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Minutes of Oxfordshire LMC

Thursday 10th September 2009

Oxfordshire PCT, Jubilee House, 5510 John Smith Drive,
Oxford Business Park South, Cowley, Oxford OX4 2LH

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Minutes of 4th June 2009

The minutes of 4th June 2009 were agreed as a correct record of the meeting.

Matters Arising

Darzi Centre

This is due to open to the public on 15th October but PML will be taking over the building shortly (to enable them to start training staff and set up systems).

PHR hoped that with the cash restrictions predicted by SR, there would be no sacred cows immune to consideration for cuts, and the Darzi Centre would not have special protection.

The PCT reassured members that the Performance Indicators the Centre has to meet are very stringent, more so than a GMS or PMS practices.

Meeting felt this did not answer the question put.

The Darzi Centre was imposed on Oxon PCT and its public, without great justification for its existence, and in many people's view was top of the list for cost cutting. Did the 5y contract signed permit its reduction or withdrawal?

Bed Fund

Community Health Oxfordshire (CHO) feels it needs a standardised contractual relationship with its medical workforce. Involved GPs could soon be seeing contractual changes (possibly letters in the next two weeks).

This would also apply to intermediate care beds.

PHR explained that in his meetings with the PCT he was often made aware of issues before the profession was. As they were confidential he could not immediately pass the information on, and hoped that members understood his position.

CEO of Oxfordshire PCT

NB informed the Committee that Andrea Young has taken up the position of Chief Executive of the SHA, and welcomed Matthew Tait as interim Chief Executive to the LMC.

It is anticipated that a full replacement will not be decided for at least 6 months.

An interim Director of Finance will be appointed to replace Matthew.

2010 Meeting Dates

The suggested dates are 25/2/10, 29/4/10, 24/6/10, 2/9/10, 11/11/10.

PHR explained that timetabling solely to comply with Conference dates produces a distorted distribution of County LMCs. In addition the deadline for motions is not yet known by the GPC.

Fitting in with the Conference schedule could mean that some County meetings would only be a month apart.

He felt that negotiations on motions could just as easily be done by email and so had set the meetings on 2-monthly basis.

If anyone has a problem with the proposed dates they should contact PHR.

Swine Flu Vaccination Programme

PHR reported that PCTs are calling meetings to try and sort this out.

The patient group priorities are:

Clinical risk groups under 65, Pregnant women, Carers of those with compromised immune system, Clinical risk groups over 65.

The NHS and GPC are negotiating whether GPs should be the vaccinator of choice for patients, and costing is proving a problem.

The other vaccination priority group is Front line Health and Social Care workers.

GPs might not be the chosen vaccinator for this group.

HR departments supplemented by other providers (eg CHO) might be selected.

PB said that 6 weeks ago at GPC it was thought that a deal had been reached but this now seems to not be the case as it was rejected by the majority of GPC members.

The DoH expected the PCT to run the call and recall programme for each practice but as they would each operate in a slightly different fashion this would be very difficult for the PCT to organise.

The GPC proposed that for a slightly higher fee the practices would handle this element too.

The whole issue now seems to have gone very quiet, especially as the number of cases and the severity of the illness had reduced.

Is the DOH having second thoughts about the cost benefit of a vaccination campaign?

It is now not known whether a national solution will be found.

The advice now seems to be to approach your PCT for negotiations.

However, there is still the worry that time will be spent on local negotiations only for these to be overridden by delayed national guidance.

In view of the short time before the availability of the vaccines in mid-October it was agreed that preliminary negotiations should be started.

One idea proposed was that the PCT should pay practices a flat fee dependent upon the number of patients who would need the vaccine, and pay them one flat amount irrespective of uptake by patients.

It would then be up to the practice to provide the service.

The PCT would be able to scrutinise any outliers if the practice had not achieved population coverage.

This would save a lot of practice and PCT administration time.

There is still uncertainty whether one or two vaccinations will be required.

However, it is clear that there are two different brands of vaccine and if two doses are required, they must be from the same manufacturer.

