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MINUTES OF MILTON KEYNES LRC/PCT LAISON MEETING Friday, 5th March 2010 Board Room 1, Sherwood House, MK PCT, MK3 6RT

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Minutes of Previous Meeting

The minutes of 9th October 2009 were agreed as a correct record of the meeting.

Matters Arising

There were no matters arising.

Summary Care Record (SCR)

PHR explained the issues he had with the MK implementation of SCR

He acknowledged that the cancellation of the January Liaison meeting due to the snow, and the absence of advance discussion on the SCR, was a significant reason for recent difficulties.

Rather than being an “early adopter” area, MKPCT is a “fast follower”.

PHR presumed MK PCT did this because of the opportunity to save money: CfH offered central funding of the PIP (Public Information Programme) if the money was spent by the end of March. Bucks and Oxon PCTs have not chosen this route, feeling that the savings were not worth the problems of rushed implementation.

PHR asked how the steering group was created and how it had got its membership. No request for LMC membership had come through the LMC office.

MK LRC is a subcommittee of Bucks LMC who have subcontracted such work to BBOLMC in Marlow. PHR thought the PCT understood this.

TK said that following a meeting expressions of interest were invited and JB had written to say that he was interested. TK had passed his name to Janet Westcott stating that he would be the LMC representative. She apologised for not following the correct process.

PHR emphasised that not involving him meant the group had not been exposed to other SCR experiences in the Thames Valley, the knowledge he could bring from the national LMC Secretary listserver, and his assessment of the practical problems for practices.

PHR felt the minutes of the MK SCR Steering Group meeting suggested that the practical problems of the PIP were hardly discussed.

The PIP is about patients being written to and informed about the SCR and that they have an opportunity to opt out.

Had he been at the meeting, PHR would have sought clarity about practice roles and workload together with the process for opt out.

The steering group had discussed that for technical reasons, a number of practices would not be able to upload an SCR. Nevertheless, all patients had been written to.

JW said that the decision was taken to write to every patient because although the letter was sent in January 2010 the PIP initiative lasted for 12 months.

It was hoped that those practices would be compliant before the end of December and patients could also move practices in this time.

PHR felt that the PCT literature needed correction.

It has stated that the BMA are in agreement with the SCR and the opt out consent model.

Actually the BMA has only agreed to a trial of opt out for the SCR pilots, and the MK initiative is not part of this.

PHR said that there were hidden workloads for practices.

If a parent telephoned the SCR help line to ask about opt out for the under 16s they were being told to visit their GP. Gillian Braunold (CfH Clinical Director for Summary Care Record & HealthSpace) has recently sought to change this interpretation of the SCR algorithms held by CfH.

Before entering the 93C3 Read code, the GP is expected to make an assessment of the benefit to a child and their capacity to make an opt out decision.

Connecting for Health (and Government) want to have the maximum number of people opting into the SCR system which is why they have pushed an opt out system.

The BMA wanted an opt out card sent with each patient letter.

JW said that it has been proven that if a form is sent out patients will automatically fill it in.

PHR said that one practice in Oxfordshire had on their patient registration form a box to tick if the patient was happy for their records to be uploaded. No one had ticked.

Because of poor patient understanding and apathy, both opt in and opt out systems tend to have exaggerated numbers in the default (or easy) option.

PJR broached the John Parnell (HealthMK) email offering to represent MK practices over a range of IT issues on the MK Strategic IT Board.

PHR felt strongly that this was a task for LMC.

Health MK is a commissioning organisation whereas LMC looks after GPs in their provider role. However, he hoped that Health MK and the LMC could work together on issues in the future.

TK chairs the MK Strategic IT Board.

It was agreed to officially ask the LMC for a representative.

Action Point: PCT to ask the LMC for a representative for the Strategic IT Board.

Violent Patient (VP) Services

PHR had concerns that the contract notice given by the VP provider BFS (Bucks Forensic Services) had ended on 1.3.10 and no new provider had been identified.

PHR attends regular meetings with the Thames Valley PCTs and VP providers (mostly BFS).

MK PCT rep has never attended (the only PCT absentee).

MK has apparently subcontracted this work (and the VP service contracting) to Bucks PCT.

However, each PCT has a role to decide who comes off and who remains on the list especially as patient allocation issues often follow.

Having Bucks PCT perform this role for MK doesn't work.

Bucks PCT are also unhappy about this, and have given notice of termination of the subcontracting arrangement.

BFS also have issues with MK PCT about unpaid invoices over 9 months.

Dr Reidy (Head of BFS) gave Nick Hicks 3 months notice of termination of the contract ending on 28.2.10. PHR showed the meeting a copy of the letter. It seemed that MKPCT reps had not seen this. PHR asked whether the PCT had commissioned a new provider.

Who would be looking after the 5 patients who were currently on the VP register?

