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# OXFORDSHIRE LOCAL MEDICAL COMMITTEE

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## Minutes of Oxfordshire LMC

Thursday 2<sup>nd</sup> April 2009

Oxfordshire PCT, Jubilee House, Cowley, Oxford OX4 2LH

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## Minutes of 29<sup>th</sup> January 2009

### Typo alert

On page 6 OOH and Harmoni, the first line should read ‘..from (not “form”) GPs.

Page 4 third paragraph, 4<sup>th</sup> line .... “it” is written as “is”.

The amended minutes of 29<sup>th</sup> January 2009 were agreed as a correct record of the meeting.

## Matters Arising

### **Diabetes Pathway Redesign**

1. This will probably be commissioned on a willing provider basis.

A decision is expected next Tuesday.

**Action Point: SR agreed to update the LMC of changes.**

2. JH said that she had been approached by the Decision Support Team to run a diabetic audit and asked LMC members to let her know of any areas that they would like to see audited.

(eg what level of HbA1c did the patient change to insulin and to look at the variations).

Many felt that results of many diabetes audits already existed and questioned whether this was unnecessary duplication.

**Action Point: JH agreed to email this item to PHR so he could circulate this to members.**

### **Banbury GP Led Health Centre**

LMC felt that even though the contract had been awarded to an organisation run by local GPs its view that the Centre was an unnecessary waste of NHS funds still held.

PML has had a meeting with local practices and tried to establish how they can work together.

Local GPs were appreciative that the contract had been awarded to local GPs.

### **Meeting with College Doctors: Loss of Square Rooting on QoF Prevalence Young Persons' LES**

PHR and RG (for LMC) and Chris Hornby + Neil MacLennan (college doctors) met with PCT (SR and Ginny Hope) on 24.3.09.

SR willing in principle to try and help those practices faced with the loss of QoF payments in 15 months' time.

PB has undertaken to write a LES for Young People but was struggling to do this as he did not know what funding would be attached to it.

PCT seem keener on an accreditation funding stream, but it did not want to see practices being paid twice to perform the same service.

Any funds had to be for genuinely extra workload and also be available to all Oxon practices.

Reps of Non-Student practices asked why LMC was specifically seeking funding for college doctors.

Other practices faced a larger proportion of elderly and chronic sick and this justified the pay differential.

RG said that it was the LMC's duty to represent every GP in Oxon and with the loss of QoF monies some of the University Practices may be destabilised.

The LMC was also concerned to avoid the £504K savings being spent by the PCT in areas other than Primary Care.

Any Young Persons LES would be open to all Oxon practices not just the College Doctors.

The PCT reported that its spending on primary care was the highest in the country.

It did not want to see any practices destabilised because of the QoF changes.

PCT plans to work on quality indicators for GP accreditation.

Practices will have to prove they deliver over and above core services.

This may mean that part of the lost QoF money can be retained.

**Action Point: The PCT and LMC to work together on practice accreditation rather than try and focus on putting money into a Young Persons LES.**

### **Practice Accreditation**

A paper from Sula Wilshire and Richard Green has gone to the Board on Thursday.

See:

<http://www.oxfordshirepct.nhs.uk/about-us/how-the-pct-works/trust-board/board-papers/2009/march/documents/09.3.26-OPCTBrd-QualityinPrimaryCare.pdf>

Practices should also have received it.

This is the first step towards collecting quality indicators for primary care.

Practices reported confusion over receipt of a proforma for them to fill out.

The PCT said that this is about collecting information on what traditional practices deliver over and above their core services.

Private organisations will have to match the level of existing general practice.

### **Early Experience of Harmoni OOH**

GPs reported that there seemed to be a lack of GP cover over night and Harmoni were finding difficulty covering short term sickness.

PHR asked that specific examples be forwarded so that the service could be properly assessed.

IN said that any specific issues should be fed back to:

[Pete.McGrane@oxfordshirepct.nhs.uk](mailto:Pete.McGrane@oxfordshirepct.nhs.uk)

**Action Point: Practices to feed back any issues to Harmoni.**

### **QoF and NICE**

The consultation period has finished and the document has been published that looks very similar to the one the Government originally drew up.

See [http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_096423The](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_096423The)

NICE will take over responsibility for existing indicators and the development of new ones.

The menu of indicators will be evidence based.

There may be an element of local QoF using LESs, but the DOH position on this has softened as it may be difficult to provide the required IT support.

