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Minutes of Milton Keynes LRC /PCT Liaison Meeting

On Friday 15th December 2006
At the Post Grad Centre, MK6 5LD
At 2.00 pm

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Minutes of Previous Meeting

The minutes of 20th October 2006 were agreed as a correct record of the meeting

Matters Arising

There were no matters arising

Equity of Counselling and Physio Provision

Negotiations have started with Newport Pagnell who have the counseling provision. Helen Corr, TW and Judith Bootle are trying to arrange a meeting between Christmas and the New Year with the counselor they employ to discuss ongoing arrangements. It is hoped to re-commission a service for primary care counseling. With physio as it was not guaranteed there would be any savings from reconfiguring the service, attention had to be given to the financial deficit; a draft paper has gone to the Collaborate suggesting keeping the providers where they are but letting practices know who the local provider was and if the collaborative endorse this, practices should agree with this.

GPs felt there were more places to send patients to now, and they needed to know which was the most cost effective method and which were the preferred option, waiting times and the efficiency of the service.

The PCT need to devise a mechanism to hold this information, although it will be known how much an episode costs in each provider.

Action point: The PCT to let GPs know the preferred provider with costs and waiting times.

MK PCT Update

The report back to PEC said that the financial turnaround plan is slowly delivering but whether it will deliver in time is not known.

The Efficiency tables showed that with out patient activity the target level is 100% and MK is at 61% which may indicate inadequate capacity or an efficient GP filter, however emergency admissions are almost 50% higher than they should be.

The data refers to MK PCT and was probably supplied by the PCT LDP/PDP returns made.

Data collected by Nick Hicks suggests that GP referrals into MKGH are less than consultant to consultant referrals and indicates that the GP workforce are very efficient.

Consultant to consultant referrals cause the PCT the most concern along with the way the hospital chose to code some of their activities, they will always code as an inpatient even if it is a day case, whereas the others work on the assumption that out patient and may code as a day case.

The problem is the PCT may not have been strong enough with the hospital in monitoring this and allowed it to happen and grow.

The SLA has shown that the hospital have to make £3m savings conceding that things have not been done properly.

It was agreed that it would be better to invite Clare Weston to attend the next LRC meeting to have a question and answer session.

Consultant to consultant refers to referrals within a department for a different procedure, it does not refer to referral to another speciality as these would come back to the GP.

Action Point: JS and TW to liaise regarding inviting Clare Weston to a future meeting.

JS Report

There is a requirement not to refer to consultant psychiatrists but to address to the Team.

Action Point: If this becomes a problem report back to PR

C&B Training

There is dissatisfaction within the profession about the time and money this wastes.

The PCT are aware of the dissatisfaction but they have an obligation to provide and try to ensure it works as smoothly as possible.

This is Government policy for PCTs but not for GPs and there is a move amongst MK GPs who do not want to do this any longer.

GPs have heard threats that there will come a point where paper referrals are no longer accepted. Once a properly worded letter of referral is written the GP has fulfilled their obligations, however there are some acute trust or referrals centres who are saying they will bounce these back unless

the GP uses an electronic format and the PCT need to consider their legal position should a patient suffer from this action.

TW said that the Acute Trust are saying that a given point they will stop accepting paper referrals, although there will still be some people who send paper referrals in such as optometrists.

The PCT need to consider this as they are commissioning the service and it is their responsibility to look after the patient.

TK reported that a hospital is sending their letters to GPs to India for typing and they are then being sent direct to the GP. They are not being checked by the hospital and the legal opinion is as GPs know this is the system and the information may not be correct, it is up to the GP to ensure the information is correct and it is their problem if it is not.

C&B has problems on a daily basis and what happens when the net goes down how do you get a referral sent?

The 2 week wait referrals and rapid access chest pain clinic letters will always be faxed to the hospital, also urgent referrals from a patient's home need to be done on paper.