MKPCT said that they had had conversations with Dr Reidy about the outstanding invoices.

A-MF said that Bucks PCT were researching the matter of the unpaid invoice which is around £7.5K, but the PCT were of the opinion that the contract was still in place and the patients would still receive services.

Dr Reidy had said that there were so few MK patients that he only rarely invoiced for his services.

CB said that in conversation, Dr Reidy had withdrawn his notice.

This had not been confirmed in writing by either side.

PHR said that NR had phoned him 2 weeks ago, irritated by the negotiations with MK PCT and inferred that the notice was still in place. The PCT said that they would check on this.

A-MF said that the PCT wanted its own contract for a VP service.

She said that several meetings had been set up but NR had cancelled them as he had been off work.

It has now been rescheduled for Tuesday 9th March.

LMC felt MKPCT needed to be sure what services they were commissioning: would it just cover violent patients or the difficult to place ones also.

Genuinely violent patient cases need a police incident number.

PHR developed VP processes with Bucks PCT some years ago and versions of these are now used across the Thames Valley.

A practice applies (to its PCT) for patient addition to the VP register using a standard form and this requires a police incident number.

Acceptance as a VP means that the patient would be unable to access usual GP services from a surgery but would have to receive care from Bucks Forensic Services as VP provider.

A-MF said that she did not see the need for practices to contact her if there was a violent incident, provided they had an incident number the patient could go straight on to the list.

PHR felt this system worked well elsewhere, possibly because practices obtained advice and guidance from the PCT about a process which they rarely used.

The priority for the PCT was to set the new contract up, and then inform practices of how to access it.

**Action Point: PCT to check whether Dr Reidy had withdrawn his services from 1/3/10.
The PCT to develop its own contract and then to inform practices how to access the services.**

Post Op Thrombo-Prophylaxis Workload

MKFT consultants want to initiate a system of injectable post op thrombo-prophylaxis.

This relates to patients who have had major abdominal, gynaecological and neurological surgery and patients with fractures.

This could have implications for workload in the community.

Elective orthopaedic patients will have an option to have treatment orally.

For elective surgical cases, the patient volumes amount to about 3 per week, totalling about 300 a year (for fractures it is about 210).

Patients will require these injections daily for 28 days.

For most, it should be a self injecting regime but there will be some patients and carers who cannot do this. The failure to self inject numbers are expected to be about 10%.

This is largely a DN issue, but there will need to be blood tests done at day 7 and 14; it is anticipated that ambulant patients will be able to get to the surgery for this at day 14 but GPs will need to interpret these tests.

The test will be a FBC: a protocol is being written also explaining the Hb results.

Patients will also receive guidelines on what to do and what to expect.

PHR asked if it would be possible to develop a relationship with MK Trust so that they recognised the LMC in the same way that Oxford Radcliffe Trust does?

TK said that this should be explored further.

Action Point: PCT to develop guidelines for GPs and patients.

Orthopaedic and Ophthalmic Referrals

The ability to refer to Orthopaedics has been removed from Choose and Book.

LMC asked how long this will remain so?

CB said that it would be a few more weeks.

He said that the PCT were working with management and clinicians to see that this is a one-off incident.

They will be working with clinicians and developing a referral protocol.
Currently GPs in MK can only refer locally to the MSK Assessment service.
Referrals can still be made through C&B to other regional hospitals.
Physically, this does not take any more time, but explaining use of non local hospitals to patients does.

CB said that the situation had occurred because the department was unable to meet the 18 week target for the volume of referrals received.
MKFT is currently working through the patients for whom appointments had been made and then carrying out the operational procedures.
The department is still accepting patients from the prison and Chadwick Lodge but the numbers are extremely small.

One potential solution is to deliver more services from primary care.
A pilot service has been set up with a physio visiting practices.
In three months a visible drop in referrals has been noted.
This will be rolled out to all practices, probably as a LES.
LMC said that LESs are voluntary.
To achieve population coverage, there would possibly need to be locality provision.

The Surgeons have been asked to use NICE and the Map of Medicine for guidance about referral management. They have been looking at backs, hips, knees and ankles.

LMC asked if referrals (for specialties that are blocked to GPs on C&B) were still being accepted when consultant to consultant (previously this had been 50% of all referrals).
The PCT said that they would look at this as they did not know.

Patients with ocular hypertension are being called up to out patients when they could be managed by other services.
This escalation in referral numbers seems to follow new NICE guidance on when optometrists need to refer patients.
LMC and PCT agreed that the right people needed to be seen by secondary care (ability to benefit argument).
The glaucoma clinic has been closed and this has resulted in a greater number of referrals going to general ophthalmology clinics.
The PCT needed to commission a service review of what is now happening.

Action Point: PCT to audit consultant to consultant orthopaedic referrals.
The PCT to review what is happening now with ophthalmology referrals.