The vaccine will not come in single shot doses but in a vial of 10 doses which once opened have a very short shelf life.

Action Point: GH to discuss the issue with Alan Webb, the Director in charge of the Thames Valley response.

QoF Appeals (PE7 and PE8)

It would appear that no appeal in the Thames Valley has been successful.

This is because of the 3 hurdles practices have to overcome:

1. to have a confidence interval of >7
2. to have a worse confidence interval than previous years
3. for practices to provide evidence of their own patient experience survey for the same period (the most difficult one).

PHR asked practices what they felt about conducting their own surveys of patients using the same questions as in the national survey.

This would enable them to produce their own evidence of patient satisfaction percentages.

The number of patients approached needed to be worked out exactly and PHR said he would pursue this should practices wish to go down this route.

Government and PCTs believe that the national patient survey is a patient perception survey.

Practice Evidence for appeals has concentrated on describing the volume and range of appointments on offer.

PHR suggested that an advertising campaign was needed to make patients aware of their access options.

Practices should advertise within the surgery that appointments are available both within 48 hours and after two weeks.

Cash Strapped NHS. Cuts and Referral Restrictions

SR spoke to this issue.

Oxon are already feeling the bite from budget cuts and have to save £240m over the next 3 years.

There will be a need to look at how services are commissioned and pathway redesign just to get through this financial year.

The Demand Management LIS was started last year and is still in existence but despite this the number of patients being referred to the NOC and ORH has continued to increase.

SR reported that he had been spending a considerable amount of time at the NOC and ORH to try and address the consultant to consultant referral thresholds.

People will not be comfortable with referral restrictions and it is hoped to be able to engage in debates on referral templates (proformas).

The PCT has agreed a financial cap this year and PBR is not in place with the ORH.

Once the cap has been reached (and the ORH are already working above the cap level) no further payments will be made.

LMC felt that the problem with the financial cap is that it will result in secondary care trusts reducing the amount of referral slots available on Choose and Book.

This is already happening, so in reality a financial cap is also an activity cap.

Patients are ringing for an appointment and being told there are no slots and that they will have to be rung back; these cases are then passed on to a specialist manager who has to find appointments to enable the referral to meet the 18 week rule and avoid penalties.

GPs reported that patients are saying (correctly in their view) that they have a right to be referred and this puts GPs in a very difficult position.

Patients are also coming to them from the hospital stating that the consultant said they must be seen by another speciality. It is very difficult to argue with patients when they have been given this type of advice.

Consultants must be asked to not say this to patients.

In East Berkshire a LES has been produced that will incentivise GPs to deal with consultant to consultant referrals and to redirect a proportion of these referrals.

Oxon may develop something similar.

The PCT said that they needed to get back to financial stability and unilateral decisions by secondary care will not be supported by them.

Members asked if the ISTC was also being looked at. Is it being used to capacity?

The PCT said that their plan is for all MSK referrals to be triaged by a consultant and senior physio and these will include referrals to the ISTC.

Two week referrals also need addressing; this service was set up for obvious cancers or emergency treatment only.

The PCT recognised that only 50% of all referrals to Secondary care came from GPs, 40% were from consultants and 10% from other sources such as dentists.

Action Point: To report back to the LRC meeting in October.

The Potential Split of Salaried/Sessional Doctors from the BMA

JH reported that there is a national threat of Salaried/Sessional doctors splitting from the BMA and being represented by the MPU.

Some Sessional GPs feel that they are not valued or recognised and are not adequately represented by the BMA. Many Sessional GPs also reported that they did not receive any communications from the PCT unless their own Practice Manager passed this down.

This was because the PCT usually communicated with contractors and assumed a cascade system. It did not use the Performer's List which would reach everyone.

PHR has complained about this for some time but PCTs and TVPCA have been reluctant to change.

GPs warned Sessional doctors that the amount of 'information' that their PMs received was extremely large and in fact 90% of it was rubbish which partners never got to see.

