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Minutes of Buckinghamshire LMC Meeting Friday 26th February 2010 The Fairford Leys Surgery, Aylesbury, HP19 8GG

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Minutes of Previous Meeting

The minutes of 13th November 2009 were agreed as a correct record of the meeting.

Matters Arising

Reinvestment of Prevalence Savings in Primary Care

PHR said that he had asked EM-S what would happen to these savings but had not received a reply.

He said that he had asked the question before and the answer was there would be no reinvestment of QOF savings until the PCT had solved its financial deficit.

Meeting accepted that LMC should not ask a question for which the answer was already known.

Some reps believed the PCT was forecasting a break even situation this year.

IAPT

PHR said that he had received a rebuttal to the view that counselling services should not be decommissioned based on the PCT belief that that counselling services are not evidence based.

AG said that there had been a reversal of the decision but this was only after the current services were given notice. The new counselling services will be under the umbrella of IAPT.

It may be that some from the current counselling workforce will be re-employed under IAPT.

When the issue of decommissioning the current counselling service went to PEC, the decision had already been made by the Mental Health Board on which there are counsellors.

South Central SHA Policy on DNACPR

PHR introduced the subject.

To avoid repetition of debate, PHR had circulated the extract from the Berkshire minutes to all TV LMC reps.

Work on the laudable DNACPR project has been going on for almost 2 years.

It was realised very late on that the LMC had not been involved.

Various LMC contributions have since been received and are reflected in Version 8 of the document (enclosed with the papers).

Oxon LMC had met the day before the Bucks meeting and an issue had arisen over the obligatory use of lilac paper when the form was printed by practices rather than taken from a pad.

It was recognised that the form needed to be readily identifiable by the ambulance service.

However, it must also be recognised that if GPs are initiating conversations with patients and signing these forms, then obstacles to GPs carrying out this role must be minimised.

Mark Rowland commented:

- Section 8.8 of the policy (the GP bit) still needs some work.
- GPs would prefer to have the form available electronically in the surgery.
NHS Creative has made this available.
It was agreed that this would be made available to practices in RTF format.
- The form will be used in the patient's home, hospitals, hospices and care homes.
The service wanted to ensure that it was printed on lilac paper as research had shown that this was the colour that was least used and it was also a colour that allowed it to be scanned without any loss of definition.
- The Project team planned to let practices have either a book of 50 lilac forms or supply the practices with a ream of lilac paper which could be kept centrally for use when forms needed to be printed.

In every place except the patient's home this form will be kept on the top of the patient's record.

In the patient's home there will be a sticker just inside the front door identifying that a completed DNACPR form exists.

Ambulance crews will then know to look in the fridge for a bottle containing a tear off slip with details of where the form can be found.

The ambulance service default policy is to start CPR within 30 seconds if the form cannot be found, and they will stop if it is found later.

It is not anticipated that practices will be producing many forms over the period of a year.

LMC asked why a wrist band (or some other identifying method) was not used?

Tracy Courtneil said that they had looked into research carried out in the USA on use of wrist bands: patients were discovered to be swapping them!!

It may be that in the future wrist bands could be developed for use in the UK.

LMC asked whether it would be possible for the ambulance service to be told when a patient has completed one of these forms and for it to be noted in their ambulance electronic records.

When a call is received SCAS will then already have details of its existence.

MR said that it was hoped to do this with Adastr software but not all services have this yet.

LMC expressed concern that if the patient took this form into hospital it would never come out again.

MR said that processes would need to change and the hospital would have to phone the GP as well as send out a discharge summary.

LMC asked if there would be any picture on the form to identify the patient, MR said that this may come with time.

MR said that they had liaised with Juliet Spiller from Lothian who had developed a similar service for about 800K patients in 2006.

They had initial problems which have now been ironed out and this policy is about to be rolled out across Scotland.

The South Central policy is the first of its kind in England and it may be it is rolled out across England.

If a form is produced electronically GPs need a Read code.

PHR said that some have been identified, but he would circulate TV reps to ensure that they were available on all systems before forwarding them to MR.

If a patient cancelled the DNACPR decision a second code was needed, rather than delete the original.

Action Point: TC to clarify whether the ambulance service would accept anything other than lilac paper.

PHR to research suitable Read codes to use.

John Lilley Resignation

AS spoke to this item.

Dr Lilley has resigned from the LMC after many years. He is also coming up to retirement from General Practice.

It was unanimously agreed that he be thanked for all he had done for the LMC over the years.

JL was a rural dispensing practice representative, NC also represented these practices but it was felt that it would be good to have a replacement rep from the North of the county.

PHR said that every time a vacancy arose he advertised for such a replacement.

Action Point: PHR to advertise the VoA vacancy.

