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# OXFORDSHIRE LOCAL MEDICAL COMMITTEE

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## **MINUTES OF OXFORDSHIRE COUNTY LMC MEETING** **Thursday, 22<sup>nd</sup> April 2010** **Oxfordshire PCT, Jubilee House, Cowley, Oxford, OX4 2LH**

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### **Minutes of Previous Meeting**

The minutes of meeting held on 25<sup>th</sup> February 2010 were agreed as a correct record of the meeting.

## Matters Arising

### **Feedback from PHR and RG Visit to Banbury HC**

RG spoke to this issue.

The visit to the Centre had been useful: the LMC team had met with the Practice Manager, Angie Anderson, Laura Spurs and an employed GP.

RG said that his letter to Fred Hucker had caused a lot of unhappiness amongst the Centre staff, particularly the apparent request to close the Centre down. He has since written a letter to apologise for this.

PHR reported that he and RG had decided not to send a LMC response to the Banbury Guardian article, because the only correction possible was to say Prit was speaking personally and not for the LMC. Instead PHR had sent the relevant section of the last LMC minutes and this was followed by a brief email exchange with the editor.

As the Centre pays a levy, GPs within the Centre receive the same LMC services as any other GP. Their practice manager is included in all communications sent out to traditional practices.

### **Getting documents to locum GPs**

PHR reported from his West Berks meetings that the TVPCA had agreed to develop an email list system to get important documents to GPs on TV Performers' Lists. He has yet to see in writing which GPs will be included (all or just locums).

Reps expressed their thanks for this. JH suggested that PB report this to the GPC so that other parts of the country could emulate it.

### **Jan Fowler Invitation to Discuss MSK Hub**

Jan Fowler had asked to attend an LMC meeting to discuss the MSK hub. The Committee agreed that this would be a good idea.

PHR felt the NOC was sensitive to adverse LMC comments about the hub despite it being a PCT initiative.

The Hub is not responsible for all the problems that have been experienced.

AC reported that 93% of referrals are now being triaged within 3 days and face to face contact is being achieved within 3 weeks.

50% of these face to face contacts are not going any further.

**Action Point: To invite Jan Fowler to the next LMC meeting.**

### **Hosting of CHO**

PHR reported that he had participated in the selection process for the preferred provider to host CHO. OBMHT had been selected.

It was recognised that there were issues within CHO that the new host will need to resolve.

### **Diabetes LES Appeals: Practice Managers' Letter**

PMs have raised the issue of a lack of an appeals process when a practice is turned down for the LES. Practices were also having difficulty ascertaining what they needed to improve should they want to reapply for the LES at some time in the future.

Brief discussion of other LES requiring accreditation (eg IUCD and Substance Misuse).

## Guest Item 1: Better Healthcare Programme Proposals for General Paediatrics

Anne Thomson, Janet Craze and Andrew Stevens attended for this item.

LMC members had received the papers submitted by AT.

PHR summarised what he thought these described.

The original ORH proposal was rejected by the IRP (Independent Review Panel) and the ORH were asked to develop alternatives. This was done via the Better Healthcare Programme.

The current proposal paper involves movement to a predominantly consultant led service in Banbury, with an extra 11 consultants working across the 2 sites.

Paediatricians have reservations about the cost of this proposal.

Additionally, covering out of hours in Banbury (where demand is low) is likely to affect OPD care in Oxford, particularly continuity of specialist.

PHR did not know if the ORH management supported the new proposals.

He was anxious that LMC should not become involved in an internal ORH dispute.

AT reassured the Committee that there was no internal ORH dispute.

She had been asked to put forward a rota to provide across site working with no increase in activity. This has been done but the Paediatricians are concerned about its implications particularly:

- The proposal does not address the needs of the children of Oxfordshire. Modern paediatrics is much more an OPD speciality but this proposal makes emergency care a disproportionate part of a consultant working week.
- The IRP turned down the original proposal as it did not improve the care of children in the North of the county. This new proposal will affect the care of the children elsewhere in the county.
- The proposal is expensive and contrasts with consultants being required to take any but cheapest of equipment requests to higher sanction.

AS responded:

When the IRP rejected the previous proposal the PCT were tasked to come up with alternatives.

The new proposal has been developed by JC with input from specialist colleagues, GPs in the North and others.

The proposal will be submitted to the clinical review panel which will comprise clinicians from paediatrics, maternity and anaesthetics along with local GPs from the North and representatives from the Better Healthcare Programme. It is also going through a financial review.

There will then be negotiations between the ORH and the PCT.

This will be to determine what is included in tariff and what may be extra.

AS said that there are examples of working over split sites elsewhere in the country and the ORH were in the process of liaising with these sites to see how things are run.

It was recognised that each area was different and local refinements would be needed.

The paper will go to the PCT Board at the end of May.

SL also responded as a Banbury rep.

He had not been personally involved in the Better Healthcare Programme but felt it was important to be fully informed.

2 years ago a poll had been carried out about inpatient services at the Horton.

This has not been repeated but possibly should be.

There were concerns that consultants would find themselves becoming deskilled in areas as they would not be experiencing them regularly and this could have serious implications on the care of children.

