
BUCKINGHAMSHIRE LOCAL MEDICAL COMMITTEE

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@bbolmc.co.uk

Minutes of Milton Keynes LRC /PCT Liaison Meeting

On Friday 19th May 2006, 2pm
At the Post Grad Centre
MK6 5LD

CONTENTS

CTRL and Click to hyperlink

Minutes of Previous Meeting	1
Matters Arising	1
ES Plans for 06/07	2
4 New DES	2
PBC Progress	2
Counselling and Physio	3
Referral Management Debrief	3
eGFR Update	4
QMAS Debrief 05/06	5
Date of Next Meeting - Friday 21 st July 2006	5

Minutes of Previous Meeting

The minutes of 31st March 2006 were agreed as a correct record of the meeting.

Matters Arising

Rationing and the Public

The Priorities Forum statements sit on the MK PCT website, but LRC felt that this was not enough.

LRC felt the PCT should be doing more through the local media to ensure that the public are kept fully aware of the current state of rationing of care and referral management. TW agreed to draft something and email it to SW and PHR. ER offered his services in the drafting of the press release if needed.

TW informed the committee that John Evans (Communications Officer) is leaving the PCT at the end of May. The PCT had advertised for a replacement; however the person offered the post declined to accept it.

The LRC asked that John Evans be thanked for his input to the PCT over the years.

The instigation of the mailbox was a very useful tool.

The LRC felt the PCT must be supported in replacing the position.

Action: TW to draft and email a press release.

Cost Rent for GMS/PMS Practices

TW reported he had drafted a letter explaining why the PCT were using GMS regulations for a PMS practice, but it had not been sent out yet.

TW believed a decision had been made regarding the date that clawback would go to, although it was felt to be September 2003.

Action: TW will forward the information to PHR.

ES Plans for 06/07

The PCT confirmed they have rolled over the previous year's ES in addition to the 4 new DES. TW felt practices had been informed of this; however it may have only been discussed with PMs. He would ensure that practices were officially notified.

There were 2 changes to the existing ES. Minor Injuries has only been commissioned for 3 months. Thereafter it will be reviewed in light of the new WIC statistics. After this it may be commissioned differently and only with practices at a distance from the WIC.

This could provoke patient irritation; if practices are not paid to provide the service they will not do so.

TW tabled a specification for a DVT service on offer to all practices. LRC received this.

The LES is for a maximum of 12 months, commencing in June.

The PCT eventually want to commission one provider for the whole pathway in a primary care setting. Once the tendering process has been completed, 3 months notice will be served on practices.

4 New DES

Practices have been offered these and only one practice has not returned them.

PBC Progress

13 of the 25 practices in the Collaborative have returned their plans.

These will be signed off at the PCT Board meeting in July to allow the aspiration payments to be made.

Two practices have signed up for PBC independent of the Collaborative and the PCT will be talking to them about production of their plan.

The collaborative have used the BMA template and they have put forward 5 objectives.

Each practice has then picked 2 specialities and most have gone for Dermatology and Orthopaedics.

They have agreed a baseline with a view to reducing activity by 2% within the year.
PHR asked to see these written objectives and TW agreed to provide these.
Prescribing objectives are vague and these will be made clearer to enable payment next March.
The PCT want to make it clear to practices that no objective is more important than the other and if they only achieve 3 of them, they will receive 3/5 of the 95p payment.
A calculation will be applied making allowances for the list changes within year in accordance with the GPC guidance.
The budgets will be issued in line with the Thames Valley timeframe.
PHR asked that he be informed when practices have been issued with their budgets.

Action:

- **TW to supply PHR with a copy of the objectives.**
- **TW agreed to inform PHR when budgets have been issued and a sample of how they have been constructed.**

Counselling and Physio

Physio: PEC considering a proposal to establish an equitable baseline service available to all 28 practices.

An outline specification has been drawn up which assumed a referral rate of 30 per 1000 with a price of approximately £50 which gave a total budget requirement of approximately £430K.

TW agreed to establish whether the £50 was per contact or care episode.

Currently the PCT spend about £600K which they cannot afford.

If practices want to develop the service more they can use PBC to do this.