PHR Report for 2009 and LMC Conference Motions

This item was included for members' to sanction PHR's report being sent to practices and also to act as a prompt for motions to conference.

The deadline receipt of motions (12.4.10) is before the next County LMC meeting so PHR asked that members email him issues for motions or motions themselves.

PHR would also produce a list of those motions he had received across the TV noting who had proposed them and which county they were from.

GB said that it was easier for the GPC to receive one motion which was proposed by two or three counties rather than 4 copies of the same motion.

Meeting agreed that motions should be with the Marlow office by 1st April.

Action Point: Reps to email motions to PHR by 1st April.

Appraisal Toolkit

There have been problems for the appraisers due to the website being down on security grounds. See <http://91.103.184.242/default.aspx>

If you email the Bucks appraisal office it will forward the present documents to the appraiser but supporting evidence may be inaccessible.

It is hoped that the modified website will be up and running again by 3rd March.

Bucks PCT has said that they will allow one extra month for GPs to get their appraisal done.

JD said that if the PCT were to take a GP off the performers' list because they had not had their appraisal done due to the site being down, that GP could go to appeal and the PCT could find themselves having to pay costs. Therefore PCTs were unlikely to be unreasonable.

Appraisers reported that there were still GPs who had not had their appraisal organised despite being contacted several times.

The LMC said that they it would have difficulty supporting the behaviour of such GPs.

It was proposed that LMC should contact Marion Lynch's department and help to encourage those GPs apparently unlikely to have an appraisal this year for reasons outside the toolkit inaccessibility.

Concern was expressed that the aim was to have parts 1-3 only available electronically next year with a view to having revalidation only available electronically.

Action Point: PHR to contact Marion Lynch for the names of those GPs who had not had an appraisal so he could contact the practices concerned.

Leg Ulcer Care, Essential Services and Enhanced Services

One meeting has been held at which PHR and TP and his practice nurse were present along with Sue Knight, a senior CHB Tissue Viability nurse who seemed very pro GPs and an international Tissue Viability expert.

Bucks PCT is starting work on defining the care pathway for leg ulcers.

PHR was surprised the PCT were not expecting to pay for the time and expertise of the practice nurse on this issue and objected strongly.

LMC and PCT need to agree the boundary between core GP services and non core services. Ulcers that have a chronic and vascular component or those that need clinical intervention after 6 weeks, or that ordinary dressings are not helping, should not be core services.

The current problem is that once the GP has got advice from the specialist nurse the patient is handed back to the PNs to treat.

Sue Knight seems not to support care not being provided by specialists in tissue viability.

The hope is that savings from reduced referrals from plastics and dermatology will fund this new service.

A wound care formulary must be developed and consistently used.

Training levels needed to be looked at.

PHR stressed that core services should not be defined by what some evangelical practices currently do. Whether use of Doppler fell into core was debatable.

Training was needed for practice nurses to reach a certain level of competency, the PCT do not have the funding available to deliver further training.

Action Point: The Committee to continue to work on this issue to reach a solution.

Can LMC Represent both Practices and Individual GPs?

PHR spoke to this issue.

When GPs worked under the Red Book the levy was paid by individual doctors and the agenda question did not arise.

Under the new GP contracts, the levy became payable by practices and this funded services to partners and paid medical employees.

There is now potentially a clash between representing the interests of the practice and individual doctors.

PHR has never met a situation where this was not easily dealt with, but it has been raised as an issue in MK.

PHR contacts any new practice within the TV and asks them to contribute to the LMC levy and become eligible for LMC services.

The Darzi Centre in Milton Keynes has declined this offer, but the equivalent Centre in Banbury did not and the one in the new centre in Wycombe is also likely to contribute.

PHR view was that LMC represents any one doctor who works in a levy paying practice or pays the levy themselves (this requires independent registration with the Marlow office) eg peripatetic locums.

In practices that pay the levy, it is the partners that pay.

The problem is the expansion of GP contracts to include APMS.

Some worried that in future a large private company might open a lot of practices and then want to dictate to the LMC, to the disadvantage of GPs and traditional practices.

One way to get around this is to represent doctors as employees rather than practices.

AG felt that the LMC should represent both the practices and individuals.

If there are conflicts within practices other members of the LMC could represent one side and PHR the other, similar to the way solicitors work.

PHR gave an example:

There has been a problem recently with the new Darzi Centre in Banbury which is run by PML with its 140 or so local GP shareholders.
Pulse and the Banbury Guardian have recently reported that Oxon LMC see the Centre as a waste of money, a position the LMC has always taken.
PML have objected saying that as GPs paying the levy they expect to be represented by the LMC.

The contradiction in the LMC was recognised; practices pay the levy but individual GPs vote in elections.
Excluding LMC from representing practices against doctors, would risk practices withdrawing from the levy and was neither a practical nor a desirable option.