### **Contact Point and CRB**

One of the requirements for accreditation to access this database is 3 yearly CRB checks.

This is currently not happening.

There are rumours that the ISA (Initial Safeguarding Authority) will make regular GP recertification (CRB) obligatory in the near future. Establishing the facts remains difficult.

Meeting discussed the dubious benefit of CRB checks (particularly recurrent ones) and the costs involved (money and time).

It was felt that the Contact point administration did not understand the safeguards built into the GP Performers List system.

**Action Point: PHR to check the ISA requirements and feedback.**

**This issue may form a motion for Conference (see below)**

### **“This conference believes that:**

- One of the requirements to access the new Contact Point database is 3 yearly CRB checks
- 3 yearly CRB checking of GPs does not currently occur
- There are rumours that the ISA (Initial Safeguarding Authority) will make regular GP CRB recertification obligatory in the near future
- The cost benefit of CRB checks is questionable
- Contact point administration does not understand the safeguards built into the GP Performers List system.

And asks the GPC to clarify matters ASAP.”

## **Demand Management LIS**

RG had written to AY on behalf of the LMC.

The main issue problem was the second part involving GPs being paid for not referring.

SR reported that this had gone to public Board meeting last week where both the LMC's and GPC's concerns had been raised.

Nevertheless the PCT Board ratified its original plan.

GPs were worried that by grouping PBC in with Demand Management some GPs would disengage from PBC. The LRC had raised this issue with the PCT in the past.

## **ORH Bid for AHSC**

The ORH application to become an Academic Health Sciences Centre (AHSC) has been turned down. The main reasons given were lack of involvement with the high quality Oxfordshire primary care and the quality of the presentation.

See <http://www.oxfordradcliffe.nhs.uk/foundation/ahsc/introduction.aspx>

The ORH may well now go ahead with a bid to become a HIEC (Health Innovation and Education Cluster) and it was hoped that they would now work constructively with the LMC and the Academic Dept of Primary Care.

## **Pay Rise for GPs**

For how the 19<sup>th</sup> formula will work, see <http://www.bbolmc.co.uk/nineteenthform.xls>

PB explained the GPC understanding.

See also: [http://www.bma.org.uk/employmentandcontracts/pay/pay\\_review\\_bodies/ddrb2009.jsp](http://www.bma.org.uk/employmentandcontracts/pay/pay_review_bodies/ddrb2009.jsp)

The DDRB has set a net percentage rise.

The 19<sup>th</sup> formula will result in a different % uplift being applied to different components of GP funding.

Practices with an MPIG of <9 will receive a much larger pay rise (6-8 times as much) than those practices whose MPIG was higher.

It is intended that over the years MPIG will shrink whilst the Global Sum will grow but it may take 30+ years for some practices to move completely to Global Sum funding.

It is anticipated that with the changes to QoF and Enhanced Services the total pay rise for GPs will be 1.7% which when applied to the 19<sup>th</sup> formula means that the overall increase to practice income will be a net 1.4%.

The GPC has tried to get the DoH to accept that the Carr-Hill formula is flawed, but has so far been unsuccessful.

The PCT shared GPs concerns about the concerns of negative growth and suggested that the LMC might write a motion about this for Conference.

GPs said that they could see the press reporting only those practices that would move from MPIG and receive a larger rise, ignoring the 70% that would not be generously treated.

## **Complaints Procedure**

A new complaints procedure has been introduced from 1<sup>st</sup> April.

See <http://www.bbolmc.co.uk/patcomplpr.pdf>

Little DOH or GPC advertising seems to have occurred.

GPs also expressed concern that this has not been highlighted by the PCT.

IN was concerned about the new processes and workload.

The main changes are that a practice will have to have a nominated Partner in charge of the process.

Now complaints will have to be solved locally by the PCT/practices and then be passed to the Ombudsman.

IN had concerns that small practices may not have the resources to fulfil this function and asked if the PCT would be able to assist them.

The PCT said that from their experience letters sent to Oxfordshire complainants have been extremely well written. Sometimes all patients wanted was an apology and recognition that things could have been done better.

The GPC had received the Government consultation document on 19<sup>th</sup> December with a deadline for reply of 5<sup>th</sup> January. The period was extremely short!!

**Action Point: The PCT to issue some guidance on this issue shortly.**

## NICE Officer

The PCT has alerted LMC to the national requirement on PCTs to monitor provider compliance with NICE Guidelines.

