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DRAFT

Minutes of Oxfordshire LMC

Thursday 4th June 2009
Oxfordshire PCT, Jubilee House, Cowley, Oxford OX4 2LH

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Minutes of 2nd April 2009

The minutes of 2nd April 2009 were agreed as a correct record of the meeting

Matters Arising

Replacing Prevalence Losses
CH (Chair of College Doctors Association) expressed disappointment that the PCT would not be progressing with a Young Person's LES and that accreditation had not been agreed yet.
The PCT has identified those practices that would be most affected (predicted prevalence loss as a % of total income) and are planning to hold a meeting with the 9 or 10 practices involved.
Three dates have been proposed at the end of June beginning July
The PCT will be communicating with practices within 24 hours.
SR said that the PCT would supply PHR with the figures that have been used.

SR responded. The problem the PCT had with a Young Person's LES was that the money involved would not be sufficient to redress the deficit of prevalence losses.
The PCT is aware of £500K that will be lost to practices and needs to be re-invested in primary care.
It intended to work with the LMC and the College Doctors to retain this money within primary care.
The PCT were aware that they needed to be clear with practices about the impact that the loss of this money will have; it is not their intention to destabilise practices.
The PCT board would not accept payment to practices for work already paid for under core funding.

AHSC Meeting 05.06.09
PHR has a meeting planned with SR (Medical Director of PCT), Tony Berendt (Medical Director of the NOC), Mike Hobbs (Medical Director of the Mental Health Trust) and David Mant (Professor of General Practice).
SR said that the aim of the meeting was try and help the ORH avoid the problems that had occurred with the first application.

Revalidation Issues
HM tabled a digest of the recent RCGP document.
This is available at http://www.oxfordprimarycarelearning.org.uk/
Revalidation will alter the way GPs present information for appraisal.
Most of the information that is required is minimal, for example only 2 colleague feedbacks over a 5 year period, and 5 patient complaints (with learning points) over a five year period.
This is information that is already being collected.
The challenge will be the 5% of GPs who do not meet the target.
The evidence that GPs need to collect will be laid out in the NHS Toolkit which has yet to be finalised. Appraisers (and the RCGP) are encouraging GPs to start collecting evidence now and will be raising this during this year's appraisals.
Currently appraisal is not a pass/fail exercise but this is what it might become.
Whether a GP does pass or fail is down to the Responsible Officer.
HM felt that it was very achievable with minimal work.

Learning credits could be a problem (Challenge and Impact Model).
The bigger the challenge and the larger the impact on the patient care, the higher number of learning points obtained. These will be allocated by the appraisee but sanctioned by the appraiser.
Currently the PCT do not know who the Responsible Officer will be.
Richard Green is currently performing this sort of role.
The amount of work required to go through every GP's appraisal and decide if they have passed or failed is enormous.
It was reported that 2 ROs are working with the GMC/PCT to try to work through what is involved and so assist the PCTs in the appointment of this officer.

It is now unlikely that the entire process will be rolled out until 2012.

LMC reps had concerns about confidentiality of the data that was submitted and that a lot of what is submitted will not be individual but practice related.
Details submitted to the appraiser should not be shared with the PCT or RO.

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HM assured GPs that evidence will remain confidential.
As details emerge on the safeguards that are in place, HM will circulate them.

GPs were reminded not to forget to reply to the recent GMC letter about whether to elect for a licence, remain simply registered or seek erasure.
If no reply is sent in, GPs will be removed from the list and unable to practice.

Minor Injury LES
Following discussion between the PCT and IN, the final version has just been sent to PHR.
IN was disappointed that the PCT have written a narrow specification; only treatment will be paid for and not the assessment of conditions such as fractures.
The PCT has the right to decide how they want to spend its money, but it could result in an increase in the number of patients sent to MIUs.

Action Points: The LMC agreed to circulate this paper to practices.
PHR agreed to investigate what the Core Contract actually specifies regarding minor injuries.

PCT New Medical Director
RG congratulated SR on his appointment as Medical Director for the PCT.
It was very reassuring that this position was being filled by an actual GP.
Currently he is working 3.5 days a week but will eventually be working for 4 days.

Pandemic Flu Issues

RG noted that PHR has been doing a lot of work on this and Oxon PCT as lead PCT for the Thames Valley.
A lot of what has been developed is as a result of the work done by PHR.

