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Minutes of NOPP LRC Meeting Wednesday, 22nd November 2005 at 1:30pm Board Room, Banbury Business Park OX17 3NS

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Nigel Webb had sent a message saying following discussions last time, he would no longer be attending future meetings.

It was agreed to share the chair of the meeting between the LMC and the PCT

Ginny Hope chaired today.

Previous Minutes

The minutes 27th September 2005 were agreed as a correct record of the meeting.
The PCT and LRC agreed that in the last paragraph of Enhanced Services there was no commitment to a separate LES for each area in the Basket; it was only agreed to discuss disaggregation and possible separate contracting.

Minor Surgery Consent Form

Extract from LRC Minutes: LRC voiced the views expressed

Members are unclear whether form was needed only for cutting procedures
Revised form is based on one developed by Newbury PCT and their LRC

In Newbury it has been agreed that written consent is not needed for needling procedures
It was agreed to ask the PCT to clarify this.
Meeting discussed storage of consent in computerised practices.
Members felt the form should be available electronically for GPs to print out.
The patient can then sign it and it can be scanned into the patient notes.
Ideally patients need to be able to sign a screen to indicate consent.
Technology awaited!

Discussion at Liaison

This form was intended to be used for cutting procedures in the main, although GPs may wish to use this for injections.
If no consent form is used a record of consent needs to be kept in the patient record.

Action Point: It was agreed to send this electronically to all practices.

DN Cuts & Impact on Primary Care

Extract from minutes of LRC Pre-meeting

PCT deficit and a vacancy freeze have led to DN managers altering the work specification of DNs
DNs are being told not to do any home visits for phlebotomy or immunisations for patients outside their caseload.

The District Nursing service is very demotivated by these cuts in staff and care.

The policy has been implemented quickly without any consultation with LMC or other GPs.

No alternative provision has been put in place.

It was felt that PCT had assumed this task would now be done by GPs.

Members felt the PCT as commissioners of the service that is cut should pay GPs to provide it.

The Community Nurses are there to provide a domiciliary service to patients who cannot come to the surgery.

If the PCT want the practices to set up another service it will take time to organise car insurance and set up the systems for health and safety.

In many parts of the Thames Valley phlebotomy has been funded as an Enhanced Service.

West Berkshire pay £1.20 per phlebotomy procedure

Oxford City PCT has a Domiciliary Phlebotomy Service involving Health Care Assistants who visit patients in their homes

In practices at present only GPs are insured to drive for professional purposes and therefore able to visit patients.

Most practices have their specimens collected at 11.30 am,

Yet GPs are usually tied up in surgery until lunchtime,

If a GP performed the service there would need to be a later blood collection service

Members criticized the speed of the implementation of this change and the apparent absence of thought.

Many practical issues seem not to have been considered.

It was agreed to ask the PCT to withdraw the directive or to develop a service along the lines of Oxford City or West Berkshire.

Another community nursing issue was also causing problems.

Health Visitors who provide smoking cessation advice are being asked to provide the service for other practices which means their other workload is not being done

Views expressed at Liaison

LRC is disappointed that this change was made unilaterally without discussions with practices.

What replacement service do the PCT have in mind to provide domiciliary phlebotomy and immunisations?

If practices provide it what resources will be made available and what time frame will practices be given to set up a new service?

All felt visiting to take blood was not good use of GP or District Nurse time.

The LMC would like to see a peripatetic domiciliary nursing service set up along the lines of that provided by Oxford City.

The geographical area to be covered in the PCT area was much larger than the City version.

Perhaps PHCTs could look together to solve these problems and even look towards PBC to help.

If primary care set up a new service, it will take a long time to sort out the health and safety issues and insurance etc and it will not be possible to have this running by January.

The PCT were asked to rescind this decision until primary care has a funded solution in place.

There are great problems with staffing in some areas as under the PCT vacancy freeze replacing people who randomly leave the service or retire is tightly controlled by CEO.

PCT reps felt:

Some practices were training staff within their teams to provide a visiting phlebotomy service and they should not be told to stop this.

Flexibility was needed and where local solutions were happening to leave these.

Other practices must be looking at alternatives.

LRC felt:

District Nurses must not be banned from providing services they have been providing for years.

The PCT should try and find an alternative, cheaper provider rather than DNs or GPs.

LRC asked who was funding the practices who are working to find an alternative solution?

It would be very unusual for practices to fund a domiciliary phlebotomy service.

Action Point:

It was agreed that the PCT would talk with Hazel Knott about a more flexible approach, There are some discussions that are ongoing with practices and this needed to be built on to develop a bigger picture and develop an alternative where appropriate.

NB and GH will liaise on this and nothing will change until these talks have happened.

Enhanced Services

Basket of Services

The PCT have agreed not to backdate the price reduction to April 05 but only pay at 40p per patient from September 05.

Unclear if this means 1.9.05 or 30.9.05

Counselling

LRC cannot see why PCT finds it so difficult to provide equitable provision of service between practices.

PCT responded.

Juliette Long is working on this; however to unpick this will be a very large job.

There are mixed views from counsellors about unpicking this service, some want to do this through PBC, some want to change and others do not and there are also mixed views from practices too.

LRC remained of the view that counsellor hours should be divided up pro rata across practices and patients can attend appointments wherever the counsellor is sited.

Action Point:

It was agreed that NB and GH and Juliette would liaise and go through the list of patients and the counselling hours and allocate these equally across the practices, once agreed it was felt this should go the PEC for ratification.

