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# BUCKINGHAMSHIRE LOCAL MEDICAL COMMITTEE

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## **Minutes of Chiltern & South Bucks LRC/PCT Liaison Meeting**

On Friday 24<sup>th</sup> February 2006, 2pm  
At Rectory Meadow Surgery  
HP7 0HG

### **CONTENTS**

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

Minutes of Previous Meeting .....	1
Matters Arising.....	1
Update on Referral Triage.....	2
Implications of the White Paper.....	4
QMAS End of Year.....	4
ES Plans 06/07.....	4
Herseptin .....	4
Medical Terminations.....	5
Financial Position of the PCT.....	5
Date of Next Meeting .....	5

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### **Minutes of Previous Meeting**

The minutes of meeting held on 16<sup>th</sup> December were agreed as a correct record.

### **Matters Arising**

#### **Cressex Imaging Centre**

The reporting will now be done by a doctor using the British format to ensure it is GP friendly.  
The images will no longer be provided on disc but will be printed out.  
GPs asked that software be developed to enable the discs to be read as consultants would probably find this more useful than a hard copy.

Consultants are not happy with the diagnostic centre imaging and are asking GPs not to refer there, when they are seen by consultants patients are being referred for further investigations. Consultants from the Trust are asking GPs to refer patients to Cressex and it was asked why? BHT does not have access to the Centre, but why they cannot use their own facilities was raised, with urgent cases being done before the routines.

The MRI scans and the ultrasound are being used to capacity, however X-Ray and Echos are down at Cressex and GPs need to be encouraged to raise their referrals.

The MRI scans are under a block contract with BHT for this year and are not charged as part of the out patient costs at hospital.

The PCT are asking that people do not switch their referrals.

The PCT are not paying twice for the same set of diagnostics.

Once the hospital reaches the monthly quota the consultant asks the GP to get the patient scanned as quickly as possible.

The PCT are paying a fixed amount for scans at Cressex so it is important that they are all being used and that they are monitored.

The timescale at Cressex is now reaching the same as for BHT.

### **Mental Health Trust**

A decision has been made to close the rehabilitation at Wycombe rather than Aylesbury.

## **Update on Referral Triage**

### **Emergency Care**

Is the fact that Peter Petri is working in A&E widely known amongst GPs, has it been published?

The PCT have commissioned a GP in A&E and MAU to help the hospital consultants make decisions about admissions that GPs would make if they were present.

From feedback they are turning around just under one admission a day.

Peter is present in the Department from 2-8 pm 5 days a week.

About 50% are going home without any extra care being provided.

About half of these were GPs patients, the rest were 999 or walking.

Almost 50% of the rest could have been sent home, had there been access to other services quicker.

The LRC are concerned about the evaluation, what is the learning need identified and what consequences were there to getting this decision wrong.

There is a process that will look at individual cases but it is still early days.

There are 2 opportunities for paediatrics, one and admission and another is an infection screen.

Infection screening could be included in emergency referrals to and if the results are normal, the patient can be sent home.

The patients who are being turned around have had enough investigations done to make a decision.

As the A&E Department learn the numbers will drop off, but the next stage is to try and stop the patients getting to A&E in the first place.

PP is being funded by the PCT extending their contract with Harmoni who sub-contract to Practice Networks to provide a GP in A&E at Wycombe Hospital.

The doctors working in this service have been subject to a different selection process to those who work for Harmoni.

When someone is turned around verification is given by the hospital team that the patient would have been admitted without the input from the GP.

This applies to any referrals made to the hospital.

The numbers would rise if there was a GP there 24 hours a day.

It mainly relates to infection where there is an IV nurse who can visit patients.

Referral triage for emergencies may be developed further by the PCT; it is hoped to have dialogue with colleagues before this happens.

The LRC were told it was going to happen but GPs were surprised to find it in operation.

**Action: JC to find out how the service has been advertised to GPs and to advertise the service in their bulletin.**

### **Elective Care**

One example was raised about a musculoskeletal referral made in August which took 6 months to go through the musculoskeletal assessment process and then the recommendation was that an orthopaedic opinion was appropriate which was the original intention.

This process should take no more than 10 days, the PCT agreed to look at this.

Practices say they have had several of these around this time too.

If a referral is dealt with in an alternative way, should the name of the person making the decision be on the letter?

GPs said it felt like an administrative letter, they are being signed on behalf of Dr McVey.

Currently VM is the only one doing the process currently to ensure that things are turned around within the timescales.

Referrals are being sent to the hub, who is then emailing the ones that need further input to VM for her opinion.

During the 8 weeks of operation, these have been things that should have gone to the priorities forum, the self paid clinic or an alternative service.

Currently in this week none have been received and there has been a 15% drop in the number of overall referrals which indicates a change in referral behaviour.

Currently all varicose veins are going through the priorities forum which has resulted in a drop in the referrals for this area.

Varicose veins are going to the priorities forum and if they meet the criteria they are going through.

If you put in the letter that they veins are painful, why does the referral need to go to Priorities Forum?

Varicose vein referrals can either be stopped before assessment or before surgery and GPs felt it was reasonable that patients should at least receive an out patient assessment.