Maternity Care/MSLC

Early in January the CQC issued a follow up report to its 2009 review of maternity care in MK
This said that although progress had been made there were 2 outstanding issues which were a significant risk, midwife staffing and the number of beds available.
The number of open beds (rather than physical beds) depends on the staff available.

The PCT have looked at the number of women who could use another local hospital rather than MK and this has reduced the total number of deliveries by 300 out of a total of 4,000.
Local hospitals do have the capacity to take on these women; Northampton has a ratio of 1:32, in MK it is 1:37-8.

In Bucks the hospital has said they will only accept women up to 30 weeks which is about 250 women.

In MK the target is a 1:1 midwife in established labour.

The PCT is also working with MKFT hospital in 3 month blocks to highlight any peaks or troughs; if there are any peaks women will be invited to go to another hospital.

Currently this is not needed as the numbers have been reduced enough to deliver 1:1 care in established labour and ensure that the women are safe.

Clearly this impacts on antenatal and post natal care when staff are moved to labour ward duties.

A Maternity Monitoring group was set up in February 2010.

Rather than monitoring an action plan it is checking patient experience against plan. The first meeting is 29th March.

The PCT was not aware of any avoidable deaths.

Since the recent publicity, although women have been saying positive things when they marked the sheets the scores were not consistent.

20 new midwives need to be recruited to the organisation so that staffing does not become a problem. Caesarean rates need to be looked at; the number of first time caesareans is high and this means that the second deliveries are also likely to be elective LSCS.

The number of assisted births is very low, and this contrasts with the high LSCS rates.

Monitor has said that they feel that the hospital has breached its licence.

MSLC does not have a GP on it at the moment; TK agreed to check this with LH.

Action Point: TK to check if MSLC had a GP or not.

Urgent Care and Emergency Admissions

Emergency Care

50% of MK mailbox emails seem to be about the hospital closure due to workload pressure.

JB said that the last 2 Whole System Resilience Group meetings had been cancelled because of a lack of people willing to attend.

There is a desire to re-route patients to the community.

The Group had said that GP representation on the group was not necessary.

The PCT said they were unaware of the group but would investigate.

Urgent Care

JB asked about walk in patients attending A&E.

A significant number of patients do not need A&E care.

The PCT was asked what plans there were for a common front door.

CB said that the PCT planned to have a common front door and there is a meeting on 11th March to discuss this.

Currently there are 31K patients for whom the PCT is paying A&E tariffs who are minor cases and could be treated by a primary care physician or a pharmacist rather than an A&E doctor.

It is high on the PCT agenda.

Action Point: PCT to investigate the Whole System Resilience Group.

Iwantgreatcare – Costs and Duration

For 2009-10, this is costing £75K, but only £25K is from the South Central Innovation Fund.

The remaining £50K is from the PCT unified budget.

This initiative is for one year only.

LMC felt that the PCT needed to ensure that it is worth the money.

LMC speculated that it was probably not achieving anything.

Joint Infection Prevention and Control Committee

PHR reported that elsewhere in the TV, the HPA had issued a document imposing infection prevention processes and spend on general practice, the development of which did not involve GPs at all. Public health had produced it alone.

MKPCT said that they had developed a policy for use in GP surgeries.

TK had not seen the South Central document and PHR agreed to email this to her.

Action Point: PHR to email South Central's document to TK.

PCT Role in Getting Information to Locum and Sessional GPs

PHR reminded the PCT that it was responsible for its own performers' list.

He had recently written to all TV PCT CEOs about ensuring locum GPs had access to PCT guidance especially when they were not part of a cascade system within a practice.

He has asked every TV PCT to commission this service from the TVPCA but MK had not yet responded.

A-MF said that she had sent an email to John Derry about this.

Date of Next Meeting – 7th May 2010

The above date is provisional as one new member has indicated that Friday would not be good for her. Before deciding, LMC will survey Liaison meeting attendees to see which days are best.

The meeting closed at 3.30 pm.

Present	Name	Organisation
*	Birchall, Carol	LMC Minute Secretary
*	Bradley, Julian	Milton Keynes LMC
*	Brookes Clive	Milton Keynes PCT
	Carter, Ron	Milton Keynes LMC
*	Frost, Anne-Marie	Milton Keynes PCT
	Hicks, Nicholas	Milton Keynes PCT
*	Kenny, Tina	Milton Keynes PCT
	Prager, Gillian	Milton Keynes PCT
	Rao, Lakshman	Milton Keynes LMC
*	Roblin, Paul	LMC Chief Executive
	Suleman, Abdul	Milton Keynes LMC

Apologies: Drs Carter and Suleman and Gillian Prager

In Attendance: Janet Westcott, Lucy Huber

Dates for Future Meetings

07.05.10 02.07.10 01.10.10