An Oxon PCT document seen by LMC had requested that all practices appoint a NICE compliance officer.

Both LMC and LPC have complained, and the document has been withdrawn pending dialogue.

**Action Point: The PCT/LMC/LPC to have a meeting to discuss this issue.**

## Revalidation

PHR went through a presentation a copy of which is available on the LMC web site.

See <http://www.bbolmc.co.uk/phrrevalid0309.ppt>

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### REVALIDATION FOR GENERAL PRACTITIONERS

(Paul Roblin March 2009)

- Autumn 2009: all GPs need a licence to practice (all registered doctors will be entitled)
- Much of the detail may change
- First meeting of GMC UK Revalidation Programme Board held on 10.2.09
- Licence to practice to be introduced before 5 yearly renewal (Revalidation)
- Only licensed doctors will be subject to Revalidation
- Revalidation is the name for the whole process
- One set of processes with two outcomes: Relicensure and Recertification
- Relicensure  
Demonstrates doctors practice in line with the generic standards set out by GMC
- Recertification  
Confirms that GP continues to meet standards that apply to his/her discipline
- Timescales for relicensure and recertification unclear
- Annual "Enhanced" appraisal will be central (appraisal content under discussion)
- RCGP proposes and GMC approves

- Portfolio of evidence for annual appraisal and a portfolio of evidence for revalidation
- Common requirements for evidence (all doctors assessed on a consistent basis)
- Good Medical Practice is being updated to define the qualities required of a good GP
- New GMP will guide the range of annual and 5 yearly evidence
- 4 domains (currently 7) become 12 generic standards from which assessment criteria are developed
- PHR feels the translation is questionable (measurable rather than important)
- Four Future Domains:
  - Knowledge, skills and performance
  - Quality and safety
  - Communication and teamwork
  - Maintaining trust
- The RCGP are proposing that every 5 years, every GP, in whatever environment, should be able to provide (see table at end of document)
- RCGP CPD Learning Credit Scheme “Impact and Challenge Model” developed by the RCGP
- Self-accreditation of learning credits
- Minimum of 250 over the 5 year revalidation cycle
- Credit value based on the effort required (challenge) and impact on patient care (not time based)
- Credits are self-attributed and verified at appraisal
- Impact and Challenge encompass the value of the learning, not simply the time spent in CPD
- Impact on patients, the individual, the service  
Positive weighting of impact compared to challenge
- Challenge is related to effort expended, to circumstances and to personal ability
- Un-answered questions. Is this definition of a credit acceptable?
  - Is the system easy to understand and use?
  - Are GPs able to produce evidence easily?
  - Are the examples of credits self-accredited justifiable?
  - Are appraisers easily able to verify an individual’s credits in terms of challenge or impact?
  - What if an appraiser disagrees with the doctor?
  - Are appraisers comfortable with this system?
  - Are GPs comfortable with this system?
  - Are we seeing diversity of subject?
  - Are we seeing diversity of method?
  - Is this an appropriate system for all GPs (sessional, OOH, overseas)?
  - Are there further training issues for GPs or appraisers?
  - What are the local resource issues of the system?
- Pass or Fail (Traffic Lighting of appraisals): Who Judges?
- Appraiser Judges
  - Quality of a PDP
  - Adequacy of a CPD folder
  - Whether PDP of previous year’s appraisal has been completed
  - Whether and how learning needs have been identified / prioritised
  - Credits scoring
- And
  - Guides future learning needs
  - Suggests upskilling or remedial action where required

- Responsible Officer (RO) in every NHS Trust (final say on the revalidation of doctors)
- Four tiers of assessment and appeal
  - RO
  - Local Group (RO, RCGP and Lay assessor)
  - National RCGP
  - GMC
- Possible Curriculum and Optional Exam
  - Essential Knowledge Update (RCGP six monthly)  
new and changing knowledge that every UK GP should have assimilated
  - Essential Knowledge Challenge will be a voluntary assessment  
(to provide evidence of keeping up to date).

