MINUTES:
Locality Forum Chairs Meeting
27 October 2016, 14.00 – 16.00
Conference Room A, Jubilee House

Present:
<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Mary Braybrooke</td>
<td>South West</td>
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<tr>
<td>Tracey Rees</td>
<td>City</td>
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<tr>
<td>Julie-Anne Howe</td>
<td>Local Co-ordinator, OCCG</td>
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<tr>
<td>Graham Sheldon</td>
<td>West</td>
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<tr>
<td>Jeremy Hutchins</td>
<td>South East (until 16.15)</td>
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<tr>
<td>David Smith</td>
<td>Chief Executive, OCCG (until 16.00)</td>
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<tr>
<td>Catherine Mountford</td>
<td>Director of Governance, OCCG</td>
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<tr>
<td>Louise Wallace</td>
<td>Lay Member, OCCG (from 15.15)</td>
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<tr>
<td>Rosalind Pearce</td>
<td>Healthwatch</td>
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<td>Helen Van-Oss</td>
<td>North East</td>
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<td>Sara Price</td>
<td>CSU</td>
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<td>Ian Bottomley</td>
<td>Head of Mental Health and Joint Commissioning, OCCG</td>
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<td>Dr Julie Anderson</td>
<td>South West Locality Clinical Director, OCCG</td>
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<td>Tony Summersgill</td>
<td>Deputy Director of Quality, OCCG</td>
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<tr>
<td>Lukasz Bohdan</td>
<td>Head of PMO</td>
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In attendance:
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<td>Lesley Corfield</td>
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Apologies
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<tr>
<td>Elaine Cohen</td>
<td>Patient Representative</td>
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<tr>
<td>Dr Joe McManners</td>
<td>Clinical Chair</td>
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<td>Anita Higham</td>
<td>North</td>
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<td>Hilary Seal</td>
<td>Patient and Public Representative</td>
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Agenda items were taken in the order 1, 2a, 4d, 4a, 4b, 2c, 2b, 3, 4c, 5, 6

1. **Notes of the Meeting Held on 25 August 2016 and Matters Arising**
   The notes of the meeting held on 25 August 2016 were approved as an accurate record.

   **Matters Arising**
   - **Quality Team and Datix**
     CM confirmed the LFCs could share the Quarterly reports more widely.
   - **Building Effective PPGs – Survey Monkey**
     JAH advised no feedback had yet been received on the survey from LFCs. GS and MB both reported their steering groups had reviewed the survey and had no issues with the content. JAH explained the next stage would be to work with LFCs on the relationship with Practice Managers around what they would like from a PPG and how they could work better. This would then be correlated with LFCs views. JAH stated the survey contained valuable information which should be used in a constructive way. The results of the survey provided a Practice Manager view and the intention had been to check if that view was acceptable to LFCs before taking forward. **Action: JAH and JAH/LFCs**
| LFC Chairs to pick up outside of the meeting.  
Evaluation Criteria Document  
It was not known if the document had been circulated. **ACTION: CM to check if the Evaluation Criteria document had been circulated.**  
Dementia Programme  
MB reported the distances between the north and south west were too far for people to attend the same meeting. | CM |
|---|---|
| **2. OCCG Update**  
**2a. BOB and Oxfordshire Transformation Plan**  
*Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (BOB STP)*  
The latest submission was made to NHS England (NHSE) on 21 October 2016. The STP had been written in a form it was believed could be published but NHSE had been clear the STP could not be published until they gave clearance. The STP had been circulated to Trust Chief Executives and local authorities and the directive not to publish had been stressed. Discussions were due to take place with NHSE in the next week. DS would raise the question of publication.  
GS expressed disquiet at the secrecy as transparency was necessary to enable all parties to work on the STP together. DS advised three out of 44 footprints had published STPs as the local authorities in those areas had decided to publish the document.  
The STP described how the health, inequality and money gaps would be met over the next five years and the overarching areas of work where there would be collective working. DS reported workforce was addressed in the STP explaining this was a big issue and there were gaps across most of the professions. One of the issues to address was those areas where it was worth working at scale without duplicating work at a local level.  
It was hoped the STP could be published by Christmas.  
*Oxfordshire Transformation Plan*  
DS explained previously it had been hoped to go out to consultation in October and then December but it was now necessary to wait until January and the consultation would be undertaken in two parts. This was subject to approval from NHSE but the intention was to consult on obstetrics, possibly paediatrics and the closing of 200 beds by the Trust. After May consultation on changes to community hospitals would take place. Between January and March discussions would need to take place in localities with GPs and other stakeholders around community hospitals and primary care. It was planned to advise MPs, councillors and other interested parties of the change in plans by the end of the week. The reasons were partly because it had not been possible to complete all the work required before going out to public consultation and partly because it was necessary to hold full engagement and discussion with Oxfordshire GPs. Temporary closures such as Wantage Community Hospital would have to be reviewed and addressed in light of the two stage consultation. Consultation in January was subject to the proposals being cleared by the Clinical Senate and signed off by NHSE.  
Points of discussion included:  
- If consultation occurred in the summer many people would be away and sufficient time should be allowed for engagement/responses |
There was danger delaying the consultation could have a ‘knock on’ effect to later plans

