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@nhs.net

Treasurer
Dr Graham Jackson
Whitehill Surgery
Oxford Road
Aylesbury
Bucks
HP19 8EN

Tel: 01296 432742
Fax: 01296 398774
graham.jackson@nhs.net

Secretary
Dr Paul Roblin
Secretariat of Berks, Bucks & Oxon LMCs
Mere House
Dedmere Road
Marlow
Bucks SL7 1PB

Tel: 01628 475727
Fax: 01628 487142
paul.roblin@bbolmc.co.uk

DRAFT

MINUTES OF OXON LRC/PCT Liaison Meeting
19th January 2012
Jubilee House, Oxford, OX4 2LH

CONTENTS

Minutes of Previous Meeting 1
Matters Arising 2
  OWLS 2
  Safeguarding Children Training Strategy 2
  MSK Hub Triage 2
Conflicts of Interest 2
Funding of ABPM Machines 2
IM+T Update 2
RIO and DNs 3
Case Managers and Access to Records 3
Unclear Enhanced Services Process 4
Health Check LES 4
Diabetes LES 5
DAAT LES 6
Leg Ulcer Dressing 6
ES for C&B and Erythropoietin 7
Flu Vaccination of Housebound 7
Counter Fraud Q+A (lessons learnt) 8
Priority Setting (MOBBB) 8
NHS111 9
QP (end of year and next year) 9
Interaction GP Provider Reps and Commissioner Reps (Sharing Issues) 10
December meeting? 10
Date of Next Meeting – 15th March 2012 10

Minutes of Previous Meeting

Minutes of meeting held on 6th October 2011 were agreed as a correct record of the meeting.

Matters Arising

OWLS
AC confirmed that this contract would continue until August 2013 in line with NICE requirements.
It was believed it was on a cost per case basis but GH to check this.

Safeguarding Children Training Strategy
AC confirmed that the word 'mandatory' has been removed.

MSK Hub Triage
AC reported that the new service has been delayed but the existing one would continue for the time being.
PHR reported that he had had complaints from GPs that they felt triage was a waste of time.
Other LMC GPs did not feel this was the case.
The MSK hub is working better now and was a good way to manage patients who GPs felt did not need to be seen by a secondary care specialist.

Conflicts of Interest

AC reported that his wife was a director of SPH (Solutions for Public Health) the organisation that provides reports and evidence for the MOBBB Priorities Forum.

Funding of ABPM Machines

NICE now recommends that the diagnosis of hypertension is supported by ABPM monitoring.
Their economic model is based on the potential drug cost savings from not treating white coat hypertension.
http://www.nice.org.uk/CG34
NICE does not have a lot of GP input, and has sometimes given poor advice on primary care issues.
Many GPs feel that there are similar savings to be made from not adding a new drug to apparently uncontrolled hypertensives, who could equally well be exhibiting a white coat effect.
Is it better to advise patients to buy their own machine?
However, if the commissioners want practices to have ABPM machines and the local health economy is the beneficiary then commissioners should be funding these extra GP costs (equipment, maintenance, software and training).
Bucks have accepted this argument in principle.

Action Point: GH agreed to take this back.

IM+T Update

Clare Davies talked to this issue.
PHR asked that when abbreviations were used they were explained in full at first use.
IAMS referred to The Capital and Estates Group.
The precise words of the acronym were not known: 'Infrastructure and Management??'.

DRAFT

LMC raised the HIE (Health Information Exchange).
The paper refers to the patient consent model being the same as for the summary care record.
However, there are 2 different consent models for the SCR, opt-out for the basic SCR and opt-in for any enhancement.
CD said that HIE would use the opt-out model with consent to view at the point of access.
No data will be uploaded from the GP record: it will be view only.
PHR did not have a problem with this but predicted some GPs will have objections.

RIO and DNs

PB has expressed concern about how much work nurses are having to do to fill in RIO.
He considered it was not fit for purpose and was diverting nurses from clinical care.
CD agreed to feed this back to Oxford Health.