Why should GPs have to do C&B at any other time than when the patient is in the surgery, it does involve the patient too so if it was done in the evening or on a Saturday they would be disturbed too.

It was agreed that a system was needed when the system failed.

If you sign up for C&B you do not need to use it for every patient.

Action Point: To ask TW to report back at the next meeting:

Milton Hall Nursing Home

ER reported a meeting with the proprietors of Milton Hall; it is understood that some practices are showing interest.

A considerable number of residents will be those purchased by Bucks PCT and they cannot be primary care, they must be intermediate care beds, it was asked what arrangements were made? Milton Hall was advised to contact every practice the PCT area to ask if they would do any cover. TW has spoken to Caroline and she gave the proposed admission plan until mid January and this only amounts to 9 people; although the building is large, they do not plan to open it all up at once, but will do it in stages and maximum capacity should not be reached until Autumn 2007. Currently the practices that cover Kents Hill and have an open list and they can call on these for GMS services and the practices are obliged to take these.

They have also talked to other practices with open lists.

TW asked for the planned number of people coming in so he could contact surgeries and work out a rota to place people with practices.

With Bucks PCT purchasing beds, these are people who have been discharged and therefore not intermediate care as they would have gone into a nursing or residential home so the patient would be entitled to GMS if more is needed Bucks PCT will be contacted.

The GMS demands on practice for this type of home is excessive; it would mean that a practice would not be able to deliver GMS to its other patients properly.

The PCT were aware of this home and have tried to tell the authorities that the building of large nursing homes is a not good thing, but it is perfectly legal to do so.

The PCT then has a responsibility to ensure all patients have access to primary medical services delivered through a GMS Contract.

The NH could be seen as GMS, but no patients will be able to go to the practice and will all require a home visit and this will too great for practices, it was asked where these visits would fit into day?

As it likely that the patients will be registered with different practices, it is possible that if the doctor is visiting their patient, they will be asked to see another one as their doctor cannot get there and this only adds to the workload.

Another problem is that the NH do not request all visits at the same time and this may mean that the GP has to make numerous visits each day.

The PCT have tried to reconcile this type of problem between both parties and written specifications of what the home should expect from the practice and the practice from the home. Another problem is the number of patients who will need a visit from a home of this size.

If it came down to allocation, the PCT would allocate around 45 patients to each of the 4 local practices and although when first started the requests are good, as staff change or agency staff go in, these standards rapidly drop.

The PCT may need to look at a more imaginative solution.

TW said that MK Doc are putting forward a proposal where they will have a list of all the NH and the patients will then become registered with MK Doc as the provider. Contractually this needs to be done through an ES, as a way needs to be achieved to get around this.

There is a period of time to come to a solution as they do not plan to have full occupancy until late 2007.

Previously when a NH was planned the provision of GMS was considered, now this is not necessary, the planners are only worried about car parking spaces and the maximum use of land. The planners must be told that MK is over provisioned with NH and the PCT are doing their best to get this message across.

With NH if they cannot demonstrate a good working relationship with GPs, they will go out of business as they cannot get their approval.

Action point:

Date of Next Meeting - Friday 26th February 2007

Present	Name	Organisation
	Carter Ron	Member
*	Kenny Tina	Member
*	Labrum Tony	Member (Co-opted)
*	Rao Lakshman	Member
*	Rose Eric	Member
*	Suleman Abdulrahim	Member
*	Whyte Sian	Chair
*	Roblin Paul	LMC Chief Executive
*	Solomon Jane	LMC Director of Development & Liaison
*	Birchall Carol	LMC Minute Secretary
	Ablett Jeanie	MK PCT
	Clark Ruth	MK PCT Clinical Governance Lead
	Savage Michelle	MK PCT Primary Care Comissioner
	Jacklin Mary	MK PCT
	Kennedy Barbara	MK PCT Chief Executive
	Lee Thompson John	MK PCT
*	Wilson Tom	MK PCT
	Murthy Satya	MK PCT PEC Chair

No apologies were received