E to hub. Will need to streamline the need for several different types of GP indemnity to work across the organisations,
- SB – Windrush - lack of primary care staff is major concern. Limited capacity to cope with additional demand if system fails
- DS Sibford – lack of will or ability to send inappropriate patients away from A&E without treatment or investigation. GP service on hospital site risks reinforcing this
- MC Deddington:
  - NOLG need to retain ownership of any primary care service on hospital site, not have resources absorbed by acute trust.
  - Will all patients be triaged through same Front Door? Will it use the same criteria as primary care?
  - Some triage could be done at practice level – subject to activity levels. Could also be a virtual service.
  - Do we need a system to prevent an individual practice from offloading activity to any IFD solution.
  - Need shared understanding of respective funding models
  - System needs to have confidence in all sides
- AH patient forum:
  - lack of patient confidence in primary care i.e. see different GPs and negative media coverage of Banbury primary care.
  - Medical undergraduates at Oxford report they are not encouraged to be GPs.
- MS – Banbury Health Centre:
  - BHC have Advanced Nurse Practitioners doing triage – manage risk and uncertainty well. Would like to see that in secondary care as works well with limited risk.
  - 24 hr service has to be sited at A&E, but needs similar triage model to

	primary care as open access tariff model. o NHS 111 triage to BHC slots is appropriate. o Can't survive now without hub service, so need to ring fence capacity to support practices. • LC Hightown: o Does A&E have system to record inappropriate attendance? (JP later confirmed this is the case but advised not consistently used). o Feel that triage remains high level due to medico-legal framework. o Do not create an easier route to GP via IFD. o Practice-based care can enable continuity - some patients better signposted to own practice. o Risk that GP triage posts might be filled by less experienced clinicians o Hub must be preserved for practices, not A&E overspill. NF noted that hub not always full and different models around county. o Suggest primary care and A&E observe working both ways. Understand each other better • KW Wychwood – if confidence of patients in primary care is low then IFD risks undermining further. What plan for OOH - already under pressure and needs support. Comments from OCCG team in response included: • GP streaming at JR – activity so far is less than forecast. • Need to use limited workforce as well as possible, i.e. working to top of licence. • LC wish to know what models being looked at, and evidence behind them • IFD funding model needs to incentivise appropriate service use. • Sustainable 2 way flow of patients in system would need development of good pathway, data-sharing and trust. We need to be clear how to review and evaluate any triage system • Confidence in clinical triage from all stakeholders is key • Early and regular feedback system is necessary for sucess	
3.	**Integrated Front Door – discussion with provider organisations** *Dr Liz Dawson (PML), Chris Hewitt (OH), Dr James Price (OUHT) and Laura Spurs (PML) joined the meeting.* LD noted that she had attended some of the planning meetings as a GP representative. Learning from existing GP hub is that not all patients appropriate so resource not maximised. Need patients to go to right place. Patients with more complex chronic illness are much better served by ongoing care from their own GP practice. JP noted that the historic ED system not fit for purpose, range of patients presenting much wider. He summarised the main drivers for service design as:	

	• Co-location at Horton hospital • getting right clinician to patient earlier in the pathway • most demand is OOH and not well guided by signposting services • surges of demand present challenges • JR more responsive to GP input CH noted that activity in OOH has grown. Developments include: NHS111 triaging patients, changing skill mix, need to retain ability to visit at home. NF summarised NOLG GP comments and questions as: • greatly increased demand in primary care without significant increase in resource. Note recent contribution of hub and visiting service. • Concerned about staffing services, and competing with other services. Not as stable as previously so vulnerable to negative change. • Don't want model which incentivises inappropriate patient activity. • Queries about how triage – how working, how staffed, will it apply to all? • What staffing proposed? • Culture and confidence. JP noted 3 relevant developments: • EMUs in Witney • AAU at JR taking calls from GPs and SCAS. GPs working alongside consultants, supervising acute registrars. • GP streaming required by NHS E. So far across most trusts this has not led to increase in attendance above long term trend. Provided by GP-led multi-professional team - has strong influence on other clinicians. Most interventions will be completed by non-medics. Comments and queries arising from the discussion included: • what joint employment and development opportunities does this create for clinicians? • current hurdles to portfolio career – 3 contracts, 3 IG requirements and 3 pay sources. Some progress made at JR. • can integrated provision be multi-site ie patient referred back to GP Surgery when appropriate? • Need to strike balance between quick intervention at time for inappropriate attendance, or referring to primary care later. Need "nerve" to dissatisfy the patient if inappropriate attendance at A&E / IFD. • MS – close working with AMPs and ECPs in primary care. Suggest not "GP-led" but "primary care led". • Need to ensure social care and mental health needs addressed in model JD summarised the patient flows arising from the discussion – see diagram below.	JD/NF

	Issues for further discussion (JD and NF to take to project executive): • Triage approach, staffing and resourcing • Joint employment opportunities • Resourcing • clinical governance and indemnity issues raised by joint working / cross referral Actions: • NF to seek more practice-level data on numbers and types of patients at A&E • FC ensure North agendas have NOLG dedicated time at future meetings (before and after IFD implementation; also circulate earlier information to facilitate whole practice discussion before locality meetings • JD/FC to ensure plenty of notice for clinicians attending meetings • NOxMed may be able to resource GP attendance – all to consider whether they could contribute • FC review options for renewed primary and secondary care liaison in locality	NF FC JD/FC All FC
4.	**Notes of 17.07.18 North locality meeting** **i. Approve minutes for accuracy** Agreed **ii. Matters arising and actions not yet discussed** None discussed	
5.	**AOB** **i. GP bypass numbers** NF advised that GP bypass numbers enabled SCAS paramedics on scene to discuss admission avoidance with GPs. Data showed this was appropriately used, and most patients discussed not conveyed to hospital. FC to contact practices for updated numbers **ii. North Oxfordshire Locality Public & Patient Forum** Confirmed that Judith Wright would continue to support the patient forum for the time being	FC
6.	**Key issues to take back for action or info to p**ractices • Integrated Front Door	All

The following items on the agenda not discussed to allow fuller discussion of North IFD.

- NOLF public forum update
- Information updates for noting
  i. OCCG Board meeting 26 July 2018
  ii. Planned care projects update
  iii. Brief information items
- NOXMED business items

North Integrated Front Door (NOLG 21/8/18)