
BUCKINGHAMSHIRE LOCAL MEDICAL COMMITTEE

Chairman
Dr Andy Sapsford
Rectory Meadow Surgery
School Lane
Amersham
Bucks
HP7 0HG

Tel: 01494 727711
Fax: 01494 431790
andrew.sapsford@nhs.net

Treasurer
Dr Graham Jackson
Whitehill Surgery
Oxford Road
Aylesbury
Bucks
HP19 8EN

Tel: 01296 432742
Fax: 01296 398774
graham.jackson@nhs.net

Secretary
Dr Paul Roblin
Secretariat of Berks, Bucks & Oxon LMCs
Mere House
Dedmere Road
Marlow
Bucks SL7 1PB

Tel: 01628 475727
Fax: 01628 487142
paul.roblin@bbolmc.co.uk

MINUTES OF BUCKINGHAMSHIRE COUNTY LMC MEETING Friday, 23rd April 2010 The Fairford Leys Surgery, Aylesbury, HP19 8GG

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Minutes of Previous Meeting on 26.2.10

The minutes of 26th February 2010 were agreed as a correct record of the meeting.

Matters Arising

John Lilley Resignation

PHR said that he had not yet advertised the vacancy and would do so.

GB said that she had been at a Faculty meeting and had been talking to a Sessional GP who was very interested in joining the LMC. She had advised him to contact PHR.

Discussion on whether Sessional GPs should have their own constituency, or (as present) be eligible for their geographical area election or attend as a co-opted rep.

Next LMC elections are in 2012.

It was generally agreed in the first instance that any Sessional GP could be co-opted to the LMC.

PHR reported that following his email to all TV PCTs about communicating directly with locum GPs, the PCTs combined had approached the TVPCA to ask that all Sessional GPs on the Performer's List be circulated with information in the same way that partners currently are.

Although this had not been received in writing he had been told by 2 separate sources that this was what was happening.

Action Points: PHR to advertise the vacancy to Aylesbury GPs.

Any Sessional GP who wished to join the LMC should be invited to approach PHR.

Commissioning Enablement Service (CES)

All TV PCTs are signed up to CES.

PHR has been approached by the SHA project manager for CES with a specific request to meet MK and WB PCT about it.

PCTs need information to aid commissioning and need a mechanism to do this.

The supplied document talks about commissioners accessing patient specific information but doesn't seem to address GP issues. Presumably they would not have contacted LMC unless this was intended.

PHR is nervous about this, especially as Oxfordshire MIND had only this week contravened information governance agreements and sent a list of patients receiving CBT to every practice in the county.

AG reported that Tribal (the private company that would manage CES) gave a presentation on CES to PEC.

This is a system with lots of different IT tools that look at contracts and secondary care.

The element that will look at primary care is a prediction toolkit for chronic disease.

It will look at patients who are currently at home but at risk of re-admission to hospital.

It talks about GP systems a lot but GPs felt it was a non-starter until it had got national governance approval.

It was suggested that this issue should be discussed with the GPC IT subcommittee.

Action Point: PHR plans to liaise with Grant Ingrams at the GPC.

2009 Accounts

GJ said that they had been sent out with the previous meeting's papers.
He felt there was nothing contentious in them.
The income costs have gone down due to staff cost savings at the Secretariat.

PHR and PHR explained the BBOLMC pensions issue over section 74 debt.
GJ said that under section 74 they were obliged.
Because of the possibility that the private company pension scheme is underfunded employers might have to find more money for the scheme.
In anticipation of this some of the savings on staff at BBOLMC were being stored in a contingency fund for section 74.
Members asked how this reserve was being invested? It was agreed to ask John Rawlinson the Secretariat Treasurer.

The current Bucks levy rate is 32p per registered patient.

Action Point: PHR to ask JR how the £100K reserve fund for the pension pot was being invested.

Health MK Letter of 6th April 2010

Dr Mahendran had brought a letter from Jeannie Ablett of Health:MK (to senior partners in MK) to LMC attention.

PHR has emailed all recipients with comments on LMC function and a warning that Health:MK was funded by the PCT and not necessarily independent.
JA has issued an apology to PHR, but then sent a second letter to senior partners describing how Health:MK want to perform functions that seem very LMC like.
PHR said that he had sent an email to JA today and a response was awaited.

