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Minutes of Buckinghamshire LMC Meeting

Friday 6th June 2008

At Board Room, Verney House, Aylesbury

DRAFT

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Minutes of Previous Meeting

The minutes of 28th March 2008 were agreed as a correct record of the meeting.

Matters Arising

GPC Representative

ER will be stepping down as the GPC rep for Berks and Bucks after the ARM in July.
GB proposed that Prit Buttar be invited to future LMC meetings as the GPC representative for Bucks and Oxon.
(Please note the GPC constituency change.)

ER has been on GPC for 19 years and on the LMC for 30.
AS suggested that the Committee agreed to do something later in the year to celebrate this.
ER will remain on the Performers List, and as a co-opted member of the Committee was entitled to attend meetings for the next 4 years.
The Committee thanked ER for all his hard work on behalf of the LMC over the past years.

Action Point: To invite PB to future meetings as GPC representative.

Post Election Tasks

The election result was AS 9 votes and TP 6 votes.
AS has therefore been elected as LMC Chair for the duration (4yr) of the new Committee.
AS thanked the Committee for voting for him for the post of Chair and he thanked TP for a good fight.
As a result of the election, AS suggested that TP be appointed to the post of Vice Chair.

ER explained that in the past the Chair had been a position held for 4 years and the incumbent then stepped down. Then either a successor volunteered or someone was persuaded to fill the position.
Previously Vice Chairs existed to prepare them for stepping up as the next Chair.

PHR explained that he felt it was up to each new Committee to elect a new Chair and the previous Vice Chair could self nominate to that position.
Qualities for the post stressed within any election address would include previous experience as Vice Chair.
A formal motion was proposed ‘that the Committee set up the role of a Deputy Chairman’ which was agreed by the Committee.

It was asked if the Constitution would need to be rewritten to take into account this change.
Members felt it was possible to appoint a Deputy without going through this process now but it was agreed to put this item on the AGM agenda for ratification.

At a vote the Committee unanimously agreed to appoint Dr Peacock to the position of Vice Chair.

AS informed the Committee that he would be having surgery for a cancer shortly.
As such he may not be able to fulfil the function of Chair for a while.
This was why it was important to have someone filling the position of Vice Chair.
The Committee wished him well.

Board Representatives
Self nominations were invited before 27th June to fill a place on the Board; currently the Bucks representatives are the Chair, the Treasurer and another.
The Board are currently very busy looking at a number of issues such as the organisation of the LMC, pensions etc.

Action Point: To put an item in the Constitution about the post of Vice Chairman and present this to the AGM for ratification.

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Review of LMC Structure

PHR is responsible for 3 County LMCs which comprise 5 LRCs.
He wished all LMC members to have input into how their own LMC carried out its functions.
There are a number of options about how this can be restructured.
With the exception of his back room office staff, PHR has been running the LMC on his own for the past 6 months due to the long term sickness of a senior member of staff.
It was agreed that although the Committee could make no formal decisions, they could listen to the suggestions and present ideas for change.

A paper from PHR was included in the papers for the meeting.
Practices in all 3 counties pay a levy to the LMC.
In return for this the LMC are responsible for delivering services which represent value for money.
The money the LMC receives is split 2/3 to the Secretariat, 1/6 to the GP Defence Fund and the remaining 1/6 is for local use.

County Population sizes (rounded)
(Divide by three to get the approximate levy income)

Berks County = 904K	Berks East = 416K	Berks West = 488K
Bucks County = 771K	M+S Bucks = 522K	MK= 249K
Oxon County = 671K		

No County LMC currently has a mechanism to decide whether there is any need to reconsider the function of the LMC or how to redistribute the funding flow, especially in light of changes in the NHS.
The biggest recent change is the merger of small Bucks county PCTs into 2 bigger ones.
In effect there are now 2 Health Authorities in the county.
PHR felt the LMC needed to develop a better system to liaise with these new organisations.
It has proven difficult to get PCT attendance at the County meetings.
They state that they place more value on the LRC Liaison meetings.
LMC needed to consider how much time and money it wanted to invest in LRCs compared to the County structure.
Currently from the levy Bucks raise £232K. This is money available to the LMC to deliver services to practices.
Unless this levy is increased members needed to consider how this pot of money is used to best effect.
Currently the only person who liaises with the PCT is PHR (JS also did so in the past).
These negotiations are difficult and require a person with a high degree of clinical knowledge and confidence.
It would be up to the Committee to decide whether this person should be local or not.
PHR felt it was important that the time and money offered to take up negotiations with the PCT is adequate.

