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# BUCKINGHAMSHIRE LOCAL MEDICAL COMMITTEE

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**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 481173 or 01628 474731  
paul.roblin@bblmc.co.uk

## Minutes of Vale of Aylesbury LRC/PCT Meeting

On Wednesday 11<sup>th</sup> October 2006

At Verney House, Aylesbury

At 1.30 pm

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### Minutes of Previous Meeting

The minutes of 12<sup>th</sup> July 2006 were agreed as a correct record of the meeting.

### Matters Arising

There were no matters arising

### Use of ISTCs

The LMC are aware that a lot of money is tied up with the ISTCs which are not being used, the PCT have issued information to practices to try and ensure they are used more, however it does

not appear that the PCT understand that GPs prefer to refer to a consultant they know and the LMC want to work with the PCT to try and solve the problem.

GPs needed to know what the ISTC do, do they offer an opinion or go straight to operation, if there is a problem what happens, is it a package etc?

To send the CVs of consultants has not helped GPs form an opinion on them.

The problem is that the PCT did not choose to use ISTCs it was imposed by government.

The Reading site does not have as large a contract as Banbury and Milton Keynes, however the PCT are negotiating to try and transfer some activity across so that the South of the county can refer in there if they want.

In Banbury it is a new building fitted out to the standards of a private hospital, the Oxford Radcliffe Trust closed the Orthopaedic Department at the Horton Hospital and transferred the work to the Capio site, and all the consultants have gone too which means they are known to local GPs.

They will offer an opinion and can be used in the same way as a Trust.

It is for a whole package of care and at a known cost, it only includes a counted amount of follow up appointments.

They will only do the simple cases as they do not have intensive care unit.

If there are complications there are arrangements in place to use the intensive care facilities at neighbouring NHS hospitals.

If an emergency occurs after a procedure the patient will be taken to the nearest Trust, however once the patient is stable, they will be transferred back to the Capio centre.

There are negotiations underway to try and get the Capio Centres to pay for this in patient care at the Trust Hospitals.

If a patient experiences difficulties there is a 24 hour follow up line that they call and, if appropriate, they will be readmitted.

As new consultants have come into the area, GPs have gradually met them and refer in and as confidence grows more referrals follow.

The problem to refer to any site would cause transport problems for the patients involved.

It was suggested that the consultants could do out patient clinics in local surgeries to enable the assessment to be done without involving long journeys.

A meeting is planned locally to introduce the consultants to local GPs.

Last year Reading were staffed by non-NHS consultants and treated 550 patients; what they are expected to do in terms of compliance and how they are monitored is very exacting, and quality information has been asked for and the number of failures.

Orthopaedic consultants sub-specialise and it was asked that the PCT obtain information on their specialities.

When patients have been approached and asked if they would make the journey to an ISTC they have all been very willing to do so without any direct persuasion.

The only feedback from patients has been positive.

If a patient has no objection to going to an ISTC, the referral hub will discuss further treatment with them and this was pathway was the PCT's preference.

Across TV last year there was £3m of work that was not taken up at the ISTCs.

Currently orthopaedics is so fully booked over the next 6 months that there are only 10% of appointments left for urgent cases which is not sufficient so referrals should be sent to the ISTCs.

It was suggested that patients from the waiting list could be telephoned and offered treatment at the centers, although the PCT found it was very difficult and dangerous to do.

It was questioned why Capio do not tackle the more complicated cases if they have an intensive care unit close by to use?

Unfortunately the DoH did not negotiate the Contract in such a way.

MD said that he would circulate the dates for the meeting with the Capio Centres and asked that if GPs had any problems, they contact him with them.

**Action Point: MD to circulate information from Capio when it becomes available.**

## Practice Based Commissioning

The PCT commitment to fund PBC was raised, it is a one year DES and the DoH have issued guidelines on how to push PBC forward, and if practices want to move on forward now, this is reliant on the PCT funding work that will be undertaken in the next financial year.

JN assured the LMC that practices will get the C2 payment.