Many GPs have concerns about the time consumed in swabbing possible cases.
There is no local information on the HPA website, and the form to use seems to have disappeared.
Couriers are inexperienced and lacking in knowledge
East Berkshire PCT has one car which travels around doing the work.
This means that individual GPs are not wasting entire afternoons swabbing households.

SR said that this model would work if the numbers were not too large but would struggle if the numbers increased.
The PCT intends to improve supply of the necessary equipment/telephone numbers so that the task takes less time.

When full pandemic workload escalates, LMC will have a role to play.
In the event of PHR being unavailable through illness Oxon LMC officers (RG, NB, LS) will stand in.

The GPC is addressing the pension issue (dependents) of sessional doctors who contracted the flu and died.

PPE Funding
The PCT reported that they would fund all additional equipment that was required but would not be in a position to refund those who have already purchased their equipment.

Sitreps from Practices in Oxon (TVEA Screen)
PMs have been practicing on the TVEA Sitreps webpage.
This involves PMs entering daily data about clinical staff and receptionist availability.
How many were expected in for duty and how many are actually in work.
This will allow the PCT to manage the practice buddy system

BR said that the contracts that her receptionists held did not specify they could work elsewhere and it may be that they would not want to work in another practice.

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LMC felt that in the event of such an emergency occurring, if one receptionist did not want to work elsewhere there would be others who would.
There is a clause in most contracts that state the job holder will perform any other duties that are deemed necessary and this is how someone could work in another practice, provided they were willing and able to do so.
PHR hoped GPs would rise to the challenge of a pandemic, demonstrate a "can do" attitude and enhance the reputation of he profession.

Looming Financial Crisis

SR reported that despite the recently reported NHS surplus, there was a real financial crisis ahead over the next few years.
Although the PCT will get 5.2% growth money, this is likely to come with strings attached (even more for 2010-2011).
The actual increase for 2010-11 will be zero and with the PCT facing a 4-6% inflationary pressure on NHS spending, means that the NHS will be in a position of negative growth.

This was an advance warning of the financial pressures and the need for the PCT to plan now.
Primary care is seen as the key to quality patient services and commissioning services to improve this is seen as a way forward.
The PCT needs to work with the LMC now to try and solve the problem.
It may be that extra pressure will be put on primary care by secondary care passing work down.
The PCT said that there were at least 20 areas in primary care and 40 in secondary care that need consideration.
LMC stressed that it was tenet of the new GP contracts that new work in primary care should attract extra funding.
If the PCT intend that work is moved from secondary to primary care, funding should follow.

The PCT is already in discussion with the ORH about this and the consultants have raised alarm that their services may be cut.
The only way to address this is by collaborative working which will involve the PCT/LMC and the Trusts working closely together.
The new Operations Officer at the ORH, Andrew McLaughlin has a better idea of what Primary Care involves and is seen as part of the solution rather than the problem.

PHR felt pre-operative MRSA screening was a potential problem area.
The DoH initiative was not evidence based and seems to have placed a large amount of unfunded work on trusts. This should not be a priority
In MK and Bucks the hospitals have passed the responsibility for swabbing and medicating the patients down to primary care; not only does this involve the practice in extra work, it incurs patients 3 lots of prescription charges for the medication.
Currently ORH are not behaving this way, but once the financial pressures start to hurt this might change.

JH asked about the responsibility for MRSA testing and prescribing for private hospitals.
Apparently the insurance companies are not paying for the medication and patients are coming to their GPs to get the medication.
PHR asked that any such occurrences should be reported to him and he would liaise with the hospital concerned.

Patient Survey Results

Practices have recently received their patient survey results for PE7 and PE8.

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Many have not achieved the higher threshold for payment and face QOF losses. The survey was designed to deliver 95% confidence (level) that the result obtained was within 7% (Confidence Interval or CI) of the real population result.
In many cases the sample size has been too low and the GPC advises practices to appeal.

RG reported that in his practice only 304 were completed
In order to achieve a CI of 7%, 573 responses were needed only 567 had been sent out by Ipsos Mori.
He urged all practices to appeal if their CI was >7%.
He has now asked all Thames Valley PCTs to supply the CI to each practice if they have not already done so.