PHR explained that with MK, due to the location of the office in Marlow, he could spend 3 hours travelling there and back to attend meetings.

With the best will in the world, this has to act as a slight disincentive to attend all meetings.
He thinks MK GPs also recognises this fact.
Current GPs have often hinted that they feel neglected because of the distance from Marlow.
Should MK think about having a local LMC presence, who would work with the Marlow Secretariat?

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PHR also asked the Committee to think about the problem of employing full-time LMC Officers.
Performance assessment and appraisal meant it was getting more and more difficult for PHR to remain on the Performers List when doing minimal or no clinical work.
He felt that LMC Officers should be working as GPs in order to experience grass root problems.
There have also been problems with the BBOLMC pension.
This has performed very badly and is about to be wound up.
Regardless of this fact, there is no private pension anywhere that compares with that offered by the NHS.
Perhaps the best way to encourage new people to work for the LMC would be to explore portfolio working.

Regular meetings of a small Executive Board of Bucks LMC should also be considered
This would monitor that LMC function, structure and funding was fit for its role in a changing NHS.

Members pointed out that attendance at the County meetings was dwindling and this had become more apparent over the past 18 months.
It was important that the LMC recognised the importance of succession planning and part of this is to look at the skills and training that might be needed.

ER felt that his LRC and PCT were small.
MK members would like to see a boosted LRC with a wider membership in MK.
He also recognised the advantage in continuing the County LMCs, probably meeting quarterly, as the feedback from other areas was useful.
It was suggested that a Thames Valley LMC Committee could be developed, with all 5 PCT areas sending representatives.
This might serve the function that members currently valued in the County Committee

In Hampshire the LMC has 3 Clinical Directors and one Chief Executive; this is an advantage as it means there is someone in the office who can be contacted.
ER reported that when he was an LMC representative he found that meetings were always being called on a Monday morning when it was impossible to leave the surgery.
Having someone with more time to devote to attendance, and being able to move around the area, might work better rather than having one person in each area.

Originally the siting of the office in Marlow was so it would be in the middle of the Bucks and Berks area.
With the introduction of Oxon this has been made more difficult.
Regular local contact in Marlow is important, local people need to be able to bring things back to a larger forum for discussion.

TP felt that the LMC had a huge amount of experience in its members, whether they were new or old and this can be tapped into more formally.

AG felt that any negotiator with the PCT must have local knowledge and felt that it should be a practising GP. The Marlow Office would complement this with its knowledge of the regulations (the PCT frequently did not know them).

PHR assured the Committee that the plan was not to abolish anything but to encourage consideration of appropriate change to the current structure.
Getting the balance right was important.
One of the problems with the negotiations with PCTs has been the absence of the LMC.

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PHR reported he had established an interim position during the absence of JS and from early experiences it was working well. GJ and TP had attended meetings in place of PHR and delivered good outcomes.
This work will be funded by the Secretariat at £70 per hour for meeting duration and the time to prepare reports and read the papers, together with mileage payments.
It was important the people doing this work were not abused and realised their input was valued.

The LMC needed to reconfigure to become more effective when liaising with PCTs.

It was asked whether it would be possible to liaise with all 5 TV PCTs at once, as it was known that they met and talked amongst themselves.
PHR said that although PCTs liaised, they all treasure their independence, and had their own ways of doing things.
His experience was that finding TV solutions was inevitably vetoed by PCT boards and CEOs.
One example of PCT individual working is the variation in the extended hours LESs offered to practices.

Action Point: To continue to debate this at the LMC and the Secretariat Board.