First impressions are that this is an extremely expensive solution.

AW (PCT) said that the PCT had set up the Clinical Review Panel to look at clinical issues such as these.

The Panel's view is that there are no issues here that cannot be resolved and that safe clinical services can be delivered.

Several LMC reps were concerned that this proposal could undermine the services provided in Oxford and that they wanted to see any funding spent wisely.

SL felt that the LMC should support an independent review of local doctors in Banbury.

## Guest Item 2: Pharmacy/GP joint training and inter-professional co-operation

Fiona Castle from the LPC attended for this item.

FC was anxious to see interaction between GPs and Pharmacists improved and suggested that a joint meeting with the LPC/LMC might be one way to achieve this.

It was recognised that this relationship varies across the county.

It is often more difficult in large organisations that employ locums on a regular basis.

Once a permanent person is in place the relationship can already be severely damaged.

There are problems with local relationships as the times when pharmacists are available are usually times when GPs are consulting with patients and when GPs are free pharmacists are busy dispensing.

It was suggested that the PBC Leads meeting might be a good starting point for joint working.

RG said that once every 2 months there is a joint LMC/LPC meeting and although only 2-3 reps attended this, it was a good basis to start from.

GPs felt that it was because of changes to both the GP and Pharmacy contracts that problems had started to occur, MURs were a good example of these changes.

IN said that frequently patients and pharmacists had good relationships and the pharmacists knew which medications these patients were taking. The OOHs service spend 8-9% of its time and 20-25% of its drug budget triaging and providing patients with medication that they have forgotten to order from the surgery. If the pharmacist were prepared to provide the patient with a limited supply of these medications to enable them to get a prescription from their surgery it would save a lot of time and money and would help improve relationships.

PHR said that FC had an open invitation to attend the LMC meeting and would in future also be invited to contribute to the agenda.

**Action Point: PHR and RG to consider the request for joint meetings in advance of the next LMC/LPC working group in 2 weeks time.**

## LMC Accounts

PHR asked that the Committee accept these accounts which they did.

Members asked that the Treasurer attempt to attend at least one meeting a year to present these accounts in the future.

**Action Point: To invite the Treasurer to attend at least one meeting a year to present the accounts.**

## Carer Administered Medicines and Forms A/B

PHR presented this issue.

He has recently received several complaints from practices about the burden of completing these forms at carer request.

He had met with 2 members of the PCT Continuing Care Team (Catherine Harker and Sue Barnes) on 20.4.10.

He had subsequently redesigned Form B to make it clearer and more user friendly.

PHR advocated that the Pharmacists should be paid via an Enhanced Service for the work involved in completing Forms A and B for regular medication but that provided the system was made easy, GPs could be persuaded to complete form A for temporary medication (eg antibiotics or eye drops).

PHR's view on good clinical care was that when a GP added to or changed a medication administered by a carer, a note should be made in the continuing care notes kept in the home, informing carers of the change and what to do with the new medication.

A supply of empty forms A will be kept in the patient's notes.

Problems occur when the patient has medication provided via a Nomad.

There are now so many patients receiving their medication in this way that it is becoming a very large time resource for pharmacies and dispensing practices.

FC said that provided the indication for Nomad use was patient disability Nomad provision was covered under core pharmacy services: however; if the Nomad was being used for carer convenience or legal protection it was not.

**Action Point: PHR will pursue development of a sensible system.**

## New C&B LES

There is a price drop in the new LES. PHR sought rep views.

PHR said that he had spent some time with a secretary in a practice where C&B was a back office function. The workload burden seemed light and the process slick.

He would not be prepared to undertake this task during a consultation as he felt it would take too long and detract from more important clinical functions.

Other reps performed C&B as part of the consultation and were happy with this.

There were problems with some clinical systems handling C&B better than others.

**Action Point: Reps to feed back to PHR on the LES.**

## RAID Access

PHR had written a pre-meeting paper on the facts of the issue.

He felt the PCT was dawdling its way towards a solution with practice and patients being caught in the middle of a dispute between the ORH and PCT.

In order to get any movement on an issue raised by a practice in August, he had had to escalate the problem to the PCT Chief Executive

This was not something he felt should be allowed happen with an issue so small.

He wanted to be able to deal with issues early, quickly and behind the scenes.

His patience had been exhausted after a meeting with PCT contracting earlier in the week.

They gave the impression that it was a low priority, despite the length of time the system had taken to sort it out and the mistakes the PCT had made.

AC said that although the issue was small, only affecting 40 patients, the lab services were concerned about funding and this was what was holding things up.

However he agreed to talk to the Contracting Team again.

**Action Point: AC to take this back to the Contracting Team.**

### PMS Review

A LMC meeting with practices is planned for 6<sup>th</sup> May.

A further meeting with the PCT is planned for 13<sup>th</sup> May.

### Interface Between Oxon OOHs and In House Clinicians/GP Systems

PHR reported his experiences as a daytime clinician trying to draw concerns about a patient's OOH care to the OOH management

He had encountered difficulty getting hold of the name of someone to contact.

There were no details either on the CHO or PCT website on how to feedback concerns.

