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# OXFORDSHIRE LOCAL MEDICAL COMMITTEE

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## Minutes of Oxfordshire LMC

Thursday 12<sup>th</sup> November 2009  
Oxfordshire PCT, Jubilee House.

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### Guest Item: Feedback from Patient Access Event: PAERS

Dr Brian Fisher, a GP from Lewisham and Company-Director of PAERS, and Kathy Broughton from the SHA attended for this item.

EMIS practices already have the ability to allow patients to have access to certain parts of their clinical notes;

they can view their current medications and problems in date order, their family history and their consultations. This has advantages as the people who usually access these pages are those who have chronic diseases such as asthma or diabetes.

If they attend hospital and their notes are unavailable they have access to their GP notes to help the hospital clinician.

They can also access their results; GPs who have been using the system have found that they can advise their patients by the use of their comments and this is reducing the number of appointments needed and telephone calls handled.

Patients are unable to view their results until the GP has filed them in the practice IT system.

It is up to the GP who they allow to access their notes, and those patients who do access them have to sign a form that they understand what they are doing. They are then issued with a practice password and PIN and then have to produce their own passwords to access their notes.

There had been concerns about permitting a patient with a psychiatric history access their notes.

This does not seem to have been a problem as GPs are able to decide which parts the patient can see.

GPs were worried that this would entail a lot of work for the practice but BF said that once the practice had decided to allow access they could put a bar to access on anything prior to that date.

The practice then ensured that any new data put on the system was patient sensitive and in line with the Data Protection Act.

Only one page at a time is accessible so should a hacker get into their computer, they will only be able to access that one page and not the surgery computer system.

The data has shown that if an elderly patient gives their password and PIN to a relative or carer, the relative/carer can then become active in monitoring the patient's care.

So far there have been no reports of any practice server slowing down as a result of this remote access but currently only 7-8% of patients are actually accessing their notes.

In the next 2-3 months the plan is to involve PCTs in a page which is disease specific, asthmatic patients would receive weather reports and have access to asthma groups.

Smokers would receive advice about stop smoking groups etc.

It was planned to fund the system by charging the PCT to put this on the website but currently for EMIS practices the system is free and was intended to be free for as long as the system was run.

The system would also have the ability to issue QoF reminders for patients to attend their surgery.

This may be an element that would be charged for.

To view the system, go to: [www.paers.net](http://www.paers.net).  
(Patient Access to Electronic Record Systems Ltd)

KB said the SHA were supportive of this initiative.

## Minutes of 10<sup>th</sup> September 2009

The minutes of 10<sup>th</sup> September 2009 were agreed as a correct record of the meeting.

## Matters Arising

### Referral Templates and Referral Guidelines (thresholds)

PHR introduced the issue. GPs and LMC are generally not keen on proformas. The difficulty was knowing which referrals needed a proforma and which did not.

SR said that the intention was, with time, to have the top 30 two week wait services on a proforma which would make it easier for GPs.

GPs said that if the PCT issued proformas that were pre-loaded so that their clinical system automatically populated the areas they could not see it as too much of a problem but until this happened they still wanted the

ability to write a traditional referral letter.

SR reassured the meeting that provided the referral letter contained all the elements requested in the proforma the provider service should accept it.

GP reps had problems with some of the data requested (eg ethnicity).

In the majority of cases this was irrelevant to the care of the patient but something required by Government.

Recently templates have been issued by Speech and Language Therapy (SALT) which had not first come to the LMC for comment or approval.

VM said that they had not come to the PCT either and she thanked the LMC for drawing her attention to this.

At a Clinical Executive meeting it had been agreed that all proformas needed to be useful and the PCT would be asking SALT to put the template through the correct process.

The PCT agreed to ask SALT to withdraw their form.

SR described the correct process.

The provider should approach the PCT with their planned proforma, which will then be vetted by staff from prescribing, public health, those with NICE guidance experience and GP Clinicians. Once this has happened they will go to the Clinical Executive for assessment and if ratified circulated to practices.

It may be that after going through this process proformas are withdrawn as they are not seen as useful.

LMC felt strongly that it should be part of the ratification process.

GP reps felt that any agreed forms have to be available on the PCT Intranet.

The PCT said that currently there were difficulties getting all 4 clinical systems to populate these templates automatically.