Currently 80% of advertisements are for Sessional GPs and not partners, so they comprised a significant proportion of the workforce.

It was asked whether the LMC could offer the same representation on the Committee to Sessional Doctors that they do to principals, based on the formula explained in the 2006 GPC paper.

PHR explained that the LMC representation was not based on the number of doctors as stated in the paper but on the number of patients.

Sessional GPs do not pay the levy if they are working in a practice that has already done so.

Tom Nichols (TN), the organiser of Oxon Sessional group, said that communication was an issue.

There are 86 non-principals working in Oxon at the moment and most of the information they receive about meetings is by word of mouth.

There is no comprehensive system for getting information to all performers on a PCT list, and any way to improve this would be welcome.

HM said that she had approached Richard Fieldhouse as she had wanted to improve communications with locum GPs but had been told that he did not want her to develop anything further as his organisation delivered this function.

The TVPCA manage the Performer's List (a function delegated by PCTs).

PCTs feel their responsibility is solely to communicate with practices. PHR disagrees with his view.

JD suggested that the Performer's List could be made available to the LMC to enable them to communicate with Sessional GPs. PHR felt the Data Protection Act would prevent this.

PB said that in reality the cost of employing a Salaried doctor was not much less than a partner when on costs and beneficial terms were considered.

His practice was in the process of making one of their Salaried doctors into a partner for this reason.

Action Point: The PCT, TVPCA, TN and LMC to work together to improve communication.

Referral Form for CAMHS

HM reported that having spoken to a CAMHS specialist about this form she had discovered that they did not like it either.

The LMC's suggestion was that provided the first page was filled in, the service would accept a traditional referral letter.

PHR would inform the profession of this again.

Action Point: PHR to inform GPs that provided the first page is filled out the referral will be accepted.

Berkshire Ambulance number for GPs is now 0844 811079

Berks Ambulances now require South Oxon GPs to refer emergency patients to them using a 084 number. Oxon Ambulance has not followed suit despite both counties being part of South Central Ambulance Trust.

The Berkshire number incurs a high cost from a mobile phone which many GPs use.

SR reported that this service will come under his authority next week and he would pursue this if PHR provided him with the details.

Action Point: PHR to email SR with the details.

Cytology Re-Accreditation

Oxon PCT public health seem about to require GPs to be reaccruited every 3 years by attending a course. Universal reaction to the first 3h accreditation course was that it was a waste of time.

The skill is simple, not easily lost, and available on DVD.

The original agreement was that each practice would have a cytology lead, who would be responsible for accreditation and re-accreditation.

Current plans suggest loss of organisational memory.

Speculation about the reason this issue has reappeared.

Is it because the programme has undergone a Quality Assessment and boxes needed to be ticked?

The PCT assured members that common sense would prevail.

Revised OBMH Out Patient Prescribing Policy and other Secondary Trust Issues

PHR said that he had objected to the original OBMH version at APCO.

Practices will now be compliant with EL(91)127.

Out patients will be supplied with 2 week's medication and inpatients one week.

GPs predicted a problem when a patient needs more medication and the discharge letter has not been received.

The ORH policy is that if a discharge summary (EIDD) has not been done at the end of one week, a blank one is sent out which is no use.

SR said that the audit that had been taking place on discharge summaries would be used to deal with this.

There were also problems with the issue of sick notes to inpatients.

Patients are going to their GPs to get them extended when there is an agreement between the LMC and ORH that trust staff would certify the patient for the anticipated length of their sick leave.

GPs who work in hospital said that when they asked for MED3s in a hospital setting no one knew what they were or where they were kept.

Again the audit will be used; if discharge summaries are late or of no use there will be a financial penalty imposed.

Low Prevalence Practices

There is a second meeting with the 10 predicted highest losers on 15th September.

The PCT have received data from all but two practices.

Reps from involved practices were "not holding their breath".

PBC Leads Meeting with PHR

PHR reported a useful meeting with PBC leads.

