
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 487142
paul.roblin@bbolmc.co.uk

MINUTES OF MILTON KEYNES LRC/PCT LAISON MEETING **Friday, 7th May 2010** **Room 1, Sherwood House, MK PCT, MK3 6RT**

CONTENTS

Minutes of Previous Meeting (5.3.10).....	1
Matters Arising.....	2
Joint Infection Prevention and Control Committee.....	2
Representation on the Strategic IT Board	2
Violent Patient Service.....	2
Post-Operative Thrombo-Prophylaxis.....	2
Consultant to Consultant and Ophthalmology Audit of Referrals	2
Maternity Services Liaison Committee (MSLC)	2
Whole System Resilience Group.....	3
SCR Rollout	3
H1N1 Vaccination Uptake and Easement of Targets for PE7 and PE8 of QoF.....	3
CES (Commissioning Enablement Service).....	3
LMC Involvement in Appointment of Responsible Officer.....	4
National Consultation on Practice Boundaries.....	4
MK's Low Priorities Change Proposal	4
DNACPR Policy	6
Adult Safeguarding	6
Vasectomy Services	6
Way forward for PBC	7
Potential Loss of Peripatetic Practice Nursing Service	7
Date of Next Meeting – 2 nd July 2010.....	7

Minutes of Previous Meeting (5.3.10)

The amended minutes of 5th March 2010 were agreed as a correct record of the meeting.

Matters Arising

Joint Infection Prevention and Control Committee

PHR reported he had emailed TK his document and it appears that the MK document is the same. PHR felt it was a secondary care document which really should not be implemented in primary care.

Representation on the Strategic IT Board

PHR reported that he had not yet received an invitation to this Board.

Violent Patient Service

A-MF confirmed that the service had not ceased.

Nick Reidy (Bucks Forensic Physicians) has received a community contract (over 100 pages) from the PCT.

A-MF explained that this was the new contract that the PCT has to use for any new services it commissions.

It appears that some practices are unaware that there is a violent patient service available and are struggling to see their own violent patients.

A-MF said that there is a need to clarify the process with practices, once the VP contract has been signed.

Practices and OOHs will have a list of patients who are on the violent patient register and this will be updated regularly.

PHR also commented.

The TVPCA red flags their records of patients allocated to GP services via the violent patient service, and this is triggered by their receipt of a registration from a standard practice.

This system will not solve the immediate problem of such a patient presenting incorrectly for GP care, but patient behaviour is usually acceptable in these circumstances.

Post-Operative Thrombo-Prophylaxis

TK has sent a document out to all practices.

Consultant to Consultant and Ophthalmology Audit of Referrals

This has not yet been done but following discussions this week it has been agreed to perform an audit. JP said that there are 3 categories of referrals, with two being 'consultant to consultant' and 'other'. Health:MK wanted to see that 'others' were included in the audit too, because it was not understood what the 'other' category meant.

PHR said that elsewhere the referral of patients from one consultant to another for the same condition was acceptable (eg physician to surgeon within the same specialty) but if it was for an incidental unrelated problem, these could be referrals that the GP and PBC might not want to make and decide to handle differently.

CB said that with the closure of the Orthopaedic Department, the PCT felt there may be a large increase in referrals from Rheumatology to Orthopaedics but after reviewing this it appears that the referrals are only up by 33 which is a much smaller than had been expected.

Maternity Services Liaison Committee (MSLC)

There is currently no GP on this group and they are looking for a volunteer.

LMC and PCT would need to see who benefitted before deciding on funding for attendance.

The current chair is Christopher Wildsmith and he should be contacted to see what functions a GP representative would fulfil.

Action Point: GP to feedback to JB on the need for a GP representative on the Group.

Whole System Resilience Group

A-MF said that she had tried to speak to Adrian House but he is currently away, she will liaise with him on his return.

It appears that with the step down in swine flu, the resilience group has stepped down too.

Heather Wicks has taken over the responsibility.

GPs have asked to be involved in how they respond to the pressure problems within the hospitals.

Action Point: JB to speak to HW.

SCR Rollout

The Government and CfH have instructed all PCTs that before any information can be uploaded to the SCR, everyone has to be satisfied that the appropriate consultation has taken place with patients.

One of the prerequisites for the upload is data accuracy.

H1N1 Vaccination Uptake and Easement of Targets for PE7 and PE8 of QoF

PHR enquired whether the PCT had figures on which practices had achieved the 50.7% uptake of H1N1 vaccination under the DES, that qualified them for easement of targets for QOF PE7 and PE8.

