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MINUTES OF SOUTH BUCKS LRC/PCT LAISON MEETING **Tuesday 11th October 2011** **Stokenchurch Health Centre**

CONTENTS

Minutes of Previous Meeting	1
Matters Arising	1
Declarations of Conflicts of Interest for this Agenda.....	2
IT Developments for Practices	2
Care Homes Pilot Proposal	3
Medicines Management	5
QP11 Update	6
Cluster Update.....	7
Seniority Claw Back.....	7
LES Clawback.....	7
Date of Next Meeting – 17 th January 2012.....	7

Minutes of Previous Meeting

No liaison meeting took place on 12.7.11 (no PCT personnel arrived).
The minutes of the substituted LRC meeting were agreed as a correct record.

Matters Arising

All matters were on the agenda.

Declarations of Conflicts of Interest for this Agenda

GPs declared that they looked after patients in Care Homes.

IT Developments for Practices

Andrew Fenton (Chief Information Officer, NHS Buckinghamshire and Oxfordshire Cluster) attended for this item andrew.fenton@oxfordshirepct.nhs.uk

LMC had received a typed briefing pre meeting.

This aimed to update the Bucks LMC on the main current IM&T issues.

AF wished to address IM&T matters of interest or concern to LMC members.

The bullets below are a selection of the key issues identified by AF:

1. IM&T support from the PCT Cluster
2. IM&T governance proposals
3. Information transfer and document management
4. GP system upgrades
5. Summary Care Record.

There are IT teams in both Oxford and High Wycombe.

A number of developments are underway.

Impact has discussed proposals for developing IM&T Governance.

AF suggests an over-arching IM&T group across Bucks with representatives from BHT, GPs, practice management and the LMC. This group would support the overall development of IT across the whole health system in Bucks.

PHR asked whether the LMC rep should be a “techie” or a generic GP.

AF thought someone with some knowledge would be best.

For now, AF will liaise with PHR (LMC are due to hold elections shortly and reps could change).

Impact supports the proposal to improve transmissions from other providers (acute and urgent care) to primary care systems.

The intention is to make the Docman system available to all GP practices and to develop the EDT (Electronic Document Transfer) system.

This will enable discharge letters or A&E letters to be transmitted directly into patients’ notes from the provider without the need for scanning.

An alert system will be generated so that the GP knows that a letter has been received.

OOHs already do this to some extent.

2 workshops are planned for next week to introduce GPs to this system.

BHT is confident it will be able to go ahead with electronic transfer of discharge documentation by their systems by the end of the calendar year.

Discussions about the Summary Care Record (SCR) are beginning.

The reduced content of SCR (current medication and allergies) and an explicit patient opt out system have been agreed with the GPC.

Practice data will be up loaded (apart from those patients who have explicitly opted out and are coded as such).

There are no plans for Bucks to do anything yet, but Oxon are hoping to upload patient records late next year.

LMC said that they welcomed the opportunity to have further discussions about the SCR.

AF agreed to send PHR further information as it became available.

LMC raised the issue of broadband width, GP2GP record transmission and reimbursements to practices who have already invested in Docman.

AF said he would look into the issue of reimbursement for those practices that have invested in Docman.

AF said that connection speed has been an issue.

COIN (Community of Interest Network) is being trialled in Oxon and could be a solution to this.

LMC asked about electronic transmission of patient records between practices (GP2GP).

This seems to have stalled as the remote servers initiative has developed.

If practices have any operational IT issues currently then they should contact Lindy Gilham in the first instance.

It was agreed that AF would produce a report for each future Liaison meeting.

For AF's benefit, the dates are:

17.1.12 13.3.12 15.5.12 17.7.12 16.10.12.

Action Point: AF to look into the issue of reimbursement for Docman for those practices that have already invested in it.

Care Homes Pilot Proposal

Jane McVea presented this item. She is trying to find a way through a problem

For this year, SIRF (System Investment Reform Fund) money was top sliced from PCTs and then re-offered on a bidding basis.

The Practice plc has put a bid into the PCT for SIRF funding to support a pilot year of their Care Homes Project.

It was then recognised that the availability of this funding had not been properly advertised within the Bucks system. Co-ordination between PCT and the CCGs seems at fault.

That money was available via bidding should have been made known to practices.

JMcV stressed that The Practice was not at fault in bidding to provide the service.

The Practice plc model was a high quality one, but when costed, it was not thought to be sustainable in the future.

After dialogue with the Practice plc, the specification proposed has been altered to reduce cost.

OOHs components have been removed.

The specification includes a requirement for an elective visit rate of 4 hours for every 35 patients.

Practices should review medications and end of life plans.

Providing an urgent response for normal surgery in hours was classed by the LMC as part of the GMS contract and selected practices should not be paid twice.

JMcV agreed to take this out of the proposal.

Information systems in the home would be determined by the practices (paper based or a laptop with security).

Practices would analyze and meet the training needs of linked care homes.

The PCT need to agree the number of sessions.

LMC felt that private homes should be responsible for their own training needs.