JF is very committed to PBC.

The PBC Steering Group will be changed to a Programme Board which will include input to the LDP budgeting process.

The first meeting will be in November and what kind of scheme that will be viable next year will be discussed.

There need to be mechanisms in place to support the development of PBC and this is something that will be addressed by the Director of Commissioning.

## New Intermediate Eye Care Service – is this a block contract?

This is the Lyn Jenkins service and will be a cost per case basis.

Diabetic Retinopathy is not included in this service, this is a government requirement and the contract has been awarded to the BHT and MKGH operating jointly and a programme is in place to get this up and running.

## DN Services and Flu

The delivery of flu to the housebound was discussed.

GPs reminded the PCT that in 2003 a lot of DN services were passed back to GPs saying that the DNs only looked after housebound patients.

As a result of this, the DN service should not charge practices £4 per patient for the administration of the vaccination for the housebound patient.

Teambuilding will be lost if practices are charged for the housebound patients, especially if they visit them as part of their workload.

The worry is that the PCT cannot pay for services twice and it was seen that the delivery of the vaccine to patients by the DN is the PCT paying GPs to do deliver it.

The worry is that if GPs are charged for services now, they will start charging the PCT for services that they do.

Flu money was taken from the global sum and paid to practices to do it instead.

CPB said she understood that it was not planned to charge for the administration of the vaccine to the housebound patient and would clarify this.

It was felt that although the majority of DNs would follow this, there were those who would not and it must be made clear to them that they cannot charge for the housebound patient.

HCAs are being trained to administer the jabs this year, CPB reminded members that they are not qualified to obtain consent or assess fitness.

Geoff Payne will be writing to all practices highlighting this.

**Action Point: CPB to clarify whether vaccinations to housebound patients would be charged for.**

## Audit of Hospital Bloods

Not all practices had received the paperwork from Carol Watkinson regarding an audit to be carried out.

Those practices who had received it were not clear what was required

The PCT wanted to have 4 weeks worth of data so the time would be extended to mid November.

The PCT would put in an explanatory paragraph of what was required from the audit.

The pre-op bloods, progress bloods and further on bloods but would exclude bloods for patients started on new medication.

**Action Point: The PCT to reissue the paperwork and write an explanatory paragraph**

## IT

Practices are being asked to submit their PDP and are being asked to highlight any service developments that have IT implications.

This year there is only IT maintenance.

There has been no major upgrades to the majority of practices since 1999.

Kevin Garthwaite said that he needed £200K a year to roll out upgrades but this has not happened.

**Action Point:**

## Premises

There is no money for premises.

John Worrall is now back at the PCT which should help things.

It was asked that this item be put on the PCT agenda as Bucks are the 8<sup>th</sup> fastest growing area in the country.

Caroline Langley is developing strategic development plans across the 3 PCTs.

It was suggested that the LMC ask the question about how premises funds will be managed in the future and the PCT will ask too.

**Action point: The LMC will ask how funds will be managed in the future.**

## Meeting with the PCT in future

CPB said that she would organise the people who would attend the county meeting.

She also asked that the agenda posed questions that needed answers rather than a statement.

**Action Point: To word the agenda with questions.**

**Date of Next Meeting – Wednesday 13<sup>th</sup> December 2006**

<b>Present</b>	<b>Name</b>	<b>Organisation</b>
*	Beck Gill	Member
*	Beesley Helen	Member
	Jackson Graham	Member (Co-opted)
*	Lilley John	Chairman
*	Peacock Tim	Member
*	Quiney Iain	Member
	Roblin Paul	LMC Chief Executive
*	Solomon Jane	LMC Director of Development & Liaison
*	Birchall Carol	LMC Minute Secretary
*	Blakeway-Phillips Clare	PCT
*	Dillon Mark	PCT
*	Newton Jeremy	PCT
	Robinson Graham	PCT
	Watkinson Carol	PCT
	Lee Whitehead	PCT

Apologies: Drs Roblin and Robinson