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Minutes of Oxford City LRC/PCT Liaison Meeting

Thursday, 5th May 2005
Meeting Room 3, Richards Building, OX3 7LG
At 2.00

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Minutes of Previous Meeting

These were agreed as a correct record.

Enhanced Services

What is the final position regarding an over/underspend?

The finances are being worked on. Some claims have been slow in coming in.
When the final position is known the PCT may be coming to the LMC for a 'letter of grant' to roll over to the current year.
The figures being discussed are the out-turn figures.
The PCT planned to spend this but the work has not been done.
If the activity has not been forthcoming there is nothing the PCT can do. It may be that the specification was not clear or they have not been read coded correctly.
It would be an unreasonable LMC that would battle if an underspend was as a result activity not being as predicted.
There needs to be a dialogue when the final position is known.
With dermatology the ES was very late and the PCT did not specify a code to use, this will be changed this year. So far 68 patients have been identified with lichen sclerosis and melanoma.
It may be that some practices decided not to send in any data on this as the numbers were so low and this probably reflects in the figures.
The PCT may have not made it clear how to claim?
This year the PCT will be clear that if they do not receive the information by a certain date the claim will be lost. Clarity is vital for this.
After the first practice year the LMC hoped that the PCT are contracting clearly and an annual bundle of SLAs are being sent to practices that are clear in specification, monitoring, pricing and payment arrangements. Have practices received these? Not yet.
Practices have received an email notifying the ones that will roll over from last year.
Prices will be uplifted by 3.225%
The individual signature sheet has yet to be sent out.
The areas that are being introduced will be sent out as soon as possible.
Oxford City PCT is an example of a good system and this needed to be made better if possible.
Are the PCT using Aspire or Chart? The PCT will be using Aspire.
Near patient testing and anticoagulation was based on information from the Trust. This has been used as a benchmark and will be payment on account with reconciliation later.
There are things that can be included in the offer to practices which do not need to be included in the floor. This may make the total spend on enhanced services different.
The first draft of this went to the last nGMS.
The baby check ES for last year was underpriced and to inflate this by 3% is not realistic.
Practices can say that they will accept the price and do it or refuse to tick the box.
When the roll over email was sent out the only query the PCT received was with IUCDs, and this related to practices being able to do reviews rather than insertions.
Neonatal checks should be done in the hospital. It was not the PCT intention that there should be many of these.
They must be done after 24 hours and before one week. This should be stated in the specification.
In Banbury a midwife has been specially trained and does these checks every day.
The check should be done at the house. The LES is to support the mother in the community and should be priced as such. The Blue Book suggested £50.
How would the John Radcliffe Maternity Department be notified if a practice has taken this enhanced service up or not?
The JR has been commissioned to provide his service and GPs should not be doing it.
The PCT want to have early discharges. On costs to do these checks should come out of the hospital budget. Currently the shift has not been sufficient to take this service out of the hospital.
The PCT should be able to invoice the JR for the cost of GPs providing this service or they could send a Paediatrician out to do this.

OOH Call Handling

This has been happening since 13th April, has the PCT noticed any problems with the change over to county wide call handling?

Patient confidentiality is an issue as you can see the notes on every patient who has contacted the service.
It has been agreed to review the situation in one month.
There is a clinical governance issue here.
How many people have opted for the Border solution? Currently it is 17/27 practices.
This service is costing practices £2,000 per annum despite assurances that small practices could negotiate but this has not happened.
There is the solution of using the BT call divert system.
It has been decided that PR will email all practices seeking any solutions to this problem. These would be passed onto GPs.
When it has become clear who has signed up to this the costs will be reviewed in 3 months time.
The cost for BT call divert is £10 per quarter.

QOF Issues

Have there been any problems in terms of QMAS not producing the right figures? Are there are any disputes with practices?
One practice has a problem. One practice has had a manual payment due to a national problem with QMAS. Two practices have been overpaid by TVPCA and they have been contacted and the relevant amount will be taken back in May.
The average score was high 900s with 3 practices achieving full marks,