It was also agreed that a letter would go out to practices saying that this was an LMC initiative and including what the model would look like.

Enhanced Services Spend

PCT reps explained that the PCT spread sheet currently showed only payments on account so would not be much help in predicting the reconciled end of year position.

PCT was asked that as soon as reliable activity figures were available they be made available to the LMC.

Practices reported that they had not received any ES specifications to sign.

Action Point: The PCT agreed to supply these.

LRC felt strongly that retrospective unilateral alteration to ES pricing or spec erodes trust. LRC asked that if PCT are rolling over any Enhanced Services into 2006 they should remain unchanged in specification or price until negotiations are completed.

They should also inform practices of any ES that are being withdrawn.

Agreed that ES Commissioning Plans across Oxfordshire will be done as a whole county,

However it would hope it would be possible to have local variations on these where this was desirable.

Action Point:

The PCT agreed that

- **Any specification that was due to be withdrawn would be made known to practices by beginning of financial year.**
- **Any services that had not been finally agreed by beginning of financial year would also be made known and would remain the same until agreement was eventually reached.**

The PCT asked for a month's grace to May 2006 to complete this work.

Practices need to know what LES will be withdrawn in April 2006 to enable them to stop providing the service.

PCT Reconfiguration

Extract from LRC minutes

The outsourcing of the management for the SHA has been put on hold; the decision is now to be made by the new Board.

Oxfordshire PCT Chairs and the Chief Executives are not in agreement about going to one management structure straight away, before formal merger.

It was agreed that moving to one team now would be sensible and save resources that could be used to fund a home phlebotomy service!!

LRC voiced the views expressed above.

West Berkshire have already moved to one Chief Executive and from 1st January 2006 there will be 3 locality directors and 4 central directors.

This will be debated in NOPP at Board meetings.

TVSHA is starting its formal 90 day consultation process on 9th December.

Demand Management/CALS

Extract from LRC Minutes: LRC voiced the views expressed.

This CLAG (Clinical Leaders Action Group) meets every 2 weeks

CLAG looking at ways for Oxfordshire to stay in budget.

Attended by PCT and Trust Chief Executives, PEC Chairs, Medical Directors of the OR and the LMC

ORH reps seem to want to downgrade the Horton.

ORH are behind the initiative to limit hernia repair surgery and cardiac neurophysiological surgery.

CALS (Clinical Advice and Liaison Service) has arisen out of CLAG.

Clinicians within CALS will vet all GP letters into the trust and consultant to consultant letters

GPs may be phoned up for a discussion on further treatment options.

The hope is that CALS will take clinical activity away from hospital outpatients as a counter to full implementation of PbR (Payment by Results) next year

Given the system has to live within budget, some cuts will be inevitable.

GPs need to decide which type of rationing was the least painful.

PR felt that CALS was reasonably acceptable to most GPs on this basis.

Oxfordshire MPs have said in Parliament that not enough money is provided for health services in Oxfordshire.

To command GP confidence assessment by any demand filter needs to be done by a senior clinician and not an executive of the bureau or even a nurse.

It is very costly to have senior clinicians looking at referrals.

It was suggested that a buddy system within the practice would be more cost-effective and could be financed as a simple initial PBC.

More follow ups could be done by GPs provided funding followed for extra clinical activity in practices.

A view has been expressed that imposed cuts i.e. hernia cuts are easier for GPs to take than having to ration themselves and face medicolegal action.

GPs have faith in the Priorities Forum and were happy to accept the cuts they proposed.

The PCT feel uncomfortable with some of the decisions that are being made but it is necessary to make them due to the current financial situation.

Services at Horton Hospital

GPs have heard that the Gynaecology ward at the Horton is to be shut without any public consultation and the future of the Horton Hospital is being put into question.

Gynaecologists have been advised that their 8 beds have been re-sited in the General Surgery Ward.

This ward is often full with general medical patients.

There has been no consultation with the LMC or General Practice.

Members wanted to know whether this is a provider or commissioner decision?

The PCT said that moving Gynae beds to the Surgical ward was a provider decision.

LRC asked whether commissioners have a say in this.

LRC felt the PCT needs to be aware of what is happening and shape it rather than reacting to it.

Practice Based Commissioning

PR said the paper on a QoF type model for PBC was impressive, but PCT reaps felt more work was needed on the task list within each domain. The workload would be reflected in the number of points allocated. Lots of comments have been received and a revised paper will go to the PECs.

LRC felt that if the Oxfordshire system wants to achieve financial balance GPs need to look at doing things differently and Boards should be incentivising them to do so under PBC.

Discharge Summaries

JW presented a proposed alteration to ORH discharge summary template

Action Point: It was agreed that JW would email PR with a copy of the proposed version and PR would send this out to constituents for comments.

The summary would also be discussed at the LMC County meeting on 8th December.

Date of Next Meeting – 24th January 2006

Present	Name
	Dr Simon Bentley
*	Dr Neil Bryson (Chair)
	Dr Martyn Chambers
*	Dr Emma Haskew
	Dr Stephen Haynes
	Dr Kulwant Pandher
*	Dr Helen Van Oss
*	Dr Paul Roblin
	Jane Solomon
*	Carol Birchall
*	Paul Roblin
	Jane Solomon
*	Carol Birchall
*	Matthew Brown
*	Dr John Galuszka
*	Dr Hugh Gillies
*	Ginny Hope (Chair)
*	Nicky Wadely
*	Dr John Walton

Apologies: Drs Chambers, Haynes and Van Oss
Jane Solomon