Instead of having a tender exercise where the PCT draw up a specification and ask providers to bid to this, they have decided to draw a looser specification and give a sum that will be spent and ask providers to say what they can provide for the money.

Once a provider has been established a full service specification will be drawn up.

PEC has agreed to this but the Board now need to ratify it.

The independent contractors have been re-issued with their contracts, the tender time will be 6 months and their notice period is 6 months.

Counselling has not yet been addressed as the budget is much smaller at £50K and PCT manpower is limited.

The service is run from 2 practices who could be asked to provide counselling for all.

It was asked who funded the City Counselling Service and how much this was.

TW agreed to look further into this issue and report back.

The LRC asked to be informed of what services were available across the PCT area.

Action: TW to check what counselling services are available across the PCT area.

Referral Management Debrief

JLT said the fact that the PCT are holding back referrals was well known, although it was not the original intention of the RSC to do this.

There are currently 1186 referrals held across 17 specialities. These resulted from the hospital imposing referral quotas and thresholds.

The hospital has told the PCT how many referrals they will accept each week; if more are received they send them back.

The PCT ensure that all urgent referrals are dealt with and do their best to ensure that this only applies to routine referrals.

It is anticipated that none of these referrals will exceed the 13 week waiting time.
This is causing inequity of access for practices that do not, or cannot, use C&B.
The PCT is trying to ensure that all practices are treated equitably.
Difficult discussions are taking place and it is envisaged that by August the RSC in its present form will disappear.
The problem is how GPs who do not use C&B know what alternative providers are available if the hospital turns off the tap in certain specialities.
The hospital have made it clear to the PCT that they want to have only one referral system, not run C&B and a paper based one.
On the C&B system MKGH is only one of more providers. If there are no appointments available the system will not give MKGH as an option.
The SLA will control the total capacity available; each SLA will have a financial threshold attached.
PEC and Board will receive a proposal aimed at solving this.

GPs preferred to refer to named consultants because they knew the speciality that the patient needed.
To refer wrongly to a generic consultant could mean that the appointment was wasted.
The GPs present felt it was not acceptable to MK GPs if referrals were bounced back.
Once the referral was made the GP had fulfilled his obligation.
GPs might need to enlist the support of the public.
GPs do not have the time to shop around for elective care.

Other areas likely to continue using hub referral filters.
Unlike them MK seem resistant to peer review of referrals.
The opportunity to use the RSC as a generic clinic assessment service is something that has been explored in the past, but not been implemented.

Government policy states that C&B will be the preferred method of referral and the hospital are saying that in line with this policy they only want to receive referrals this way.
The PCT plan that 90% of referrals will go through C&B by March 2007, although this should happen sooner in MK. Nine of the 28 practices in the MK PCT area currently use C&B.
The LRC did not feel comfortable with this proposal and asked that this be discussed further.
The PCT Commissioners are drawing up referral guidelines; PHR asked to have view of this document when it has been drafted.
The PCT will ensure that all practices have the ability to use C&B, all the hardware will have been installed and training given by August this year.
Practices who currently use C&B report it is no more time consuming than making a standard referral.
The PCT felt that the PBC Collaborative supports the use of C&B.
The PCT have offered the C&B DES as it has been written nationally.
The PCT are always obligated to put 4 or 5 providers that GPs can refer to, the problem is the local hospital may not be available on the system if the activity threshold has been reached.
If a patient wanted to be seen locally but there were no appointments available, they would have to travel.
If a patient is happy to wait to be seen locally but wait, the referral will still be returned to the GP.

The LMC had received reassuring letters following the previous meeting. However LMC has spoken to Dr Gamlin. He appears not to support EGFR provision.
TW agreed to take this contradiction to the next SLA meeting with the hospital.
PHR said that until eGFR was available GPs would be unable to populate their GKD register and thus not be able to do the required work for QOF.

Action: TW to take this to the next SLA meeting.

QMAS Debrief 05/06

TW reported that there were no problems and he would be forwarding the results paper to the PEC and then emailing it to all practices.

Date of Next Meeting - Friday 21st July 2006

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 PCR
	Murthy Satya	MK PCT PEC Chair

Apologies: Drs Labrum & Suleman
Jane Solomon