

---

# 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 LMC Meeting

Friday 14<sup>th</sup> November 2008

At Board Room, Verney House, Aylesbury

### CONTENTS

#### **CTRL and Click to hyperlink**

Minutes of Previous Meeting.....	2
Matters Arising.....	2
Letter from Dr Rose.....	2
Charities Commission.....	2
Choose and Book.....	2
Phlebotomy.....	3
Warfarin.....	3
QoF and MPIG Changes 2009/10.....	4
The Future of General Practice Premises.....	6
Practice Accreditation.....	6
LMC Conference 11 <sup>th</sup> and 12 <sup>th</sup> June 2009.....	7
BBOLMC Board Day 25.11.08.....	8
Potential Withdrawal of Ground Rent Reimbursement.....	8
Tom Wilson Letter of 20.10.08 re MK Practice Funding and email of 7.11.08.....	8
Darzi Centre, APMS and Financial Downturn.....	8
The New DESs.....	9
Pharmacy White Paper.....	9
DNs and Flu Vaccination.....	10
Extended Hours – PCT Update.....	10
QoF - Prescribing.....	11
MRIs from Cressex.....	11
MRSA, MSSA and BHT.....	11
Date of Next Meeting – Friday 30 <sup>th</sup> January 2009.....	12

The Chair welcomed Dr Prit Buttar (GPC rep for Bucks and Oxon) to the meeting and hoped he would be able to attend on a regular basis.

## Minutes of Previous Meeting

Page 4, LMC Accounts, final sentence ‘... passed to the Cameron Fund’ be changed to ‘... passed to BMA Charities such as the Cameron Fund’. The amended minutes of 12<sup>th</sup> September 2008 were agreed as a correct record of the meeting.

## Matters Arising

### **Letter from Dr Rose**

Dr Rose has written to the LMC thanking them for the gift of the tankard and hoped the LMC would carry on with their good work.

### **Charities Commission**

GJ has yet to look into this issue.

### **Choose and Book**

Practices have received a letter from Emma Haffenden (Bucks PCT) stating that the Referral Facilitation Centre will cease to exist after 31<sup>st</sup> January 2009.

How practices will refer into hospital after this is not clear.

Enthusiasm for and function of C+B varies across practices. Any new system needs to cater for both types of practice.

Some felt use of C+B still needed an incentive such as a LES.

Vision practices have particular difficulty as C+B crashes the system.

Connecting for Health has said that PCTs and hospitals cannot make C+B the only method of referral to hospital.

Many patients also dislike C+B because of problems with booking at local hospitals.

They complain of being held in a queue at the hospital booking system, eg they start at 17<sup>th</sup> in the queue and once they reach 5<sup>th</sup> they are cut off.

AG views were:

C&B is a national must do for PCTs.

TVPCA RFC was intended to have a triage and referral counting function.

Some GPs use C&B themselves, others give TVPCA the proxy C+B rights and others do neither.

Bucks PCT does not reach its 50% target for C+B despite spending £500K on the RFC.

This is why the contract has been cancelled.

The PCT has accepted that once the RFC disappears, direct paper referrals will begin again.

BPCT has agreed to spend the £500K on sorting out the IT problems preventing C+B uptake.

Ed Macalister-Smith is a C&B enthusiast and believes that if it works nationally it must be fixable in Bucks.

The Collaboratives also received this letter and have responded saying that this is a contractual responsibility and as such is an LMC matter and nothing to do with PBC.

There is a brainstorming workshop on 20<sup>th</sup> November at 1.00 pm in the Board Room at Stoke Mandeville Hospital. Surprisingly, the PCT has not invited the LMC to this.

It was believed the meeting was being convened by Sharon Handley.

Meeting felt that communication needed to be improved between the PCT and the LMC.

In MK a similar brainstorming session has been held. SW attended as an LMC representative and a GP user.

GP opinion in MK also varies. Provided the IT is working, C+B is quite quick.

Where it works, a lot more is being done either during or after the consultation.

It uses a lot of secretarial staff time and is costing practices money.

One problem for patients in MK is that MKFT hospital is setting itself harsher targets.

Patients are not able to book their appointments on the day but have to phone back.

All are still being seen within 6 weeks.

