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MINUTES OF SOUTH BUCKS LRC/PCT LAISION MEETING
Tuesday, 17th January 2012
Stokenchurch Medical Centre, HP14 3SX

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Minutes of Previous Meeting

Minutes of meeting held on 11th October 2011 were agreed as a correct record of the meeting.

Matters Arising

Seniority Clawback
3 appeals are to be heard on 30th January.

LES Clawback
Decisions being made at a high level within PCT. Result soon.

Consultation over "Better Health Care"

Three months consultation on this began on 16th January.
The proposal is that Wycombe will have:

- A diagnostic centre by appointment only, where for example patients with possible chest infections will be able to have a CXR.
- A service for the elderly and frail (but not confined to the elderly) led by geriatricians with a consultant presence.
- Front door signposting an MIU.
  It is hoped with time there will be no need for such signposting.

A&E will be moving to SMH which will not be liked by the public in Wycombe.
HM-K said that the local shuttle bus service had been stopped in November and although a new service has been introduced it only takes patients from the bus depot in Wycombe to the Hospital a journey of about 4 minutes with a flat rate charge of £1.50.

It was recognised that duplicating services in one county was not affordable.
Clinical areas would have to be located in one place eg Stroke and Breast Surgery at Wycombe and Gastroenterology at Stoke.

Funding of ABPM Machines

This has been discussed at Medicines Management Working Group (MMWG).
The initiative reflects NICE guidance that diagnosis should be confirmed by ambulatory recordings. Since the argument for using ABPM is largely partially financial (drug cost savings from not starting patients on unnecessary medication), MMWG agreed with PHR's view that the local health economy should fund ABPM.
PHR felt that Jane Butterworth had equipment and training costs.
Maintenance and training costs also need to be funded.
Some practices already have a machine but with a limited life span.
Often these have been provided by patient groups or bequests, but this means of acquiring equipment is not sustainable.

LS said that a business case needs to be developed and presented to the Capital Group (has CCG representation). The likely end of year under-spend might be used.
Depending on their size, practices might need more than one machine.
LS said that the Capital Group may consider seeing what funds were available and dividing it up across the practices.
LMC suggested that practices could invoice the PCT directly for the purchase and maintenance of these machines but it was probably better for the PCT to know exactly what they were spending.

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LMC suggested that the PCT should consider approaching companies to see what the cost of the machines would be if they obtained them in bulk.
HM-K reported she had obtained a price of £1200 + VAT for a single purchase.
PHR felt the researched Oxon bulk purchasing costs were lower than this.

PHR agreed to send LS an email outlining the equipment and renewal costs.
The LMC would like to see a system which funds these on an ongoing basis.
GJ said that as the data from this recorder was downloaded to a computer it could be seen as an IT peripheral and may be funded that way.
Therefore, PHR will copy Andrew Fenton into the email to LS.

Action Point: PHR to email LS with details, copying to Andrew Fenton.

E-Profile Website

This is a Bucks PCT website that allows practices to upload documents for QOF Pre Payment Verification (PPV) and the GMS Contract monitoring.
Wycombe practice managers had understood that all practices would have to do each year would be check these documents online and make the small alterations that were needed.
Otherwise the bulk of documents would be rolled over each year.
It now seems that all past documents have been removed and are therefore un-editable.
Practices found this out late, and the deadline for receipt of this year's documents is 31st January.
Whilst the time taken to edit documents is the same, whether on line or at a practice computer, the uploading time for the editing in the practice is considerable.
Some practices will not have time to complete the uploading of these documents to meet the deadline.
The website is very cumbersome to use: it takes more than 3 minutes to upload one document and then the system refreshes which takes you to the top of the page and you need to scroll down to where you want the next document to be.

LS responded. The documents have been archived not deleted.
If the documents were available the practice would still have to download them to make the changes and then upload them again as the system will not allow changes to be made.
HM-K said that this was not made clear at last year's presentation and demonstration to PMs.
LS said that the PCT would look at changing this for 2012-13.
The same system is being used in Oxon.

LMC asked if it was possible to move the deadline to allow practices to complete this work.
LS said that this was a national deadline so the PCT would not be able to change it.
KB said that there were practices that were already editing and uploading.
It was mainly Wycombe practices that had not started.

