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# BUCKINGHAMSHIRE LOCAL MEDICAL COMMITTEE

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## Minutes of Buckinghamshire LMC Meeting Friday 13<sup>th</sup> November 2009 The Fairford Leys Surgery, Aylesbury, HP19 8GG

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### Minutes of Previous Meeting

The minutes of 18<sup>th</sup> September 2009 were agreed as a correct record of the meeting.

## **Matters Arising**

Resignation of Sian Whyte from LMC.

Following her announcement that she would be resigning from the LMC, Dr Whyte had contacted AS about whether she should still be representing the LMC on the Buckingham University Ethics Committee.

The LMC agreed that as long as she was happy to do so, the LMC could nominate anyone to attend these meetings and that she should continue.

## **NCAS Seeking Extra Medical Assessors**

AS tabled a paper (summarised below)

PHR will send this paper to all practices

NCAS (National Clinical Assessment Service) is seeking extra GP assessors, particularly those with experience of single or small practices, OOH and inner city practice

Candidates must offer 15d/year

The application deadline is 20.1.10

Shortlisted candidates will be invited to a 3 day training workshop on 17-10 March 2010, which will include assessment and selection at the end

See [www.ncas.npsa.nhs.uk](http://www.ncas.npsa.nhs.uk)

Contact details [Vicky.voller@ncas.npsa.nhs.uk](mailto:Vicky.voller@ncas.npsa.nhs.uk)

0207062 1630

## **H1N1 Vaccination**

Practices began receiving Pandemrix from 26.10.09.

According to the national agreement, GPs should be vaccinating their own workforce (partners and employed).

Receptionists are not part of the target group but could receive vaccine from the vials that are partially used for patients or staff in the target group.

Practices cannot claim the £5.25 for vaccinating their own workforce.

The PCT should have supplies of the Baxter vaccine (Celvaplan) but no practice had yet tried to access these.

Larger practices who needed more supplies were anxious that if smaller practices had received too big a stock, they should be able to pass them on.

It was suggested that LMC send an email asking practices with a vaccine surplus to share it with the larger practices who could organise their own collections.

Currently practices are only vaccinating those in the highest risk groups and then in alphabetical order.

They are contacting eligible patients by either phone or letter.

Because of vaccine supply shortages, it was not considered appropriate to hold drop in clinics.

Carers of the immuno-suppressed are being contacted individually (the work involved is considerable).

PHR encouraged practices to give the PCT a list of their housebound patients and let them organise how to administer them.

It would then become PCT responsibility to sort out payment for the chosen provider. There have been reports of South Bucks DNs being unwilling to vaccinate the housebound. PHR will remind the PCT of what has been negotiated nationally under the DES.

Reps felt that the bonus of the negotiated QoF benefits for administering the swine flu vaccine to a target level are unlikely to be met as vaccine supplies were inadequate.

The DES Directions describe the patient details required to be submitted and these are more than for seasonal flu:

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_107719.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_107719.pdf)

#### Patient data required

- the patient's name;
- the patient's date of birth;
- the patient's NHS number, where known;
- confirmation that the patient is in a priority group;
- the date on which the vaccine was administered,

#### Caveat

but where a patient, parent or carer objects to details of a patient's name or date of birth being supplied to the Primary Care Trust, the contractor need not supply that information provided it supplies the patient's NHS number.

Bucks County Council had contacted the LMC and asked if PHR would sanction practices taking on the work of vaccinating its workforce. In the absence of a mandate to negotiate business deals for all practices, PHR had felt unable to do so.

He advised that they should contact individual practices to ask if they would do this and how much they would charge.

BCC has received a supply of vaccines and wanted them administered.

Their frontline staff are still presenting at practices saying that they have been told to contact them for their vaccination when they are not on the clinical at risk list.

## **Practices and District Nursing Services**

Reps with long memories felt that historically GPs took over the care of leg ulcers if the DNs would take over the care of housebound patients.

It appears that this agreement has broken down.

DNs are now saying they cannot help patients to self-catheterise and that they need referral to hospital to do so.

The PCT receives funding 17% below the national average and is not in a position to fund things that are funded in other parts of the country.

The perception that the payment for the administration of the flu vaccine is an income bonus is wrong. The payment made to practices is used to fund the overheads involved in administering the vaccine.

In the past EM-S has gone on record stating that QOF Prevalence savings will not be going back into primary care (eg community services) but will be going to help reduce the PCT deficit.

