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# BUCKINGHAMSHIRE LOCAL MEDICAL COMMITTEE

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## MINUTES OF BUCKINGHAMSHIRE COUNTY LMC MEETING The Fairford Leys Surgery, Aylesbury, HP19 8GG Friday, 11<sup>th</sup> November 2011

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## Minutes of Previous Meeting

The minutes of 9<sup>th</sup> September 2011 were agreed as a correct record of the meeting.

## Matters Arising

### **Health Check LES**

PHR has received emails on this from Jane O'Grady and her colleague Veena De Souza. Apparently 10 out of the 69 Bucks practices have not yet signed up to this LES. There is also concern that those who have signed up have not yet invited many patients. The PCT is proposing to go out to tender for the service where practice populations are not covered. Should the LMC be encouraging practices to sign up to the LES?

Meeting felt that it was a lot of work for the money being paid. Concern that if the service was tendered out then practices would still end up doing the work but for no remuneration. Meeting felt that any organisation that was appointed must provide a high quality efficient service for no more funding than practices were receiving.

GJ reported that Vale and Chiltern Health had looked at the possibility of providing the service to practices but had been told that all practices had signed up.

The LMC could consult each practice on its intentions and whether they would prefer the service to be tendered.

Meeting queried whether as a LES it was possible to ask a neighbouring practice to take on the service on one's behalf.

GB felt this was possible.

It was not anticipated that the specification contained any clauses about sub-contracting work but it would be sensible to check this with the PCT.

GJ said that a lot of work is needed before invitations can be sent out.

It may be that a practice has got this in place and employed an extra HCA to do the work.

They could take on another practice's patients.

The target in the LES is for 20% of the population to have been invited for a health check in one year.

The target by the end of March 2012 should be pro rata to the part of the year the LES has existed. (introduced half way through the year) ie 10% not the 12% quoted in Veena De Souza's letter.

Meeting felt it was premature of the PCT not to wait until at least April 2012 before considering sanctions for those signed up.

It appears PCT does not understand general practice and what they are asking for in the LES.

LMC felt that for better understanding, it would be useful if Jane O'Grady visited a practice and talked to those running the service.

### **Removal of Sutures LES**

The PCT is now paying £7.50.

Practices that held put for a fee higher than £5 were thanked for their role in achieving the change.

GJ said that the new offer was triggered by the practice chosen by the PCT to cover his practice's population giving only 5 days notice of withdrawal.

The PCT had apparently just accepted this, rather than insisting on normal notice.

GB said that the Practice Nurses were identifying clinical governance issues with ever more complex suturing taking up to 45 minutes.

PHR said that if there were any areas that the nurses did not feel competent to handle they should return the patient to the person who inserted the sutures.

GB said that it was not always possible to refer the patient back to the hospital especially if the procedure had been done outside county.

**Action Point: PHR to raise suture complexity at the ES Committee.**

### **QP End of Year**

PHR reported that he had clarified this with the PCT and had circulated the email response.

The PCT has been quite explicit about targets and light touch.

### **NHS 111**

Bucks are now progressing with NHS 111.

Oxon have gone with SCAS as the call centre provider (mirrors existing role).

In Bucks the equivalent is BUC, yet at a meeting organised by Oxon they had invited SCAS and NHS Direct as a potential new provider.

This doesn't seem to be consistent with the Cluster policy of a pre-procurement pilot using existing providers.

Bucks have decided to go with the national start date of April 2013.

Oxon are starting much earlier.

There are fears that a lot of the transferred workload will fall on General Practice (In hours and OOH).

A significant number of the NHS Pathways patient dispositions are "contact the GP within a specified timescale".

One of the items in the specification is that a GP must respond within an hour when the call represents the third call in 4 days.

Meeting felt GP workload and response times should not be distorted by 111.

GJ reported that in parts of the country where the pilots were run, practices have had to free up 2 appointments in the morning and 2 in the afternoon to fit in patients referred from 111.