Dossett Scripts

Is this Committee delivering anything on this issue? The minutes appear to be waffly.
Is the use of repeat dispensing moving forward with the new pharmacy contract?
A paper is going to PEC stating that patients currently getting prescriptions through an existing pharmacy will need to be re-assessed in line with the DDA. Pharmacists will be asked to do this and if they meet the DDA criteria will be entitled to ongoing assistance.
This removes the obligation to practices as weekly scripts will no longer be a requirement.
For patients who fall outside the DDA, the proposal is the PCT will continue to honour them.
To redress the picture of patient having medication visits or those patients were not in the scheme a county group has been charged with putting together some proposals for each PCT to consider for a consistent county wide approach to give to the Pharmacists to meet this.
The timescale is that an LES will be developed in the summer and further clarification is being sought.
The LMC are planning to have a forum and ask for practice views on local issues and they will mandate the LMC to either drop issues or take them up. Dossetts will come up and more and more as practices are commenting on this.
There are several ways that a patient ends up with a dossett box. Disability: the pharmacist's new contract allows for this. The ability for social care staff to manage this in the past has been done by dossett; they will now give it out of a bottle. Money that has currently been paid for this service will be left for patient care.
Medication only visits are being reviewed.
The third is an LES for pharmacists.
Another option is for patients to have an alarm which reminds them to take the medication. The problem with this is that some patients will not know what this means.
If this group sets up this LES the PCT should be in a position for the pharmacists to take this up in 6 months.
Progress will be made and the PCT and LMC will be reviewing matters.

Locum Appraisal Payments

At the last nGMS meeting it was agreed the PCT would produce a position paper.
This will be produced for the nGMS meeting.
PR tabled a list of payments made by PCTs in the Thames Valley.
Oxford City is at the bottom of the list. The average is £300.
The email from Katie does not make accounting sense. The superannuation is 14% not 20%. The locum is responsible for paying the 6%.
£150 net is paid to the locum, and the 6% should be added to this figure.
Within Thames Valley what is expected within this £300? Locums should only do what they are paid for. It is normally 4 hours preparation and 2 hours discussion.
The appraiser's assessment of the appraisees work indicates the amount of preparation.
Lower payment produces lower specifications. This is not fair to the locums.
Oxford City have over 100 non principal performers on the list and this is a financial implication.
GPs would take local work rather than travel long distances.
The PCT felt that other areas were paying too much.
To tick the boxes on the forms takes 2-3 hours.
GPs are paid £38.50 per hour at attendance at meetings and this is the rate that is used.
This is a form of imposed obligation and is a requirement to be on the performers list and the PCT should support this.

Choose and Book

There is no recognition in PEC that this is part of GPs responsibility.
There have been meetings because of the link between CAB and PBC the focus of PCT dialogue is to sign people up to CAB
At meetings about PBC, CAB has not been mentioned.
The IT meeting influences this as the money coming to PCTs to achieve targets will enable IT investment.
The PCT want to incentivise CAB by putting practices ahead of others for new PCs, the others will get these but will be next in line.
Practices have been told they can sign up to the smart card and will get upgraded screens and equipment, but practices will not be obliged to provide CAB.
To enable smart cards some computers will need to be upgraded.
Signing up to the smart card does not commit you to CAB or PBC. CAB does not commit you to PBC either; it is the other way around.
Ultimately everyone will need smart cards. What happens if you lose it? You will not be locked out of your practice system, only CAB.
You will have a personal PIN.
The PCT has a target to reach by December which will be difficult.
This is very well covered in the GP press.
The whole agenda is very complicated.

Case Management LES

The codes need to be finalised.

Practice Based Commissioning

Have practices been asked to express an interest in PBC?
A workshop was held in November and all practices have received a letter explaining the situation and asking for expressions of interest.
Practices said that they had not received this letter, it was agreed it would be sent out again.
Could the LMC be copied on documents that are sent to practices? It was agreed to copy JS and PR with anything that is sent to practices.
How will the administration costs etc be approached?
From discussions with practices, they are keen to see information and work with the PCT. They have agreed what practices will receive.
Practices will receive activity figures on an annual basis, this will be 04/5 activity information and pricing. This will be available electronically and GP can even identify patients using the services. There will be comparative data coming out after this.
Will the coding of activity be done by the commissioner rather than the provider in the future?
At the moment the national system is done by the provider.
Chiltern and South Bucks are looking at every suspicious coding with a view to making savings.
They appear to be riddled with errors.
There have been thoughts about tracer practices who will look at the accuracy of data.
The PCT have looked at the Aylesbury system.
The proposals are to use the Chiltern and South Bucks system across the Thames Valley.
If you trust the figures you will be more encouraged to go into this.
The PCT are promoting an enhanced service to reduce avoidable admissions and the elective side of musculoskeletal. These are ways into PBC.
They also want practices who have their own ideas to come forward.
Will there be a fundholding preparation year, because if the les is implemented on admission avoidance before practices are given their budgets, they will be making savings before they are given their first budget. This has been recognised elsewhere.
Will practices want to hold an indicative budget? Practices will only want the case management les if they already have their budget.
You cannot make any decisions until information is available and the PCT are working on this.
Comparative data is needed for this to be valuable.