A lot of referrals were being made for cosmetic reasons which GPs should manage, there are those where there are varicose ulcers which need to go through, it is those patients in the middle that the GPs need to have discussions with the Priorities Forum and this process will be refined over time.

To have an out patient appointment will enable the patient to receive the best care possible, they may not go to operation but could see the nurse who can supply better support stockings than are available in general practice.

The PCT felt that this service needed to be expanded into general practice.

Experienced GPs, consultants and the PCT need to get together to define care pathways.

Is the time needed to develop care pathways being funded?

The management costs with PBC was suggested as a source of funding, but where things are being done for the benefit of the whole PCT there is separate funding, if it only benefits a practice it will come from PBC.

VM has had discussions on about 20 referrals over the past 6 weeks, whereas the hub receives between 80 and 100 referrals a day.

The quality of referral letters has changed and it is important to look at locum and register referrals as locums refer earlier as they want to sort out patient care before they leave the building and do not have the opportunity to see them again.

If GPs ring the consultant they are being told to fax the referral direct and not go through the hub.

The PCT agreed to check that there was a procedure in place to look at this and feed back to the LMC.

GPs are now not able to refer 'soon' as the category has gone, there are now only routine and urgent.

The danger is that an appointment clerk will send out appointments 13 weeks into the future.

The fact that consultants do not see the letters is a hospital policy.

One GP asked for an early opinion on a patient in early October, he then referred another patient urgently and rang the consultant, who said to put him in his next clinic, both patients had an endoscopy on the same day and both have been diagnosed with cancer; the original referral in October said he was worried and wanted a soon appointment, but he had to wait 12 weeks.

This means that GPs are overusing the 2-week wait clinics.

The PCT need to take this forward with the Acute Trust.

In the past the consultant used to mark the letters with the urgency of the appointment, now this is not happening.

The PCT are asking for an audit of the 2-week wait system as it is being swamped at the moment. GPs who are trying to use the system correctly should be rewarded.

It would be helpful to GPs to have an idea of how long a patient will wait if the letter is marked urgent, soon or routine.

BJ said that the cancer wait from referral to first treatment is 62 days, it is 31 days from assessment to treatment; there is a 31 day wait from out patient to treatment.

How long a test takes to register the cancer is not known, it is from the diagnosis to treatment that is 31 days.

The PCT agreed to publish this information in their Bulletin.

The LMC asked to be included on the Bulletin Circulation.

**Action: The PCT agreed to publish the cancer times in their Bulletin and investigate urgent referral pathways.**

### **Implications of the White Paper**

VM is holding a GP Forum to discuss the White Paper at the Misbourne Surgery on 16<sup>th</sup> March. There are a lot of hidden things in this and it will hurt in a year or two.

### **QMAS End of Year**

PHR has sent round a paper to practices on the process. The cut off day is Sunday 2<sup>nd</sup> April 2006.

### **ES Plans 06/07**

A document, revisions to the GMS Contract has been received.

There are now the 4 new ES and the PCT agreed to look at these and liaise with the LMC

**Action: The PCT to look at the new ES and then liaise with the LMC.**

### **Herseptin**

A local lady will be the first case to hit the press following the judicial review.

## **Medical Terminations**

There was an article on this in the press and it named the medical director, Shirley Butler and she has links with C&SB.

C&SB are doing a pilot which is coming to an end and the pro-lifers may become active.

If practices see anything unusual they are advised to let the PCT know as they are doing a risk assessment.

## **Financial Position of the PCT**

Currently there is an outturn of £5m over as a PCT and the Bucks Health Economy will be £30m out of a total budget of £500m.

This will have an impact on discussions over ES next year.

It is about shedding 1500 staff, approximately a quarter of the staff, from a total of about 4000 at the Acute Trust and 2000 elsewhere assuming an average salary of £25K, the merger will not solve this.

The SHA Chief Executive will be putting a freeze on recruitment.

The PCTs will be told to save money where possible and it may be that the PCT will have to look at other providers for services that GPs have provided in the past.

The PCT need PBC to start ASAP.

The aim of the PCT is to sort out the big expenditure first, such as hospital admissions.

When the guidance came out that shifted secondary care to primary care, it made the Thames Valley position £92m worse overnight and is a political decision.

The PCT and the LMC need to work together to deliver maximum patient care to the money available.

**Date of Next Meeting – Friday, 28<sup>th</sup> April 2006**

<b>Present</b>	<b>Name</b>	<b>Organisation</b>
*	Corlett Helen	Member (Co-opted)
	Daily Simon	Member (Co-opted)
*	Mallard-Smith Rebecca	Member
	McDermott Hilary	Chairman
*	Sapsford Andy	Member
*	Stoneham Mike	Member (Co-opted)
	Thompson Simon	Member
*	Roblin Paul	LMC Chief Executive
*	Solomon Jane	LMC Director of Development & Liaison
*	Birchall Carol	LMC Minute Secretary
*	Carmichael Jonathan	C&SB PCT
*	Johnson Bart	C&SB PCT
	Langley Caroline	C&SB PCT
*	McVey Vivienne	C&SB PCT PEC Chair
	Wilson Tom	C&SB PCT

In attendance: Dr Amar Sattar – GP Registrar

Apologies: Dr McDermott