The problem is that although they could give the appointment out, the hospital is finding that MKFT blame the GP for not sending the letter in the right timescale and preventing validation of the appointment request.

Apparently discussions about the PCT withdrawing the TVPCA contract were being held as early as February 2008.

These escalated 2 months ago and the decision to cancel the contract was made about 3 weeks ago, (the last week of October) and notice was given on 1<sup>st</sup> November.

When the LRC met with the PCT on 9<sup>th</sup> October they probably knew that the decision was about to be made and could have raised it with the LMC.

Was the PCT seeing the Collaboratives as the way to liaise with GPs rather than the LMC?

If so, this must be raised with them.

AG wondered if when the PCT raised an issue with her as Collaborative Chair it felt it had also liaised with the LMC. This was not the case.

#### **Action Points:**

**PHR to investigate the lack of invitation to the C+B meeting on 20<sup>th</sup> November.**

**PHR to raise the communication issue with the PCT (not to use the Collaboratives as a mechanism to liaise with GPs but to use the LMC as the representative body).**

#### **Phlebotomy**

The PCT has negotiated an extension to the old system for phlebotomy with BHT until new arrangements can be established (possibly by April 2009).

#### **Warfarin**

Neither the PCT nor the BHT knows how many people attend the Warfarin Clinic.

BHT says that the funding for Warfarin is in A&E and the General Budget (odd labelling!).

Some felt that if a service is being withdrawn the Hospital Trust must inform the PCT and both notice and negotiation should take place.

The minutes of the last LMC record the intention of Bucks PCT to offer GPs a token £7.50 per patient per year.

This would cost the PCT £18.5K per year.

Subsequently, the PEC didn't sanction this offer, possibly because its prescribing team felt that prescribing was part of essential services and GPs had an obligation to do this.

Practices have also been notified that a shared care protocol to ensure the safe prescribing of Warfarin would be ready for circulation at the end of November.

One member felt these two statements were in direct conflict: if the prescribing was part of core essential services there would be no need for a shared care protocol.

("Shared care protocols are part of the Near Patient Testing Enhanced Service").

The PCT have given a commitment to offer level 3 to all practices from the start of the next financial year.

In other areas dosing is done by the RAID system within the hospital anticoagulation lab.

GPs take blood, prescribe and take responsibility for ensuring that Warfarin is used safely.

This should attract a level 2 fee.

A view expressed that practices cannot cover their costs for £118 per year.

One problem with the RAID system is that it will state the dose for the patient in an odd way eg 3.74 mgs a day.

This needs translation into a daily dose by the practice.

The paper that went to PEC stated that historically the PCT have not paid for level 1.

This is not true as in the South practices were paid for this until about 18 months ago.

The new Director of Commissioning, Colin Thompson, has been in post for 4 days.

He has come from the Institute of Innovation and Improvement.

PHR will make contact.

GPs want to provide the service for a decent fee.

If the PCT want to move the service out of the hospital, it is unfair that large amounts of money have been paid to BHT when there is penny pinching with GPs.

**Action Point: PHR to contact Colin Thompson as the new Director of Commissioning on the matter of Warfarin.**

### **QoF and MPIG Changes 2009/10**

Laurence Buckman's letter of 14/10/08 details the changes agreed for the GP contracts in 2009/10.

See <http://www.bma.org.uk/ap.nsf/Content/gmsconletter14Oct2008>

Some QOF indicators will be lost eg the patient questionnaire. These points will be added to existing indicators or used to fund new ones.

Practices could still conduct patient questionnaires if they felt they really wanted to but in future the Government will be writing to individual patients for their experiences.

Prevalence will be handled differently by QMAS for 2009/10.

On 1.4.09. the square root adjustment goes and on 1.4.10 the 5% cut off goes.

The GPC have asked LMCs to work with PCTs to help lessen the burden on those practices that are worst affected by the changes and at risk of failing.

The GPC have received DOH information on which practices will be hardest hit by the Prevalence changes but have been also been told by the DoH they are not allowed to release this information!!

PHR has therefore developed an Excel Calculator that allows individual practices to assess the impact on their future income of changes to the way QMAS handles Disease Prevalence.

It calculates the likely practice loss on 1.4.09 (Square root goes) and 1.4.10 (5% cut off goes).