LMC felt that Practices are contractually obliged to submit evidence via a method of their choice.
LMC suggested that as practices had this information already stored on practice computers the PCT should accept an email with them attached or a memory stick with them on, or they could print them out and send them in to the PCT.
GPs said that the PCT would need to supply the memory stick as ones sent in would not be allowed to be used.

LS said that she would discuss the options with her team.

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The PCT would not want to receive paper versions but as a compromise would be prepared to accept documents emailed or on a memory stick.
LS said that the system obviously has teething problems and that the PCT would be looking at these.

HM-K said that 90% of the documents would not be changing as they related to issues outside their control such as where allergies were recorded on the clinical system so all the practice needed to do was to check they were correct and change the date on them.

Action Point: **PCT to look at changing the E-Profile system so that documents do not need to be downloaded for editing and re-uploaded.**
The PCT to accept documents by memory stick or email from practices.

QP (end of year and next year)

End of Year:
Clarification is needed on what the PCT expect in the end of year report.
This should tally with the original emails from Anne Ronan.
LS said that she would be sending out an email on what is expected in line with AR's previous communication. Practices should expect to receive this by the end of January allowing them 2 months to produce the required report.
PHR said that if nothing had been received by the end of January he would re-send the email from Anne Ronan.

Action Point: **LS to send out an email to practices on what is expected for QP reports for the end of the year.**

Next Year:
The LMC said that they wanted to encourage both the CCG leads and locality leads to generate their own ideas for care pathways for QP in 2012-13.
It was suggested the CCGs develop a picking list of pathways where the data has shown there are problems.

LS said that this was not dissimilar to what was suggested this year.
This went to Impact and CCGs are represented there.
The ones that had come out were the ones that were visible at the time.
This year they want to see that the choice is better informed.

Some of the people on the Urgent Care Forum developed pathways with GPs for QP and QoF but did not understand the implications of what they were asking for.
GJ stressed that QP 9-11 did not come through the Impact Group last year.

LS reported that she would be attending an urgent care meeting next week and a meeting with Lou Patten and the urgent care team on 7th February about what pathways might look like.
"Right Care" is waiting to hear about this.
PHR said that in the past Right Care seem to have operated in isolation and made decisions without reference back to clinicians in either the CCG/localities or the LMC (over a GP contract matter).

Meeting was suspicious that that the data was not good.
CCG should have system data to identify any problem areas and should be able to develop a picking list for practices.

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GJ said that a few years ago practices analysed 200 referrals and as a result had been able to identify problem areas. Now it is the CCGs who should be identifying these areas.
HM-K reported that her cluster had data about high referral areas, one of which was gynaecology. Practices had gone through 6 months of referrals to EPU and it had transpired that BHT had charged a first attendance on the first and subsequent 2 visits which was why the data was wrong.

LMC asked LS to liaise with CCGs to identify the top areas for care pathways and to produce a picking list to present to practices and the LMC for care pathway choice.
Coding issues probably account for apparently high referral costs.

Action Point: LS to liaise with the CCGs to identify the top areas for care pathways choice under QP and produce a picking list to present to practices and the LMC.

SHA Waste Initiative

Jane Butterworth presented this item.
As part of the QUIP programme South Central are looking at how to reduce waste of medications.
They are funding a patient advertising campaign involving sending a pack to all practices.
The aim of the campaign is to improve patient awareness.
Before 20th February dispensing practices and community pharmacists will be given 30 patient evaluation questionnaires to hand out to patients and to then collect back and send off to a central collection point. These questionnaires will be supplied with return envelopes.
NC as dispensing lead said that he could see no problems with the questionnaire he had seen.
Only dispensing practices will receive the questionnaire, other practices will receive a pack with leaflets, posters and a flier to attach to prescriptions.
There will be a presentation slide pack to use with computerised patient boards in waiting rooms.
The aim is to stress that medications cannot be re-cycled and must be disposed of safely.

