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Oxfordshire Primary Care Trust and Local Medical Committee LRC/PCT Liaison Meeting 6th October 2011 Jubilee House, Oxford, OX4 2LH

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Minutes of Previous Meeting (21.07.11)

Accepted as a true record.

Planned Care Programme and LMC

Mary Keenan and Andy Chivers spoke to this.

Oxfordshire is experiencing pressure in staying within its overall budget.

Oxfordshire is the eighth worst funded county in England.

LMC support or intelligent interaction is being sought by OCCG.

The system is no longer within a comfort zone.

Savings in Secondary Care will allow more spend in Primary Care.

OCCG is looking at variation in practice, particularly outliers and welcomes ideas for savings and inter-practice working.

AC felt that thresholds may need to rise rather than banning certain clinical activity or referrals.

PB felt that boundary issues presented problems when thresholds were altered: salami slicing no longer works.

PHR and RG stressed that shift in activity not regarded as part of contractual essential services into primary care, required resourcing.

LMC asked about Breast Cancer follow up proposals.

MK described a “dramatic rethink”. OCCG is now seeking evidence that follow-up is useful.

PHR commented that the LMC requests for funding is designed to concentrate the minds of commissioners as to whether the activity was really worthwhile.

Free activity is often taken for granted.

JH asked about the commissioning of complex gynaecology.

MK replied that OCCG is discussing this with Steven Kennedy (ORH Lead).

The following figures were given for this financial year:

7% reduction in first outpatient referrals, but follow up OPD percentages are going up.

LMC stressed that GPs have no control over the latter. An external audit is being planned.

OWLS

Stephen Richards had given localities the impression that the OWLS contract was being withdrawn.

PCT attendees felt that this was not so.

LMC asked how the expenditure on OWLS fitted into the QIPP plan.

AC felt that all weight management programmes generally suffered from a poor return on investment.

PB felt obesity management was an evidence light zone.

However, a commissioning strategy on obesity was required by NICE. LMC queried whether the PCT should spend as little as possible until value for money was proven. LMC felt the NICE Box could have been ticked a lot more cheaply.

JG commented that you are castigated if you do and if you don't. Overweight people get a raw deal.

LMC felt that there was no evidence based good deal and that the opportunity cost of committing £1.2million to OWLS was too big.

Safeguarding Children Training Strategy

Jane Bell presented.

CQC inspection of safeguarding in Oxfordshire was generally complimentary, but comments were made about Oxfordshire not having a strategy for system wide training.

LMC commented about the paper supplied pre meeting.

LMC is not in favour of a **mandatory** 3 yearly training schedule.

Nationwide objections to “Diplomatosis” explained.

The wording in the paper needs to be modified to replace mandatory by “advised practice”.

Medical Appraisal Policy

Sula Wiltshire and Liz Wragg presented.

LMC found this a confusing paper (as did the BMA).

It is not clear about what is needed now as opposed to what might be needed in the future.

It will be difficult for any new revalidation system to require “evidence” prior to a point in time at which it defines the “evidence”.

References to RCGP papers are not up to date.

Medical Performers List: PCT Proposals

The PCT had withdrawn this paper following LMC criticism.

Many of the recommendations stem from the Organisation Readiness Self Assessment template which does not have the force of regulation.

The PCT has no power to insist on locum exit reports from practices and their absence does not permit locum removal from the MPL.

Policies for the management of single handed GP practices

Ginny Hope presented the draft paper outlining PCT Policies for the management of single handed GP practices and the provision of primary medical services following the termination of a single practitioner contract.

LMC had asked for national listserv comments on this paper.

“Was it discriminatory or legitimate targeting of a GP sub group deemed to be a particular risk”.

The prevailing view was that the policy as written was discriminatory and that selection of practices for governance visits should be based on adverse performance indicators (KPIs identified practices other than single handers who were a cause for concern).

LMC advised OPCT to replace single handed with (“cause for concern”).

The section in the document about handling the retirement of a single handed doctor seems to conform to the rules.

Health Checks

LMC raised this issue. The PCT has recently taken DoH advice and discovered that recent historic data and data obtained by opportunistic screening are not eligible for LES payment.