Case Managers and Access to Records

NB reported that all NE practices had received an email from two Case Managers (a nurse and a social worker) asking for unrestricted remote access to practice clinical records.
This has been happening for a while in the North without any problems.
NE GPs had mixed feelings on whether this was desirable and how patients would give consent.
LM drew attention to the consent form that all patients sign when they went on to Case Management.

AC felt this was an issue for the Information Governance Group on which Chris Hornby was the LMC rep.
It was understood that the Case Managers were visiting every practice and explaining the rationale.

Currently the PCT subcontracts the case management service to PML.
LMC asked what the contract contained on this issue.

Now DNs and HVs are moving to locality working remote access will be more of an issue in the future.
Currently DNs who are off site do not have access to patient records and do not write in them.
Some had asked for a link but had been denied one.
As practices move to EMIS Web, this will enable flexibility as they can give access to case management for an agreed cohort of patients. They will be able to read and message but not write to the system.

SL said that in the past his practice used to receive a list of patients who were in hospital.
It was a very useful piece of information for practices but has stopped.
Clare said that with the introduction of Cerner this had stopped temporarily, but it should be up and running again in about 2 weeks time.

LMC GPs said that there were also problems with A&E reports being too basic and maternity reports being too long.

Action Point: To sort out A&E and Maternity reports.

DRAFT

Unclear Enhanced Services Process

LMC felt it needed to be involved earlier in the PCT process for changing, deleting or adding to Enhanced Services.
Dialogue can then take place before changes are irrevocable.
GH said that originally the ES group had LMC involvement but somewhere along the line this has been lost. LMC felt this was not of its making.
PHR felt he did not need to attend every meeting but if he was sent copies of the draft LESs he would be able to comment productively on them.
There are now 3 agencies issuing LESs, Public Health, DAAT and the PCT primary care team.
PHR said that he did receive the ESG minutes but he also needed to see the supporting paperwork.

The LMC view was that any activity that was moved to primary care should be properly funded and if LESs were stopped then it should not be automatically assumed this work would become part of core services eg the LESs for C+B and Erythropoietin.
LMC thought that OCCG and locality groups needed a better understanding of what was needed to design and write a LES.

Health Check LES

Paula Jackson and Gail Stockford attended for this item.
PB had been rather dismayed by the fact that what he had set up originally had been changed and become onerous to practices for the funding received.
LMC felt that although the PCT has altered its fee, given the workload to reward ratio, it was still not very attractive to practices.
Bucks are paying at a higher level.

PJ reported that the Bucks model was more involved than the Oxon version and contained 5-6 more elements. Oxon had commissioned the basic Health Check that the DoH had recommended with no added extras.
The PCT aimed to have maximum population coverage across the county.
To date 15K patients have been invited to attend for Health Check and 56% of these have taken this up which was surprisingly high compared to the national figures.

In Bucks practices

- have to send a questionnaire out to patients 4 months after their check
  There have been problems with their software, whereas in Oxon the PCT pays £150 per practice for the software outside the fee to practices.
- have to submit their data monthly
- have to send 3 invitations and if no uptake they have to send a non-responder letter with a life style questionnaire
- organise a complete set of fasting bloods, whereas Oxon only requires a basic Cholesterol
- require 2 appointments, whereas Oxon only needs 1.

The price in Bucks starts at £15 per check and increases in thresholds.
Oxon decided that thresholds were not wanted.

The LMC view was that it was down to practices whether they wanted to accept this altered LES or not.
Last year the price had been £6.50 for all checks up to 50% and tiered up to £13 for more than 60-70%, the in between tier was £9.00.

DRAFT

A Health Check Taskforce, including LMC, PMs and patients had spent time looking at the spec and pricing.
They had used the LMC cost tool and based the price on an experienced HCA at around £8.50.
The new £12 fee recognised this.

LMC asked for clarification within the LES of the lipid test required.

LMC asked whether a practice putting in the correct codes now would still be paid for 2011/12?
PJ said that if the check was done after April 2011 then they would receive payment if they coded them correctly.
If a practice had not signed up for the LES in the current year and wanted to, they could send out invitations to patients before the end of March and start seeing them in April 2012.