LMC Conference Agenda

Bucks are leading on 2 items.
ER will be presenting a special topic of General Practice Funding.

PR said that he had sent members a much shortened version containing solely the motions to be debated, containing a contents page hyperlinked to the motions.
He asked GB if the Agenda Committee could consider producing this type of document centrally. Practices are more likely to read this than the bigger whole agenda.
Members said that it would be useful to receive the document in this format in future years.
It would save the office time having to produce it.

GB said that the Conference may not go on after the first morning as a motion of no confidence in the Agenda Committee had been raised.
If this is passed the Conference cannot continue.

Action Point: To ask that a shortened version such as the one PHR had produced could be sent out centrally in future years.

Supporting Your Practice Campaign and Darzi Centres

Practices have reported that the response from patients has been very positive.
In Cambridge over 20K signatures had been collected in a 2 week period.
There are plans centrally to keep the pressure on and there will be further campaigns in the future.

PHR suggested that Bucks might like to follow the Oxon lead and conduct a follow on ballot of patients about the Darzi Centres, asking them how they would like to see the £1m spent.
The posters sent out by the BMA could remain up in practices during this ballot.

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The ballot paper which is being sent out in Oxon would need very little adjustment to make it applicable to Bucks.

PHR reported that on Wednesday Jim Easton (SHA CEO) had gone on record as saying that GP led health centres will not be imposed in any area and there will be local flexibility.
In response to Jim Easton's web-chat statement, PHR had emailed back asking if the PCTs have been informed of this.
It appears that a SHA response is being written.
It could be that this response will set a precedent for the country.
If a patient ballot can show that the public do not want Darzi clinics, it will empower PCTs to decide themselves.
The PCT have been told that the £1m is already in their budgets.
A recent article in the Bucks Free Press about the Save Our Surgery campaign used the word polyclinic. Confusion over this term has allowed politicians to manipulate media questioning.

Rumour had it that the plug had been pulled on the Darzi Centre in Wycombe.
AG reported that the plan had been to site this at the urgent care centre and the OOHs.
Although all GPs has opposed the Darzi Centre, to have it based with the OOHs and urgent care made the most sense.
However the timescale is very tight, with the Darzi Centre having to be operational by March 09. Co-location would mean that the other two services would also have to be ready at that time.
The PCT have pulled the plug on this plan and have informed the potential bidders of this.
They have now approached the SHA for permission to start again.
They have also asked to be allowed to not have a GP led health centre at all.
It does not seem likely now that the Centre will be operational by March 2009 as the time is too short.

ER reported that in MK there have been capacity problems along both the Eastern and Western Flank to the point that 18 months ago his practice on the Eastern flank had had to close it list despite having asked the PCT to help them plan for the future.
The new Darzi Centre will be in ER's practice area, so this will be the problem resolved in terms of capacity issues for the PCT.
It is not known what the solution will be for the West.
Members said that the Centre would also cover the West as there would be no practice boundary from them to observe.

GB reported that nationally the talk is that these Centres will not be pulled and that every PCT area was still expected to have one.
The Overview and Scrutiny Committee could be approached to ensure that the public are properly consulted on the need for these Centres.
The problem is that the remit for these Centres is coming from the DoH and it is unlikely they will waiver; they will impose them on PCTs in the hope that it will stimulate APMS.
The only hope is to delay the process.

GB asked if it was possible for PHR to ask practices how many signatures they had got to the 'Birthday Card' petition and include this information on the ballot paper.

Action Point:
LMC supported a Bucks Darzi Centre campaign similar to Oxon.
PHR will send out a Bucks version of the Oxon Darzi centre ballot papers out to Bucks reps.

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Public Perception of GPs

TP reported that at a recent meeting on the Extended Hours DES, the PCT had asked 4 members of the public to attend.
It soon became apparent that these people did not have a clue how GPs were paid and were appalled when they learnt how this was done.
He suggested that it might be useful to invite them to a presentation to explain.
The public see GPs as being directly employed and do not understand that they are independent contractors.
The Committee said for LMC to have independent interaction with a patient forum.