PHR said that the LMC also have OOHs organisations asking to be represented.
On these occasions he had adapted the levy so that it was based on the number of WTE salaried GPs who were working there and then basing the cost on £25 per session.

Any LMC is not bound by the way other LMCs operate and there is no rule book that can be imposed by the GPC.

The answer to the original agenda question was 'Yes'.

Action Point: To continue the debate in the future and keep representation under review.

Medicines Management and QoF Med 6 and 10

GJ had forwarded this to members today in exactly the format he had received it, including visible tracking changes.

It was originally discussed in January when he was not present and had been revisited in February.

This applies to the 2010/11 QoF.

A lot has been taken out which would have made it non-achievable.

He hoped this would be accepted by LMC so that it can be signed off by the Medicines Management meeting next Thursday.

The first part is CQC policy implementation for all practices for 2011-12 about medicines at the interface.

A mandatory part of the QoF for this year is good quality practice and the PCT are asking practices to provide a policy to look at discharge medication issues.

A template page is provided, which can be used in the first 3 months.

In the second quarter, there is a requirement to audit 2 patients per 1000 registered population.

At the end of the next 6 months practices will have to consider what changes to systems might make a difference.

Overall it is a very simple process. GJ recommended it to members as being quite achievable.

PHR summarised.

The PCT has produced a menu of 5 items, 2 of which are mandatory: practices have to pick another one from the remaining three.

Medicine 6 of QoF gives points (and funding) for practices meeting with the prescribing advisor and agreeing three actions: Medicine 10 is the same but adds the provision of evidence of change.

No PCT is going to allow practices free rein to define their own three actions: there has to be a PCT judgement about the challenge associated with the tasks, hence the menu options.

Overall GJ recommended this to GPs as a very favourable document. Once it has been signed off he intended to circulate it to every practice so they would have it by the end of March.

Action Point: LMC supported the options within the PCT menu.

Referral Quotas (Elective and Emergency)

GPs said that the quotas were not a problem: it was the behaviour of BHT which was. GPs were having to write many times and inappropriate discharges meant that GPs have to refer again.

Any problems should be reported to collaborative leads.

GB gave an example of a patient with a hearing aid going to audiometry and then being told to visit their GP to get a referral for follow up.

GPs said that the quota system was good as it concentrated GP minds on the appropriateness of their referrals.

There were no consequences if GPs exceeded their quota.

The figures so far were very impressive, with drops in referrals likely to help with financial balance.

Action Point: Send problems to collaborative leads.

Safeguarding Children and GP Training

PHR enquired whether GPs could get access to training.

CHB has a team which will take on training and give a certificate at the end.

The certification is valid for 2-3 years.

Action Point: CN to email PHR the details of the training.

National Audit for Falls and Bone Health in Older People

AS said that the paper had been circulated on behalf of the Royal College of Physicians (RCP).

During the period Sept to Dec 2010, practices will be asked questions about patients attending A+E. This is part of an audit programme to improve care for this group of patients.

A questionnaire will be sent out but it is not yet known how onerous this will be.

The second document is reassurance for practices that it is OK to share the data.

Individuals will only be identified for the purposes of linking up data from primary care and secondary care.

Only aggregate anonymised data will be submitted to the RCP.

Action Point: Practices to inform PHR if the questionnaire proves too onerous.

Enforced C+B Use

PHR asked whether this is still an issue: it is.

Despite three attempts at training, Bucks PCT has been unsuccessful in getting C+B to work in GB's practice.

The Vision system will not allow the letter to be uploaded and the PCT trainer, Lindy Gilham, does not know to do it.

GJ said that his system crashed when C+B was used.

In Bucks PCT Board papers (in the public domain), the 5 practices that do not use C+B have been named.

EM-S's view is that everyone should be using C+B: the PCT seems blind to the practical problems.

Many demand management initiatives are incompatible with C+B. C+B does not permit a delay in referral decision.

Reps felt tick box tokenism seemed acceptable to Bucks PCT.

Provided the PCT C+B figures looked OK, and irrespective of whether practices valued or properly used C+B, the PCT was happy.

One rep reported that she was told that if her practice did their Advice and Guidance letters through C+B, the PCT would accept this and count the practice as a C+B user.

The PCT have a 'hit squad' which is visiting practices that are not big users of C+B.

One rep said that there was one positive spin off: when the PCT had visited the practice, they said that the equipment was very old and should be updated at PCT cost.

That C+B is not mandatory is enshrined in the recent C+B guidelines from CfH which PHR has sent to EM-S.

One rep stressed that when C+B does work it is good for patients.

Action Point: PHR and AG to work together on this.

PCT Reinvestment of Savings

The most recent Bucks PCT Board papers describe an in year £5.9m underspend in the primary care budget with a predicted outturn of £6.2m saving. There have been underspends on QoF, Enhanced Services and GP premises.