Future Meetings

There was concern with the overlap between the Liaison meeting and the nGMS meeting.
It was a forum where the LMC could bring things that needed discussion with the PCT.
The nGMS forum was not appropriate for commissioning issues.
Other PCTs have both forums.
GPs on the LMC are representative local GPs.
After the pre meeting the LMC will have a local GP view which will not happen at nGMS.
The Liaison meeting with be a consultation meeting not a negotiating meeting.
There are some areas where the PCT has an obligation to consult with the LMC. This meeting will ensure that there is sufficient understanding.
The PCT is now about service delivery.
It is about getting a general feel from local GPs and taking this back to the PCT.

Communication with Practices

What other avenues would GPs like the PCT to use.
There should be short punchy bulletins.
It should be relevant to commissioning issues but there are delays from the PCT.
The PCT agreed this needed to be tightened up. Within the PEC they do not feel they have a strong hand in commissioning.

The GP Forum had a variety of meetings, these stopped as they were poorly attended. There is a proposal to start these things again with topics such as PBC or OOH. If the LMC would like to hold meetings with PCT and GPs there they would like this. It was agreed to hold joint meetings as the aim is the same. The aim should be not to hold too many meetings.
This is the purpose of the newsletter as feedback is invited by email.

Commissioning

Oxford City are the lead commissioning PCT for Orthopaedics and a letter has been received from the NOC regarding a patient from South Oxfordshire, who do not have a facility to access physio. This is a rejection letter from the Director of Nursing for the back triage clinic, stating that this patient has not had the required amount of physio so could not be seen.
This sort of letter should not come from a provider trust and certainly not from a Director of Nursing as opposed to the Medical Director.
Commissioning should not happen this way.
The same things have happened with endoscopies.
If you have not got the facilities to put them through the pathways you cannot fulfil the criteria.
The PCT would not have powers to commission physio in the south, however they are the lead commissioner.
The NOC are saying the commissioners were involved in the discussions.
The PCT need to find out who were involved in the initial discussions.
Endoscopy referrals are being bounced without the new tests being in place.
Patients are also being written to saying the referral is inappropriate.
The PCT may not hear about reject letters being sent.
The PCT must establish with the providers that they cannot interfere with the specifications of the SLA. It is very specifically in the SLA that they cannot change things without discussion with the commissioner.
They will say they did discuss it, but the question is who should inform the GP.
It is about who should manage this change?
Endoscopy referrals were being sent using the local form and no one knows why they are being bounced back.
It was felt the PCT should publicise this. GPs feel the PCT are not commissioning right and if they are doing it right they should let GPs know about this.
If GPs know the provider cannot change a pathway without consultation it would be helpful.
These NOC issues should be used to lay down ground rules. The spinal pathway has been agreed and the fact that there is no physio in the area needs to be discussed.
The PCT will investigate the pathway.

Cataract Referrals

How does the Cataract choice operate?
A paper is received from the optician, is it sent to the PCT Patient Care Adviser too?
When a GP wants to make a cataract referral where is it sent?
The PCT will check this.

Removal of Patients

An increasing number of practices are reporting that the TVPCA are removing patients who should not be.
There has been a big list cleaning exercise with the Universities.
One practice had a list of about 20 who should not have been removed.

Date of Next Meetings

The PCT said that 9th June was an Executive Committee meeting so the next meeting was agreed as **Thursday 2nd June 2005.**
The timing of the meeting was discussed, should it be 2-3 or 3-4?
PR agreed to do a strawpoll of all members to find a mutually convenient time.
2-3 was a preference of the PCT.

Present	Name
*	Benson Catharine
*	Budden Maggie
	Hornby Christopher
	Merriman Honor
*	Rand Bettina
*	Roblin Paul
*	Solomon Jane
*	Birchall Carol
*	Astrop Penny
*	Chivers Andy
*	Mather Robert
	McWilliam Jonathan
*	Mountford Catherine
	Young Andrea

Apologies were received from Dr Hornby and Merriman