Extended Hours LESs

Both PCTs have now produced a final version of this LES based on what is expected in the DES when it is eventually published and the Dyson Guidance.
In areas where access was considered a problem, PCTs have been hard nosed about reception opening during core hours.
In some areas PCT LESs have included paid nursing hours and GP concurrence.
MK PCT was not prepared to move on the surgery not being open at the start and end of the working day.

Are PCTs agreeing to allow doctors providing extended hours to start work later that day?
All PCTs have taken the line that the practice must not reduce its current in hours availability with the extended ones added on.
However, the practice and not the person needs to provide the existing in hours service, implying workforce substitution is possible.

ER was concerned that PHR had not had time to have face to face negotiations with any of the PCTs as he felt it was harder for the PCT to argue a point when there was someone there in person. Email discussions do not have the same impact.
Practices have been advised that they can negotiate individual cases with the PCT, but it is likely that once 50% of practices have signed up, the PCT will no longer be interested in such negotiation.
MK PCT will allow concurrent GP working only for practices over 7.5K in size.
ER felt it could be very difficult for a GP on his own should an emergency arise when he/she has no other staff on the premises other than receptionists.
Other PCTs in the SC SHA area have given greater flexibility over concurrence.

PHR agreed that face to face negotiations were better, but due to LMC and PCT leave, he had not been able to arrange this in time.
As very much a second best, and when it became clear she was under pressure from above to get a LES out quickly, he had eventually opened individual talks with Anne-Marie Frost.

MK PCT did agree to reduce the threshold list size for concurrent GP working from 10K to 7.5K but no movement could be achieved on the opening times of the practice.
He has told the PCT that they cannot now say that the LES has been issued with the LMC agreement to the document.

ER felt that pressure should now be put on the PCT to conduct face to face negotiations as the opening hours issue is ridiculous.
In MK the first half hour is covered by the Co-operative and practices do not need to have their doors open.

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To provide these extra hours would mean that the practice would have to pay for 5 hours more staff time each week and this makes the LES even more uneconomic.
There are still some practices that close during the middle of the day and this has remained since staff budget became the way practices were funded for staff .

PHR reported that he was going on annual leave from Tuesday to the end of the month and would be not in a position to have contact with the PCT. ER agreed to conduct these meetings on behalf of the LMC. PHR agreed that the Secretariat would fund this work.

The new Bucks ES was felt to be a relative success.
However, there were concerns that the actions agreed at the LRC to move the wording on funding above the item on access had not occurred.
Some Bucks members felt that the LES effectively gave the PCT power to remove the LES immediately should the DES be significantly different.
PHR pointed out that on page 5 of the DES it states that 3 months' notice will be required from each side to end the LES.
Any withdrawal of the LES would therefore be subject to this paragraph.
The problem for practices is that staff will have been appointed and had their contracts changed. It will make the LES even less attractive if the PCT can stop it at any time without any notice. Clarification was needed on this point.

Members felt that to protect against any changes the PCT may impose, LMC should be warning practices to make changes to their contracts with staff reversible.
GPs were reminded that enhanced services were not mandatory and practices did not need to sign up to them.
To be able to sign up to ES contracts, PCTs and practices need to be clear what the words mean.

GPC has concerns that the final DES when it is issued will only run until March 2010; funding will then stop. GPs will then have to decide whether to continue to provide extended hours or not, and will be watching to see what the neighbouring practices are doing.
It may be that what a GP does as part of their core hours increases with no additional funding and practices should be alerted to this.

Action Point:
ER to attend meetings with the PCT in MK.
PHR to write to Bucks PCT asking why the agreements made at LRC were not implemented in the final version of the LES.
To alert practices to the fact that the DES will stop in March 2010 and to consider the implications of stopping extended hours when no funding is available.

Choose and Book – Adverse Impact on Practices

GPs reported that patients are finding it very difficult to find their password in the letters they receive; especially if they do not have English as their first language, or if they cannot read.
Receptionists are having to spend a lot of time finding this password when patients come in asking for the GP to explain the system.
PT agreed to look into this and asked if practices had found that urgent faxes had not been acted upon? No practices reported problems.