JB said that he was attending a meeting tomorrow on this issue and he expected it to be discussed at the next MK Liaison meeting.
JB said that he had raised the issue a month ago about how MK doctors felt disconnected from the LMC and that this is another issue that needs to be tackled.

PHR said that in an attempt to solve the problem of wider involvement in MK LRC, the first part of the Liaison Committee meetings will be in the form of a forum with members from Health:MK and a Practice Manager representative present.

AG said that there is always a problem of where the roles of collaboratives overlap with the LMC.
BPCC are clear that they are a commissioning collaborative.
LMC is a statutory body and has statutory duties.
The PCT would like to engage with the collaboratives rather than the LMC but in Bucks the Collaboratives are clear on the role of LMC.

Are Health:MK a provider or commissioning collaborative?
JB said that they were a commissioning body who are heavily non-doctor at the top level.
They also have a subsidiary body which is a provider.
GP representation is weak on this body too.
JA is seconded from the PCT and there could be a conflict of interest if the PCT liaises with Health:MK and not the LMC.

JD felt that if doctors in MK were not prepared to become involved in either the LMC or Health:MK then there was very little that could be done to protect them.

Bucks PCT Medical Director appointment process and Responsible Officer Role

Ed Macalister-Smith (EMS) has alerted practices to the advert for the role of Bucks PCT Medical Director.

PHR has expressed concern to EMS that this alert went out on Fri 9.4.10 with an application closing date of Wed 14.4.10.

GPs present said that they had not seen this letter in general practice but through either the LMC or the PBC paperwork.

All agreed the time for nominations was extremely short.

PHR is concerned that the job description makes no mention of Responsible Officer (a key new Revalidation function). Would it be automatically part of the MD role?

EMS has replied that that this would be considered post appointment

The appointment of a Responsible Office (RO) is causing a lot of nervousness nationally. The RO will be making career threatening judgements on whether a GP is able to continue in practice.

In other areas this function has been held by the Medical Director but there were concerns about the two roles being combined in Bucks.

GB said that she had attended a seminar on the RO presented by the Faculty which had specified the competencies needed to fulfil this role.

The person must be competent, even handed and able to tackle problems when wearing two different hats.

The issue is a national concern at BMA level.

JD said that there were many people within Bucks PCT who knew what role the RO would need to fulfil but GPs felt these people were not having discussions with EMS.

MK are doing pilot work on Revalidation.

The appraiser needs to be confident that the appraisee is making satisfactory progress toward revalidation, if they are not that person will be reported to the RO.

RMS said that Marion Lynch had stated that the RO needed to appointed soon.

If a doctor does not reach a certain level in appraisal they will be reported to the RO.

PHR said that the new revalidation process was not due to be implemented until April 2011 at the earliest and that ML should not be stating that this is a transitional year with the new rules of evidence in operation.

The current process of negotiated adequacy of evidence remains in place.

In Bucks the assumption is that the Medical Director and RO will be one role filled by GP, currently GP only fills the role of PEC Chair.

GP is thought to only work 2 days a week for the PCT when in other areas the role requires 4 days a week. He seems already overstretched, and if the position of RO was added in to this what other work would be dropped?

Members suggested that it would be a good idea if the RO from a neighbouring LMC could fulfil the role in another county ie MK and Bucks cover each other's area. This would stop personality issues interfering with RO assessment.

The LMC felt strongly that it needed to have significant input into the appointment of the RO.

GB said that the BMA have a consultation document on Revalidation available on their website and GPs have until early June to make comments on this.
She urged GPs to do so.

JD said that the South Central SHA has a RO as part of the revalidation process.
He is also the Medical Director at the SHA, Peter Lees.
Other ROs will support each other and be available in case of disputes or disagreements.
It was agreed PHR should contact Peter Lees

It was asked how a GP who was not practising manages to undertake revalidation.
PHR said that as BBOLMC CEO, he was having to work a minimum of 2 sessions a week clinically to enable him to pass appraisal and be eligible for revalidation.