A piece of work with GPs and stakeholders was required and to consider with Healthwatch design of the consultation piece

There was a need to move ambulatory diagnostic work into the community although the practicalities of how this would be achieved had to be worked through

A particular area for consideration would be beds in community hospitals as the acute state could not support all the beds at their current level

OCCG was not yet in a position to say whether there would be a preferred option or several proposals and the available estate might have a bearing

Plans needed to be discussed alongside district council plans and there would be a need to work together

Providing a preferred option could be seen as making a decision before the consultation. It may not be possible to provide arguments for a preferred option and reasons why other proposals were not recommended as the case would not be black and white

There was a national contract for delivering primary medical care (GP practice) services but in some parts of the county practices had resigned the general medical services (GMS) contract. It was very difficult to get a strategy for primary care at a level of detail that gained agreement from all and the recruitment of GPs in this area was very difficult

GMS practices had contracts in perpetuity – they were able to give notice on their contracts but OCCG could not serve notice. Any merger or acquisition was also the decision of a GMS practice

Discussion around federations linked to considerations around services available to practices. Discussions and contracts will be based on delivery on an individual basis. Contracting with 10 practices rather than one federation would be acceptable as long as the services required were delivered

It was not possible to plan and build with 72 practices. Localities were looking at neighbourhoods (groups of practices) and currently 18 neighbourhoods had been identified and discussions around delivery of services within areas were being held

GPs were overloaded and would be unable to take on more work without releasing something – as an example, if out-patients were to be moved from the John Radcliffe it would be necessary to also move the staff to undertake the work

GP engagement and involvement in the design would be crucial. If GPs did not have confidence in the transformation plans, neither would patients

There would be a point when patients would need to be involved and to understand the change was for their benefit and not for the convenience of the GP

It would be necessary to get the whole primary care team in each practice on board with proposals

Practices should be encouraged to incorporate at least one patient voice in the deliberations.

2b. PPG Data Protection Guide

JAH explained the guide had been produced to help PPGs with the
governance around holding contact details of PPG members. TR requested the document was renamed guidance as information governance gave the impression of being enforceable. Any comments on the guidance to be provided to JAH. CM added the document was intended as a good practice guide to be shared with PPGs around how voluntary groups could work in an electronic world. **ACTION: Any comments on the guidance to be provided to JAH.**

**2c. CCG Savings Taskforce Update**

Lukasz Bohdan and Dr Julie Anderson attended for this item and gave a presentation. There was a minimum £12.6m saving requirement for 2017/18. OCCG was reviewing services and engaging with localities, patients and LFCs to work through ideas. It was believed changes could be implemented and savings achieved without harming patients or services. Providers were being challenged around costs and areas being considered were procedures of limited clinical value (PLCV); Lavender statements; prescribing; and moving services into the community. Work with GPs was also being undertaken around thinking and discussing different options and methods with their patients.

Work was still in the early stage of ideas generation. There was internal work with partners to cost and describe schemes in more detail. Some of the schemes could be implemented quickly whilst others would need resource and work up. If there were any proposals to change prescribing criteria or Lavender statements a consultation may be required. Locality meetings would be used for engagement and to share plans but a steer on the method of engagement with locality fora was requested. Briefing papers would be prepared and shared. LFCs were happy to invite attendance at monthly meetings. JA offered to attend. **ACTION: LB to liaise with LFCs for meeting dates.**

DS commented a broader public piece to obtain views would be required and he anticipated there would be a number of lobby groups for whom the approach would need to be considered. JA commented encouraging patients to talk to pharmacists would free up time in practices for GPs to see patients with more complex needs.

**3. Forum Updates**

**North East:** A Health Fair had been held in Bicester. The Fair had been well attended by various groups but not by the population of Bicester. It had been a good networking event, had provided some insights and led to the recruitment of some new members.