Action Point:
PT (TVPCA) to explore:
- **the issue of English not being the first language**

- **whether it is possible to put a slip in the envelope advising patients where to find their password easily**
- **providing the telephone number to ring if there are any queries.**

Problems with TVPCA

GB reported that there were referrals being received and scanned onto the system and then being left.
She asked who should be alerted within the TVPCA to the fact that there were problems.
Francis Johnson was the person to contact.

It was asked if it was possible to have an update of contact names and numbers.
PT agreed to provide this.

GPs reported problems with getting training grants.
JD reported that he is meeting with the Deanery to sort out how to co-ordinate payment and the methodology on how trainees get on the Performers List.

Action Point: TVPCA to provide an update of names, positions and telephone numbers.

Request from Treasurer

GJ reminded members that if they attended any meetings on behalf of the LMC they needed to advise him within 6 months, otherwise payment would not be made.
Invoices for standing in for PHR should be sent to the Marlow Office.

Med 6 and Med 10

GJ reported following discussion with the PCT he had committed the proposal to emails that all reps had seen.
Reps felt the LMC should support this.
PHR felt that that each practice should be asked to sign up to their own QOF action points and agree what evidence will be needed at year end as part of the QoF process.
Practices who do not sign up cannot even claim Med 6.
The Committee agreed the handling of Medicines Management that GJ had negotiated.

MK meeting with Nick Hicks (NH)

AS asked MK reps about how MK practices' meeting with Nick Hicks (PCT CEO) had gone.
ER reported that the general feeling was the PCT valued general practice and quality.
Any underperforming practices will receive funding, but those who are not underperforming will receive little.
ER felt it was perverse to reward those performing least well.
NH also intends to visit every practice individually.

Phlebotomy

AG felt that until the recent PCT paper, nothing had happened on this since December.
The PCT proposal is seen as complete within the PCT and will come out to practices for the 2nd quarter in 3 weeks time.
Some Wycombe practices have approached Hillingdon Hospital for pathology as they will provide the phlebotomy without cost.
What will then happen to the baskets for those practices?
AS reported that he had raised this with Alison Wakeford.
There were further concerns that when you take the blood from unregistered patients it is not clear how payment will be made.
PHR felt that this would only happen in blocks when one practice did not wish to take up the basket and all their patients were contracted to another practice for basket activity.

Action Point: AG agreed to pursue this issue on behalf of the LMC and the Collaborative.

Date of Next Meeting – Friday 12th September 2008

The meeting closed at 4.20 pm.

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Present	Name	Organisation
*	Beck, Gill	VoA LMC
*	Birchall, Carol	LMC Minute Secretary
	Bradley, Julian	Milton Keynes LMC
	Carter, Ron	Milton Keynes LMC
	Cowland, Nick	Wycombe LMC
*	Derry, John	TVPCA
	Frost, Anne-Marie	Milton Keynes PCT
*	Gamell, Annet	Wycombe LMC
	Glinski, Anton	TVPCA
	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
	Macalister-Smith, Ed	Bucks PCT
*	Mallard-Smith, Rebecca	C&SB LMC
	Marshall, Johnnie	PBC Lead
	North, Christopher	Wycombe LMC
	Payne, Geoff	Bucks PCT
*	Peacock, Tim	VoA LMC
*	Rao, Lakshman	Milton Keynes LMC
*	Roblin, Paul	LMC Chief Executive
*	Rose, Eric	Milton Keynes LMC /GPC Rep (Co-optee)
* **(Chair)**	Sapsford, Andy	C&SB LMC
	Sattar, Amar	Wycombe LMC
	Solomon, Jane	LMC Director of Development & Liaison
*	Suleman, Abdul	Milton Keynes LMC
*	Thompson, Simon	C&SB LMC
*	Thorpe, Penny	TVPCA
	Whyte, Siân	Milton Keynes LMC
	Wilson, Tom	Milton Keynes PCT

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Apologies: Drs Lilley, Sattar, Whyte & Jane Solomon

Dates of future meetings:
12.09.08 14.11.08