See <http://www.bma.org.uk/ap.nsf/Content/QOFPrevalence>

Practices that predict they will be badly affected should contact PHR who will feed this back to the PCT.

PCTs might like to use it to identify which of their practices will be more affected by the change.

Prit Buttar (GPC rep for Bucks and Oxon) has also analysed the prevalence of each QOF clinical performance indicator for his area and compared it to the national average.

From this programme it looks as though the average practice will lose 9-10% of QOF income with the loss of the square root formula. Some practices will lose 45% of their QOF clinical earnings.

PB view was that as a result of the change to the square root formula his PCT will save about £600K.

PHR gave an example of a practice (high student list) earning £106K from QOF (clinical). After 2009 they will lose approximately £32.5K and this will rise to £41K with the changes in 2010.

PB felt some practices had an artificially low prevalence and this could be a recording problem. That neighbouring practices can often have very different prevalances is likely to be due to coding artefact.

### **MPIG in the Future**

For an explanation of the nineteenth formula, Laurence Buckman's letter directs readers to: [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFgmscontractagreement/\\$FILE/GMSCContractAgreement.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFgmscontractagreement/$FILE/GMSCContractAgreement.pdf)

This document is a bit obtuse, so PHR has put this explanation into an Excel spreadsheet. See: [www.bbolmc.co.uk](http://www.bbolmc.co.uk)

Whatever % uplift is recommended by the DDRB will be subjected to the calculator.

For 2009/10 only (ie the mechanism after this year will be subject to further negotiations), MPIG and Global sum will be handled as described in the boxes below and in the Excel calculator.

Provided the DDRB does not advise a zero uplift all practices will receive an uplift to the second row below labelled MPIG (GS + CF).

The uplift in GS will be greater than the MPIG uplift so Correction Factor will be eroded.

The Government has made it clear that it will not tolerate MPIG existence in perpetuity, so this is a damage limitation exercise on behalf of the GPC.

For various DDRB uplifts the table below shows what % uplift will be applied nationally to each income stream of GPs' contracts:

With the current deal practices on zero MPIG will receive 5 times the increase of those who do have it.

	DDRB 1%	DDRB 2%	DDRB 3%
GS (7/19)	1.07%	2.13%	3.2%
MPIG (GS + CF) (2/19)	0.3%	0.61%	0.91%
QOF (5/19)	0.76%	1.52%	2.28%
ES 5/19)	0.76%	1.52%	2.28%
Locum Payments (0/19)	0%	0.00%	0%
Seniority (0/19)	0%	0.00%	0%

Across England, LMCs have received alerts of unexplained reduction to practices' MPIG (GSE). The 2008/09 changes to Global Sum and Correction Factor were finally implemented after 1.10.08.

There has been speculation that the Exeter system is not handling the 6% OOH reductions correctly.

PHR reported that nationally he was getting opposing views on this explanation.

He asked that practice managers analyse their recent MPIG payments and compare them to previous ones. Any practice with an unexplained drop in MPIG should contact him.

### **Discussion at LMC**

MK practices have low chronic disease prevalence because they serve a young population.

This type of population brings with it work that is not recognised by the Carr-Hill allocation formula.

GPs will argue that some of the work they do requires additional funding streams because it is not covered by essential services monies.

Student practices will have to counter the argument that some of their patients are only present for half the year so why should they receive extra monies.

The PCT, on QoF visits, are scrutinising diagnostic codings this year.

Practices currently often do not code patients with depression.

It appears that PCTs have been told to squash down on inflationary coding.

The Vision system has coding problems, resulting in codes not counting towards the prevalence scoring. It has failed to correct this over 4 years.

PHR heard today from the TVPCA that the back payment for 60-70% aspiration payments will be made at the end of November for GMS practices and mid-December for PMS.

**Action Point: PMs to check if they had received an unexplained reduction in MPIG this month and if they have to advise PHR.**

## The Future of General Practice Premises

PB chairs the Finance Sub Committee which is focusing on premises.

On average a surgery building will require major refurbishment every 20 years so 1/20<sup>th</sup> of premises should be replaced every year. This has not been happening for the last 10 years and may in future force smaller practices to merge.