### **Websites**

<http://www.gmc-uk.org/about/reform/Revalidation.asp>

<http://www.rcgp.org.uk/revalidation.aspx>

| Evidence                              | Conventional portfolio |
|---------------------------------------|------------------------|
| Description of roles                  | ✓                      |
| Exceptional circumstances             | ✓                      |
| Evidence of 5 appraisals              | ✓                      |
| Five PDPs                             | ✓                      |
| Four reviews of PDPs                  | ✓                      |
| 250 Learning Credits                  | ✓                      |
| Two MSFs from Colleagues (360 degree) | ✓                      |
| Two Patient Surveys                   | ✓                      |
| Review of Complaints                  | ✓                      |
| Five significant event audits         | ✓                      |
| Two conventional audits               | ✓                      |
| Statement of probity and health       | ✓                      |

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**Action Point: PHR to provide updates as they occur.**

### **Discussion at LMC**

Nationally there is talk that attendance at LMC meetings could count towards learning credits. Members did spend time reading papers and the meetings were often very informative. It would be up to individual GPs how they scored their CPD Credits (depending on challenge and impact).

Pilots are running in Bucks (on evidence) and in Birmingham (on the credit system).

Concern was expressed that current appraisers may feel that their work has changed so much that they no longer wished to continue. If there are too few appraisers, might NESC (NHS Education South Central) fill the void?

GPs voiced concern that some non-coalface GPs or GP academics would be assessing.

They would not know how full-time GPs worked.  
Members suggested that Dr Merriman (LMC co-optee) should be invited to speak to the issue.

The appraisal of freelance locums could be a problem.  
Much of the evidence portfolio requires practice data  
(MSF or 360 degree, patients' surveys, complaints reviews, Significant Events Audit).  
The RCGP is looking at alternative assessment tools eg knowledge tests.  
See [http://www.rcgp.org.uk/practising\\_as\\_a\\_gp/essential\\_general\\_practice.aspx](http://www.rcgp.org.uk/practising_as_a_gp/essential_general_practice.aspx)

PHR felt that the questions require knowledge that GPs would not (and should not) memorise.  
Sensible GPs know the limits of their competence, and when (and where) to look things up.

PB reported that Revalidation had been discussed by the GPC.  
The RCGP has produced the document for the GMC to finalise it and provide sufficient funding.

One issue highlighted by the GPC was that of remediation.  
Should a GP require this, he/she would be responsible for his/her own costs and income.  
PB understood that in secondary care, hospital trusts pay.  
The PCT said that this comes down to whether a GP is employed or self-employed.  
Many GPs feel that it should be up to the individual GP to pay.  
They did not want to see PCT resources (which could be spent on LES etc) being used to help underperforming GPs that had let their training needs go.

IN stressed that the blue book from the RCGP has not yet received approval from the GMC.  
[Guide to the Revalidation of General Practitioners](#)  
The dates given on page 4 may change.

## Motions for Conference

Motions to Conference have to be submitted by 14<sup>th</sup> April.

**Action Point: Reps to email any motions to PHR.**

## Practices Hosting IAPT Workers without Payment

One month ago an unexpected £200K cost pressure on IAPT (Improved Access to Psychological Therapies) appeared.  
Commissioners have asked if they could put high intensity workers into 24 different venues across the county without charge.  
PHR explained that practices could not charge for the use of the room as they were already receiving cost or notional rent reimbursement. However, charging a service charge would be appropriate (heating, lighting, cleaning and receptionist time etc).  
The advantage of this type of arrangement would be that it would be available locally to the patients.

Some members were concerned that currently there are gaps in provision in their practices.  
Staff have left the service have and not been replaced.  
Was the PCT still paying for an undelivered service?

There were rumours of a requirement for workers to be minimum 80% WTE.  
This will exclude many of the current staff (mums with young children).  
Not really family friendly hours!

## Practice Charging OU Occupational Health in Advance of a Report

Katherine Venables at the Occupational Health Department of Oxford University has written to LMC about some practices insisting her department pays in advance for a report.

She quotes the GMC's Good Medical Practice.

The report is usually going from doctor to doctor and she says that the University are good payers.

Some GPs present said that the latter was not the case and they had waited over 18 months to receive payment.

The meeting felt that provided LMC got reassurance that the University would pay promptly, GPs would be encouraged to provide the reports without requesting upfront payments.

However, should payments be delayed in future, this view would have to change.

**Action Point: To inform OU that provided they received reassurance that payments would be made promptly LMC would encourage practices to supply reports without requesting payment in advance.**

## Minor Injury LES Changes

IN reported that there were 2 changes to this LES.

First that rather than be capitation based payment would be made on the actual numbers of patients seen. Although this would involve practices in extra administration they did not see a problem with it.

The second change was more important.

The list of what will be paid for has changed dramatically.

