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MINUTES OF OXFORDSHIRE COUNTY LMC MEETING Thursday, 24th June 2010 Oxfordshire PCT, Jubilee House, Cowley, Oxford, OX4 2LH

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Sir Jonathan Michael, Chief Executive ORH

RG introduced Sir Jonathan Michael the new CEO of the ORH.

See <http://www.oxfordradcliffe.nhs.uk/aboutus/people.aspx>

He has a clinical background in renal medicine, having worked as a consultant in Birmingham before moving into general management and becoming the Chief Executive of University Hospital in Birmingham.

He was then CEO of Guys and St Thomas' Hospital for 4 years.

For the last 3 years he has been the Managing Director of BT Health, mainly focusing on the NHS IT Programme. He has now taken on the role of CEO at the ORH which is a position he has held for approximately 8 weeks.

He acknowledged that the Trust has had financial, operational, performance and relationship difficulties.

In the current financial year the ORH have been told they need to save £47m which is about 7.5% of its total budget.

There was disappointment that the ORH had failed in its bid to become an Academic Health Sciences Centre (AHSC).

This was partly because of the way it worked with its colleagues in the NHS in Oxon and the Educational Sector. He wanted to improve this.

He did not plan to dwell on past history but wanted to move forward.

There have been problems with organising services at the Horton Hospital in Banbury.

The ORH has now agreed to try and deliver commissioner expectations.

LMC asked whether the fact that the ORH was a local monopoly provider had deprived Oxon of the benefits of competition.

JM said that the ORH's greatest responsibility was to ensure that they provided what the community, colleagues and health service wanted.

LMC asked about the communication of data between secondary care and GPs.

Would it be brought up to the standard of other Trusts such as the Royal Berkshire Hospital?

Their systems seem to be more clinician friendly and work better.

JM said that a decision has been made to go with the new national computer system used by the NOC (Cerner Millennium) but with a few upgrades at the ORH in about 18 months' time.

LMC said that the ability to pass on problems through Andrew Stevens had worked well and the relationship was valued

JM elaborated on the finances: with the savings that need to be made approximately 65% of the costs are on staff, work was needed to become more efficient and rationalise some of the estate.

By more efficient working, more can be done in the 'nicer' buildings, so that the older ones can be vacated and produce cost savings.

All areas of the workforce will be looked at.

LMC said that General Practice has changed a lot and asked how the ORH would encourage change?

The impression has been that the ORH has moved slower than most Acute Trusts.

JM said that he intended to move the ORH into the 21st century for its customers, patients, GPs and commissioners.

PB said that consultants work very differently within the ORH; the breast clinic works extremely well for both patients and GPs but there are problems in other departments.

He suggested that a forum be set up to discuss these types of issues, probably with consultant input.

JM welcomed this proposal.

The consultants were aware of the need to be more responsive.

PC felt that whenever changes were proposed, PHR should be contacted early so a full consultation and GP viewpoint could be obtained.

This would save time trying to unravel areas where problems have occurred when no consultation had taken place.

JM felt the services at the Horton were fundamental and should be developed.

A vision paper on how to work with colleagues and the PCT and how to take this forward has been produced.

He was conscious that rather than ask Banbury patients to travel to Oxford they should be seen at the Horton.

LMC asked about the view of the ORH Paediatricians expressed at County LMC on 22.4.10.

They had said that having the proposed services at the Horton would mean that services across the county would suffer.

JM said that it was up to the PCT to decide what they wanted to commission.

Banbury is a small general hospital and has pressures because of this in terms of volume and activity.

Training positions have been lost because the levels of activity have been falling.

It may be that in future there will be a change in the roles of people; it may not be a consultant who sees patients.

GPs said that moving work from secondary to primary care without resources was causing unhappiness.

JM said that he was in favour of vertical integration.

JM said that there was a new Finance Director who had just started and a new Medical Director, Ted Baker, would be taking up his post shortly.

Minutes of Previous Meeting

Page 5, line 9 should be '**form B**'. The amended minutes of the meeting held on 22nd April 2010 were agreed as a correct record of the meeting.

Matters Arising

Jan Fowler Invitation to Discuss MSK Hub

PHR apologised for not inviting NOC to the meeting.

He now intended to have an individual meeting to discuss the problems faced by practices.

SM said she had email correspondence which would be helpful for PHR and agreed to forward this.

Action Point: SM to forward email correspondence to PHR.

Cervical Cytology Accreditation

LMC has received a paper, considerably modified from earlier versions.

Members were encouraged to read this and feedback to PHR.

Action Point: GPs to feedback issues to PHR.

GP Survey and Prevalence

PHR sought rep and practices' feedback on QOF issues resulting from annual patient survey results and final QMAS points calculation.