**Action Point: PHR to write to all the PCTs suggesting that the LMC be involved in the selection process for a Responsible Officer.
PHR to recommend GPs visit the GMC website and participate in the consultation on revalidation.**

Bucks PCT and PMS Practices

There are 8 PMS practices in the county and the PCT proposes to undertake new contract negotiations with them.

The LMC's role was to support and advise them during these negotiations.

Meeting discussed the ethics of the differences in what practices are paid per patient, both within PMS and comparing PMS versus GMS.

It would be very difficult for LMC to support those practices who have been receiving more funding than others without justification.

PHR said that Caroline Langley was very anxious not to destabilise PMS practices and avoid unnecessary conflict.

It was suggested that as there was a vacancy on the LMC the PMS practices should be approached to see if they could put forward someone to fill this position. PHR felt more comfortable with an open advert to all practices.

EMS Letter dated 6th April 2010 to LMC

This letter was sent to PMs, probably as a result of the LRC meeting in March when pressure was put on the PCT to let GPs know of the significant amount of money that had been saved and their part in these savings.

LMC applauded this approach.

LMC Conference Motions

The motions were noted.

GB asked that next year the meeting dates should be scheduled around the need for motions to be written.

Some experienced reps expressed the view that they have never been able to engage with the conference process or benefits.

PHR said that he felt it was as useful to have ideas put forward and to develop the motions behind the scenes.

National Consultation on Practice Boundaries

See http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_113437

Meeting felt that even though the consultation form is tedious to fill in, as many GPs as possible should do this in their role as patients.

The idea is that people who work outside their practice can register with a practice local to their workplace.

There are many practical issues that have proved insurmountable over many years.

The BMA has a paper which can be found at:

http://www.bma.org.uk/images/reformgpboundaries_tcm41-193919.pdf

GPs reported that they had capacity problems and would struggle to manage this without some control on registration applications.

AG said that 2 years ago her practice had 6,900 patients, but currently 8,700.

The practice has always said that they would reach capacity at 9,000.

This was dictated by there being no money forthcoming from the PCT for new premises.

Recently a local councillor had asked if they had the capacity to take on an extra 1,000 patients.

What he should have said was that 1,000 new homes were being built so there would be in the region of 2,500 new patients wanting to register with the practice.

Action Point: As many GPs as possible to complete the consultation form in their role as patients on the DOH website.

Shared Care Protocols and Funding for Activity Shift

This discussion was provoked by the consultation on Apomorphine Shared Care Protocol (used in difficult to control Parkinson's Disease patients).

In Oxfordshire this drug is classed as red (ie consultant only prescribing).

This has yet to go through the Medicines Management Committee and it is expected the protocol will not be passed.

GJ said that these types of papers were sent out but this was the first to be copied to the LMC members.

LMC welcomed the opportunity to see new shared care protocols early on in their development.

Early sight permitted assessment of GP opinions.

Action Point: GJ to take to the Medicines Management meeting that the LMC do not consider this a shared care drug.

SCR

The BMA has announced the government plan to suspend upload of patient's summary care record in areas of accelerated roll out.

JB asked where MK were on this: were they suspended or not?

PHR felt that they were as they were one of the fast followers.
JB said that he had heard that Janet Westcott has over-ridden this ruling.

Action Point: PHR to contact JW to see what the position was.

Leg Ulcer Care

PHR reported having met with Caroline Langley and Geoff Payne and leg ulcer care had been discussed.

The suggestion is that Doppler assessment occurs early on in leg ulcer care.
This would be funded by a LES. The work will then remain within primary care for 6 weeks before being passed on to tissue viability.

TP reported that his Practice Nurses had attended training in Swindon last week and had come back very shocked and feeling vulnerable.

She felt that they did not have the skills or knowledge that was required.
In fact they felt that to treat patients would be dangerous.

AG said that the training issue had come up at PEC.

The PCT are going back to Sue Knight to find out what the training was.

The key element in the LES is the training and it had been agreed that training would be undertaken within the county to take into account local policies and systems.

Phlebotomy LES

The requirement to do domiciliary phlebotomy has been taken out of the LES.

A suggested trade off that practices do secondary care initiated phlebotomy in return for continued practice access to hospital based phlebotomy has been abandoned.

