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Minutes of Oxfordshire LMC

Thursday 25th February 2010
Oxfordshire PCT, Jubilee House.

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Stephen Richards has been on sickness absence since Xmas Eve.
LMC asked its officers to send him its best wishes.

Minutes of 12th November 2009

The minutes of 12th November 2009 were agreed as a correct record of the meeting.

Darzi Centre invite

PHR and RG have received an invite to visit the Centre and will be doing so on 1st April, the delay being due to booked leave commitments on both sides.

PHR has received a letter from John Harrison about LMC involvement in the media coverage of the PML run Darzi Centre in Banbury.

PB explained how the story arose.

He was approached by Pulse who had got hold of a copy of the Liaison Committee minutes.

The reporter asked him how he had reached his estimated calculations for the costs of the Darzi Centre.

After the Pulse article appeared, he had then been contacted by the Banbury Guardian.

PB (and LMC) has tried to discover details of the Darzi Centre contract and funding.

His calculation was based on the oft quoted cost of a Darzi Centre and the consultation figure already supplied by OPCT for the first few weeks.

His figures are £140 for a Darzi Centre consultation and £27 for a consultation in his practice.

Because PB was quoted in the Liaison minutes his calculation was seen as being an LMC view, despite it only being a personal view.

PB had not had an opportunity to speak with either PHR or RG prior to giving the interview.

JH felt that the press coverage had been damaging to those who working in the Centre, and within PML.

The Banbury Guardian had reported 'Prit Buttar from Oxon LMC states that the Darzi Centre is a waste of money'.

As there are about 100 LMC members who are either PML shareholders or staff, PML had expected the LMC to support it.

RG said that LMC had always opposed the imposition of a Darzi Centre in Oxfordshire and this held true whatever the nature of the contract holder.

Oxfordshire were being asked to spend less money on local health services and the LMC felt that the Darzi Centre should not be immune from any cuts.

PHR said that he had not personally seen the Banbury Guardian article because, living in Oxford City, it is not a paper he reads.

It was therefore difficult for him to know what JH wanted him to rebut officially.

PHR had received a telephone call from a Banbury Guardian reporter after the Pulse article appeared. He had stressed that the figures quoted as being discussed at Liaison with the PCT could only be a rough un-interpretable calculation.

PHR remembered PB saying at Liaison that until the PCT refuted his figures, these were the ones that he would use whenever appropriate.

Despite PHR dissociating LMC from the Pulse article in his conversation with the Banbury reporter, the Banbury Guardian continued with the Pulse line unaltered.

JH felt that PB should write a distancing or clarifying statement.

PB's view was that even though the Centre was run by a consortium of local GPs, the commissioning of the Centre remained a waste of money.

The LMC said that it supported GPs who were working at the Centre in the same way as it did all GPs, but LMC still wanted commissioners to reassess and reduce spend on the contract.

It was agreed that PHR/RG would consider what LMC could reasonably write to the Banbury Guardian.

GH said that this new practice had only existed for 3 months and only time will tell whether the APMS contract delivers value for money.

The figures for cost of a GP consultation vary across practices in Oxfordshire.

The PCT believed that the contract with PML is robust and will deliver valued services to patients. The PCT would check if it could divulge anything that would reassure LMC.

24 hr earlier, the PCT had supplied PHR with their first calculation of the average cost of a consultation at the Banbury Darzi Centre (£76). All LMC representatives have been sent this paper.

The PCT has also tried to calculate the average cost of a consultation at a GMS or PMS practice but in PHR's opinion had used a rather odd methodology.

PHR felt the PCT could have asked its PEC committee to divide their annual income by the number of consultations, and not used unreliable statistics on practice wte, surgery hours per wte per week, and an hourly consulting rate of 5 patients.

The PCT wanted to agree with LMC the methodology for future calculations.

LMC wished to ensure that in future, the Centre should not be immune from any recession based cuts experienced by other Oxon practices.

MT said that there are a number of PMS and GMS contracts in Oxon and that no practice would be exempt from cuts.

Action Point: PHR/RG to consider what LMC should write to the Banbury Guardian.

Matters Arising

Email Advice from Secondary Care

AW said that he had asked the question but had yet to receive an answer and would chase this.

Action Point: AW to chase a response to this.

Sick Notes being replaced by Fitness Notes

On 1st April sick notes will be replaced by fitness notes. No one (including LMC) has any details.

PB has seen the new yellow A4 form and feels is not as bad as had been expected.

One rep thought practice managers had been emailed with these the day before.

Sent to LMC by GPC three days after meeting

Fit notes

From 6 April 2010 the current Med 3 and Med 5 medical statements are being replaced with the new Statement of Fitness for Work. The DWP have produced a short guide on these changes here:

<http://www.dwp.gov.uk/fitnote>

PCT Provider arm

PHR introduced the subject.