The problem is the PCT cannot 'road test' them as they do not have the IT systems.

The need for ethnicity and smoking status on the MSK Triage Template was queried; SR said that in certain cases the smoking status would decide whether a procedure was performed but the ethnicity status would not be so useful.

In future the PCT were asked to email all templates to PHR for his ratification as being acceptable to GPs.

The PCT reassured GPs that the use of proformas would not be mandatory and that as long as the referral letter contained all the relevant points they would continue to be accepted.

### LMC Letter about Darzi Centre

Following the LRC meeting of 15.10.09, Rick Godlee had written to Fred Hucker (Chair of the PCT), expressing the view that the Darzi Centre in Banbury was a bad use of local funds and asking the PCT to re-negotiate with PML on the grounds of affordability.

Fred Hucker replied on 10.11.09.

This Darzi Centre contract is for 5 years, and has loss of income clauses for early termination.

PCT reps were asked what penalties the PCT had imposed on the contract should the Centre not perform to the KPIs?

PB said that from data supplied the Centre is running at an average GP consultation cost of £140 per patient whereas his average cost was £24. Were the PCT monitoring the value for money of Darzi Centre activity?

The PCT must consider these costs as one consultation with the Centre would equate to one out patient episode with an Orthopaedic Surgeon.

GH responded that because it was an APMS practice, the PCT have added in more deliverables that have not been asked of other practices.

GH said that the PCT were having fortnightly contract performance management meetings with the Centre.

The Centre will be having considerable monitoring against KPIs and will be also be bench marked.

PB asked if the cost of these fortnightly meetings and processes were being included in the overall cost?

Matthew Tait (Interim PCT CEO) said that the PCT recognised that it needed to improve performance monitoring of practices across the board.

The FOI questions so far have been in terms of the budget allocation and what is being delivered for this money. Activity monitoring is done with other practices in terms of enhanced services.

Information is needed on the Darzi Centre.

SR said that this would probably be an area scrutinised by PCT Non-Executive Directors. They had done so with the ISTC in the past.

SL reported that the Darzi Centre had been sent the same 500 swine flu vaccines as every other practice in Banbury when they did not have that many patients registered with them. He had heard that they were vaccinating everyone who requested it, possibly outside national guidelines.

## Prevalence Losers Arrangements

GH spoke to this issue.

Meetings continue with this group and sub-groups have been established to look at various issues.

Dr Gancz has written a paper that is being discussed and St Barts have also been providing useful information.

It has been agreed that various elements will be worked up further to provide a presentation paper for the January PCT Board meeting.

The PCT will be looking at whether new funding is applicable to delivering services for young people.

The PCT has been looking at practices list turnover and workload involved. One practice reported this was as high as 49%.

The PCT's Executive Board (EB) has also agreed a transitional payment scheme for the top 10 losing practices (50% of the loss in year one and 25% in year two).

The PCT justified this on the grounds that some of the biggest losers would lose enough to destabilise them.

GP reps asked how the PCT could justify this payment to only the top 10 practices.

The PCT would need to be able to justify these payments in the future and also to the 11<sup>th</sup> practice.

The PCT said that these payments were being made in recognition of the fact that Carr-Hill does not recognise the amount of work young people require or the high turnover the practices are experiencing.

The LES that is being developed for young people will also be offered to all practices.

**Action Point: SR will provide PHR with a full explanation of this which will be sent out to GPs.**

## Ambulance Issues at the JR

SL reported that in Banbury the Maternity and Paediatric Services was part of the Better Health Care programme. In discussions it has been recognised that better ambulance transport services between the 2 sites would be very helpful.

However, it had emerged that there were problems at the JRH with ambulances being held waiting to discharge their patients.

SR said that this was only the position for a short while and had now been rectified.

## MSK Hub

PHR introduced this issue.

The issues he identified were:

- the short notice
- the predicted overheating (unaffordability) of referral rates to the NOC
- the referral figures from the PCT being at variance with practices' own figures
- the failure of the promised 48 hour turn around for sanction by the Hub because Hub staff did not know of this target.

It was reported that only 5% of referrals were being rejected as against the planned 10% predicted by the NOC.

The PCT became aware of a potential problem in late July when crisis talks were held with the NOC.

GP reps asked why this was introduced so quickly when they PCT had been aware of the problem for so long.