JB asked what the situation was in MK.

PHR said that he had a complete postcode lottery in attitude to phlebotomy.

In Bucks the services were not considered to be core.

JB suggested that the LMC approach MK practices and find out how many do in house phlebotomy.

NC asked about the current arrangements for domiciliary phlebotomy.

PHR explained that the system had not changed.

Provided every effort was made to take the blood during the GP visit, CHB would take it where this was not possible.

NC said that this was not happening, CHB were bouncing requests.

PHR asked for this to be feedback to him so he could pass it on to the PCT and Dallas Pounds (CHB).

AG said that the LES was based on 100% of phlebotomy being done within practices; practices said that because of space issues this just was not possible.

The PCT have now agreed to produce a staged LES.

Difficult to bleed patients and paediatric cases would still be dealt with at the hospital.

Paediatric phlebotomy would be priced at more than the £1.50 being paid for the ordinary service but would not be as much as a day case which had previously been the case.

Action Point: To feed back problems to PHR.

Any End of Year QoF Issues?

Practices were unaware of any but it was too soon to know.

Practices who had been picked for the 5% PPV visit had not been notified as no payments had yet been made.

PHR to contact the TVPCA to see if it was OK to inform those practices that had been picked in the LMC tombola.

GB asked what the plans were to pay those practices that had achieved the swine flu targets and were eligible for easement of PE7 and PE8 targets within QOF.

The PCT had told them to work out their own figures which they had done and there were several practices who had achieved the figure of 50.7%.

PHR later discovered that the GPC plans to issue detailed guidance on this.

ISoft practices used a system called ContractPlus to work out their figures, others used QMAS data, the calculation was not easily described or readily available. ISoft had charged their practices for it as they had had to write a new programme. EMIS used population manager.

Action Point: PHR to check with TVPCA if it is OK to notify those practices that have been picked for a 5% PPV visit.

Choose and Book

PHR said that his own surgery operated C&B as a back office function (EMIS LV)

He had spent some time with the practice secretary.

The workload burden seemed light and the process slick.

He would not be prepared to undertake this task during a consultation as he felt it would take too long and detract from more important clinical functions.

Some Bucks reps performed C&B as part of the consultation and were happy with this.

There were problems with some clinical systems handling C&B better than others.

GPs said that it was not always as easy with ISoft and Vision.

These could be difficult to work with.

GJ said that his practice had managed to get a new server but due to problems they were still unable to perform C&B.

He said that when the PCT had visited his practice the staff were told that his was the only practice in Bucks not doing C&B, which is not the case. LMC recognised this as a well tried unfair tactic.

GPs said that with the double signing of referrals it was not possible to do the C&B element within the consultation but this could be a function that is passed to the back room staff when the referral is agreed.

GPs said that C&B increased the work done by the Secretary and their postage bills (the patient had to be sent the relevant paperwork by post).

TP said that in his practice the patient was notified by text to collect the paperwork.

Action Point: PHR to check if C&B is still a target for the PCT.

Date of Next Meeting – 25th June 2010

The meeting started at 2pm and closed at 3.45 pm.

DRAFT

| Present | Name | Organisation |
|---------------|------------------------|----------------------|
| * | Beck, Gill | VoA LMC |
| * | Birchall, Carol | LMC Minute Secretary |
| * | Bradley, Julian | Milton Keynes LMC |
| | Buttar, Prit | GPC Rep |
| | 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 |
| | Macalister-Smith, Ed | Bucks PCT |
| * | Mallard-Smith, Rebecca | C&SB LMC |
| | Marshall, Johnnie | PBC Lead |
| | North, Christopher | Wycombe LMC |
| | Payne, Geoff | Bucks PCT |
| Chair* | Peacock, Tim | VoA LMC |
| * | Roblin, Paul | LMC Chief Executive |
| | Sapsford, Andy | C&SB LMC |
| * | Thompson, Simon | C&SB LMC |
| | Thorpe, Penny | TVPCA |

Apologies:

Drs Buttar, Kenny, North, Payne and Penny Thorpe

Dates of Future Meetings:

17.09.2010 12.11.2010