The PCT said that from their figures there was only one practice that had met the target.

PHR felt that for those who were close to the target of 50.7% there may be mitigating circumstances that the PCT should take into account, eg the clinics being in place but the vaccine not being available.

The PCT said that they would accept appeals but these appeals must be supported by substantial evidence.

Once the data has been verified the practices will be informed of their figures.

Action Point: PCT to inform practices of their achievement once the figures have been verified.

CES (Commissioning Enablement Service)

MK had introduced the SHA lead for CES to PHR.

All TV PCTs are planning to use CES as a supplier of information on patients to improve the quality of commissioning.

PHR presumes that CES wishes to speak to LMC to discuss access to data on GP systems.

PHR had no objection to the system using such information provided the right safeguards were in place.

JW said that the system (run by a company called Tribal) would be looking at hospital and primary care data to look at patient pathways.

RM said that PMs were nervous about this.

To be able to access the data the patient's NHS number must be known.

PHR said that the practices must know when and what was being searched for and have the ability to say no.

The problem is that these requests will be sent to non-clinical staff who may comply too easily and without question.

PHR said that he was dealing with this on behalf of the Thames Valley and would report back.

Action Point: PHR to report back developments.

LMC Involvement in Appointment of Responsible Officer

PHR has emailed all TV PCTs about their plans for appointing a Responsible Officer.

TK has been appointed Responsible Officer for the Pilot Scheme only.

PHR was anxious that the LMC had dialogue with the PCT about potential conflicts of interest where a Medical Director is also the Responsible Officer.

This is a national issue.

A-MF said that TK has agreed to talk to the LMC about the process.

Action Point: The LMC to have dialogue with the PCT regarding the appointment of a RO.

National Consultation on Practice Boundaries

A-MF said that she had attended a national 2 day conference on this issue where PCTs had raised many practical issues with civil servants and ministers.

The message back was that this would be going ahead.

MK is thought to be a net importer of around 25K people during the day.

MK's Low Priorities Change Proposal

JP said that the proposal for restructuring the TV Priorities Committees had been sent to practices.

Practices were interested in developing other ways of working together and had concerns about the low priorities referral process.

The current paper is at an early stage and is a discussion document representing the views of some MK GPs.

PHR felt that MK and Bucks had a different approach to priorities forums than other PCTs in the Thames Valley.

Their issues are often more contentious, especially the need for permission for a wider range of referrals.

GPs have expressed the opinion that they consider obtaining permission a waste of time.

GPs felt that the process was very bureaucratic, had too many hurdles and caused them difficulties with patients.

GPs would like to see the PCT inform the patient that their treatment cannot go ahead.

IH said that the document from JP contained inaccuracies.

The main problem is that the hospital cannot cope with the number of patients that are being referred.

All in MK PCT are trying to get the best value for money they can.

A lot of evidence based policies have been developed over the years.

The number of Priorities Committees in South Central has already been reduced to 4 and is about to be reduced to 2.

IH stressed that the policies have been developed after thorough research of relevant evidence. All policies are discussed South Central wide.

TK has sent an email out to GPs asking for anyone with an interest to become a member of the Board. CMK Practice have been contacted individually and asked to join the Board but they did not want to. IH said that the Board would welcome GP involvement in developing these policies. LMC asked how input to these Boards would be funded, as elsewhere the funding comes from PBC.

GPs were concerned that some local Priorities decisions went against NICE guidance (eg access to infertility care). How can these policies be evidence based? IH said that although a lot of policies are based on evidence, some are based on affordability eg the IVF policy. The NICE guidance on this is not evidence based. There is a narrower age band in MK and only one cycle is given (NICE guidance advises 3).

JP responded.

The list of policies that Diane Grey has sent around has been read, but the evidence base is not understood and does not seem to be available on the PCT Website. GPs have problems explaining the process to patients.

IH said that the policies were available on the internet. Primary care should be working together with hospital clinicians for further policy development. There is another document due out next week.

JP asked how a patient could get a second opinion; the process seems unclear. He recognised the financial problems but was unsupportive of using thresholds. Work has been going on with the hospital and draft protocols are about to be circulated for referrals to orthopaedics to ensure that management pathway has been followed appropriately before the referral is made.

CB said that the financial pressure was £2.2m not £1.5m. The PCT had been trying to get policies approved for many years and they have now been firmed up.