The GPC lawyers were working up a case that this year's questionnaire was flawed.
PHR hoped that they may be successful.
PB (GPC rep) was less optimistic.

LMC Conference Agenda

Unfortunately EH would be unable to attend Conference this year and MB would be attending in her place. Those representatives attending will liaise. There is one motion where Oxon is the lead proposer.

Patient Confidentiality

PHR had circulated guidance for practices facing a PCT request for disclosure of personal patient information without individual consent.

This is largely based on the "NHS Code of Practice on Confidentiality 2003"
See:
http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH_4100550

Many PCTs are not passing such requests through their Caldicott Guardian (Sula Wiltshire in Oxfordshire)
The law permits release of personal information without consent when there is an overwhelming public interest and the risk of harm from disclosure is considered low.
PHR plans that in future all such requests will come text similar to his guidance and a clear non-technical explanation of what will extracted.
Practices have the right to refuse to supply the data if they consider these requirements are not met.

GPs expressed concern about who they would be passing this information on to within the PCT.
The PCT said that everyone in the PCT had signed a strictly enforced confidentiality agreement.

LMC Medical Director Appointment Failure

PHR received no enquiries or applications for a new Medical Director despite being widely advertised.
IN felt that the title of Medical Director may have been forbidding.
The BBOLMC Board will consider re-advertising in the New Year.
PHR intended to retire in 4 years time so succession planning was needed.
It may be that a new candidate would have no experience at all and would need training.
This would need to be addressed by the Board.

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Genetics Questionnaire Meeting 28.05.09

GPs in Oxon and Bucks have complained about a unilateral change in the process of referral to Clinical Genetics at the ORH. LMC was not consulted.
GP letters have now to be accompanied by a completed 8 page patient questionnaire (genetic pedigree).
This was insisted on by the SHA specialist commissioning group to comply with the 18 week target, however, the solution was an ORH one.

GPs feel that the questionnaire is complicated and difficult to complete by those whose first language is not English.
PCTs were meant to have communicated the change but this appears to have been patchy.
The questionnaire can be found at:
http://www.oxfordradcliffe.nhs.uk/forclinicians/referrals/genetics/clinical_genetics/Docs/cancer_questionnaire.doc

PHR has met with senior administrators from the department and the ORH, together with the lead clinician and has received an apology for the lack of consultation.
He has also re-drafted the questionnaire to include a prominently displayed departmental help number for those patients experiencing difficulty with completing the 8 pages.

GPs also raised the problem that if this service was available on Choose and Book the completed questionnaire would need to be scanned and attached to the electronic referral.
This may not be possible in all practices.

National Cytology Policy on Results to Patients

From the end of 2009, national policy is to withdraw the option for practices to communicate cytology results to patients.
The TVPCA will take over responsibility for the task, with the aim of speeding up referrals to colposcopy.
PHR has received reassurance that should errors of communication occur GPs will not be liable even though they are the initiator of the test

Royal Berks Hospital unfortunately has not yet adopted this policy so practices need to remember this when results are received from them.

Issues for Recent Liaison Meeting with PCT

Harmoni
IN reported that although issues have been raised about the new overnight service, only one official complaint has been received by Harmoni and this has been dealt with.
He reminded reps that if there are issues, GPs should feed these back so that they can be investigated.

Bed Fund
IN was pleased to see this discussed at LRC.
GPs currently have no contracts and there had been no pay rise for many years.
He hoped the related issue funding for intermediate care patients in nursing homes would not be neglected.
SR said that the PCT were planning a major review of the service and at the end GPs would have new contracts which would reflect value for money.

5% QOF PPV Random Selection

The list of those chosen for this year can be found at
http://www.bbolmc.co.uk/qofpract09.xls

PHR stressed that the selection was completely random.
All practice that had not been selected in the past 2 years went into the hat.

Feedback from GPC

PB reported that the Government wanted to cut the number of practices on MPIG and were pleased that 30% had now moved from this.
There were no other issues he could report back to the Committee on.

Next Meeting – 10th September 2009

The meeting closed at 9.00 pm

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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)
*	Milligan, Julia	S Oxon LMC
	Mountford, Catherine	Oxfordshire PCT
*	Neale, Ian	S Oxon LMC
*	Pandher, KS	NOPP LMC
*	Pengilley, 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: No apologies were received

Future Meetings **12.11.09**

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