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# BUCKINGHAMSHIRE LOCAL MEDICAL COMMITTEE

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## MINUTES OF MILTON KEYNES LRC/PCT LAISION MEETING Friday, 15<sup>th</sup> May 2009 Training Room, Milton Keynes Village Practice, MK10 9BQ

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### Minutes of Previous Meeting

The minutes of 3<sup>rd</sup> April 2009 were agreed as a correct record of the meeting.

### Matters Arising

There were no matters arising.

## Pandemic Flu

The communications from the PCT have been greatly appreciated as they highlight the new information. This has not been done in other areas.

One issue however has been the time taken from taking the swab to the courier arriving to take this to the HPA.

It was suggested that the PCT could develop a dedicated swabbing team.

They would have full FFP3 protection which is in short supply and costly.

Using the same team to swab would have the added advantage of consistency.

AM-F agreed to discuss this with Adrian House.

Another suggestion was to use the MKDoc car for the swab team.

Such a service would need to be properly funded.

LMC felt a debrief at the end of current crisis was required to see what had been learnt.

**Action Point: AM-F to take back the idea of having a dedicated team to take the swabs to Adrian House.**

## MRSA Screening and Treatment

This was discussed at Liaison on 3.4.09 and LMC concern about MRSA swabbing by GPs was raised then.

The same day MK PCT issued mailbox 37 without discussion taking place or anything being agreed with the LMC.

This outlined how GPs would prescribe for positive cases and reswab.

PHR reported that the Downing Street Policy Unit instructions on MRSA workload were that hospital trusts cannot hand this work to GPs. Other areas had stuck to this.

PHR suggested that every MKHT patient gets swabbed at the pre-op assessment.

Housebound patients can be swabbed by DNs on instruction from MKHT.

If the result is positive, a MKHT liaison nurse (accredited as a nurse prescriber) can either write a prescription or organise for a treatment pack to be sent to the patient (PGD needed).

The liaison nurse should know exactly when a repeat test is needed and can organise this via the MK district nurses.

Another advantage of this system would be that the hospital will not call patients for surgery before their MRSA status is sorted.

GP apologised for the problems this had caused; it had not been intentional.

She had attended a GP Infection Control Committee in March with Helen Chadwick who is the Chief Pharmacist.

It had been presented that GPs had been doing this for 18 months and the numbers of patients with positive results was extremely small, on average only 1 patient per practice per month.

LMC felt that if the MRSA workload was so small, then this was also true for MKHT whose responsibility it actually was.

There had originally been a GP on the Committee but unfortunately he had left and not been replaced. The GP view was therefore not heard.

The PCT stated it was their intention that the patient should not have to pay for the treatment so it would be better to send the patient a treatment pack rather than a prescription. It would also ensure greater compliance.

GP said that this was due for review in 6 months time; the LMC said that a change should be discussed now.

PHR agreed to produce a summary of the problem and the suggested solution (see above).

**Action Point: PHR to commit his views to paper for the PCT to take to the next committee meeting.**

### Giving practices details of what each MIQUEST query will extract

The LMC suggested that when the PCT approached practices asking for non-anonymised personal patient information, a better system was needed.

The PCT should state why this information was being required, the law that allowed them to request it, and allow a reasonable timescale for response.

Requests are being sent out which do not contain the above.

Understandably nervous PMs are approaching the LMC asking if they should be supplying the information.

If patient specific information is being requested this should be sanctioned by the PCT Caldicott Guardian in the first instance. This did not seem to be happening at the moment.

The PCT Caldicott Guardian needs to be very familiar with the law on information provision and act in the patient's interest not that of his/her employers.

AM-F gave PHR a copy of the latest request where on page 4 it had stated what the information was needed for.

On brief glance at the tabled document, the description of the data to be extracted used so many specialist computer coding terms that a lay person/PM/GP would be none the wiser.

The description needed to be written in plain understandable English not cut and pasted computer code.

TK said that this suggestion should be passed on to Chris Knibbs.

LMC suggested that information requests should go through one person at the PCT.

PHR reported that when this was suggested to another PCT the response was that this would cause a bottle neck.

This indicates how much information is being requested from practices and why PMs are so stressed.

The PCT said that their systems needed to be tightened up, especially with regards to consulting the Caldicott Guardian.

PHR suggested that when the QoF prevalence calculation alters next year (loss of square root adjustment) the PCT would have freed up resources which could be used to fund practices to provide information over and above their core obligations.

AM-F agreed to take this back to the PCT.

**Action Point: AM-F to ensure PCT information requests are done properly and legally. PCT to consider the suggestion that QoF savings be used to help fund practices to supply PCT with information over and above core obligations.**

## IUCD LES

There is a section in this LES that states that GPs should only be performing the insertion of Long Acting Contraceptives if they have a letter of competence to do so.

AM-F reported that last year the PCT had undertaken to provide the courses that would enable GPs to achieve this letter.

TK reported that she had attended such a course but felt that it was now only open to nurses as GP attendance had been poor.

TK said that only GPs who had decided to obtain the DFFP and continued to be a member would be able to obtain such a letter but that this would only be after they had attended the training.

GPs asked what the position was regarding GPs who had performed many fittings last year and felt competent and confident to continue to do so but did not have a letter.

Could the PCT implement a “grandfather clause system” (accreditation through past experience and throughput) until GPs obtained this letter?

GPs are obliged by the GMC “Good medical Practice” to only carry out a procedure if they felt confident to do so safely.

**Action Point: AM-F to check that there is still a course available.**

**AM-F will check how many GPs are unable to get a letter of competence.**

**If this information is unavailable she will contact PHR re seeking the experience of all GPs.**

## DEXA Scanning

The Osteoporosis DES requires that patients have a DEXA scan and GPs in MK have traditionally used the scanner at the Saxon Clinic.

GPs recently received a letter informing them that this machine was now obsolete and needed replacing. Although currently working it was not sure how long it would last.

To establish the facts, AM-F agreed to speak with Ian Murdoch.

**Action Point: AM-F to speak with Ian Murdoch.**

## Darzi Centre

The PCT have received 11 PQQs and these will be scored over the weekend.

Those passed to go through to the next stage will then be sent an application pack.

The premises solution is close to being finalised.

The aim is to have the Centre open by 1<sup>st</sup> December.

## LMC Medical Director

PHR reported that the closing date for receipt of applications to the post was Friday 15<sup>th</sup> May and none had been received.

He felt that this may be because the LMC were unable to offer NHS pension.

The successful applicant would have to reduce NHS work and therefore contributions to his/her NHS pension would drop.  
The BBOLMC Board will discuss what to do next.

Date of Next Meeting – 10<sup>th</sup> July 2009

The meeting closed at 2.45 pm.

DRAFT

Present	Name	Organisation
*	Birchall, Carol	LMC Minute Secretary
*	Bradley, Julian	Milton Keynes LMC
	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
Chair	Whyte, Siân	Milton Keynes LMC
	Wilson, Tom	Milton Keynes PCT

**Apologies:** Dr Whyte and Tom Wilson