JB said that everyone understood there was a need to save money but GPs were concerned about the development of a post code lottery. In his old practice he had patients who came under MK and others from Northampton and they had different access to services.

The thresholds need to be clear and GPs need to be clear about them. If a patient wants to be referred at the moment it often appears to be a waste of time; the consultant will need to apply to the Panel for approval. However, this does take the pressure away from the GP.

PHR felt that the way the GP phrased the referral was important. GPs need to be canny about what they request. Ask for an opinion on care rather than a rationed intervention and explain the restrictions to patients eg by showing patients the policies on the internet (see URL below).

IH said that he had developed the website so that if GPs wanted to access the top 20 policies they could click a box and these would appear.

<http://www.miltonkeynes.nhs.uk/default.asp?ContentID=548>

The PCT also aim to improve C&B.

The Group were aware of what NICE were working on and avoided duplication.

It was agreed to continue work on this and for IH and JP to speak behind the scenes and to revisit this in July.

Action Point: IH and JP to liaise on this and to put this back on the July agenda.

DNACPR Policy

GP brought this to LMC, not knowing what involvement LMC had had.

PHR said that this had been discussed at all the County meetings but very late in the policy development.

Despite the document being ready to roll out as policy, the LMC had managed to make changes at that late stage.

SHA had acknowledged that the LMC should have been involved from the outset.

The main problem for GPs was the fact that the form needed to be printed out on lilac paper.

Primary care practices are more IT orientated than secondary care.

GPs wish to use an electronic version of DNACPR document but it might not always be possible to find the lilac paper for printing. This area may be impossible to change.

GP said that the PCT are charged to ensure that practices are informed and there is some training.

Brian Smith (the consultant responsible for end of life in MK hospital) intends to provide training.

This current version of the policy relates to adults, but a children's one is being developed.

It was suggested that the PCT approach the MK CME Programme (Nessen Carsen) as a good route to getting the message across.

PMs should also be involved, probably through Practice Liaison.

The policy is due to launch in July.

The process is that if a patient has a completed DNACPR form, there will be a notice just inside the front door alerting the ambulance crew.

They will then go to the fridge to find a bottle containing a message about where the form is kept in the house.

PHR felt the system needed to be clear about where to get stocks of lilac paper, stickers, bottles and messages.

Action Point: PCT to publicise the new DNACPR process.

Adult Safeguarding

Linda Bull, Director of Adult Social Care, is renewing the Adult Safe Guarding Board. She would like GPs to be on this Board.

PHR said that he was happy to receive the agenda and papers and be a virtual member of the Board until it became obvious that LMC was needed in person.

Action Point: PHR to be sent the agenda and papers and to become a virtual member of the Board.

Vasectomy Services

The new provider has stated that they will not be responsible for the follow up or the sperm tests and many GPs feel this is unsafe.

Nick Hick's email to PHR has recognised that there were problems with the new arrangements.

It is hoped that these will be dealt with ASAP by the PCT.

Way forward for PBC

JP and TK have had informal discussions about how to get more GPs involved in making financial savings.

The initial plans are a federation type model which will work along the lines of practices being given a fund holding type budget for elective care with the group being co-ordinated to ensure that they deliver cheaper services.

The first of the meetings occurred last week and they would like to see the LMC invited.

Action Point: PCT to issue a formal invitation to the LMC to attend the Group.

Potential Loss of Peripartetic Practice Nursing Service

PHR enquired about PCT intentions for this service

A-MF said that an announcement will be made next week.

RM and JP said that this was a service that was valued but the nurses were employed on zero hours contracts.

Many only worked during term time whereas the greatest need was during the holidays.

It was not clear whether this service was subsidised or not.

If any PCT subsidy was discontinued, then it could still continue as a viable fee based service.

A-MF and PHR to liaise on this following the announcement next week.

Action Point: A-MF and PHR to liaise on this following the PCT announcement.

Date of Next Meeting – 2nd July 2010

The meeting opened at 2pm and closed at 3.35 pm.

Present	Name	Organisation
*	Birchall, Carol	LMC Minute Secretary
Chair*	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
*	Marshall, Rob	Practice Manager MK
*	Parnell, John	Health MK
*	Prager, Gillian	Milton Keynes PCT
*	Roblin, Paul	LMC Chief Executive

Apologies: Dr Kenny

In Attendance: Ivo Haest, Janet Westcott