Meeting felt the software was a signposting tool only.

It should only advise patients to contact their GP within a certain timescale not dictate the specifics of the GP response.

Worries that certain patients will learn how to play the system and will jump the queue for an appointment with their doctor in competition with a patient who rings the surgery direct.

PHR reported that Bucks have only just had their first meeting on NHS111.

Oxon are pushing ahead quickly but possibly using a flawed development structure.

The DoH has said that there must be a clinical lead for NHS111 working 4 sessions a week.

How will such a commitment be possible?

PHR will need to liaise with this new person to make them aware of known problems.

**Action Point: PHR will continue to monitor implementation of NHS111 in Bucks.**

### **LMC Elections**

The window for self nominations is between 1st December and 20<sup>th</sup> January 2012.

Full paperwork is now on the BBOLMC website:

<http://www.bbolmc.co.uk/elec2012/elec2012.html>

The forms have recently been altered to correct an omission.

PHR encouraged current reps to self nominate and also encourage others to become involved in the LMC.

Any partner or salaried GP employed by a practice that is paying the levy, or an independent locum who pays his own levy, is eligible to self nominate and vote.

### **Future LMC Rep payments**

GJ said that meeting attendance was paid at £150 per meeting and he did not intend to change this in 2012.

Currently it costs approximately £16K a year for meeting attendances, £7-8K for LRC and £7-8K for the County LMC.

As email workload is increasing in between the meetings, he proposed that that a new quarterly retainer of £100 is paid.

Additionally if any members undertake any authorised work on behalf of the LMC, then on receipt of an invoice this will also attract payment.

The extra £100 retainer will cost the LMC in the region of £8K per year or 1p per year on the levy.

GJ reported that the maximum levy was currently set at 35p by signed mandates.

However, the most he had ever drawn was 30p and he hoped that this would be less for the next quarter.

AS felt it was not appropriate for the Executive Officers to receive this retainer as he saw the role (already funded) as reading extra papers etc.

GJ said that he did not see the role of the Treasurer in that way and the retainer should be paid to that post.

Agreement that AS argument applied solely to the Chair.

It was agreed that this would be implemented from 1<sup>st</sup> April 2012.

It was agreed that a paper be produced which could go on the LMC website outlining payment arrangements. GJ agreed to produce this.

GB asked how these increases would affect tax and pensions.

GJ said that Rick Godlee had been tasked by the BBOLMC Board with finding this out and PHR said that he would ensure that this was done.

**Action Point: GJ to produce a document to go on the website explaining payments.**

**PHR to ensure that the work on tax and pensions in relation to payment to representatives is completed for the December Board meeting.**

## **Changes to the GP Contract for 2012/13 (BBOLMC email 2.11.11)**

The GPs' contract for 2012/13 has now been agreed and announced by the Department of Health. Changes to the contract include:

- 0.5% expenses increase delivered through QOF
- piloting of arrangements that will allow commuting patients in three cities a greater choice of which GP to use
- changes to practice boundary rules for patients moving a short distance
- the introduction of a new scheme that aims to reduce avoidable Accident and Emergency (A&E) visits

- revisions to the Quality and Outcomes Framework (QOF).

The GPC chairman's letter to the profession, giving more information on the deal, may be seen at: [http://www.bma.org.uk/representation/branch\\_committees/general\\_prac/letter2012contractagreement.jsp](http://www.bma.org.uk/representation/branch_committees/general_prac/letter2012contractagreement.jsp)

There will be a 0.5% increase in expenses which will be achieved by an increased QoF £/point. QP1-5 will be retired and QP12-14 (looking at A&E attendances) will replace them. There will be a second wider ring to the practice boundary for existing patients who move out of first smaller area.

They can remain registered with the surgery.

Meeting felt this has been introduced to try and stop the Ombudsman getting involved when patients do not want to change practices when they only move 1-2 miles away.