For PE7 and PE8 easement over H1N1 vaccination DES coverage, the PCT had made an undertaking that they would look at practices that were very close to the 50.7% target figure. The data for % coverage has apparently been extracted later than the start of the DES campaign, which could distort the denominator figure.

Goodwill and Dispensing

Members were reminded that updated GPC guidance was available.
See <http://www.bbolmc.co.uk/gpcgdwdisp.pdf>

The size of the financial challenge in 2010/11

MT tabled a paper which he went through.

The PCT needs to make savings of £215m over the next 4 years.

Over the last 18 months there has been a reduction in activity in secondary care especially around GP referrals but this has not led to a reduction in costs due to the national payment by results prices.

On 1st April the PCT got £43m more funding of which £7.75m was immediately sent to the SHA Reserve and Investment Fund and £6.17m was allocated to cover a reduction in central budgets.

Of the remaining £29-30m, £7m goes on inflation for GMS, dental and prescribing. Community providers will not get any inflation funding.

£6m goes to Commission Quality and Innovation: if the providers improve the quality of their organisation they will receive performance payments. These will gradually increase year on year.

£12m has gone to the ORH. Last year the contract overspent by £20m above the cap and the PCT have only made a payment of £5m, the remaining £15m will be managed out of the system.

The NOC over performed by £5m and have been paid £2m, the remaining £3m will be managed by demand management. Out turn has not been funded.

Invest to save schemes receive £4m. The aim is to spend £1m and receive £2m in reduced activity.

Other investments will receive £5m.

To fund these, a contract reduction of £3m with OBMH and CHO will be achieved by additional efficiencies to support the system.

It was recommended that prescribing should be uplifted by 8% but this is not considered necessary in Oxon so 1-2% has been given to this which will make a saving of £2.7m.

Primary care needs to save £1.2m.

Corporate management need to save £0.65m, the PCT have targeted staffing reductions to deliver the services.

The total package of savings will amount to £24m.

No inflation has been given to providers because the expected inflation cost was estimated at 3.5% which is the same as the national efficiency expectation.

So far this financial year the ORH have overspent by £2.4m which for the year amounts to around £14-15m.

Demand management will reduce this over the year.

The PCT has agreed with the ORH and NOC that they will only fund 60% of any activity over the agreed contract level.

If they manage to get the activity down they will be incentivised financially.

LMC raised the issue of PCT pleading unaffordability, yet sometimes spending unwisely.

Meeting discussed two examples:

- the new OWLS service for morbidly obesity (provider RBH) costing £1.2 m over 2y at a cost per case of £820.
- the capital spend of £28K on BMI machines (£2.3K each) for pharmacies under the CVS LES and which delivered only 114 checks in a year.
Practices were doing this with a set of scales, a wall tape measure and a free chart, at a cost of £80 in total.
SM felt that £28k was a relatively small sum compared to the overall financial challenge.
PCT felt that NICE recommend commissioning of morbid obesity services.

LMC asked for details of commissioning intention for all specialties, particularly where plan was lower than last year's out turn.

MT agreed to supply this.

Knowing where OPD availability would be tight was important knowledge for all GPs.

GPs did not have the time to look up and study the PCT plan on the web.

Demand management policy was particularly a problem for locum GPs who did not work regularly within practices.

The PCT are looking at:

- Orthopaedics
- Ophthalmology
- Dermatology
- Gastroenterology.

GPs said that they were aware that there were problems with other areas.

Patients were ringing into Choose and Book and being told there were no appointments.

The PCT would probably be unaware of this as the ORH are not directly bookable yet and the only way GPs are finding out is when patients tell them.

LMC felt that when planning for reduced referral activity, the PCT should be telling patients what restrictions to expect using articles in the media and possibly posters.

The population in Oxfordshire is demanding and GPs are in the middle.

Lavender statements were useful and the principle could be expanded.

Ramsay ISTC is now running at 95%. The contract will expire in 18 months time.

Action Point: MT to supply PHR with a table of plan against out turn for all specialties.

Referral Targets STAR-PU

The PCT has calculated referral targets using STAR-PU as the population denominator.

There is a wide variation across practices on what % referral cut is needed to reach the target.

This called into question the calculations.

LMC considered it reasonable that practices should be visited by PCT clinicians to talk about referrals and the appropriateness of the given targets.

PB said that his practice had reduced the number of referrals they made already by 20% but now have to cut another 20% which they felt they could not do.

This was seen as a demoralising disincentive and as a result the practice might consider referring as they wished.

Meeting discussed the payment for referral reductions.

This is frowned upon by the GPC as being a conflict of interest.

MT said that the ORH were being incentivised to get their activity down and thus practices were being incentivised to refer less.

GPs said that they did not want to take this money but would prefer to give it to charity or to their PBC consortia.

However, there were practical difficulties in doing this; AW said he would look into this.