Plans for better communication have been made
Often directives come from the PCT stating that they have been discussed with one or other group.
PHR made it clear that informal discussions with him did not constitute LMC consultation.
He needed to send documents around members for comment for this statement to be possible.

Referral Templates (e.g. Urogynaecology)

PHR managed to get the PCT to make use of the Urogynaecology template optional rather than mandatory. Compliance with NICE guidelines was the key, whichever way the referral was made.
The same principles should apply to 2WW referrals for lower bowel cancer and dermatology.
However, today's letter from SR and James Morris says template use will become mandatory at the end of October (ie referrals will be rejected).
Members felt this was unsafe and illegal.
What would happen medico-legally if a referral was rejected because the wrong referral method has been used?

GPs said that to use these forms they would have print them out, fill them in by hand and rescan them to be able to use C&B. It would be more acceptable if the PCT provided them in a form that their own clinical software could populate.
GH and SR agreed to take this up at the PCT and to only insist that this form be used as the only referral method once it is possible to automate patient detail inputting.
The solution ignores the problem that GPs may not remember which services require a form and which do not; it would make more sense to have all 2 week wait referrals on a standard format.

2 week wait referrals were discussed.
Of all colorectal referrals only 5% were found to be actual cancers (conversion rate).
GPs asked how many of the 95% that were not cancers would still have met the NICE criteria for 2 week wait referral, ie it is the NICE criteria that are inadequate, not GP compliance with them.
SR felt that consultants believed that many referrals would not comply with NICE guidance.
GPs reported that looking at the NICE guidelines and the local guidance on TIA/Stroke referrals there was a very large gap which has become a medico-legal issue.
PHR pointed out that some criteria on the templates have different ages to NICE. Did the author realise this?

Action Point: The PCT to only insist these templates be used once they can be populated by practice clinical systems.

C+B Achievement Issues

PMs have reported that although their practices work solely with C&B they were only reaching 60-70% achievement.
Amazement expressed that they have been told by Cindy Clark **that the evidence is no longer available** but they have been asked to produce their own.
GH agreed to take this back to Cindy.

Action Point: GH to discuss this issue with CC.

Focus on Improving GP Services

The PCT are tasked with managing the quality of primary care services commissioned by them.
To do this balanced scorecards (a set of performance indicators) are being developed by the PCT.
PB and PHR have been involved.

GPs should look on this as a potential opportunity rather than a threat; a chance for Oxon GPs to demonstrate their high standards.

Mirena Coils

IN has used the PHR PPA Calculator to look at the finance of Mirena coils.

It has appeared that dispensing GPs and those using the PPA reimbursement system are losing out financially on prescribing and fitting these due to the drop in the discount rates and an NHS price below purchase cost.

If a non-dispensing GP writes a script for the patient who takes it to a pharmacy the cost will be borne by the pharmacist instead.

This option is not available for dispensing doctors.

The same thing is apparently happening with the adult pneumovax.

Action Point: PHR to investigate this issue.

LPC Update

PHR reported that he attends a meeting with the LPC every two months.

The issues of MURs and repeat dispensing recur.

LPC is holding a meeting on the evening of 3rd November at which the usefulness of MURs and repeat dispensing are being discussed.

Doctors who use repeat dispensing say that it works well for doctors whose practices are only served by one or two pharmacies but in the city it could be more complicated.

SR said that in April there is a new pharmacy contract and it will be an opportunity for the PCT to negotiate a more useful function for MURs.

Next Meeting – 13th November 2009

The meeting closed at 9.45 pm.

Present	Name	Organisation
*	Benson, Catherine	Oxford City LMC
*	Birchall, Carol	LMC Minute Secretary
Chair *	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
	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: Drs Godlee, Haskew, McDonald and Andrea Young

In Attendance: Shamia (Registrar), Tom Nichols (Non-Principal), Matthew Tait (Interim Chief Executive PCT), Tara Al-Salihi (Salaried GP)

Future Meetings

12.11.09

25.02.10

29.04.10

24.06.10

02.09.10

11.11.10