## Practice Accreditation

PB had drawn up a prototype for a two tier practice accreditation scheme and wishes to discuss this with both counties he represents.

The first level has a lot that practices are already doing either in QOF or in their basic contract such as an appointment within 2 working days or urgents on the same day.

It is probable that most practices can already achieve 90% of the targets as it is known that Thames Valley practices provide a very high quality of care for patients.

The second tier permits practices who have qualified for Tier 1 to ask their PCT for additional payments for services they provide that are not covered in the existing contract.

This could help practices that have lost out with the impending QOF changes.

An example might be the care of insulin diabetics within the practice system.

Once many practices are accredited to either of these standards they can be used as a benchmark new APMS practices have to attain when seeking contracts.

PB asked that PHR circulate his paper to all Bucks LMC members.

PB asked LMC members for comments on the direction of travel initially rather than the detailed contents of the document.

Once there is agreement on the direction the detail can be looked at more fully.

This document needs to be extremely widely consulted on.

Some trading will be necessary. There will be performance indicators that the PCT have to satisfy centrally.

It may be that some things have to be included that GPs would rather not see included, but this is part of trading.

The Collaborative in the South have recognised the need for practices to increase their income and the way they hope to achieve this is by enhanced services or the equivalent.

Practices currently do not commission services, this is done by the PCT.

All the achievements with Bucks Primary Care Collaborative have been extensions of GMS provision.

The Collaborative have negotiated with the PCT for money for services which can be made available for individual practices to bid for.

The Collaborative want practices to show how they can make a difference and write the templates for them to follow.

The GPC Finance Sub-Committee are not allowed the information on how much APMS practices cost, but they are still able to work out that a consultation within general practice costs £24, with NHS Direct £27 and with APMS £29.

Referral rates from APMS practices are probably higher than GMS or PMS general practices but this needs to be proved.

There have already been examples of increased A&E attendances following the formation of OOHs organisations such as Harmoni.

In Milton Keynes the feeling is that the PCT do not care sufficiently that practices with a low Carr-Hill factor are heavily dependent on MPIG to provide high quality practice.

Practices have asked the PCT for years for funding to permit expansion.

They cannot do this for Global Sum.

Practices are losing money for every patient they take on and continue to do so.

The PCT virtually told them to reduce the quality of care they provided.

PB said that in Oxon the PCT have seen a change in staff and attitude.

The ethos now is that if it has a problem it approaches the LMC for help in trying to solve it.

PB said that this paper was drawn up in collaboration with Nigel Watson from Wessex LMC (another GPC rep).

The aim by 1<sup>st</sup> April 2009 is to agree an accreditation scheme and its funding so practices can work out how to recover the QoF money they have lost.

It is hoped once successfully piloted other PCT areas will adopt similar schemes.

**Action Point: PHR to circulate the draft document to all Members.**

### **LMC Conference 11<sup>th</sup> and 12<sup>th</sup> June 2009**

The current self nominees are GB and AS. Another volunteer is requested.

Rep nominations are needed by 9<sup>th</sup> January 2009.

The deadline for receipt of motions is 14<sup>th</sup> April.

Bucks LMC meets on 27<sup>th</sup> March and will discuss conference motions on that date.

**Action Point: Nominations for reps to Conference are needed by 9<sup>th</sup> January 2009.**

## **BBOLMC Board Day 25.11.08**

All BBOLMC Board members will be attending this strategic meeting, along with SW from MK.

The other Bucks representatives are GB, GJ and AS.

It will look at the medical staffing needed by the Secretariat.

Members with suggestions were encouraged to contact one of their representatives.

## **Potential Withdrawal of Ground Rent Reimbursement**

Historically Bucks practices got their ground rent reimbursed along with their notional rent. GJ reported that their lease had only 69 years left and John Worrall from the PCT has advised that by getting a new lease negotiated the ground rent reimbursement could be withdrawn and incorporated into notional rent.

**Action Point: GB recommended contacting Peter Holden.**

## **Tom Wilson Letter of 20.10.08 re MK Practice Funding and email of 7.11.08**

TW's letter of 20<sup>th</sup> October raises the possibility of targeting deprived areas for extra local funding. The problem is who quantifies unusual need and its cost.