LM queried the ruling on opportunistic checks.
Why could the PCT not accept cholesterol tests that were 6 months old?
It was not considered ethical to re-needle a patient because their check was more than 28 days old.
PJ said that she had followed DoH guidance on this.
PHR said that as this was a LES with a locally decided spec and fee, it should be up to the PCT to decide what they would accept.
GS said that currently the software would not allow this but she would contact the software manufacturers.

Action Point: PJ to contact the software manufacturers about changing the cholesterol check time window.
PJ to rewrite the LES to specify what lipid test was required.

Diabetes LES

Dr Gavin Bartholomew attended for this item.
Only RG had received the paper via his locality, and he had sent it on to PHR.
LMC had not received it directly. No other GP present had seen it.
GB was asked to circulate it again.
This LES had been sent round to all practices and was now open to all practices.

GB explained the paper.
At the start of the year the practice would be told which quartile they were in and to achieve payment they needed to be in the top quartile or improve their results by 5%.
They would be measured on HbA1c of 9% or less and a blood pressure of 140/80 or less.
For those practices who do not to do this they can take some of the money from the LES to subsidise training.
Practices have received diabetes graphs and data with their own ranking.
LES data will take into account all the patients who were exception reported under QoF.
LMC asked if payment for the LES population was based on real practice population, weighted practice population or diabetic population.
GB said that he would come back on this.
LMC was worried that the pot was limited and as more practices achieved higher results they would achieve less payment.
In order to make a decision on whether to take up the LES, practices needed to know how much they might be paid for the work.
GB said that he would provide a working example with the LES.

SL recommended this LES to the LMC as a big improvement on the one that had previously been offered.

Action Point: GB to look into the documented LMC queries.
GB to provide a working example with the LES.

DAAT LES

LMC has not been shown this LES.
Involved LMC GPs did not like the way it has been re-written.
It talks about a GP being present 52 weeks of the year: no other DES/LES says this.
Apparently some practices have GPs who are interested in this work but there have been problems when they have been away. The implication is that the practice as a whole will sign up to this LES.
LMC speculated that the intention was that the service should be offered in the practice for 52 weeks of the year rather than have the same GP available.
There is an education element which insists that 6 hours of learning are done per annum.
DAAT should provide adequate training and this should be in the LES.
It does not take into account the fact that the GP may have already done basic RCGP training.
Could training also be in-house?
In a practice where there are 2 GPs who offer this service there is nothing to say that they may not both be absent at the same time.

GPs felt that that it was most important that they had a drug worker on a reliable basis.
This drug worker must be able to do basic nursing and issue prescriptions which can be signed by the GP. The LES does not stipulate a nurse yet the drug worker must have the ability to generate prescriptions.
This needs to be made clear in the contract.

As to why PHR had not seen this document, AE said that DAAT did not use the shared PM email that the PCT did.

LMC asked how OPCT finds itself in the situation where a new LES has been offered to practices without any competent GP or LMC input.
LMC felt the LES needed to be revisited.

Action Point: LMC will seek to re-visit the LES.

Leg Ulcer Dressing

Leg ulcer care has increased the workload burden on practice nurses and the overheads of practices.
These patients take a lot of practice nurse time and a degree of expertise to treat.
It is clear that as soon as a patient becomes semi mobile then the DNs say they must visit their surgery for leg ulcer dressings.
One practice said that it was taking more than 50% of their nursing time to treat them.
Historically the use of Red Book staff reimbursement was translated into MPIG-Correction Factor.
In Oxfordshire, this has funded activity outside the core GP contract but MPI-CF is now being eroded nationally.
LMC feel a leg ulcer LES is needed.

GH said she understood that the PCT were waiting for Oxford Health to come back.

DRAFT

LMC suggested as a starting point, that OPCT consider a LES to cover this service similar to the Bucks one.

LMC would like the PCT to work with practice managers and use the LMC cost tool to work out what it costs to deliver leg ulcer care (staff and consumables).

ES for C&B and Erythropoietin

Notice was given on the Erythropoietin LES before any dialogue with LMC.
If the LMC had been consulted PHR could have thrown light on the implications before the LES was withdrawn.
LMC was clear that withdrawal of the LES means the work will no longer be done in Primary Care but returned to Secondary Care.