PB said that looking at the figures for the first 10 months of last year and comparing them with the first 10 months of this year, the variance was only 3.

However the NOC figures show an over-performance against plan.

GP referral data shows GPs were making 2.5% less referrals than last year, **but the PCT had commissioned less services than last year.**

It was believed that the MSK Triage would bring down the number of referrals to the NOC in the second half of the year.

It was also felt that the demand management enhanced service would mean that referrals would come down.

GPs asked where the figure of 40% over performance was coming from when their referrals were 2.5% lower.

VM said that GPs in Oxon were amongst the highest referrers to Orthopaedics, being 14/152 nationally.

This is not so with other specialities.

In other words the problem is a PCT plan (unadvertised to those making the referrals) that has ignored historic referral volumes.

The MSK Triage Hub was set up as the NOC wanted to stop all non-urgent elective work.

SR said that it seemed the LMC would like a business case about how this had all happened so quickly and he proposed to deliver this.

He said that the HRG structure changing from version 3.5 to 4 was a major contributor to the predicted overspend.

Whilst activity had risen (GP and consultant to consultant combined) it was also the cost of each activity that has risen.

GP reps asked that the PCT make the public aware of the PCT MSK plan and the MSK Hub solution.

VM have talked to the LINKS and NOC patient group.

GPs said that Orthopaedics was not the only area where there were problems. ENT have also started to say that they are seeing a 40% increase in activity.

SR said that GPs needed to recognise that the current system is not affordable in terms of what the PCT have got to spend but that the PCT were not just addressing a change with GPs but they were also working with secondary care to try and find a solution.

**Action Point: SR to provide the LMC with a business case for the MSK Hub.**

## Shaping the Future of Primary Care

SR spoke about the Accelerated Solutions Event (ASE), held over 2 days at Capgemini Headquarters Woking on 22<sup>nd</sup> & 23<sup>rd</sup> September and attended by about 70 people from health, social care, district councils and the public. This was well attended by primary care.

The key issue was how to deliver the PCT strategy in a difficult (frightening) financial environment?

	2010	2011/12	2012/13	2013/14
<b>Present Budget</b>	£840m	£840m	£840m	£840m
Cost Growth		£40m	£80m	£120m
Demand Growth		£40m	£80m	£120m

Cost Growth            Tariff  
                              Pay and Prices  
                              Organisational productivity  
Demand Growth        Service & Pathway redesign

From the ASE event, several work streams had been developed.

One work stream was to look at the way to change general practice from the current 60-year old model.

SR is working with David Mant and will be working with a number of pilot practices across the county. Initial approval is needed from the PCT Board and once this is received he will share details with LMC.

The main aim is to look at the practice structure, with more work being done by nurse practitioners leaving GPs to use their resources more appropriately.

The pilot will be by invitation to individual practices.

PHR reported that RG had re-convened the PMS practice group and asked why this may be.

SR said that the PCT were paying between £75 and £120 per head for PMS practices but only £65 for GMS.

The PCT would be looking at PMS practices as there was nothing they could alter in the GMS contract funding.

**Action Point: SR to feedback on PCT initiative once approved by the Board.**

## PBC / Clinical Commissioning

SR said that a paper will be going to the PCT Board in 2 weeks.

Its aim is a slicker decision making system. He would circulate this to the LMC and PBC Leads by Wednesday 18<sup>th</sup> November.

**Action Point: SR to circulate the paper.**

## Swine Flu Vaccination Programme

Not all practices have received their Pandemrix allocations.

The PCT has a supply of the Baxter vaccine (Celvaplan 3x200) and LMC asked how practices could access this.

GPs reported that the uptake of Swine Flu vaccine by the NHS workforce was poor.

It was also proving very difficult to get some patient groups in for vaccination, especially pregnant women.

There was also a problem with identifying the co-habitees of immuno-compromised patients.

A code was needed from the PCT so that practices could claim for the procedure.

SR said that he would be looking for a volunteer from the LMC to work with him on swine flu as two members of the PEC had recently been patients of the NHS. He needed GP support.

PB volunteered to fill this position which was agreed.

PB offered to assist SR.

## Diabetes LES

The originally paper shown to the LRC was very complicated, with much of the detail buried.

PHR had condensed the essentials into 2 pages.