JMcV said that part of the pilot was to reduce admissions and training staff to do this was important.

Care Homes have a high turnover of staff, so there needs to be a rolling program of training.
It was agreed to change the wording of bullet 5 on page 1 to:

- providing an analysis of the care homes training needs and **advising how to meet** ~~meeting~~ those needs.

The specification expects a proactive relationship between the provider and the care home staff to develop a relationship that delivers GMS.

LMC stressed that Care Homes consumed a vast amount of District Nursing time as they invariably do not have enough staff in the home to cope with the patients they have.

LMC said that because it is based on 2010 figures, the list of care homes is out of date.

NC said that his practice looked after 60-65 patients in a home which they had taken on in September 2010 and this was not on the list.

JMcV said that homes had been selected using several criteria (Highest emergency admissions in 2010, Highest score on BUC callout, Known poor performers, SCAS knowledge).

For the pilot the PCT is looking at 1 thousand patients.

Currently The Practice has 400 patients registered with them.

The list provided to LMC is colour coded.

Blue indicates homes looked after by a private arrangement with a local practice.

Yellow are looked after by The Practice.

The rest have not got one named practice looking after them.

The proposal is that anyone who is interested in taking on this work should approach the PCT.

JMcV said that the original Practice bid for this work estimated the cost at £317 per patient.

The new model will be priced at £85.

The Practice plc will receive this fee.

The PCT have 6-9 months to draw up a proper specification and convince the CCGs to commission an appropriate service for the future.

The outcome required is to see a reduction in admissions and to save £197K over the year.

LMC raised the issue of The Practice plc being both a commissioning and provider organisation.

Until recently The Practice plc has had the status of a commissioning group and was therefore privy to advance information (eg about SIRC).

Did this give their provider arm an advantage in bidding?

Was there an unrecognised conflict of interest?

JMcV said that the CCGs were aware of this pilot.

They could have passed the information on to their constituents but they did not.

It was recognised that everyone was too naïve and that the PCT and CCGs have got to get smarter.

JMcV said that she wanted to write to practices with a proposed specification which had been discussed with LMC.

RM-S raised the issue that one practice had had a lot of patients deducted (presumably because the Home had gone with the enhanced Practice plc service).

JMcV said that she would contact this practice to find out why this had happened.

Juliet Sutton from Poplar Grove is the lead on this and JMcV said that she would work with her.

Action Point: JMcV to remove the element about urgent response for normal surgery in hours from the proposal.

JMcV to send LMC the updated Proposal.

JMcV to work this through with Juliet Sutton from Poplar Grove.

Medicines Management

PHR spoke to this issue.

Drugs (mainly for ADHD and dementia) were removed from the NPT LES list on 1.10.11.

LMC was critical of the process for agreeing this.

PHR felt a LES was part of the GP contract and should not be managed in the way that it had.

No dialogue took place with LMC either via the Liaison meetings or the Enhanced Service Working Group (ESWG).

The change was discussed solely within the Medicines Management Group.

LMC only heard about the change when practices were given 2 months notice.

PHR complained to Lindy Gilham by email on 26.7.11.

LS responded on 5.8.11 making suggestions about preventing this in future, but no mention was made about revisiting the drugs about to be removed from payment.

The ideal opportunity would have been the July Liaison meeting but no PCT reps turned up to this.

PHR raised the issue at ESWG on 6.10.11.

Jane Butterworth's view was that the drugs required no more blood test monitoring than was required under GMS.

PHR's view is that workload moved from secondary care and not covered by GMS should be funded by a LES. Blood testing was not the only transferred workload.

Discussion at meeting

LMC reps agreed with PHR

Shared care protocols now exist for monitoring of dementia and ADHD medication.

For dementia patients a 6-month review with a mini mental state examination needs to be undertaken. This is not part of normal general practice care.

The LMC asked LS to re-open negotiations on how to fund practices for this work.

GJ said that Bucks have a Formulary Management Group attended by himself, Raj Bajwa, Amar Sattar and others, but there is no representative from the LMC on this.

It is a BHT committee which looks at the whole formulary for Bucks, part of which is dealing with shared care.

The group discusses clinical evidence and suggests changes to clinical processes.

However, converting its decisions into commissioned services has not been done well.

Jane Butterworth is the lead for Medicines Management and not a commissioner.

Medicines Management make a lot of decisions which relate to the GP contract and general practice.

General practice accepts these suggestions because they are based on good evidence.

However, at the moment work seems to be transferred to Primary Care without any resources.

LMC policy is now that if GJ was unable to attend any future meeting of the Medicines Management Group PHR will attend in his place.

The ESWG should look to Medicines Management for guidance, but commissioning decisions should lie outside of Medicines Management.

Monitoring of Aricept and Ritalin do not involve blood testing, but do involve extra work.

GPs have the right to refuse a shared care protocol if they wish so it cannot be core GP work.

LMC reps felt funding of moved activity should be discussed at ESWG and then come to LMC Liaison for ratification.

LMC asked the PCT to look again at how it funded shared care of dementia and ADHD drugs.