BR said that her practice had received a visit from a new PCT employee, who had not bothered to understand what he was presenting.

It had taken 4 clinicians 1.5 hours each to listen to this which they felt was unreasonable and not the standard they would expect.

It was suggested that like the prescribing meetings, the PCT sent out any papers 2 weeks prior to a meeting to allow the practice to study them.

Action Point: AW to look into whether practices could nominate where their incentive money could go rather than them having to claim it and then pay it out.

PMS Review

This is happening.

There is a PMS workshop planned and members have been invited to look at the new contract.

Practices are attending individual meetings with the PCT.

GPC Sessional GPs Report June 2010/Communication and Representation

The GPC commissioned a Working Group to look at Sessional GP issues after the threat of a breakaway from the BMA: Sessional GPs felt they were being poorly represented by the GPC. Part of the paper dealt with GPC issues and part LMC issues.

PHR said that he has been trying to deal with this across the Thames Valley for a while.

LMC needs to be representative of all GPs and he has been trying to engage with Sessional GPs but had experienced apathy in certain quarters.

One proposal in the report was for separate constituencies for Sessional GPs.

PHR noted that there is rarely a need for LMC elections in geographical constituencies; the number of places usually exceeds self nominations.

PHR preferred to improve Sessional GP knowledge of LMC, imminent election, self nomination process and voting access.

This was why he had asked the TVPCA to compile lists of email addresses for all doctors on the Performer's List.

The TVPCA has agreed to do this but are also stating that every Sessional GP who agrees to this will need to be supplied with an NHS.net email account which will have cost implications.

The person to liaise with at the TVPCA is Jeniene Scott.

Others had sympathy with the need for a Sessional GP constituency.

JH said that she had sent an email around to approximately 100 Sessional GPs.

HM said that everyone knew a Sessional GP and it would probably be worth asking them to come along to observe the meeting.

Action Point: PHR to liaise with Jeniene Scott at the TPVCA regarding the production of a list of email addresses for Sessional/Locum GPs.

Report from LMC Conference

PHR, RG and MB had attended LMC Conference on 10/11 June.
Most of Oxon's motions had been voted through.
The Carr-Hill Formula motion was not debated.
There was a motion on abolishing the SCR which was narrowly lost, possibly due to the reading out of a ministerial letter on SCR modification by Laurence Buckman.
The Coalition Government and the GPC will have discussions.

OWLS (Oxfordshire Weight Loss Lifestyle Service)

After LMC comments, the referral template has been amended.
There is no longer a need for a letter from the cardiologist or respiratory physician.

The costs are not inconsiderable, yet the paper does not describe in any detail what activity is being purchased and what outcomes are expected.
Would patients need to go through this service to be eligible for bariatric surgery?
At a recent Oxford City presentation to local GPs it was not clear what the tier 2 service provided.
LMC felt there was a need to know what evidence base exists for the proposed activity/interventions.

Oxford City OOH Workforce Letter to CHO

Meeting has seen the letter sent by OXEMS clinicians to CHO.
IN has emailed to say that the intention was to improve communication with OOHs GPs, and to encourage OXEMS GPs to be part of the management team.

GPs said that they did not like what the new SystemOne OOH software was sending practices about OOH contacts.
Instead of printing information out once, practices have to print individual sheets; this is taking so long it is a function that has had to be passed to the administration departments.
EMIS practices were told that they could download contact information.
It is taking 2 days from transmission to receipt by the practice which is not acceptable.

PHR said that Westcall in Berks had voted to go for Adastra, but Oxon had ruled this out at a very early stage, possibly on cost grounds.
He asked what GP input had been sought.
LMC said that as this would affect all GPs, it felt that wider consultation should have been sought.
BM thought that the views of involved GPs had been overruled by managers.
He said that the new system is supposed to save time but is taking 3 times as long to use, and as a result patient targets are not being met.
It was hoped that this would improve in the future.

Medical Input to Oxon Community Hospitals

PHR said that PML had approached the LMC to advertise for OOHs doctors to look after Community Hospitals.

This was the first time he had heard who had been awarded the Contract; he has seen no official announcement.

PHR asked about termination of contracts with current GP providers.

View expressed that the process was diabolical, with no letters having been sent terminating the existing contract and giving the required notice.

It appears that even though PML have got the contract, GPs are currently still doing the job.

Childhood Vaccination (SHA and PCT Issues)

A paper has arisen from the SHA which confuses the aspirational with the contractual requirements.

There has been no LMC input and no reference to the GP Regulations or relevant DES Directions.

PHR thought the SHA would have learnt from its experience over DNACPR, but apparently not.

PHR plans to meet with SHA in early July.

Carer Medication form A: Progressing a Pharmacy LES

This appears to have disappeared into a vacuum.

There is an LPC/LMC liaison next week.