The PCT has now circulated this together with appendices as the new version of the LES.

GPs were concerned that the practice obligations within the LES would make it unattractive for the fee.

Overheads such as staff training etc did not seem to be covered in the fee.

IC said that it was proposed that the money not used by practices that did not take up the LES would be used to provide training and resources for those that did.

It was intended that the application process would be as simple as possible.

## ONPOS (On-Line Non Prescription Ordering Service) from 7.1.10

This new system will be operational for the supply of dressings from January 2010.

This has been developed with support from the DoH.  
The PCT will be performance managing this initiative.  
It is not a national requirement yet but is following the system that other areas are already operating.

Although the PCT regards this as desirable it is not a PCT requirement or mandatory on practices.  
Practices that do not use ONPOS must be aware that funding has been taken from their prescribing budget so they will be paying twice.

## PCT Choice Questionnaire

Sindie Clark has contacted Practice Managers asking them to circulate a questionnaire to patients.  
PHR is unhappy about the wording of the second question.  
Patients are being asked if their GP offered them 4 choices of provider, implying that this is obligatory.  
When he had asked SC if she could change this she had responded that she would not.  
He is therefore inclined to advise practices not to comply with the PCT request for help

GP reps said that although they had signed up to the Choice and Booking LES it was not believed it contained a requirement to offer a minimum of 4 choices to patients, but this needed to be checked.

**Action Point: GH will follow this up.**

## Performance of IAPT

Reps are reporting that access to psychological services seems worse under IAPT.  
Government ring fenced money was received.  
The IAPT service has recently asked practices to hold their own waiting list for counselling services.

The PCT said that the Executive Board are receiving a paper from IAPT on Tuesday.  
Speculation that counsellors are having to complete too much paperwork which is reducing the amount of time they have to see patients.

RM reported that following a presentation from IAPT it appears that they are now managing the referrals they are receiving.

## End of Year Change to Cervical Screening Letters

The national deadline (Julia Patnick letter) for this is the end of 2009.  
The implementation of this appears to have stalled.  
Reps stressed that practices need a decision on when the new service will start and their own systems should cease.

**Action Point: PCT to provide an exact date for the start of the new service.**

## Annual Appraisal

See <http://www.bbolmc.co.uk/hottopic/hotall/hotall.html> (21.10.09)

The PCT and TVPCA have recently tightened up processes.

GPs that have not had an appraisal in a financial year have been sent notice of intention to remove them from the

performers list.

GPs are reminded to have their appraisals or to notify the PCT/TVPCA of any mitigating circumstances eg maternity or sickness absence.

**Action Point: To ensure that mitigating circumstances are notified or to have their appraisal in time.**

### Category B Ambulance Calls

Currently Category C ambulance calls are being directed to GPs when the ambulance crews feel it is appropriate. SCAS wants to add Category B calls to this process.

At the LRC meeting of 15.10.09, LMC asked for examples of such calls, but so far no response has been received.

**Action Point: LMC to wait for examples of what Category B calls would involve before a decision is made.**

### Slimming Vouchers – recent letter from PCT

EH raised this issue.

These cost the PCT £40 each and some patients are taking them and not using them.

The profession needs to be made aware of the cost so they can inform their patients.

**Action Point: To advertise the cost of these vouchers to GPs.**

### E-Mail Advice from Secondary Care

Currently the service GPs receive is variable.

The intended target of 48 hour turn around does not always happen and the quality of the response depends on who answers the email.

They can be answered by either a consultant or a registrar.

GPs wanted to be able to request that a consultant answered.

The cost to the PCT was £30 regardless of who constructed the answer and whether it was made within 48 hours.

GPs also wanted the cost to be waived if the consultant felt that an out patient appointment was most appropriate.

The PCT agreed that this area needed to be looked at.

**Action Point: The PCT to investigate what is happening and the quality and cost of responses.**

### Next Meeting – 25<sup>th</sup> February 2010

The meeting closed at 9.45 pm.

<b>Present</b>	<b>Name</b>	<b>Organisation</b>
	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)
*	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:** Dr Benson, Coffey Godlee & Galuszka

**Guests:** Dr Brian Fisher and Kathy Broughton & Ian Cave

#### **Future Meetings**

25.02.10      29.04.10      24.06.10      02.09.10      11.11.10