GPs felt that there must be some boundary and once the patient had crossed it that was it.

Some of the QoF indicators have retired or changed.

The Osteoporosis DES has gone and it is now in QoF.

Patients being able to register both at home and work with any surgery is being piloted in 2 or 3 large cities.

### Individual Case Review Panel (ICRP)

The main issues are thresholds and patient pathways.

For bariatric surgery, the threshold the patient must achieve is BMI >50.

However, there are no clear pathways on what to do with a patient with a BMI of less than this.

What is the Panel working to?

LMC had the following concerns:

- The anonymous nature of Panel membership.
- Lack of transparency of decisions.
- Absence of statistics on rejection rates.
- Consistency of decision making.

Recently patients who have been listed for surgery have been diverted to the Review Panel and it was not known why this had happened.

GB gave one example of a lady with BRAC1 gene who had had a mastectomy and was in the process of reconstruction having had the tissue expanders inserted when she was told that she needed to go and see her GP and get a referral to the low priorities Panel.

The patient was told this by the secondary care trust.

There is also administrative confusion.

One patient got a letter telling her that she had been removed from the waiting list so visited her GP to ask for what procedure this referred to.

The GP had written to the PCT who had then contacted the patient to ask.

It appears that she had been removed from the list for carpal tunnel surgery which she had had in May!

The letters are coming from the BHT but it appears that the PCT are sanctioning this.

PHR asked for a copy of this letter. ST said he would supply him with one.

The Bucks Herald and The Overview and Scrutiny Committee of Bucks County Council have now got hold of this story.

GPs asked why they (and not the Consultants) were being asked to write to the Review Panel.

GPs said that they will write a long and detailed letter to the Panel and then receive a letter back telling them to fill in a proforma which does not contain enough space to explain the problem.

If a proforma was essential then they should be readily available to GPs.

PHR said that he was now on the Right Care Committee so he would be able to see what issues went through the Committee.

Contacts with the Committee are made through the Secretary Sarah Robson who appears not to have any clinical knowledge.

Another example of odd logic was given.

A patient who had had 2 ectopic pregnancies (and so had no tubes) had put in a request for funding for IVF.

The response from Sarah Robson was that she was too young and if she had not become pregnant within 2 years to refer her back.

This case had gone straight to the Chief Executive to sort out but was indicative of some of the quality of the Panel's work.

PHR felt it was time to invite himself to meet the independent Care Review Panel and discuss how it works.

JB reported that in MK if the GP writes a really good referral letter then the patient will not get turned down.

**Action Point: ST to supply PHR with a copy of the letter from the Trust to the patient.  
PHR to meet with the Independent Care Review Panel.**

### MOBBB Priorities Forum and Prescribing by GPs

The MOBBB (Thames Valley) Priorities Forum is increasingly making pronouncements about what drugs GPs can prescribe and how much.

The latest one concerned erectile dysfunction drugs (only allowing patients 2 per month).

PHR reminded members that this was only guidance: GPs can prescribe whatever they feel is appropriate for the patient.

In Oxon Gluten Free foods have now been targeted, but they are not on the national black or grey lists, so it may be difficult to sell such rationing to patients.

GPs were concerned that if coeliac foods were now targeted what would be targeted in the future, baby milk?

GJ said that in Bucks Coeliac Disease patients are prescribed on a unit basis, being allowed a set amount of units per month depending on their age.

JB said that the same applied in MK.

Bucks has addressed the issue of Ensure and Complan and these are now only available over the counter.

There have been problems with dieticians recommending to patients what they should be taking.

GPs said that they only followed advice if it was issued reliably by a consultant.

Jane Butterworth has attended a dietitian forum and helped them to understand the problems that are encountered in Primary Care.

### Nursing Home Pilot and SIRF Bid Process

The Practice plc has apparently sent nursing homes a letter stating that they would like to register

their patients and implying they were able to provide a service that was not available from other GPs. PHR asked if he could have a copy of the letter that was sent. SK said he would provide this

It needs to be made clear that funding to provide the extra service is available to all practices involved in the thousand patient pilot.