Practices reported that they had received packs of both forms.

It is logical for Pharmacists and dispensing practices to be completing form A.

Julie Dandridge would like to commission a LES for this, which will save the PCT money.

Action Point: PHR to liaise with Julie Dandridge and Sarah Bright.

Pharmaceutical Needs Assessment Update

GH has produced a paper on this which was sent out with the agenda papers.

There will be a full consultation assessment on PNA which will start in September and run for 60 days.

A workshop will be held on 8th September to which GPs will be invited and there will be 4 public events in October.

Details of the PNA have been discussed at the joint LPC/LMC liaison meeting.

Minutes of these are always sent to both LS and PHR and it was hoped that the LMC felt that they were being involved in the process.

Talking Space

Following the lack of consultation over the new referral form, it was agreed at the Liaison Meeting that both forms could be used in the interim.

This is to be discussed further on 1.7.10.

GPs reported that the service telephones were not being answered.

It had taken 7 weeks to get a response on whether a patient could see the local practice counsellor.

If patients do not make their appointment within 2 weeks, they are discharged from the system.

If there are problems with the form such as a box not being ticked it is taking over a week to get back to the practice to sort out.

Action Point: To discuss ongoing issues at the Liaison Meeting on 1.7.10.

IT in Oxon

The paper from Richard Foggitt has been circulated after discussion at the last at the last Liaison. Reps asked to feed comments back to PHR.

Coalition Health Policy

PHR had provided a list of high level Coalition objectives from the health section of the Coalition Programme “Freedom, Fairness Responsibility”.

GPs undertake Commissioning: will this be voluntary or mandatory and will it be adequately funded? Government still seems to want to abolish practice boundaries.

Statement of intent to re-negotiate the GP contract, but it is not known what this might entail.

Foreign doctors will be stopped from working in the UK until they have passed robust language and competency testing.

SM said that the PCT had received a revised operating framework.

It reasserts what is going forward such as the dementia strategy.

It still stated that the provider services will be separated from the PCTs by April.

The White Paper was expected on 5th July but an email has just been sent around saying that it is delayed and it may now be a Green Paper.

The Nuffield Trust has just produced a document which she agreed to send electronically to PHR.

Action Point: SM to send the NOC document to PHR.

Pertussis Serology Access

Most practices do not seem to want or need this.

This was an example of many things that may be difficult to justify continuing in the financial climate.

It was suggested that the lab could reject the ones they thought were inappropriate rather than GPs having to ring in to speak to the lab every time they wanted to request one. The lab must not just reject all of them just those that were unsuitable.

In future PHR will email issues such as these to members for their opinion, prior to giving a general LMC view.

Date of Next Meeting – 16th September 2010

The meeting began at 7:30pm and closed at 9:30 pm.

Present	Name	Organisation
*	Benson, Catherine	Oxford City LMC
*	Birchall, Carol	LMC Minute Secretary
*	Bryson, Neil	NOPP LMC
*	Budden, Maggie	Oxford City LMC
*	Buttar, Prit	S Oxon LMC/GPC Rep
*	Chapman, David	Oxford City LMC
*	Chivers, Andy	Oxfordshire PCT
*	Coffey, Paul	S Oxon LMC
*	Derry, John	TVPCA
	Douglas, Anna	S Oxon LMC
	Eachus, Angie	Oxfordshire PCT
	Galuszka John	Oxfordshire PCT
Chair*	Godlee, Rickman	S Oxon LMC
*	Harris, Jessica	S Oxon LMC
	Haskew, Emma	NOPP LMC
*	Hope, Ginny	Oxfordshire PCT
*	Hornby, Christopher	Oxford City LMC
	Jackson, Graham	Oxon LMC Treasurer
*	Large Stephen	NOPP LMC
	Mather, Rob	Oxford City LMC
*	McDonald, Brendan	NOPP LMC
*	Merriman, Honor	Oxford City LMC (Co-opted)
	McWilliam, Jonathan	Oxfordshire PCT
*	Milligan, Julia	S Oxon LMC
*	Mills, Sonia	Oxfordshire PCT
*	Mountford, Catherine	Oxfordshire PCT
	Neale, Ian	S Oxon LMC
	Newman, Jessica	Practice Manager
	Pandher, KS	NOPP LMC
*	Rand, Bettina	Oxford City LMC
	Richards, Stephen	Oxfordshire PCT
*	Roblin Paul	LMC Chief Executive
	Silver, Lisa	S Oxon LMC
*	Tait Matthew	Oxfordshire PCT
	Thorpe, Penny	TVPCA
*	Webb, Alan	Oxfordshire PCT

Apologies: Drs Neale and Silver

In Attendance: Sir Jonathan Michael, Jonathan Crawshaw, Therese Moran and one other

Dates for Future Meeting:
11.11.10