PCTs have been told to divest themselves of their provider arm, and develop a true commissioner provider relationship.

Since the financial downturn, the Government seems to have vetoed the formation of new organisations, and instructed PCTs to find an existing organisation to host their provider arms.

Across the country PCTs are opting for various degrees of vertical (hosted by secondary trusts) and horizontal (hosted by local authorities or GP organisations) integration.

MT replied.

Oxfordshire PCT has been assessing the hosting possibilities for some months.

They have not chosen the ORH because of its financial instability and the need to avoid a local monopoly.

This leaves the options of the Mental Health Trust, the Ridgeway Partnership and the NOC.
The PCT are now looking through different business cases for these options and have invited the LMC to be part of the assessment process (meeting on 17th March).

Some LMC reps felt that the Acute Trusts could take on community hospital provision but Primary Care should take on the DNs.

MT said that the decision has been made not to fragment CHO.

The new organisation must have foundation trust status and provide stability and size.

PHR felt that whoever became the CHO host, a detailed commissioning spec would ensure CHO activity was not dominated by secondary care need.

The PCT must be very clear what they are commissioning from any new organisation and ensure it had excellent links with Primary Care.

SL asked why the horizontal model with a primary care provider (eg PML) is not an option.

MT felt that such an organisation would not be large enough to become an NHS Foundation Trust.

Reps asked whether Practices could employ HVs and DNs directly.

Some reps felt this was not a viable option as practices cannot afford Agenda for Change and that primary care in Oxon was not ready for this type of change.

The PCT Board will make the final decision.

They will look at how CHO will be integrated with primary care and local authority services.

The PCT would encourage acute services to work closer with practices.

JH said that practices already employ practice nurses who work to a very high level and PML are doing the same at the Darzi Centre: it was difficult to see how the PCT could rule out a bid from the organisation which might be very beneficial to patients.

PML are having discussions with CHO regarding the DNs and are also becoming involved with the acute hospitals in a new way (to develop services embedded in primary care).

GPs said that the removal of HVs from their surgeries had had a very bad effect and were worried that the same would happen with DNs.

Relationships had been built up within primary care teams and these needed to remain. GPs did not want a pool of DNs available who did not know them and the way they worked: they wanted to retain the current relationship. Any change would be detrimental to the care patients received.

LS said that the meeting of her collaborative with Geoff Rowbotham had been very dispiriting.

MT said that the LMC had been invited to a meeting on 17th March which will be making the recommendation to the full Board later in the month. The SHA will have the final say.

The new organisational arrangements need to be in place by the end of March 2011.

Guest Item: South Central SHA policy on DNACPR

Tracey Courtnell attended for this item

She apologised for late involvement of LMC but stressed that GPs have been involved since the start.

PHR introduced the subject.

Reps had been sent the minutes of Berkshire LMC where the issues had been extensively presented and discussed.

Having discussions with patients and relatives about prognosis and CPR is difficult.

The hope is that with time GPs will become more comfortable having such discussions with a wider spectrum of patients.

There are still some outstanding issues:

The need to use lilac paper to print out the completed DNACPR form.

The SHA team feel a standout colour is needed so that ambulance and resuscitation staff can recognise it quickly. Research has shown that was not widely used for other purposes.

TC said that GPs wanted to have this form electronically and they had agreed to supply practices either with a book of 50 lilac forms or a pack of lilac paper.

The SHA team is not keen on a watermark solution, as it would be very difficult to see in a set of notes.

GPs were concerned that when they needed to print the form they would not be able to find the lilac paper.

It was suggested that using a distinctive border might be equally good in making the form stand out.

The proposed system is that:

1. Just inside the patient's front door is a sticker stating that a form exists.
2. Ambulance crews know to look in the patient's fridge for a bottle containing a tear off strip describing where the form can be found.
3. The form would accompany the patient wherever they went.

The "book of forms" was designed to allow quick and easy audit.

If forms are to be produced electronically audit arrangements would need to be different.

Using agreed Read Codes was suggested.

Currently in Oxon there are 2 forms that are needed, one for the OOHs and one for the DNs, this form will replace them both.

GPs said that this form was needed in an RTF format so that all word processor programs could read it.

If the DNACPR decision was cancelled, practices could write delete clearly across any form and use a read code for this action.

Action Point: PHR to identify Read Codes to use.

PHR Annual Report and LMC Conference Motions

PHR said that he had written this to remind members of the issues that had been discussed in the past year and to help them to write (or just come up with ideas for) motions to conference.

JH had already produced 3.

PHR encouraged other members to do the same.

The motions need to be received by the GPC by 12th April, which is before the next County LMC.

Action Point: Members to email PHR with either motions or the ideas for motions.

LMC Treasurer Honorarium

This was discussed at the Marlow Board meeting.

