

---

# OXFORDSHIRE LOCAL MEDICAL COMMITTEE

---

**Chairman**  
Dr Rickman Godlee  
Church St Practice  
The Health Centre  
Mably Way  
Wantage  
OX12 9BN  
Tel: 01235 770245  
Fax: 01235 770727  
rickman.godlee@gp-k84033.nhs.uk

**Treasurer**  
Dr Stephen Large  
12 Horse Fair  
Banbury  
Oxon  
OX16 0AJ  
Tel: 01295 259484 or 259661  
Fax: 01295 279293  
stephen.large@gp-k84040.nhs.uk

**Secretary**  
Dr Paul Roblin  
Secretariat of Berks, Bucks & Oxon LMCs  
Mere House  
Dedmere Road  
Marlow  
Bucks SL7 1PB  
Tel: 01628 475727  
Fax: 01628 481173 or 01628 474731  
paul.roblin@bblmc.co.uk

## Minutes of South Oxon LRC/PCT Liaison Meeting

Thursday, 1 December 2005

Tait Room, Marcham Road Medical Centre, Abingdon  
OX14 3JY

## CONTENTS

### **CTRL and Click to hyperlink**

Appraisals .....	1
ORH and Prostag .....	2
Category M Drugs .....	2
Oxfordshire Beds.....	2
Interpretation of QOF .....	2
Enhanced Services Spreadsheet .....	4
Hernia Surgery Decision .....	5
LRCs versus County LMC .....	5
Date of Next Meeting – Thursday, 2 <sup>nd</sup> February 2006 .....	5

---

## **Appraisals**

PCT wished to discuss reports that other PCTs outside Oxfordshire are planning not to fund 100% appraisal coverage this year.

By January it is likely that South Oxon PCT will have 50% coverage.

The LMC view was that annual appraisal was a contractual requirement but that any contract can be overridden by mutual agreement.

The PCT may ask some GPs if they are prepared to move this year's appraisal into the early part of next year.

## ORH and Prostag

SR sought LMC opinion on ORH suggestion to move from Zoladex to Prostag.

This will cost the PCT more.

The LRC felt this issue should be taken through the APCO.

Extra costs can only be justified if they bring proportionate clinical benefit.

## Category M Drugs

Issue raised by PCT

Explanation below was written by PHR after meeting using email from LS.

To fund the new pharmacy contract a ring-fenced £300m was taken out of pharmacy profits from 1.4.05.

The tariff (reimbursement) price of nearly 500 generics (a new Category M) was forced down

This could be a perverse incentive for dispensing practices to revert to prescribing branded drugs, with consequent extra costs for the NHS.

The limit of £300m has produced a problem when a large volume drug goes off patent.

Many older generics have had to go up in tariff price to compensate.

LS pointed out that it may actually be better to prescribe branded drugs because many are now cheaper than generics.

PCTs, however, are performance managed on their generic percentage and may have a conflict in encouraging appropriate swops from generic to branded products

PHR suggested the PCT contact Jane McVey, Pharmacist and Clinical Governance Lead at Vale of Aylesbury PCT who has produced an incentive scheme for dispensing practices avoiding increased prescribing of trade drugs.

## Oxfordshire Beds

A new look at Oxfordshire beds will take place in January 2006.

This may involve community hospital redesign as well as another look at JR and Horton beds.

LMC reps will be needed.

The PCT felt that there could be a dilemma between the expansion of community hospital beds versus the expansion of Oxford Radcliffe beds.

## Interpretation of QOF

### 1. PCT wanted to discuss interpretation of Records Indicator 9

Neither wording of Indicator nor text of SFE brought to meeting.

Relevant text of SFE written below

#### **Records Indicator 9**

**For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004)**

**Minimum Standard 80%**

At the meeting, LMC felt this did not refer to an electronic link. LRC felt that provided the start date of the drug as listed on the computer could be tracked back to an explanation within the consultation record, practices would have fulfilled QOF requirements.

**Guidance on Records 9.1 within SFE 05/06 is also written below.**

When reviewing medication, it is important to know why a drug was started. This information in the past has often been difficult to identify in GP records, particularly if a patient has been on a medication for a long time or has transferred between practices. It is proposed that this information needs to be recorded clearly in the clinical records. It is recognised that most practices utilise computer systems for repeat prescriptions and it is intended that an IT solution will be available to assist practices in meeting this indicator. The start date for this indicator has therefore been delayed to 1 April 2004 as not all GP clinical IT systems can link diagnosis to repeat prescriptions. A system for doing this will need to be initiated in many practices when the software has been modified. This criterion will not be assessed until after 1 April 2004. In practices where the computer is not utilised for repeat prescriptions, the clinician should write clearly in the patient record the diagnosis relating to the prescription. This need only be done once when the medication is initiated

PR conclusion post meeting:

We need to know when the IT solution became available from the 3 main IT suppliers before a sensible judgement can be made.