GB felt it might be worth raising this again with the PCT.

Lawrence Buckman has said he would welcome evidence that PCTs are not redeploying these monies.

The problem is the PCT has a duty to try and balance the books and if there are pots of money available to them they will use them.

The main difference between the 2 PCTS is that MK has a SLA for community services but Bucks does not.

In MK the Community Health Services are being commissioned in accordance with a SLA between PCT and provider which was written for use from April 2009.

However, JB reported that services were already being cut. In Stony Stratford the DN service had lost one wte and the HV service had reduced from 3 to 2.

In South Bucks there is talk about an ICO (integrated care organisation).

It was agreed that the LMC should press Bucks PCT for a community services SLA asap. LMC should be involved in the development of this to ensure it was adequate.

**Action Point:**

- **PHR to write to EM-S asking for clarification that he did not intend to re-invest the prevalence savings in primary care.**
- **PHR will remind Bucks PCT about housebound arrangements under the DES.**

### **Domiciliary Phlebotomy in Bucks PCT**

The Bucks PCT temporary solution was to instruct CHB that DNs are responsible for domiciliary phlebotomy where it is not possible for the GP to do it at the time of a consultation and it would be inappropriate for the GP to make a second visit.

It seems that this agreement may not have been passed from CHB to all its staff.

GP reps reported that if they needed bloods taken, a PCT form had to be filled in.

PHR clarified that this form was to ensure that the system was not being abused. No pre-approval was needed.

Reps stressed that domiciliary phlebotomy and secondary care phlebotomy had always been outside the previous basket of services.

The PCT promise had been that this was an issue that would be renegotiated in the future.

The basket funding purchased in-house phlebotomy only.

GP reps agreed that if they had time at a visit they would also venesect, but there was a hit and miss element to this depending on the time of the Brake collection.

RM-S said that her Brake collection was 10.20 am so it was not possible for her to take any bloods when she visited patients.

Many reported a problem with regular INR testing, and if the patient required a follow up blood test a few weeks later.

No GP clinical visit was planned, yet DNs seemed loathe to accept this task.

GPs also reported co-operation in some clinical areas. DNs were arranging to visit all their housebound patients on one day so that they would only use one vial of swine flu vaccine.

### **Leg Ulcer Care in Bucks**

Bucks PCT has written to 3 practices that (according to PCT records) had been receiving DN care for leg ulcers for their ambulatory patients and the service has now been withdrawn.

Now all practices are in the same position regarding the care and management of leg ulcers.

PHR suggested that a LMC leg ulcer policy was needed.

Practices would look after these for a period of 6 weeks and provided the appointments did not exceed 15 minutes.

Once these criteria were exceeded, the patient would be referred to the tissue viability service. The Wiltshire Leg Ulcer LES (Bucks PCT were made aware of this a month ago) could be used as a reasonable starting point for a LMC policy.

It was agreed that the LMC should take the initiative on this issue.

GB reported having had a meeting with Dr Payne.

She had discovered that he had been told by CHB that DNs had been doing routine leg ulcer dressings for her practice but in fact this was specialist complex work only.

The reason DNs were doing leg ulcer clinics in surgeries was because they wanted to see patients in one location rather than having to visit them all individually.

CHB information was also incorrect in describing DNs as doing a lot of the work.

These services were often carried out by HCAs.

In MK there had been an absence of tissue viability nurses for a few months, which meant that GPs found other ways of dealing with ulcers.

Now the post was filled GPs were starting to use the service again.

**Action Point: To tell the PCT how the LMC feel leg ulcers should be treated.**

### **IAPT (Improving Access to Psychological Therapies) and Counselling in Bucks PCT**

Bucks PCT has announced its intention to de-commission counselling services now that IAPT (Healthy Minds) is up and running.

IAPT will not provide counselling services.

The PCT has stated that they have consulted with the LMC.

PHR described meeting Kurt Moxley on 14.10.09 at his routine meeting with Caroline Langley and Geoff Payne, and receiving a tabled paper about PCT counselling intentions.

This was the day after Wycombe practice managers had been told about the decommissioning.

From his perspective it had been presented as a fait accompli, without LMC involvement in the policy development.

AG reported that the PEC argued that there is no evidence that counselling works.

As a result of funding withdrawal, the Dove Centre will stop accepting new referrals immediately, but will work through those already in the system and finally close in March 2010, probably with some redundancies.

It previously provided approximately 1300 free counselling sessions with the funding received from the PCT.

