LOCAL MEDICAL COMMITTEE
LMC
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MINUTES OF AN LMC/CCG NEGOTIATORS' MEETING HELD AT SANGER HOUSE ON THURSDAY 28TH JUNE 2018 AT 12:30

Present:

Dr Tom Yerburgh	(TY)	Meeting Chair and LMC Chairman
Dr Christian Hamilton		CCG Head of Planned Care
Dr Bob Hodges	(RH)	LMC Vice-Chair
Dr Andrew Seymour	(AS)	CCG Clinical Chair
Helen Goodey	(HG)	CCG Director Locality Development & Primary Care
Anneka Taylor		
Mike Forster	(MF)	Meeting Secretary and LMC Lay Secretary

ACTION

Item 1 – Apologies

Nil

Item 2 - Declarations of interest

No new declarations.

Item 3 – Minutes of last meeting (29th May 2018)

Approved.

Item 4 – Matters / Actions Arising

All complete except as shown in Annex A

Item 5 – Main issues for negotiation/discussion
(Taken out of agenda order in order to allow some attenders to leave early)

Phlebotomy. The various arrangements across the county for taking blood had been unresolved for years. The CCG proposed that by removing some funding from the Acute Trust they would be able to make a contribution (not an enhanced service) of £1.02 per registered patient to practices on a locality/cluster basis so that GPs could decide between themselves how best to offer the service to patients. The LMC was concerned that this 'contribution' would fall short of the actual costs of providing the service, that it might be easier to arrange in an urban environment than in a rural area and that some practices would be 'losers'. The LMC also considered that there should be consideration of chronic disease prevalence and consider the availability of point of care testing. After discussion it was agreed that the CCG would forward their proposal formally for urgent, out of committee, discussion ..... **CCG**

Endoscopy forms. The LMC were concerned that the new forms required the GP to tick boxes saying that the patient had consented to the treatment and that they were fit to receive it. The LMC were prepared to accept that the GP could be asked to confirm that the patient was capable of giving consent and whether there were any clinical contra-indications to the treatment and even whether, given the patient's circumstances, a community hospital was an appropriate location for the treatment. The CCG agreed to change the forms accordingly ..... **CCG**

	ACTION
Dermatology Form. The LMC could accept the need for a new form, bearing in mind the inadequate information sometimes provided in letters, but were opposed to its being introduced at very short notice. They recommended a three-month lead in. They quoted the careful introduction over a few months of the paper referral switch-off, which had gone well. The CCG agreed to find out, as a reasonable first step, how many letters were being received from which practices and to plan the introduction accordingly	**CCG**
Two week wait forms. The LMC agreed to stress in their newsletter the need for practices to use the new 2ww forms	**LMC**
e-RS - Advice and Guidance. The LMC had posed 4 questions/points to which Dr Hamilton gave answers as under:	
• Q. Requests for A&G cannot be directed to a particular consultant. A. This can be done if the Trust sets up individual consultants on the system, but in practice this is not done because of the continual and frequent change of duty consultants in each specialty. The work-around would be for the practice to state at the beginning of the A&G "for Mr <consultant's name>" and also give the email address of the GP to whom the response should be sent. The LMC would publicise this	**LMC**
• Q. When the consultant sees the patient the consultant cannot see the A&G. A. Not quite true. If on the A&G form the GP clicks "Refer Now" then the contents of the A&G form are automatically transferred to the Referral and the consultant will be able to see it.	**LMC**
• Q. The LMC cannot agree that A&G has to be used before every referral. There is a risk of de-skilling GPs. The senior partner is generally able to give all the advice necessary in most simple cases. A. In due course the intention is to use the referral form as a 'request for a referral or guidance'. It will then be up to the consultant to action it as a referral if it is obvious that it should be so.	
• Q. If the guidance is that this should be a referral could the consultant not convert the A&G into a referral there and then? A. Unfortunately not. There are technical and policy reasons why at this time that cannot be done.	
Delays in histology reporting. The LMC raised the issue that the waiting time to receive histology reports was increasing to 6 or even 8 weeks, which was unacceptable bearing in mind the anxiety levels of the patients. The CCG advised that in cases of high concern there should be immediate referral to secondary care rather than excising the mole etc and sending it for analysis. However in less certain cases the accompanying note to the histology laboratory should state 'possible malignancy'	**LMC**
Data extraction contracts in accordance with the DPA 2018. The CCG had responded, and the LMC would consider that response	**LMC**
District Valuer report delays. Both sides agreed to report the problem experienced by Leckhampton Surgery to NHS England	**CCG/LMC**
Appliance ordering on POL. The CCG position was unchanged – that this scheme was designed to save money that could be otherwise better invested	

	ACTION
in primary care. They would be policing it to ensure that savings were being made. The LMC wanted to know how well practices were doing, especially as funding under the Primary Care Offer was involved. The CCG agreed to provide benchmarking figures.....	**CCG**

Item 6 – Any other business

Nil

Item 7 – Date of next meeting

Tuesday 24th July at the LMC Offices.

M J D FORSTER
Secretary

Annex:
A. Negotiators Action List

ANNEX A TO
LMC/CCG NEGOTIATORS MEETING MINUTES
DATED 28th JUNE 2018

NEGOTIATORS ACTION LIST

Outstanding actions arising from previous meetings.

Action	On	Progress
Midwives' flu vaccination of pregnant women from 2018/19.	**CCG**	**Sep Agenda**
Harmonization of DNAR forms.	**CCG**	**Sep Agenda**
The CCG would share with the LMC the projected service for prescribing Tamiflu for prophylaxis	**CCG**	**Done, but remuneration still to be negotiated**
Inflationary uplift for existing enhanced services.	**CCG**	**To be considered at the 17th July meeting**
Provide a system specification for Minor Ops	**CCG***	**Not done. TY to email Alan Gwynn**
Consult with the LMC once figures obtained from practices about the Key Lines of Enquiry	**CCG**	**In progress**
Countermand that emailed directive	**CCG**	**Not yet done**
Commission adult ADHD shared care services	**CCG**	**In progress**
Call meetings in late summer for early discussions on the format for enhanced services in 2019/20	**CCG**	**Not yet done. The intent is to base it in future at Locality level rather than county-wide**

Actions arising from this meeting.

Action	On	Progress
Forward formal phlebotomy proposal to LMC	**CCG**	
Change endoscopy forms as detailed in these Minutes	**CCG**	
Base the reasonable period of dermatology form introduction on the number of practices sending letters and the number of letters	**CCG**	
Promote the use of the new 2ww forms in the Newsletter	**LMC**	**Done July Newsletter**
Publicise the A&G responses in these Minutes	**LMC**	
Emphasise the need to stress the urgency when asking for histology reports on possible malignancies	**LMC**	
Consider the CCG's response to the data extraction question	**LMC**	
Raise concerns about delays in District Valuer reports top NHS England	**CCG/ LMC**	
Provide benchmarking figures for use of POL for appliance ordering	**CCG**	

*Dr Alan Gwynn to provide to Helen Goodey