PCT need to supply this information

**2. PCT wanted to discuss interpretation of Education Indicators 1 and 5**

Neither wording of Indicator nor text of SFE brought to meeting.

Relevant text of SFE written below

**Education Indicator 1**

**There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months**

**Education Indicator 5**

**There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months**

**Guidance on Education 1 and 5 within SFE 05/06 is also written below.**

The primary care team members deal with cardio-pulmonary collapse relatively rarely, but require to have up-to-date skills to deal with an emergency. This is best undertaken at regular intervals through practical skills-based training sessions, as it is known that these skills diminish after a relatively short time. The timescale has been set pragmatically at 18 months, although many practices offer training on a more frequent basis.

This training may be available from a variety of providers including your local Accident and Emergency Department, BASICS, the PCO, out-of-hours co-operative, Red Cross, St John's Ambulance or equivalent. It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.

Although it is rare for practice non-clinical staff to have to deal with a cardiopulmonary collapse, the situation may arise within or outwith the practice premises.

See Education 1.

The interval for training is pragmatically set at three years although many practices offer training on a more frequent basis.

### **Discussion at meeting**

The LRC view is that:

The rules for QOF are as written in the SFE.

The most relevant sentence from the SFE is:

**“It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.”**

Provided governance can be assured, it is appropriate for CPR training to be given by a doctor within the practice using the correct equipment.

PCT insistence on the trainer having been trained as a trainer was inappropriate.

The PCT accepted this with the proviso that practices not buying in official trainers would produce a description of the governance arrangements ensuring training was to an adequate standard.

## **Enhanced Services Spreadsheet**

The LRC worried about the predicted underspend of £264,132.

The LRC made their position clear to the PCT.

LRC will not sanction ES underspend roll over into the next financial year.

LS went through LRC reservations about the spreadsheet.

Pneumococcal spend may need adding.

How can there be a Basket underspend and Huntercombe overspend against budget?

Expansion of GPs with special interest never discussed.

Zero spend against orthopedic service, community COPD service, GP with special interest expansion, insulin conversion and diabetes education

The PCT felt that the underspend projection was a best guess because many practices have been slow to return Aspire queries on disc.

SR felt official arbitration was likely to be needed on underspends.

The PCT explained that several budgets were an initial best guess with some imprecision.

Included in these were access, influenza, child imms, basket & prison health service.

PCT felt that what actually mattered was the predicted end of year spend and its comparison to the ESF.

The LRC felt the budget and spend for both the primary care heart failure service (£109.5K) and MIU in Abingdon (£301.6K) was excessive.

LRC felt PCT had agreed that only in-hours staff costs would be included within ES floor

The PCT agreed to provide a breakdown of both row spends.

The underspend carry forward from 04/05 is written as 82000. In fact it was described as 82463 in paper to May 2005 LRC (with a promise of a final reconciliation)

It is the latter figure that should appear in the spreadsheet.

## **Hernia Surgery Decision**

PB had several examples of retrospective rejection of hernia referrals where it was obvious from the original letter that the patient was an exception, usually on the basis of considerable pain and discomfort.

LRC felt the process had been poorly handled.

## **LRCs versus County LMC**

LMC supports suggestion to restart county level Liaison with the three PCTs together.

Discussion of need for S Oxon LRC/PCT Liaison if this happens

County Liaison is likely to remove a lot of work from LRCs, which may eventually become redundant.

The LRC, however, wanted to retain the S Oxon date on 02.02.06, recognizing that if agenda items were all dealt with at County level this would be cancelled.

It is predicted that South Oxon LRC will at least meet to discuss the breakdown of ES costs identified above.

**Date of Next Meeting – Thursday, 2<sup>nd</sup> February 2006**

<b>Present</b>	<b>Name</b>	<b>Organisation</b>
	Bartholomew Gavin	LRC Member
*	Buttar Prit	LRC Member
	Coffey Paul	LRC Member
	Copping David	LRC Member
*	Godlee Rick	LRC Member
	Langley Christopher	LRC Member
	Milligan Julia	LRC Member
	Neale Ian	LRC Member
*	Silver Lisa	LRC Member
*	Roblin Paul	LMC
	Solomon Jane	LMC
	Birchall Carol	LMC Minute Secretary
*	Dudley Jane	South Oxon PCT
*	Gale Kate	South Oxon PCT
*	Mackenzie Ian	South Oxon PCT
*	Richards Stephen	South Oxon PCT
*	Stringer Michelle	South Oxon PCT
*	Thompson Colin	South Oxon PCT

Apologies:     Dr Milligan  
                       Jane Solomon  
                       Carol Birchall