Reps had fears that if the wrong formula was used there would be disproportionate funding diversion to the detriment of some practices.

PHR will liaise closely to ensure the LMC are aware early on of any proposed formulas.

Involving LMC in planning was seen as a positive move.

Members suggested that Bucks PCT should be alerted to this initiative in MK as an example of how the PCT should work with the LMC.

TW's email of 7<sup>th</sup> November emphasised that the PCT is a commissioning organisation and hints that the GP as the preferred provider may change.

This could tie in with the Practice Accreditation scheme.

Practices need to show that they deserve to be the preferred provider compared to private organisations.

## **Darzi Centre, APMS and Financial Downturn**

In Shinfield, Reading, the ATOS surgery has given up their APMS contract after only 6 months. Similarly Virgin has withdrawn its interest in Swindon.

ATOS took on the contract because of the promise of a growing list due from a nearby housing development; this increase has not occurred.

This is evidence that private providers are less reliable in staying the course than GMS/PMS.

The message is that traditional general practice should be regarded first as the provider of choice.

We need to prove that GMS/PMS do provide high quality care and value for money.  
In the future general practice needs to become the yardstick that every new entrant is measured against.

Bucks PCT wanted a largely walk in and emergency centre model and argued that another GP practice was not needed.

Unfortunately the press got hold of this and the PCT were told by the SHA that it could not be different to any other PCT.

A walk-in facility would have saved more money for the PCT but this was vetoed by the SHA and Government who insisted on a list based practice.

## The New DESs

So far the Directions have not been published so they have not been officially offered.  
This could form the basis of a motion to Conference (the DoH is making it impossible for GPs to earn the extra 1.5% investment in primary care).

### Learning Disability (LD) DES

Various concerns exist :

- the County Council may refuse to give out a list of learning disabled patients
- no Learning Disability training course exists
- three members of staff have to attend a training course. The cost compared to likely income might be a disincentive for most practices.

MK PCT are developing a better LES for LD.

In Bucks the PCT seem slow in developing the training course for the Learning Disability DES.

East Berkshire PCT has developed a course and it may be that Bucks GPs could attend this.  
PB felt that there may be a business opportunity for the LMC to provide this but PHR said that currently there was no manpower within the Secretariat to undertake this.

### Ethnicity DES

This is not cost effective for practices, and the prediction is little uptake.

If PCTs want this information, they should develop a LES.

### Osteoporosis

One member had concerns about the letter from Dr Edmunds the Rheumatologist stating that due to lack of secretarial staff they would not be able to comment on any DEXA scan result that is sent to GPs.

**Action Point: PHR to ask if the East Berkshire training course would be available to Bucks GPs.**

**PHR to raise the issue of the reporting of DEXA scans with the PCT.**

## Pharmacy White Paper

One dispensing practice in the North has written to his MP asking for support on this issue.

It is hoped that the status quo on control of entry will remain.

The Paper also states that Pharmacies will become Healthy Living Centres.

PHR felt that pharmacies are ill equipped to provide a holistic service (an isolated cholesterol check also needed a risk analysis and skills in behaviour change).

There is no new funding so practices and pharmacists will be competing for funding.

**Action Point: LMC agreed to support Dispensing Practices.**

### **DNs and Flu Vaccination**

Bucks PCT Provider Arm has stated that they needed to make a decision and had liaised with Caroline Langley.

LMC felt the communication process has gone wrong again.

PHR felt that most PCTs would not sanction DNs immunising housebound patients without the movement of funds.

The question is how much of the £7.58 should be paid for subcontracting the administration of flu vaccine.

Bucks are taking the highest proportion of the funding amongst Thames Valley PCTs.

In the past it was accepted that if a special trip was needed, because the patient was not on the DNs list, then practices would be charged. This is still accepted.

Some felt that the quid pro quo of work exchange had disappeared.

In some practices PNs spend a lot of time doing complex leg ulcer dressings for patients as they are not housebound and the current cross charging didn't recognise this.

Practices also reported that the PCT are not reimbursing DN heat or light.

Last year the fee was £6 and the rise this year was above inflation, at a time when GPs have had successive zero % uplifts to practice income.

It was reported that Katie Donlevy (Head of the Provider Arm) had resigned from the PCT.