This would appear to have been done without any consultation with the LMC.

The PCT said that this had been discussed in their Steering Group but it may have been before the LMC had started to receive such minutes.

PCT agreed that this issue needed to be revisited and would revert to the previous 08/09 LES specification until dialogue has occurred.

Practices in non-rural parts of Oxon reported that they were also doing this type of work but not getting paid for it. They asked that the PCT should consider a county-wide LES.

**Action Point: PCT and LMC to discuss the LES.**

**Revert to the previous 08/09 LES specification until dialogue has occurred.**

## CVD Les - Pharmacy

The PCT has identified certain deprived localities and given both GP practices and pharmacies in those areas a LES for CVD screening.

The Pharmacy fee seems to be better and patients from any practice could receive more than one pharmacy screening at unnecessary cost to the NHS.

GPs expressed concern that Pharmacists were sending patients to their surgery (even those not involved in the LES) for further attention.

If 2 people from different surgeries were tested and only one was taking part in the LES, one GP would be paid to do the work and the other would not.

It would appear that members of the Public Health Team from whom this had come, needed further education.

At liaison one of the consultant authors of the LES reported that as part of her CPD, she was visiting practices to see how they actually functioned.  
LMC was surprised a consultant should admit to such ignorance.

## New Occupational Health Provider

PHR reported that this was PTH.  
See <http://www.pthgroup.co.uk/>  
The PCT has already sent details to practices.

## MDS

MDS issues have occurred again.  
MDS has featured twice in Prescribing Points recently.  
May 2008  
<http://www.oxfordshire.nhs.uk/documents/Vol17.08PrescribingPoints.pdf>  
and Jan 2009  
[http://www.oxfordshire.nhs.uk/documents/PrescribingPointsVol18.01January20097DayRxingClopidogrelUpdatedGuidance\\_001.pdf](http://www.oxfordshire.nhs.uk/documents/PrescribingPointsVol18.01January20097DayRxingClopidogrelUpdatedGuidance_001.pdf)

Page 3 of the May 2008 document describes a PCT commissioned pharmacy service providing MDS for patients who fall outside the Disability Discrimination Act indications:  
“the practice should contact Continuing care on 01235 205480”.  
However, many practices seem unaware that the PCT has commissioned this.  
Worries were expressed that the PCT had placed the contract for this with only one pharmacist in Oxon.

**Action Point: SR will investigate this and get a formal response.**

## Better Healthcare Programme

Ann Thompson (Paediatric consultant at ORH) has asked LMC if it knew of the Better Healthcare Programme. Part of this is looking at paediatric provision at the Horton (safety and viability).  
AT has expressed concerns about the safety of the Horton service.  
The PCT view was that there is currently a 2 year service in place for Paediatrics at the Horton Hospital. Was Ann Thompson trying to break this?  
The service requires consultants to be on call which is proving difficult.  
There appears to be a shortage of staff to cover the work, and the 3 new consultants apparently do not want to cover the night shifts.

AY said that a workshop to see how to continue the service until April 2010 (which is a Government required deadline) will take place on 20<sup>th</sup> April.  
Local GPs, Consultants and the Community are invited.

The ORH has said that to send one of their consultants to the Horton would destabilise their JR service.

The meeting felt that the LMC response to AT should be that they supported the 86 GPs in North Oxon and want to see the continuation of paediatric services there.

**Action Point: RG to respond to AT.**

**PCT Medical Director**

AY announced that in the near future the PCT would be advertising for a Medical Director.

**Next Meeting – 4<sup>th</sup> June 2009**

The meeting closed at 9.40 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/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                 |
|         | Mountford, Catherine | Oxfordshire PCT            |
| *       | Neale, Ian           | S Oxon LMC                 |
|         | Pandher, KS          | NOPP LMC                   |
| *       | Pengilly, Lorraine   | Practice Manager           |
| *       | Rand, Bettina        | Oxford City LMC            |
| *       | Richards, Stephen    | Oxfordshire PCT            |
| *       | Roblin Paul          | LMC Chief Executive        |
| *       | Silver, Lisa         | S Oxon LMC                 |
|         | Thorpe, Penny        | TVPCA                      |
|         | Webb, Alan           | Oxfordshire PCT            |
| *       | Young, Andrea        | Oxfordshire PCT            |

**Apologies:** Drs Douglas, Macdonald & Mather

**Future Meetings - 04.06.09      10.09.09      12.11.09**