The NPT LES needs to be changed or a new one developed.

PHR said that he and Jeremy Newton seemed to be in agreement on the need for “An Invest to Save” philosophy.

Removing activity from Secondary Care required spend in the community.

LS said that the Enhanced Services Working Group is due to meet in 2 weeks time.

She would add a review of dementia and ADHD drugs to the agenda.

LMC asked that the following items also be added:

Leg ulcer level 2 LES, GNRH analogues and subcutaneous implant removal.

LS agreed to take this forward.

Action Point: LS to ensure above items are added to the next ESGW agenda.

QP11 Update

LMC asked about in house proposals for new emergency care pathways (QP11).

How many have been accepted or rejected?

LS said that of the ones received, all had been accepted.

GPs commented that as the senders of the proposals they had not been told this.

LS said that she was only commenting on an email Anne Ronan has sent to all CCGs.

She would check that her first comment was correct.

RM-S said that in her GP commissioner role, she had been sent 2 proposals, and asked to comment.

Her view was that one was a repeat of something that was already happening.

Topics suggested were over 80s, diabetes, Care Home patients, COPD, patient education/follow up, referrals modules, fall/stroke/accidents and publicity campaign.

PHR commented

The expectation of QP11 is that emergency care redesign of pathways will reduce emergency spend and contribute to QIPP.

However, practices were not provided with emergency care data that might have enabled them to see where the problems lay.

LS said that A&E data is poor and the PCT needs to find a way to improve this.

The ACG tool should be used to risk assess patients.

PHR said that in Oxon the localities have been asked to look at data on emergency care.

Payment under QP11 would be for the work involved in analyzing this data and using this to suggest a redesign.

QP11 payment is for coming up with ideas that could save the system money.

LMC reps felt Bucks PCT needed to re-think their approach to QP.

Hopefully this will be better next year.

Better data should mean better ideas for change.

GB asked that practices be told that at the end of this year a written report and not 7 audits would suffice. She asked for this to be put in writing by the PCT. This would be necessary to satisfy external auditors.

Cluster Update

PHR reported that Matthew Tait has been appointed as CEO for the Cluster, replacing Sonia Mills.

Seniority Claw Back

LS reported that the PCT had received monies back from some practices.

LS and PHR have agreed that if there has been a breakdown in the relationship between the partnership and a retired partner, the individual doctor would be approached for refund of the money.

Several reps felt the retired partner should always be approached by the PCT.

LS maintained that the money was paid to the practice not to the individual and the practice should be pursued first for the money.

Reps replied that this money was paid to the practice but that it was the individual GP who was being rewarded for long service. The payment was not part of practice income.

It was agreed that PHR and LS would work on how to get money back from the person who held it on a case by case basis and to behave pragmatically.

LS said that she would seek guidance on the claw back appeals based on a change in working pattern first.

LES Clawback

This issue is still being worked on.

Establishing the facts for each practice has been a difficult process.

PHR felt that before the PCT can claw back anything it needed to present a foolproof case.

Practices should supply as evidence any writing off statement they held.

If pay back is agreed the practice, LMC and PCT needed to agree an appropriate timescale.

PHR said that he would check the minutes from 2006 as members felt it had been minuted that any advance paid to practices would be taken from the final payment that year.

Action Point: PHR to check the minutes from 2006 on this issue.

Date of Next Meeting – 17th January 2012

The meeting opened at 2pm and closed at 3.35 pm.

Present	Name	Organisation
*	Beck, Gill	VoA LMC
*	Birchall, Carol	LMC Minute Secretary
	Corlett, Helen	C&SB LMC (Co-opted)
	Cowland, Nick	Wycombe LMC
	Derry, John	TVPCA
	Dickson, Rodger	VoA LMC
	Gamell, Annet	PBC Lead (BPCC)
	Holy, Kristian	Wycombe LMC (Co-opted)
	Howcutt, Mark	VoA LMC
*	Jackson, Graham	VoA LMC
	Kennedy, Jim	LMC Medical Director
*	Kuetter, Stefan	Wycombe LMC (Co-opted)
*	Mallard-Smith, Rebecca	C&SB LMC
	Marshall, Johnny	PBC Lead (UC)
	Morris-Khan, Helen	Practice Manager
*	Neale, Tom	VoA LMC (Co-opted)
*	North, Christopher	Wycombe LMC
	Payne, Geoff	Bucks PCT
*	Peacock, Tim	VoA LMC
*	Roblin, Paul	LMC Chief Executive
	Sapsford, Andy	C&SB LMC
*	Smith, Louise	Bucks PCT
	Thompson, Colin	Bucks PCT
	Thompson, Simon	C&SB LMC
	Thorpe, Penny	TVPCA
	Wilson, Ingrid	C&SB LMC

Apologies: Drs Howcutt, Marshall, Payne, Sapsford, Thompson, Wilson and Helen Morris-Khan

In Attendance: Andrew Fenton, Jane McVea

Dates of Future Meetings (Tuesdays)

17.1.12

13.3.12

15.5.12

17.7.12

16.10.12