PB stressed that this is counter to the assumptions used in the original LES pricing and therefore the agreement with LMC was null and void. Since they were in the same cluster, LMC asked the PCT to adopt the Bucks LES.

AE felt this issue would be dealt with by Paula Jackson and the taskforce group she is convening.

LMC felt that unless there were changes, they would have to advise practices not to take up or discontinue the LES.

Amended 2WW lower GI form: delay in implementation

PHR expressed concern that there was a PCT delay in advertising the new system for direct to test lower GI problems after the joint meeting between LMC, PCT and ORH.
It seems that the requirement to make the form auto-populatable produced this delay.
PCT agreed to look at this.

Open Access Upper GI Endoscopy: unilateral change by department

LMC was concerned about apparent unilateral (ORH) alteration to the process for obtaining upper GI Endoscopy. Practices had found out after rejected referrals, that the system had been altered so that access was by 2 week wait. LMC stressed that changes to processes need to be agreed between providers and well advertised.

Lost U/S requests

This follows Morag Keen's email to LMC of 28/9/11 and subsequent confirmation of the problem by many practice managers.

LMC reported that many practice managers have complained about ultrasound losing too many request forms and patients not receiving an appointment. Commissioners asked to raise this in contract meetings.

Tony Berendt Liaison Team

Tony Berendt (Deputy Medical Director of ORH) and PHR met for the first time under new arrangements on 5.10.11.

The issues discussed are listed in the box below.

PHR welcomed such meetings as a good way of solving provider to provider problems.

- Sickness certificates
My experience of visiting surgical wards and Trauma Out Patients earlier
Poster devised by LMC and ORH not visible anywhere ("never seen it") and surgical F1s(x6) said they were told by their registrars to give 1-2 weeks then ask patient to see GP. Interaction with GPs does not figure in their induction
I offered to contribute to a junior doctor handbook or speak at their induction
- TOITF has agreed that ORH should stop the copying of GPs into results of test initiated by ORH clinicians
- ED clinicians are responsible for receiving and reacting to test results that return after the patient has left the department
- ORH website section for clinicians
(http://www.oxfordradcliffe.nhs.uk/forclinicians/forclinicians_home.aspx) seems to need a better system to keep it up to date and transfer bits of the ORH e-bulletin onto the departmental pages

- Casenotes registration via OHIS is difficult especially for locums and new employees of practices
- Will the ORH be formally notifying practices of what has happened to Grant Bates?
- Many practice managers are telling me Ultrasound are persistently losing written GP referrals and then patient gets no service.
- Paediatric EEG asking GPs to prescribe liquid melatonin (very expensive) when its ragged Red
- Open Access Endoscopy apparently unilaterally making it obligatory to sue 2ww referrals (no consultation or advertising)
- Complaint about 2ww rejecting GP referrals on a new or temporary patient because no NHS number was given
- Liaison means issues can be passed in both directions
I should probably get to know the chair of MSC

IM+T Issues

Andrew Fenton Presented.

Responsibility of test initiator to deal with the result (Copying of Results to GPs)

LMC asked about the TOITF decision to agree to LMC request that copying of results to GPs should stop. AF felt the imminent adoption of Cerner Millennium by the ORH would solve this. LMC unconvinced by this argument.

PHR asked JG how the TOITF decision had been implemented. JG felt Jonathan Kay had altered departmental practice. PHR stressed that the solution involved more than just the laboratories. Both ED and In-Patient Doctors tended to write in letters that GPs should chase up results that weren't yet back. This was unacceptable, tests initiators should be responsible for receiving and acting upon their own results then if appropriate handing formally over to GPs.

The Oxford Radcliffe apparently stopped sending paper results to test initiators without ensuring that there was an adequate IT replacement. PHR felt his decision did not exhibit much common sense.

Health Information Exchange (HIE)

LMC felt that the consent model for this was difficult to define in the absence of detail about what information would be exchanged. AF described "programme governance work" that would take place this month which he hoped would make matters clearer. AC encouraged LMC to become more involved in the ORH Information Governance Group chaired by Chris Bunch. LMC agreed to ask Chris Hornby to attend on behalf of LMC.

Casenotes Access

PCT felt Casenotes may be the HIE portal.