LMC reps felt that Bucks PCT should recognise this publicly.

For 2010/11 the primary care budget is smaller as the PCT are using the outturn from last year as the budget figure. In other words efforts to reduce spend are rewarded with budget cuts, hardly an incentive.

The SHA have said that ES should be regarded as invest to save opportunities.

Services from secondary care should be moved to primary care with the money following.

View expressed that nationally the ES budget should have been protected as practices have concentrated on the swine flu vaccinations and have not had time to do the ES work.

Bucks PCT seems to control resources available to primary care more than it does within secondary care.

LMC to raise this issue at the next Liaison meeting (10.3.10).

The Planning of ES for 2010-11

PHR said that he had not seen details of Bucks ES for 2010-11.

AG said that when these were discussed in PEC, she had been told that the LMC had been involved.

30 papers had gone to PEC to be discussed and the ES section was last on the Agenda.

The PCT had said that the majority would be rolled over so it was not a problem, but GPs felt that this needed further discussion.

There had been a further meeting which had lasted 3 hours to discuss these ES.

The Zoladex ES has been changed to now include Prostag as it is cheaper than Zoladex.

It will be rolled over but called GNRH.

PHR felt he had suggested this to Medicines Management last week and they had rejected this.

The worry is that it is now 26th February, and the PCT have not consulted with the LMC and ES specs have been rolled out.

Specifications have already been sent to Practice Managers.

PHR said that he had definitely not seen any specifications.

CL and GP had brought them to the PEC.

If the further meeting had not occurred H-pylori and Removal of sutures would have gone.

LMC felt that Bucks PCT should recognise the contribution GPs have made to bringing the PCT back into (or close to) balance.

It was agreed that this should go on the LRC Agenda for further discussion.

Action Point: To put this on the LRC Agenda.

List-server Behaviour

Following some postings, PHR had circulated a plagiarised copy of code of practice for list servers and members' behaviour.

It is the same as the BMA version.

PHR intended to take this to the BBOLMC Board.

JB said that Yahoo who host the list server have their own code of practice and terms and conditions and it may be that nothing needs to be done to replicate this.

PHR said that he would not just remove anyone from using the server for a breach: it would go to the Board in the first instance.

PCT divesting its Provider Arm (CHB)

The contract for managing the provider arms has gone to a collaboration of BHT, the 2 collaboratives and The Practice.

BHT is now the official hosting body, but only because a pre-existing organisation was needed.

There have been a lot of negative comments.

This is part of the Government initiative of "Transforming Community Care".

Bucks and Oxon are the only two TV counties to start, and Bucks are the closest to achieving their aim.

GJ spoke on the issue.

GJ said that the Government did not want new organisations with Boards and Chairs.

CHB will be hosted by BHT organisation.

BHT will have an additional Community Directorate.

The new organisation will be looking for GPs to work with them from the start.

Work will be paid for out of the CHB budget.

View expressed that DNs need to be employed by GPs.

Date of Next Meeting – Friday 30th April 2010

The meeting closed at 4.20 pm.

DRAFT

Present	Name	Organisation
*	Beck, Gill	VoA LMC
*	Birchall, Carol	LMC Minute Secretary
*	Bradley, Julian	Milton Keynes LMC
	Brookes, Clive	Milton Keynes PCT
	Buttar, Prit	GPC Rep (Co-optee)
	Carter, Ron	Milton Keynes LMC
*	Cowland, Nick	Wycombe LMC
*	Derry, John	TVPCA
	Frost, Anne-Marie	Milton Keynes PCT
*	Gamell, Annet	Wycombe LMC
	Hicks, Nicholas	Milton Keynes PCT
*	Howcutt, Mark	VoA LMC
*	Jackson, Graham	VoA LMC
	Kenny, Tina	Milton Keynes PCT
	Langley, Caroline	Bucks PCT
	Lilley, John	VoA LMC
*	Mallard-Smith, Rebecca	C&SB LMC
	Marshall, Johnnie	PBC Lead
	Macalister-Smith, Ed	Bucks PCT
*	North, Christopher	Wycombe LMC
	Payne, Geoff	Bucks PCT
*	Peacock, Tim	VoA LMC
	Rao, Lakshman	Milton Keynes LMC
*	Roblin, Paul	LMC Chief Executive
Chair*	Sapsford, Andy	C&SB LMC
	Suleman, Abdul	Milton Keynes LMC
*	Thompson, Simon	C&SB LMC
	Thorpe, Penny	TVPCA

Apologies: Dr Buttar, Kenny, Payne and Rao

In attendance Toby Gillman and Sarah Hudson GP Registrars
Tracey Courtnell and Mark Rowland

Dates of future meetings

30.04.10 25.06.10 03.09.10 12.11.10