**West:** Three public events on health services had been held during the year with the last one taking place in Bampton. Bampton Surgery had received glowing reports.

**South East:** A piece of work had been undertaken with Healthwatch and School Nurses to interview youngsters around what they wanted from health services and why some were frightened to go to doctor.

**South West:** The Forum had not met since the last LFC meeting. No one had yet volunteered to be the Forum Chair.

**City:** Four more people had been recruited but not to the Chair post. Members would continue to share the responsibilities.

**4. Topics from LFCs:**

**4a. Hospital quality – Commissioning levers for improvement and hospital administration standards**

Tony Summersgill attended for this item and explained how the Quality
Directorate undertook to ensure quality of services. When aspects of poor quality were found, OCCG would work with providers to improve the service. In addition there was a feedback service called DATIX through which GPs were able to report any issues or concerns around quality. The hospital had an electronic system which produced letters to be sent to GPs following an intervention; a discharge summary was also issued on the release of a patient from hospital; but TS advised there were some admin problems with these services.

Following expression of concerns around slippage against targets and hospital admin, TS advised the indicators of particular concern to OCCG were the amount and speed of discharge summaries issued on time; and how quickly and efficiently test results were communicated. Current performance was around 80% when it should be around 90/95%. Levers did exist in the contract but on occasions to obtain a contract at a certain price there had to be agreement not to impose financial penalties. The Director of Quality and TS continually met with the Trust Medical Director and this area was monitored by the OCCG Quality Committee.

TS reported the strategy to date had been to achieve consistency and for the content to be of sufficient value. Changing the discharge summary template was being considered. TS acknowledged there were inconsistency between services and advised the aim was to achieve a single appointment for a patient and for them to be seen within a reasonable time.

DS commented some cultural change within the hospital was required and currently the content of the letters themselves was very variable. He reported the hospital was trying to push through the changes.

**4b. Adverse Effects of CQC Inspection Reports**

JH expressed concern around the Care Quality Commission (CQC) approach when inspecting practices which was often in an unhelpful and demoralising way. TS advised as a regulator with a statutory function which had to be adhered to, OCCG did not have much of an influence on the CQC. However, there were variations in the skill and competency of inspectors and OCCG had fed back to CQC that the inspectors should all be working to the same level. JH advised the practice had written to the CQC Chief Executive. TS observed there were some benefits from CQC inspections where unsafe care had been picked up.

RP requested incidents such as this should be reported to Healthwatch and advised a consultation on the CQC was due to be issued next year. She would circulate details when they were available. **ACTION: RP to circulate details of the CQC consultation when available.**

TS reported Oxfordshire fell within the average category for CQC inspections with no inadequate ratings, three outstanding, five or six requiring improvement and the remaining practices being satisfactory.

**4c. General Practice Changes**

Concerns were raised around the process, decision making, and communication elements for the closure of Deer Park, Witney. CM accepted there was a need for OCCG to look at engagement and communication around changes in primary care but advised the situation had been very complicated. Initially discussions took place either between the practice and
OCCG or the practice and potential other partners. At that stage discussions could not be made public. The situation at Deer Park had not been anticipated as it had been presumed the contract would be re-let however only one proposal had been received and that did not meet the specification.

At that point the alternative options were considered: another re-procurement; a merger with another practice; list dispersal. All options were considered around ensuring on-going, sustained, reliable services. After discussions with the other Witney practices the decision was made to disperse the practice list. The contract with the current provider was extended to 31 March 2017 to ensure dispersal was undertaken in a safe way. CM acknowledged OCCG needed to reflect on the experience and learning in order to do better in the future.

GS felt the general practice delivery model was not working well. He was concerned at the dispersal of patients to other stretched practices in Witney and suggested this might result in other practice failures. He stated the decision had not been thought through in a strategic way and not been communicated effectively. CM was not prepared to accept the decision had been made without careful thought and consideration, including consideration of the longer term direction for primary care/practice size but agreed the communication element could have been better.

HVO felt the dispersal of patients at North Bicester had also been handled badly. CM advised Deer Park and North Bicester were two very different cases. The partners at North Bicester had given notice on their contract. At Deer Park the contract had been extended to allow time to manage the situation better and work with the Witney practices. All Deer Park patients had been sent a letter explaining the contract would cease on 31 March 2017, that there would be somewhere for them to register, there was no need to do anything immediately and a further communication would be issued in January 2017 with further details. CM had met with Witney District Council and explained the work being undertaken to support patients.