Meeting speculated about generic access for locums in whatever surgery they were working.

Information governance safeguards are essential.

A look at Casenotes access was also desirable to solve the problem of getting information on new registrations with practices.

RG and PB had reservations about open access to results as happens in hospital practice at present. They did not feel there was sufficient control and monitoring of who was accessing what.

The RBH apparently allows GPs to see results of all patients, irrespective of whether they have a clinical relationship with that patient. LMC has concerns that this is open to abuse and has not been sufficiently looked at by information governance.

RIO issues

HVs and GPs continue to complain about the inadequacies of the RIO software used by community nurses. Child Health Surveillance checks or HV referrals are all recorded on paper (often coloured so rendering them unscannable).

LMC felt that Oxford Health needed to have more dialogue with the rest of the local health system.

Too many unilateral decisions were being made, e.g. how the ambulant obtained catheter changes.

GB leads on the Oxfordshire Health contract and will be asked to manage this problem.

NMS

RG met with LPC just prior to meeting.

LPC has produced pink post-its for GPs to indicate to pharmacists patients for whom an NMS should be considered. PCT will supply these to practices.

Paediatric EEGs and Melatonin

LMC has received a complaint about GPs being requested by the EEG department to provide expensive melatonin preparations. Medicines management (OPCT) feel this drug is traffic lighted red and therefore should be prescribed by secondary care only. Commissioners will take this issue to the area prescribing committee.

MSK Hub Triage

This service is being tendered for, with an advert imminent. LMC felt there were problems with the current arrangements and was aware of a SUI being investigated by the ORH over hub performance (Bicester). LMC remained unhappy that many rejections by the hub gave no name for the GP to respond to.

There should be an easy to use challenge mechanism when GPs disagreed with the decision.

Hub staff also needed to have a list of open access imaging before advising on what GPs should request themselves.

Blue Badge Scheme

GH spoke to this.

Oxfordshire apparently changes its system from 01.04.12.

PHR has already had experience of this change in Berkshire.

The funding pot is to move from health to the local authority with the national instruction to use predominantly an independent medical service.

It is still possible for the local authority to request a GP report.

PHR stressed that any such request should be funded from the pot of money transferred across.

Failure to do this has been a problem elsewhere in Berkshire.

DNs & Prescriptions

NB felt the problem continued with DN's being instructed by their new management not to ask for repeat prescriptions. KG asked to take the action agreed at the last meeting.

C+B

Explanations from the PCT continue to confuse Practice Mangers.
LM agreed to take this to the PM group for resolution.

Dates for Future Meetings

19.01.12

15.03.12

17.05.12

19.07.12

18.10.12

DRAFT

Attendees and Guests

Present	Name	Organisation
	Birchall, Carol	LMC Minute Secretary
*	Bryson, Neil	NOPP LMC
*	Budden, Maggie	Oxford City LMC
*	Buttar, Prit	S Oxon LMC
*	Chapman, David (second part)	Oxford City LMC
	Birchall, Carol	LMC Minute Secretary
*	Bryson, Neil	NOPP LMC
	Budden, Maggie	Oxford City LMC
*	Buttar, Prit	S Oxon LMC
	Chapman, David	Oxford City LMC
*	Chivers, Andy	Oxfordshire PCT
*	Eachus, Angie	Oxfordshire PCT
*	Galuszka John	Oxfordshire PCT
Chair*	Godlee, Rickman	S Oxon LMC
	Hobbs, Colin	Oxfordshire PCT
*	Hope, Ginny	Oxfordshire PCT
	Kennedy, James	LMC Medical Director
*	Large Stephen	NOPP LMC
*	McGuigan, Lynette	Oxfordshire Practice Managers
	Richards, Stephen	Oxfordshire PCT
*	Roblin Paul	LMC Chief Executive
*	Silver, Lisa	S Oxon LMC
*	Webb, Alan	Oxfordshire PCT
*	Harris, Jessica	W Oxfordshire LMC

Apologies: Maggie Budden, David Chapman, Stephen Richards.

In Attendance: Andrew Fenton, Mary Keenan, Sula Wiltshire, Liz Wragg.

DRAFT