Additionally on 16.4.10, he had also attended a meeting of the discontented City OOH GP workforce, worried by a mismatch between the workforce size and clinical demand within Oxford City OOHs. Minutes are not yet available.

IN said that the contact details were published in the LMC minutes about a year ago but accepted that they were not available on the websites which was something they were addressing.

Pete McGrain was always available either through email, mobile, or the OOHs office.

PHR accepted this willingness to help but his issue was about initial access and advertising.

IN said that he did not understand why the 3 components of Oxon OOHs services operated so independently of each other (there are different times for triage etc).

It was accepted that Oxford City were under extreme pressure over the Easter Weekend with an 18% increase in workload.

A Nurse Practitioner has been introduced to the City OOHs who will be able to triage and help with other services from the East Oxford Health Centre base.

OXEMS GPs had concerns about the new OOH software.

IN explained that with the new software (Control Plus) a decision had to be made on how much information to transfer over from the previous system (just the frequent fliers or details of any attendance over the previous 5y).

It was decided to transfer only details of frequent fliers and patients with terminal illness.

### Prescribing Incentive Scheme – incentive to use ONPOS

LS spoke to this issue.

Previously it had been agreed that practices could continue to issue prescriptions if they did not want to use ONPOS.

However the recently issued demand management paperwork does not refer to this agreement.

**Action Point: PHR to discuss with Judy Dandrige.**

## NHS Health Checks in Oxfordshire

PHR reported attending a new Steering Group to discuss NHS Health Checks in Oxfordshire.

PCT attendees include Tom Porter, Angie Eachus and Anne Ambler.

The previous health check LES confined to deprived localities attracted funding from the SHA of £1.25m.

The LES (GPs and pharmacies) delivered about 1400 health checks.

**This equates to £860 per check.**

The Government plan that everyone from 40-74 should have an extra health check.

The PCT has identified £200K per annum for this (a check on 240K patients every 5y).

**This equates to £5 per check.**

FC said that Pharmacists would not be prepared to do this work for this £5.

PHR felt GPs would be in a better position to deliver this check.

Their computer systems could identify those who already had an up to date CVS risk score and exclude them from a call system. The available £200K could then be better targeted.

AE said that this was Group were initially discussing options but the current Enhanced Service was only available for deprived and difficult to reach groups and is run in a more opportunistic way.

Reps felt that the opportunistic way would not work and the money needs to be more targeted.

Pharmacists are seeing those patients who generally do not attend their GP practice.

## Introduction to New PCT Chief Executive

Sonia Mills was welcomed to her first LMC

SM said that she had been in healthcare since 1976, mainly in a hospital setting.

She identified the future financial squeeze as an issue.

She wanted to focus not on what money was coming out of services but what money the PCT were receiving to deliver them.

The downsizing of providers within the NHS will have to occur.

She wanted to work out how to provide a comprehensive NHS service, and how to resource this.

She felt that all the documents produced so far were too large.

Various issues at the Horton also needed to be sorted out, not just Paediatrics.

The Darzi Centre in Banbury is changing the dynamics in the area.

The Community Hospitals also need looking at. Work at Henley and Bicester is continuing and the PCT wanted to ensure procurement is safe.

Oxfordshire need to come up with a solution which is safe for the whole county.

Relationships with the County Council and Social Services also need to be developed further.

PHR has also met with Sir Jonathan Michael (new CEO of ORH).

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

He plans to attend the next County LMC on 24.6.10.

## LMC Conference Motions

These have been submitted, in total 30 motions have gone forward from across the Thames Valley.

## Fast Track Continuing Care for Terminal Patients

PHR said that he was expecting a PCT paper to support this item.

He asked if there was an issue with bureaucracy and paperwork when terminal patients required such fast tracking.

There appears to be a local form which is very much more complicated than the one PHR had seen. This was a task which was usually performed by DNs.

## Fraud Prevention Tips – What Can You Do?

The LMC had no objections to the wording in this paper and it being sent to practices.

## Electronic Delivery of Dermatology Outpatient Letters Similar to eIDD March Edition of the ORH GP e-bulletin

PHR explained there had been a misunderstanding over this.

PMs thought initially that the electronic version would be the only correspondence.

Reps raised the issue of ORH discharge summaries: The Trust are now not using the version designed by John Galuska but their own which is very long and often incomplete.

A suggestion was made that every time an incomplete discharge summary was issued, the Trust should be fined.

Members asked what had happened to the data which had been collected by practices on discharge summaries. They had been promised feedback by December but had received nothing.

AC agreed to take this back.

**Action Point: The PCT to determine what has happened to the work on discharge summaries completed by practices.**

## Date of Next Meeting – 24<sup>th</sup> June 2010

The meeting began at 7:30pm and closed at 9:20 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
	Thorpe, Penny	TVPCA
*	Webb, Alan	Oxfordshire PCT

**Apologies:** Drs Benson, Bryson, Mather, McDonald, Milligan and Penny Thorpe

**In Attendance:** Thomson Anne, Janet Craze, Fiona Castle and Andrew Stevens

**Dates for Future Meeting:**  
**16.09.10, 11.11.10**