Jane McVea has now written to the Nursing Homes directly.

The LMC congratulated Jane McVea on what she had done in making the funding available to more practices and clarifying matters with homes.

GPs reported that it is not unusual for The Practice plc to subcontract work to local practices as they were not able to get the staff to fulfil their obligations.

GJ reported that Jane McVea was still formulating a letter to The Practice plc.

**Action Point: SK to provide PHR with a copy of the letter sent by The Practice plc.**

### Letter from Deborah Sumner re HPV Testing on Cervical Cytology Sample

PHR asked if this was a national issue as it had not been raised elsewhere in the Thames Valley.

If the change reflected design of a better patient care pathway nationally, there could be no GP objections unless it significantly increased the workload for practices.

GPs felt any alteration in workload would be difficult to assess, but they did not want GPs to have to take an "HPV diploma".

GB said that the general feel was that after a few teething problems the repeat smears that are required for HPV would decrease.

### MK Issues

#### **Servicing NHS MK Meetings in Northampton**

PHR explained the clustering of MK PCT with Northampton.

He was finding it difficult to get to meetings in Northampton as the journey time was 1.5 hours each way.

He has to make a decision about what is the best way to spend his time and sitting in a car for 3 hours to attend a meeting was probably not the best use of his time.

Should MK GPs be asked how they want LMC to represent their interests?

JB reported that it is now likely that community nursing services management will be moving to Bedford Hospital so that is yet another liaison direction.

The PCT is clustered with Northampton but the hospital and others also have relationships with the Thames Valley and Bucks.

JB attending Northampton LMC has been helpful.

Overall there was no overwhelming desire to change the situation at the moment.

He said that he had attended the Northampton LMC meeting and from the North of the county it was 28 miles and took him 40 minutes to get to the venue so there are significant travel times to meetings.

PHR has been considering how best to meet the needs of MK GPs, and asked JB whether (if the funding was available and the change was thought desirable), he would be willing to work 2 sessions rather than the one attached to the post of LRC Chair?

JB said that it may be that he would be leaving clinical work and so would not be on the Performer's list. PHR said that this was OK as the position holder did not need to be on the Performer's List.

PHR said that how things will work in MK needs to be worked on.  
JB and PHR will work together on MK issues.

**Action Point: JB and PHR to work together on MK issues.**

### **MK CCG Election IT**

PHR reported that he been asked to run the elections for the combined CCG.

PHR posed various questions:

1. What is the electorate?  
The CCG has now decided it will be everyone on the MK Performer's list which is not a list the LMC hold, only the PCT does.
2. How to prevent voting twice.  
Will the ballot papers have to be numbered or be signed?

PHR has asked the CCG to reflect on his queries.

He proposes to act as an advisor only, with the possible exception of counting any signed votes.

The timeline is short.

There are 2 weeks for receipt of self nominations, and 2 weeks to conduct the ballot.

JB said that MK GPs would have more confidence in the LMC doing the counting than other organisations.

He asked if the LMC intended to charge for this.

PHR had not intended to, meeting felt this should be considered.

JB said that MKDOC were considering approaching the LMC to ask them to run their elections and were intending on paying for this.

### Docman in Bucks

Some practices have purchased this software themselves and wanted to know if the PCT had any plans to recompense them. They have been told that there are none.

This was someone in the PCT IT Department and not Andrew Fenton.

GB said that the N3 connections for practices needed to be checked as the speeds were too low to cope with Docman.

PHR felt that Andrew Fenton generally solved such problems when he was made aware of them.

The Docman system that is being proposed is not the basic version but the one with EDT.

### South Bucks Enhanced Services Working Group

This has become a key committee for negotiating extra income flows for practices.

Historically the PCT have always ring fenced the ES money but this has now changed.