Enhanced Services Update (end of year and next year)

PHR said that he had seen the specifications and had been through them.
He was happy that there was one overarching document which covered the wording common to any ES contract.
He asked that the PCT highlighted any significant changes in the wording from last year.
KB said that each specification will follow the same format and having a cover sheet makes it easier.

PHR comments
The anticoagulation hyperlink did not work.
The Health Check LES starts on 1.10.11 and runs to 30.9.12: is this correct?
KB said that the LES had started in October 2011 so the current end date would be 30.9.12.
PHR queried why this was: other LESs were for the whole of the financial year.
KB said she would ask public health.
PHR raised a query about the flu vaccination text.
It states that GPs are responsible for ensuring that the housebound patients are vaccinated but it is not explicit that GPs need to administer the vaccine.
KB felt that the wording was unchanged from previous years, but she would clarify this.

LMC pointed out that there has been no change in the fees from last year and disputed this outcome.
Some of the LES contain reimbursement of overheads for both staff and consumables eg the suture removal LES.

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Practices might tolerate no rise in the fees this year but this cannot go on indefinitely without them considering opting out of delivering the service.
If fees do not go up practices will take an unfair financial hit.
Next year there is a need to identify overheads and adjust fees accordingly.
PHR asked if the fee structure had been discussed by the ESWG. He felt it hadn't but it should now.

With suture removal an HCA can carry this out but as they are paid below the DDRB threshold they have received a national mandated annual pay rise.
There has also been a VAT increase and rising cost of consumables (which constitutes a third of the LES). The same applies to H-Pylori testing.

PHR attends the ESWG and there was no practice manager representative on the committee.
Nick Reidy is the Chair and discussions have taken place on inviting a PM on to the group.
It has formally extended an invitation to anyone who wants to attend the meeting.
HM-K felt that PMs were "meetinged out".

Action Point: KB to ask Public Health about the duration of the Health Check LES.
PCT to look at developing LESs that included regular assessment of labour and consumable costs.

Flu Vaccination of Housebound

PHR felt that this was a nursing task and therefore in the community it should be the DNs that are responsible for administering flu vaccine to the housebound.
The DES says that practices are responsible for identifying and for setting up a recall system for each patient getting vaccinated and to ensure it is delivered.
CHB (now hosted by BHT) should be responsible for vaccinating all the housebound and should not be charging practices for this.
The contract between the PCT and CHB is not written in enough detail to say whose responsibility this is.
HM-K said that ACHT (Community Health Teams) specifications were being re-written and these details could be put in it.
PHR reported that he had asked the same question of GP commissioners.

HM-K said that the specification had been discussed at a collaborative meeting and had highlighted that they helped with services that were required under QoF for practices.

The housebound phlebotomy is still not sorted out.
If a DN is asked to do this it takes a long time and eventually the patient is put on a 'maintaining independence package'.
If the ACHT service specification could include housebound phlebotomy, it would be extremely useful.

The delivery of services to the housebound needs to be defined, eg diabetics, DSN says that this is a nursing role within the practice and the community team say they will not provide this.

Leg Ulcer Dressing

At a previous Liaison meeting, there had been a PCT attendee commitment that Tier 1 could roll forward several times but this was subsequently rescinded.

The original suggestion was a holding position until a tier 2 service was developed.
At the moment practices have a heavy unfunded practice nurse workload.

LS anticipated a tier 2 service. Work is being undertaken by David Roscombe.
PHR said that he would ensure that this goes to the ES Working Group.
It causes considerable overheads for practices to commit nursing care to these patients.
One GP said that a 95 year old lady who was virtually housebound managed to get a bus to the surgery to have her ulcer dressed and because of this the DNs said that she was not housebound so would not treat her.

Action Point: PHR to ensure that leg ulcer care is discussed at the ES Group.

Care Homes LES

The ES Group has queried why a care homes LES was going forward for 2012/13.
Impact had earlier supported it.
Because of this discrepancy, Jane McVea is not currently pursuing the LES.
An emergency meeting is planned.
It is also going to the Clinical Commissioning Board and Executive Team ASAP.
A corporate view will be taken.
LMC asked whether the PCT had sought the views of practices who had undertaken the pilot.
Meeting commented that only The Practice PLC had done this work for long enough for information to be possibly meaningful.