JAH advised CCGs were not allowed to allocate patients to practices as this element fell within patient choice. RP commented the lessons from Deer Park would enable OCCG to do better in the future and Healthwatch was pleased to see the statement that had been made by OCCG. RP hoped it would not be long before everybody in Witney considered the patients rather than the politics as Healthwatch was concerned patients might be left ‘high and dry’ whilst arguments continued around what should have happened. CM reported the current provider was working really well with OCCG in identifying patient groups and how support could be provided in helping patients to register. JAH commented Witney GPs were concerned about the patients who did not register with another practice and queried whether Healthwatch could help. **ACTION: JAH and RP to discuss outside of the meeting.**

JAH advised Horsefair practice was not closing and was in discussion with another provider to continue providing services. Kennington Health Centre had realised their statement had been issued prematurely and discussions were now underway with other local practices.

GS suggested the model of care at Deer Park was an alternative that worked whilst the current model clearly did not. RP advised the model at Deer Park...
had been offered at a high premium which worked at a cost to all other GP
surgeries in Oxfordshire and this model could not be afforded across
Oxfordshire. CM reported in Oxfordshire there were particular areas of
pressure, some areas of general pressures and some areas where primary
care was working well.

GS stated he wanted transformation to take place and to work but the system
needed to continue to work whilst transformation occurred. It was advised
Chris Wardley, a PPG Chair, was the Chair of the primary care patient
advisory (PAG) group and sat on the Oxfordshire Primary Care
Commissioning Committee. TR added that Elaine Cohen was also a member
of the PAG. GS advised he was also a member of the PAG but he did not
believe it was very useful and it was not engaging with the current primary
care strategy. TR was aware there were discussions in the group around a
patient concordat and she felt concern around generating something locally
when there was already an NHS Constitution. She felt this might be
reinventing the wheel.

4d. Mental Health Update
Ian Bottomley joined the meeting for this item and provided a presentation
(which would be circulated after the meeting). IB advised the mental health
and learning disability sections of transformation planning were largely
complete and areas which impacted the main services were now being
considered.

LFCs queried whether it might be possible to get services into schools
commenting on the incredible amount of work being undertaken in this area
by School Nurses. IB advised as part of the current review of children’s
services, Oxford Health NHS Foundation Trust was being asked to identify
ways in which the “front door” to services could be broader. Sarah Breton,
Lead Commissioner (Children and Maternity), could be asked to attend the
next meeting.

DS advised mental health was a priority at the moment and a bid for funds
could be made but in order to receive funding it was necessary to
demonstrate good services were being provided.

5. Healthwatch Update
RP reported on the areas currently being reviewed by Healthwatch:
- Lack of support and long waiting times for patients with mental health
- GP waiting times although GP services received a lot of praise
- Long waits for hospital out-patient appointments
- Poor communication from hospitals
- Obstetrics at the Horton Hospital
- Closure of Deer Park, Witney – a formal response to a communication
  with OCCG had not been received but the statement on the website
  covered the items raised
- Asylum seekers and vulnerable residents in Oxford City and the
  services they received: interpreters and translators; doctors being able
  to provide a longer consultation time
- Projects undertaken by the voluntary sector (bereavement, female
  genital mutilation) – these were the last of the voluntary sector
  projects as there was no more money available.

Looking to the future Healthwatch would:
- Respond to the Health Inequalities Commission Report which would be available soon
- Was engaged in the transformation agenda and was pushing for full engagement and advising on the consultation to ensure listening
- Undertake a targeted Healthwatch in a local geographical community – this was a pilot and if the idea worked the intention would be to undertake two or three a year
- The third sector annual conference would take place on 7 February 2017.

TR advised Healthwatch was looking to work closely with the voluntary sector to assess the impact of cuts locally on services.

6. **Any other business**

   **World Diabetes Day**
   JAH tabled information from the Oxford Centre for Diabetes, Endocrinology & Metabolism (OCDEM) around an interactive event to mark World Diabetes Day on 18 November. The information would be circulated electronically. **Oxfordshire Youth Forum**
   SP advised she was involved in the launch and set up of the Oxfordshire Youth Forum through which it would be possible to regularly engage with young people on many areas not just health. The Oxfordshire Youth Forum would be launched on 18 November at a ‘take over’ day. **ACTION: SP to provide feedback to the next meeting.**

   There being no other business the meeting closed at 16.40.

7. **Date of Next Meeting**
   22 December 2016, 14.00 – 16.00