The Treasurer, GJ, is not paid the same rate for the identical functions he performs in Oxon and Bucks.

The BBOLMC Board recommended payment equivalent to one hospital practitioner session.

To do this would cost Oxon LMC an extra £1300.

The Committee agreed to this.

Action Point: To pay GJ one hospital practitioner session per annum for his work as Oxon LMC Treasurer.

Appraisal Toolkit

This website is temporarily inaccessible for security reasons

Appraisers and appraisees will find it more difficult to share appraisal documentation hopefully only for about 3 weeks.

GPs said that the appraisal office had been very helpful with producing word documents and making the old forms available.

Universal agreement that the PCT would be silly to consider removing GPs from performers' list where appraisal delay was solely due to website issues.

However, GPs who do not get their appraisals done in any one financial year (for less defensible reasons) need to be aware of the professional risks they are taking.

Feedback was that the website issue had been a problem for a few and that it was important that these people were not penalised in any way.

SCR

PHR felt this could become an Oxon issue as it is in MK and Berks currently.

These PCTs have taken advantage of the free mail warehouse for the Public Information Programme during 2010 only. The rushed implementation has led to several problems for GPs.

CfH have implemented an opt out policy whereas the GPC prefers an opt in system. Accessing an opt out form is difficult.

The SCR helpline is telling parents wanting to opt out their under 16 children that this requires authorisation by the GP.

No PCT has supplied a Read Code that the national computer will recognise.

Hopefully by the time Oxon get around to this, a lot of the problems will have been sorted out.

London PCTs have come up with a very good poster that practices could use to explain the initiative and opt out.

IN said that the OOHs would find SCR information very useful, and LMC needed to voice both the positives and negatives of SCR.

To know what medications a patient is on at a glance saved a lot of time OOH.

PB said that the fact that this information was not readily available in the past and that no one had come to any harm indicated there was no real need for it now.

Many people were also concerned about the Government's track record on caring for personal data.

Exceptions to NICE Guidance on antibiotic prophylaxis for dental procedures

This issue was explained in the Liaison Minutes.

The European Society and NICE cannot agree on this, and a senior ORH cardiology consultant is Chair of the former. The ORH has asked APCO to sanction exceptions to the NICE policy of not prescribing prophylactic antibiotics for dental procedures.

PHR felt that if a specialist indicated that the patient would benefit from dental prophylaxis, most GPs would be willing to prescribe even if this was against the NICE guidance.

APCO have not made a decision but referred it to LMC.

LMC reps felt that APCO needed to make a decision on the evidence themselves.

Action Point: To ask APCO to make a final decision.

ONPOS

Various practical issues have emerged since this initiative began.
LMC has been emailed about ONPOS problems by Practice managers and nurses.
PHR said that he was taking these up regularly with the Medicines Management Team.

Action Point: PHR to progress this issue.

Rejection of practices for Diabetes LES

Some practices' bid for the LES had been rejected on dubious assessment of past diabetes care performance.
PHR said that this was an outcome based LES and he failed to see why unreliable past records should be a reason for rejection.
The PCT would only have to pay out if a patient's HbA1c and OPD attendance was reduced.

One practice that has been rejected has asked how to appeal but the PCT has said that there was no appeal process.
Nevertheless, the PCT wanted to ensure that practice requests were dealt with fairly.
The PCT said that there were certain criteria within the LES that practices had to fulfil and there were some practices who had not met these.

JH has seen the reasons given by the PCT committee, and felt that to base the past performance of practices on Exception Reporting in QoF was ridiculous.
She was a QoF assessor and had visited practices that had a high level of exception reporting, and on investigation, all of them were appropriate.

LS said that her practice had not applied as the training requirements would cost more than the LES income.
The total funding was £300K and the LMC asked what would happen with the unspent majority.

Early experience of the new Occupational Health Service offered by PTH

Issues have emerged with the PTH service.
PTH is a national occupational health company which has taken over from OBMHT as the provider of the occupational health service
The Dovedale Counselling service ended when the new contract began.
A recent appraisee was advised to contact PTH but found them unhelpful (eg "please get your manager to sign an authorisation").
PTH has taken this up with both the PCT and PHR.

New PCT CEO

Sonia Mills is the new CEO and will be taking up her post on 1st March.
RG and PHR will be meeting with her on 2nd March.

MT was thanked for his help over the past few months in dealing with LMC/PCT issues.
MT made some points about the future:

- The PCT will be receiving a 5% uplift for the coming financial year.
The new NHS term "flat real" means that they will be getting an uplift for inflation only.