Deregistration patients and the regulations

LMC asked whether involved care homes and practices had been told that The Practice PLC would be in breach of their contract if they sought deregistration of patients who had not changed address.
LS said that Matthew Tait and Stewart George were looking at this.
LMC stressed that practices may not be aware that The Practice PLC would be in breach if they encouraged re-registration of patients.

Action Point: PCT to look at informing practices and care homes on the rules surrounding deregistration of patients.

IM+T Update

Nothing in the paper was contentious.

Priority Setting (MOBBB)

LMC believes the PCT contract is with Solutions for Public Health (SPH) and that it is inappropriate for the PCT to accept that supplied information that informs a MOBBB decision is not in the public domain. LMC feel an urgent revision of the SPH contract and MOBBB terms of reference is necessary.

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PHR now receives MOBBB papers.
This was after having recently been offered them, then refused them and then been re-offered them.
This is necessary so LMC can comment when prescribing for GPs is being considered.

NHS111

PHR is on the both the Bucks and Oxon committees.
Oxon was going live (soft launch without advertising to the public) with this in 1 month's time.
The Call Centre questions a caller and concludes with a nationally defined patient disposition.
This usually defines the appropriate professional that should provide input and a time scale, eg a patient needs to see their GP or OOHs in 1, 2, 6 or 12 hours.
LMC has been looking at whether this will produce a work burden for practices.
The new system needs to ensure that any call handler disposition to GPs is appropriate.
Debbie Breen is leading on this project in Bucks.

It is hoped that the national "NHS Pathways" software will not over-escalate issues and cost the local health economy.
Cases where this might have happened will be analysed with a view to software editing or call handler retraining.
Emergency departments at the hospital are also worried about an escalation of workload in their departments.

BHT Dossetts

It appears that recently there has been an increase in patients being discharged from BHT and BHT asking GPs for dossett boxes.
PHR is dealing with this directly with BHT.
LMC felt that BHT needed to speak directly to the pharmacist.
Pharmacists are funded under their contract to assess and supply MDS (Monitored Dosage Systems) to those with sufficient disability.
This is backed up by the DDA (Disability Discrimination Act).

Action Point: PHR to copy any correspondence with BHT to Jane Butterworth.

Medicines Management 6 + 10: Proposals for 2012/13

This has been delegated to Jane Butterworth's Medicines Management Team.
The LMC feels that the outline proposal is acceptable.
PHR will liaise with Jane.
A joint agreement between Medicines Management and the LMC is needed.

Action Point: PHR to liaise with Jane Butterworth.

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Next Meeting – 13th March 2012

The meeting opened at 2pm and closed at 3.15 pm.

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Present	Name	Organisation
	Beck, Gill	VoA LMC
*	Birchall, Carol	LMC Minute Secretary
	Corlett, Helen	C&SB LMC (Co-opted)
*	Cowland, Nick	Wycombe LMC
	Dickson, Rodger	VoA LMC
	Gamell, Annet	PBC Lead (BPCC)
*	Howcutt, Mark	VoA LMC
*	Jackson, Graham	VoA LMC
	Kennedy, Jim	LMC Medical Director
*	Kuetter, Stefan	Wycombe LMC (Co-opted)
*	Mallard-Smith, Rebecca	C&SB LMC
	Marshall, Johnny	PBC Lead (UC)
*	Morris-Khan, Helen	Practice Manager
	Neale, Tom	VoA LMC (Co-opted)
	North, Christopher	Wycombe LMC
	Payne, Geoff	Bucks PCT
	Peacock, Tim	VoA LMC
*	Roblin, Paul	LMC Chief Executive
	Sapsford, Andy	C&SB LMC
*	Smith, Louise	Bucks PCT
	Thompson, Simon	C&SB LMC
	Wilson, Ingrid	C&SB LMC

Apologies: Drs Beck, Kennedy, Neale, North, Payne, Peacock, Sapsford, Thompson and Wilson

In Attendance: **Kaileigh Brown, Jane Butterworth**

Dates for Future Meetings (*Tuesdays*)
13.03.12 15.05.12, 17.07.12, 16.10.12

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