**Action Point: To put this issue on the next LRC Agenda for January 2009 and get any agreement in writing.**

### **Extended Hours – PCT Update**

West Berkshire has withdrawn its Extended Hours LES quoting SHA instruction and an obligation to do so in the DES Directions that PHR cannot see.

Will Bucks PCTs also give notice of withdrawal of their LESs?

PHR view is that LES and the DES can co-exist if PCTs want.

The DES has to be offered if the LES is not compliant with the DES guidelines or cannot be made so.

MK PCT has already stopped signing new practices up to its LES but not withdrawn it for exiting signatories.

They are also increasing the number of Saturdays which must be offered from the national average of 47 to 50.

The LES did not state when it had to be started but one practice was told they could not start from 1<sup>st</sup> January 2009 and were given 6 weeks notice which means they will start on 8<sup>th</sup> December.

## QoF - Prescribing

GJ said that he was keen to agree Med 6 and 10 of the QOF with the PCT Prescribing Advisor at a meeting in December 2008.

Hopefully the first draft will be available for the January LRC meeting.

The question of when the savings needed to be accessed was raised. GJ said that this had moved to the end of November.

PHR said that he was unaware of these dates.

## MRIs from Cressex

Geoff Payne sent out a letter stating that the Centre will no longer accept GP requests for MRIs. LMC reps predicted that this will result in an increase in referrals to Orthopaedics and ultimately will cost the PCT more.

It was reported that in January 2008, the PEC were aware of an overspend on MRI, but did not say anything to GPs.

Frustration from reps that the new system is supposed to accept emails, but won't do so without a signature! LMC felt emails and signatures were incompatible.

## MRSA, MSSA and BHT

GJ attends The Medicines Management Steering Committee (MMSC) on behalf of LMC. MMSC recently received a letter from Dr Waghorn (consultant microbiologist at BHT) detailing plans to screen knee replacement cases for nasal carriage of MSSA (Methicillin Sensitive Staph Aureus) and ask GPs to treat positive swabs preoperatively with Mupirocin ointment.

It is not known who in Bucks PCT has agreed to this without consulting LMC. GJ made his objections known to MMSC.

**In subsequent negotiations with BHT their Medical Director has written the boxed text below**

“A letter was sent to all GPs from Geoff Payne, Jean O’Driscoll and Kathy Cann, in August 2007 explaining the policy on screening for MRSA and the role of GPs. It indicates which elective procedures are relevant (eg joint replacements) and that following preop screening, if MRSA is detected, the GP is asked to prescribe the necessary nasal cream and body wash/shampoo (sample GP/consultant and patient letters were also sent out) and that following preop screening, if MRSA is detected, the GP is asked to prescribe the necessary nasal cream and body wash/shampoo (sample GP/consultant and patient letters were also sent out). The special measures needed for orthopaedics patients were also detailed.”

**It therefore appears that the PCT to have told LMC and BHT different things (see Liaison Minutes from 14.12.07 below):**

### LRC minutes 14.12.07

PR reported that the last county minutes (16.11.07) contained suggested wording to be used if a practice is asked by the hospital to screen or treat a patient preoperatively for MRSA.

The view of the county LMC and the LMC GPs present today was that this activity was best performed in secondary care.  
GP reported that this had been conveyed to the Trust, who had been told that the position was non-negotiable.

**Action Point: GJ and PHR to deal with this.**

**Date of Next Meeting – Friday 30<sup>th</sup> January 2009**

The meeting closed at 4.25 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
	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
*	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
	Rose, Eric	Milton Keynes LMC (Co-optee)
Chair*	Sapsford, Andy	C&SB LMC
*	Sattar, Amar	Wycombe LMC
*	Suleman, Abdul	Milton Keynes LMC
	Thompson, Simon	C&SB LMC
	Thorpe, Penny	TVPCA
*	Whyte, Siân	Milton Keynes LMC
	Wilson, Tom	Milton Keynes PCT

**Apologies were received from Drs Howcutt, North and Thompson and Ed Macalister-Smith, Dr Payne, Penny Thorpe and Tom Wilson**

**In attendance:**

**Dates of future meetings:**

**30.01.09      27.03.09      05.06.09      18.09.09      13.11.09**