Jeremy Newton is now actively involved as is the LMC. Nick Reidy is the new Chair.

It is hoped that this committee will facilitate funding following shifted workload.

The working concept now is that there is no ceiling for ES spend provided it can be recovered from secondary care streams.

CN asked who was looking at the budgets set aside by the PCT for Primary Care. The Secondary Care budget is negotiated but there did not appear to be anyone looking at the Primary Care side of things.

These budgets are being looked at now.  
Catherine Woolley is the person to approach to see the figures.

**Action Point: PHR to approach Catherine Woolley to see the Primary Care budget for 2012-2013.**

### CCG Developments

PHR said that there were concerns that the PCT was declining rapidly but the CCGs were developing in a much slower fashion.

The Cluster Chief Executive and Finance Director were from Oxon and they may not have sufficient grasp of Bucks issues.

A lot of work needs to be done in the next 16 months by the CCGs in both Bucks and MK.

In Bucks there have been meetings to consider the 2 CCGs merging, and although it was thought a consensus view had been agreed, it now appears this is not the case.

Johnny Marshall has apparently resigned his post on United Commissioning but this had not been fed back to the joint meeting.

Grass roots GPs would seem to support a merger but the real current position was not known.

### Update from GPC Rep

#### **Revalidation**

The criteria for evidence is currently unchanged; there are guidelines available to help on this.

### Historical LMC Minutes: keep or shred?

PHR reported that the storage space in the Marlow office was full and asked what members thought about keeping or shredding old minutes.

JB said that storage facilities were readily available and not too expensive.

Another suggestion was that one set of minutes per year could be kept as a historical record.

### Social Event

AS suggested that the LMC hold an evening meal before the new Committee is formed.

This was agreed.

Suggestions of venue to PHR.

**Action Point: To suggest venues for a social evening to PHR.**

Date of Next Meeting – 3<sup>rd</sup> February 2012

The meeting opened at 2pm and closed at 4.10 pm.

DRAFT

<b>Present</b>	<b>Name</b>	<b>Organisation</b>
	Alifoe, Hopeson	Milton Keynes LMC
*	Beck, Gill	VoA LMC
*	Birchall, Carol	LMC Minute Secretary
*	Bradley, Julian	Milton Keynes LMC
	Brookes, Clive	Milton Keynes PCT
	Buttar, Prit	GPC Rep (Co-opted)
	Cowland, Nick	Wycombe LMC
	Derry, John	TVPCA
	Dickson, Rodger	VoA LMC
	Gamell, Annet	CCG Lead
	Hicks, Nicholas	Milton Keynes PCT
	Holy, Kristian	Wycombe LMC (Co-opted)
*	Howcutt, Mark	VoA LMC
*	Jackson, Graham	VoA LMC
	Kennedy, Jim	LMC Medical Director
	Kuetter, Stefan	Wycombe LMC (Co-opted)
	Macalister-Smith, Ed	Bucks PCT
	Mahendran, Muttucumarasamy	Milton Keynes LMC
*	Mallard-Smith, Rebecca	C&SB LMC
	Marshall, Johnny	CCG Lead
	Moore, Darren	Milton Keynes LMC
	Neale, Tom	VoA LMC (Co-opted)
*	North, Christopher	Wycombe LMC
	Payne, Geoff	Bucks PCT
*	Peacock, Tim	VoA LMC
*	Roblin, Paul	LMC Chief Executive
Chair*	Sapsford, Andy	C&SB LMC
	Smith, Louise	Bucks PCT
*	Thompson, Simon	C&SB LMC
	Thorpe, Penny	TVPCA
	Whiteman, Sarah	Milton Keynes PCT
	Wilson, Ingrid	C&SB LMC

**Apologies: Dr Cowland, Gamell, Mahendran and Sarah Whiteman**

**Dates of future meetings:**

**20.04.12      22.06.12      07.09.12      09.11.12**