Choose and Book
The same argument applies with C&B.
If funding is withdrawn practices may decide that they will stop using C&B.
AW said that when this had been discussed last year, the plan was to continue the LES for one year only. LMC felt this was conditional on directly bookable appointments being available at the JRH.
This is not expected to happen until December 2012.

PCT view was that the funding for C&B has gone but there is an option to use the funding set aside for peer review of referrals.
This funding would be time limited and there would be the need to achieve C&B targets.

LMC asked what would happen to referrals if practices decided not to use C&B.
The PCT said that there was a danger that the hospital would refuse to accept paper referrals.
GPs said that their responsibility was to refer the patient and it was up to the hospital to accept them in whatever format they were sent in.

LMC said that if directly bookable appointments come about then GPs must be informed about this.
Currently C&B is generally a back office function carried out by secretaries.
This will be fed back to Sindie Clark.

PCT felt that C&B provided a good service.
The view of LMC GPs was that it did not work for the elderly or those who were confused.
There was also the need for patients to hang on to speak to someone to book their appointment.

Action Point: PCT asked to look again at C&B incentives.

Flu Vaccination of Housebound

PHR felt that

- flu vaccination was a nursing task and that such tasks should be delivered to the housebound by district nurses without a charge back to practices.
- It is not acceptable for DNs to categorise a housebound patient as not being on their case load when these patients have annual flu vaccine needs.
- The DES pays was for offering flu vaccination and operating a flu vaccination system, not to actually administer the vaccination to each patient.

DRAFT

The LMC felt that the role of DNs in administering flu vaccination should be written into the commissioners' contract with Oxford Health.
At a recent meeting with PHR, Oxford Health seemed sympathetic to the LMC argument.

GH agreed to take this back.

Counter Fraud Q+A (lessons learnt)

LMC asked what lessons had been learnt form the PCT wrongly sending out the NHS Protect FAQ document on overseas visitors.
LMC felt that no documents should go out from the PCT without first being read to understand the target audience.
PHR said that he had spent a whole day sorting this issue out.
When PHR had contacted the Counter Fraud Department in London they said that it was clearly only for internal in-house counter fraud use.
GH agreed to feed this back.

Action Point: GH to feed this back.

Priority Setting (MOBBB)

(MOBBB = Milton Keynes, Oxford, West Berks, East Berks and Bucks)

LMC was concerned that the PCT has a direct or indirect (via MOBBB) contract with SPH (Solutions for Public Health) to produce reports and evidence for the MOBBB Priorities Committee on which the Committee made priority recommendations.
Thames Valley PCTs fund SPH or MOBBB for research review services yet the output is not in the public domain.
AC said that the problem was that Oxon were paying for this advice and if it was made public other areas would obtain it for nothing.
PHR suggested that on request, Oxfordshire residents or health professionals could be provided with a user name and password to access SPH data purchased by Oxfordshire.
This was much preferable to using the FOIA which was what SPH had suggested.
LMC felt the contract with SPH and MOBBB needed looking at.

LMC also queried the make up and constitution of MOBBB.
Oxfordshire has one GP on the MOBBB Committee yet it was unclear who she represented or to whom she was accountable.
LMC was also concerned that secondary care providers were routinely represented on the Committee, yet general practice had no equivalent representation.
Commissioning GPs could not represent the views of provider GPs; that was the role of LMC.
MOBBB has agreed that LMC would be consulted if there was an issue that would concern GPs as providers, yet this has not happened with the current agenda which contains the issue of private prescribing for Viagra. It contravenes the GP regulations for GPs to top up privately a NHS Viagra script for a registered patient.
MOBBB might only know through contact with LMC.

NHS111

An engagement event is planned for 25th January at the Kassam.
PHR has been part of a group looking at NHS111 algorithms.
Development of the NHS111 initiative has improved since Angela Jones was employed as clinical lead for 4 sessions a week.

PHR feels there is still work to do with the interaction between the NHS111 call centre and practices over what paper work will be sent in hours and how patients will be diverted OOH to the call centre.
The paperwork is currently not very user friendly.
The end of algorithm diagnosis which is currently at the end of the report needs to be at the top.