- There will be no funding for increased demand.
- The PCT will receive approximately an extra £40m for the next year. However, there is a national requirement for PCTs to immediately put aside 2% of the total budget (which is about £16m).
- The PCT is not giving the ORH or other providers any inflation uplift but they will honour the national GMS settlement.
- £15m has to be spent on “Sequin” which will reward providers for quality improvements. An example of this is funding to get fracture neck of femur cases treated within 48 hours.
- The PCT intends to use some of the extra money on invest to save schemes eg case management.
- There will be a cost improvement programme to cut prescribing which will mean not spending more than the national average.
- PCTs are required to reduce their management costs.
- The PCT plans to consult with and involve GPs.
- Currently the ORH want £45m more than the PCT can give them next year and the NOC want £6.5m more. Discussions are taking place about demand management and price changes. The PCT are asking how much of the demand is internally generated.

LMC stressed that if the PCT are setting the contracts based on totals which are less than this year’s outturn; GPs need to know what the new referral reductions are in percentage unlike the MSK situation last year. PCT discussions with Trusts are currently weekly: once the contract detail is agreed, GPs will be involved. The plans will undoubtedly carry a high level of risk. The PCT is committed to developing these plans together. There will be more significant debates about the future of primary care.

GPs raised ongoing issues with the MSK Hub at the NOC. Patients can now not be seen unless they have received physio yet the wait for this is currently 20 weeks. The public needs to be told what is happening. LMC suggested that the PCT produce a document which could be given to patients by GPs to explain the MSK referral process.

The national planning for 2011-12 states that pricing will be reduced by 2% per year. It will become payment by results and this type of financial logic will be applied across the NHS. It is not known what money will be available for primary care or GMS contracts. The PCT was asked if they were considering reducing the price of LES or LIS. MT said that they were considering this move.

RO’C said that he had gone out to the media just before Christmas but would be doing so once the PCT had got to where they want to be. He acknowledged that the PCT needed to liaise with the public.

Action Point: PCT to inform the public of the cuts in service.

Ex-officio representation from LMC on executive committee of Oxford Division of BMA

LMC was not in favour of sending an ex officio rep to the Executive Committee of the Oxford Division of the BMA: it did not have the required resources.

Prevalence Losers Update

RG thanked GH for all her work. The PCT has been looking at new LES options. The PCT wanted to ensure fairness and equity and any LES needed to be available to all practices. Having been through the Enhanced Services Review Group, a paper will now go to the Clinical Executive on 11th March.

Jackie Moss (deputy chair of Clinical Executive) has agreed that 2 representatives from the group of affected practices will be invited to the discussions.

The practices who will lose the most will receive staged relief payments.
LMC asked if the PCT had taken out the £12K and made it a solely a 2% percentage?
GH agreed to check this.

Action Point: GH to check whether the £12K had been removed and replaced with a percentage only.

Cervical Smear Training

PHR reported he had attended a meeting where PCT reps wanted to impose 3 yearly cytology training on GPs as per the National Screening Guidelines
These directions on training clash with the GP contract, where GPs are responsible for their own training needs.

GPs felt that there was a fundamental philosophical issue between nurse managers and GPs.
Nurses need training to get everyone to the same standard in a small range of defined situations.
GPs have 6 years of medical and general vocation training to function in all fields of medicine and do not need a certificate for everything they do.
DC said that the new GPs did not receive the same type of training and this may be necessary for them but it was certainly not needed for the older, more experienced GP.
PHR will continue to advocate the GP view.

Oxon Accounts

PHR said that he had not had a chance to go through these but would do so for probity before they were sent out to practices.

Action Point: PHR to study the accounts before they are sent to practices.

Safeguarding Children Medicals

NB reported that HVO (GP rep on the Safeguarding Children Board) has said that some of these medicals were done to a very poor standard and she wanted to invite a smaller number of GPs to perform them.
Each medical attracted a fee of £250.
Anyone who is interested should email HVO.

Action Point: To email HVO if interested in doing Safeguarding Children Medicals.

MKS Hub

PHR said that all emails outlining problems to LMC from practice managers and GPs were being sent to Val Messenger.

Action Point: To continue to send in problems with the MSK Hub.

Next Meeting – 29th April 2010

The meeting closed at 9.35 pm.

DRAFT

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
*	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 (Co-optee)
*	Large Stephen	NOPP LMC
	Mather, Rob	Oxford City LMC
	McDonald, Brendan	NOPP LMC
	McWilliam, Jonathan	Oxfordshire PCT
*	Merriman, Honor	Oxford City LMC (Co-optee)
	Messenger, Val	Oxfordshire PCT
*	Milligan, Julia	S Oxon LMC
*	Mountford, Catherine	Oxfordshire PCT
*	Neale, Ian	S Oxon LMC
	Newman, Janet	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 Mather, McDonald, Rand, Stephens and Andrew Stevens

Guests: Tracey Courtnell, John Harrison (PML), Ronan O'Connor, Kieren Collison

Future Meetings

29.04.10 24.06.10 02.09.10 11.11.10