One problem is that if you refer to IAPT for counselling you will be told to refer to the in-house counsellor who is no longer available.

The Collaboratives were only made aware of this change at the PEC meeting last week.

In MK it has been agreed that counselling should be renewed on the basis that they did not want to increase referrals to psychiatry.

They want to work with the implementing agencies.

The need for counselling is driven in part by the current economic situation.

The difference is that in MK it went to the PEC before it was implemented.

Some suggested that the LMC should write to the press about the decision making processes within the PCT.

However, it was felt this would harm the LMC relationship with Bucks PCT, an undesirable outcome after the difficulties of recent years.

It was suggested a better route would be to write to the Health Overview and Scrutiny Committee as this was a forum that Bucks PCT listened to.

If the OSC were not happy with the PCT's response to an issue they had the ability to refer it to a minister.

**Action Point: To write to the OSC raising concerns about the decommissioning of counselling services by Bucks PCT.**

### **Referral Obstacles/Diverting GP Direct Referrals to Triage Teams/BHT Radiology Rejections**

GP reps gave examples of what is happening:

- Referrals are being bounced quoting that they do not meet the map of medicine (no other detail).
- A referral to Gynae made 2 months ago and expedited a month later has now been tracked as going through the triage system and the patient has yet to be seen.
- Triage and the C&B system seem to be contradictory.
- Some 2ww referrals have been re-graded by gastroenterology in Wycombe without the GPs being consulted. It appears this is being done by Dr McIntyre. When it was discovered the practice re-referred the patient again under the 2ww rule.
- A 2ww referral with abnormal bleeding to gynae cannot be made unless an ultrasound has been performed but as a consequence of the new BHT radiology policy, GPs no longer have access to ultrasound.
- A 2ww referral was made and the patient was given an appointment 10 days later on the very day that the trust new he could not attend; the patient was then told to go back to their GP for another referral as they were unable to accept that the deadline would be exceeded.

The views of the Committee were:

The issue of the 2ww re-grading should be raised with the PCT.

The service must not re-grade referrals without first talking to the clinician who made the referral.

The GP concerned said that he would be taking this matter further once he had established all the facts.

Reps accepted that 2ww referrals had to comply with the NICE cancer referral guidelines.

Reps reported that as well as the known vetting of MSK, gynae and ophthalmology referrals, there also appears to be BHT triage of cardiology, urology, general surgery, general medicine, ENT, Radiology, Plastic Surgery and Dermatology. This has been sanctioned by the Bucks Healthy Leaders Group, which collaboratives and PHR attend.

The current system is that a consultant and GP establishes the referral thresholds and looks at referrals. Those that clearly do not meet the thresholds are sent back to the referring GP.

Reps asked whether correct decisions were being made.

Reps were concerned that there is no tracking of the referral pathway.

A GP does not know where the referral is and there were worries that some could get lost.

The triage timescales were unknown, and there was uncertainty about how long referrals would be held up.

GPs have not given details of the experience of those carrying out the triage.

In the ENT department some referrals are reported as being outstanding after 2 months with the triage team, when the agreed turn around time is 10 working days.

Some criticised the changing thresholds for creating uncertainty about what will be deemed an acceptable referral.

Mr Dada was reported as saying that new gynaecology guidelines for referral would not meet the NICE guidelines for menorrhagia.

The PCT must be asked to make the guidelines available for everyone; they should be available on the PCT website for GPs to view.

AG said that she attended the Bucks Leaders Group in her capacity as collaborative lead as did Johnny Marshall. These meetings are held every 2 weeks on a Thursday morning and the LMC do have an invitation to attend.

The triage system had been developed as being preferable to the original cap.

The new system should be educational and provide feedback.

She asked that LMC attended regularly as she found it difficult to attend in both a LMC and collaborative capacity.

PHR said that he had been attending these but had missed 2 due to annual leave and a clash of commitments.

MK reps suggested that as this is an issue that will affect every PCT shortly, the Thames Valley should become leaders in referral guidelines and demand management and get proper guidance on it.

BHT has apparently started rejecting many GP direct access radiology requests.

The service will no longer perform interventional radiology.

Reps asked whether this had been discussed in advance with GPs or LMC, or sanctioned by Bucks PCT.

To get a back X-Ray, patients need to go to A&E.

Spiral CT will not be performed for renal colic.

The new BHT radiology policy is working in direct opposition to the referral requirements that would lessen the PCT deficit.

A scan or CT should be performed prior to referral.