Nationally 111 want practices to have an answer machine stating the 111 number to be called.
Apparently if the call is diverted it remains a cost to the patient which is not what is wanted by the DoH.
LMC GPs raised concerns about this as elderly or confused patients may not be better off with automatic call diversion.
If it was decided that practices needed answer phones then LMC felt these should be a system expense.

Currently there are algorithms for contacting the surgery within 1, 2, 6 and 12 hours.
The software is sufficiently precise to specify whether the patient should contact (ie see) or speak to a GP.
If in a particular case it was felt that the wrong patient disposition had been arrived at, the call will be looked at again with a view to either giving more call handling training or altering the national Patient Pathways algorithm.

It was unlikely that there would be many instances where the patient would be told to see the GP within 1 hour but if they were told to do so they would expect a face to face consultation.

How Docman receives and handles the information from 111 will be discussed with practices.
The local NHS 111 team will initiate a dialogue with practice managers on this.
It may be that when a patient comes to the practice, this contact will act as a prompt for the practice to look up details in Docman.

111 will be soft launched (ie no patient advertising) in a month, with hard launch a month later (advertised to the public).

NHS Direct will be phased out in Oxon in 12 months time because SCAS will provide their current call handling and health advice role.

QP (end of year and next year)

LMC asked the PCT for clarification on what was required of practices for QP at the end of year.
It was hoped that the end of year process would be fair to practices especially if they did not achieve what they had expected to. If practices felt that this process was unfair there needed to be an appeals process for them to go through.

QP 8 and 11 (elective and emergency care) require that the practices demonstrate engagement in pathway development, then follow the agreed pathways and then produce a report by 31st March 2012.

DRAFT

LMC GPs said that some practices did not have the pathways agreed as they had been told 'they were sitting on a desk somewhere at the PCT'. To be able to produce a report practices need to have their pathways agreed.
Practices had been working on steroid and antibiotic use (and had intended to use these) but were told that they needed to produce new pathways, not ones they had already been working on.
Practices are having to develop 6 ideas and the localities are then choosing 3 to work on.
LS said that in the South they are having problems coming up with 6 new ideas.
It seems that everything they come up with someone is already doing.

GH said that practices were asked to submit their report by 1st March and the PCT would look at these and then contact the practice if more work was needed.
GPs said that they were not aware of this and GH was asked to send this information out again.

GH said that the reports would be looked at over 3 days 6, 7 and 8 March and the LMC were invited to sit in on the process.

PHR said that in Bucks practices had signed up to pathways 3 months into the year and then had 9 months to demonstrate adherence to the pathways.

Action Point: GH to send out the information on submission of the report deadlines.

Interaction GP Provider Reps and Commissioner Reps (Sharing Issues)

With OCCG becoming more involved in commissioning discussions and decisions, LMC felt it was important to have them attending the Liaison meetings.
Historically GH has usually managed to look at the agenda and invite those PCT employees who she considered would contribute usefully to discussion.
LMC asked if GH could continue to do this and invite the CCG leads when appropriate.

Action Point: GH to invite CCG leads to the meeting when appropriate.

December meeting?

GPs felt that there was a need to pencil in a December meeting to discuss ES plans.
As has been discovered this year, January is rather late.
PHR said that Bucks have produced their ES with one cover sheet including all the common elements.
This has meant that the individual SLAs were shorter and easier to digest.
GH to liaise with Kaileigh Brown.

Action Point: LMC to pencil in a December date for a LRC liaison meeting.
GH to talk to Kaileigh Brown about how to present the ES paperwork.

Date of Next Meeting – 15th March 2012

The meeting opened at 2pm and closed at 4.05 pm.

DRAFT

Present	Name	Organisation
*	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
	Harris, Jessica	W Oxfordshire LMC
*	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

Apologies: Drs Buttar, Galuszka, Harris, Kennedy and Richards

In Attendance: **Clare Davies, Paula Jackson, Gail Stockford, Gavin Bartholomew**

Dates of Future Meetings:
17.05.12 19.07.12 18.10.12

DRAFT