Even if a case is agreed with a radiology consultant there is no guarantee the procedure will be performed.

Exasperatingly, if a GP requests an ultrasound for a soft tissue injury, the patient will only get an X-Ray with a recommendation on the report that an ultrasound is the only way to detect the problem.

Patients referred for an MRI are also only receiving an X-Ray.

The only way to get an MRI is to refer to MSK.

The general feeling was that this was not about guidelines but about budget cutting.

It was agreed to write to Bucks PCT Director of Commissioning and Chief Executive stating that this is a provider initiative which is affecting the way GPs handle patients in the community and their ability to avoid secondary care referrals.

AS raised the issue of Amersham Hospital closing some out patient departments.

There had been no obligatory consultation on this as it was a service reduction rather than cut.

**Action Point: PHR to write to the PCT pointing out the problems GP have obtaining the imaging required to comply with local guidelines and avoid unnecessary secondary care referrals.**

## **ISA (Independent Safeguarding Authority) Vetting and Barring Scheme**

Practice Managers have received a LMC email explaining the new rules applicable from 12.10.09.

See <http://www.bbolmc.co.uk/hottopic/hotall/hotall.html>

It is now illegal to employ someone who is barred.

LMC enquiries to the ISA have confirmed that it is sufficient for practices to ask a new employee about barred status, ie there is no need to obtain a CRB check at a cost of £61.

However from November 2010 each new employee must have their own ISA registration and from 2015 all existing employees must have one.

The lifelong registration will cost about £60, and will probably be payable by the individual.

## **Patient Survey Access Advertising**

PHR wishes to develop practice systems encouraging patients to give the right answers in the quarterly patient survey.

Greater advertising in practices might ensure a higher percentage of the right answers.

One practice reported that their PPG felt that if the answers were all negative, the practice would get more funding!!!

If this is how the public perceives the questionnaire, we are all doomed!!

To be useful in the event of appeals, a surgery conducting its own survey should use the same questions as those asked in the national survey.

See [http://www.gp-patient.co.uk/download/questionnaire\\_example.pdf](http://www.gp-patient.co.uk/download/questionnaire_example.pdf)

Pages 2 and 3, Section D, Questions 8-14.

## **Consequences of Missing an Annual Appraisal**

See <http://www.bbolmc.co.uk/hottopic/hotall/hotall.html> (21.10.09)

The PCT and TVPCA have recently tightened up processes.

GPs that have not had an appraisal in a financial year have been sent notice of intention to remove them from the Performers List.

GPs are reminded to have their appraisals or to notify the PCT/TVPCA of any mitigating circumstances eg maternity or sickness absence.

PHR intends to negotiate with both PCTs a system of alerting LMC prior to any letters being sent, in the hope that informal LMC contact can avoid escalation.

## **PMS**

PHR reported that the national World Class Commissioner guidance is making the PCT look at all classes of expenditure.

One specific area outlined in national guidelines to PCTs seems to be the value for money of PMS contracts.

The differences in cost per patient between GMS and PMS are not seen as defensible.

### **LMC Reps for Bucks PCT Urgent Care Project**

Following a presentation at the last liaison meeting Bucks PCT has requested an LMC

representative for the IMPACT project.

GJ said that his urgent care contract had been signed off and was due to start the month before this one.

He queried whether there was any likelihood that this would progress and the need for a LMC rep.

PHR and GB will monitor the paperwork and attend where appropriate.

AG reported that she was attending the meetings on behalf of the collaborative.

### **Death Certification and GMC Licencing**

The Bucks Registrar of Births and Deaths has recently written to practices with concerns about assessing whether a doctor is eligible to sign death certificates when GMC licences to practice are introduced.

PHR does not see the change as significant. Just as registrars could look up GMC registration they can now look up licence status see <http://www.gmc-uk.org/doctors/register/LRMP.asp>

Reps felt it would not be a problem to write their GMC number next to their signature.

### **ICOs**

AG reported that BPC had had a planning day at which over 100 people had been present, including EM-S, Jane O'Grady and John Wallace from the PCT.

A presentation had been given on ICOs, which had triggered lots of discussion and questions. The PCT are now happy to devolve a budget in a shadow form which is what was requested originally.

### **Date of Next Meeting – Friday 26<sup>th</sup> February 2010**

The meeting closed at 4.15 pm.

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, Derry, Marshall & Payne

**Dates of future meetings:**

26.02.10      30.04.10      25.06.10      03.09.10      12.11.10