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# BUCKINGHAMSHIRE LOCAL MEDICAL COMMITTEE

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## MINUTES OF MILTON KEYES LRC/PCT LAISION MEETING Friday, 7<sup>th</sup> October 2011 Room 1, Sherwood House, MK PCT, MK3 6RT

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### Minutes of Previous Meeting

#### Amendments:

Page 1	Cluster Medical Director should be Sarah <b>Whiteman</b> .
Page 2	Cluster Update should be <b>Kathryn</b> Moody
Page 5	RIO and Child Health should be <b>Jill</b> Wilkinson.

The amended minutes of meeting held on 8<sup>th</sup> July 2011 were agreed as a correct record of the meeting.

## Declarations of Conflicts of Interest for this Agenda

No declarations voiced.

## Matters Arising

### **Cluster Arrangements**

PHR reported that it is very difficult to find information about the cluster on the MK Website, which does not seem to be maintained and updated. He cannot find a cluster website.

GB said that he would address this in his new role; it was important that there was no barrier to communication.

Although the 2 PCTs are clustered they remain separate entities.

SF said that the Northampton cluster was listed but only on the intranet. She will send PHR a link to this. MK PCT said that their cluster arrangements were also on their intranet.

### **Concerns Group**

PHR felt that the concerns he had expressed about this group have produced dividends.

It has improved as a committee.

PHR said that he attends these meetings and is constantly monitoring them.

The minutes are strictly confidential and are only circulated to meeting members.

SW said that any lessons learnt are communicated to GPs in her quarterly bulletin.

### **Application for inclusion in a list of patients**

JB said that he had recently worked in a practice that only accepted registrations at a specified time during the day and had been confused by this.

PHR felt that if the system was not patient friendly, it was poor practice.

It was accepted that the tasks might be complex enough to require a particular member of staff, and the timing was dictated by her availability.

### **RIO and Child Health**

Use of the RIO software continues to be an issue.

SW said that she had spoken with Jill Wilkinson who acknowledges that there are problems with the software, but there is nothing else to report.

### **Leg Ulcer Issues**

**Action Point: PHR to contact Nicola Smith and Darren Moore to start negotiations on a leg ulcer LES. SW to take this forward also.**

### **Conflicts of Interest**

GB said that in the PCT, the officer's conflicts of interest were not on the website but were held by the PCT and available if requested under the FOIA.

Anyone with budgetary access within the PCT (commissioner or provider) has to complete an annual submission.

The PCT insist on 100% return of signed submissions.

## Update on Clinical Commissioning Groups (CCG)

The 2 groups are now merging. The Transition Board has been set up.  
GB reported that they had completed a joint response to the new hub structure.

### LMC View

The CCGs will be making important decisions that will impact on Primary Care.  
In the past, LMC had dialogue with the PCT but need to replace this with the CCG.  
CCGs are busy setting themselves up and find meeting the LMC difficult to timetable.  
However, it needs to happen.

The leaders need to be encouraged to meet with the LMC to discuss issues and share initiatives at an early stage.

It is far easier to sort issues out before they become recognised practice than to try and unpick them in the future.

PHR said that the LMC represents GPs in their provider function, but needs interaction with Commissioners (what they decide impacts on the ability of GPs to perform their role).

## Communication with Locum/Sessional GPs

JB spoke to this.

The CCGs need to be able to communicate with locum GPs who are involved with MK practices.

Locum or salaried GPs represent 30% of the GP workforce.

For elections to the CCG it is important to ensure the inclusion of everyone on the Performer's List not just partners.

Dame Barbara Hakin has sanctioned the use of Performers List contact addresses (email) for this type of issue. It would not be prevented by the Data Protection Act.

PHR said that in Bucks and Oxon LMC pressure had led to a PCT locum email listing using NHS.net addresses, so that they can now be sent important information.

LMC felt MK should follow suit. PHR agreed to send MB the Oxon information.

MB said that A-MF had sent her something on this and that she should be able to set up a locum address list.

SF said that Northampton PCT provided the LMC with an address list which both the PCT and the LMC used to communicate with locums and salaried GPs.

**Action Point: PHR to send MB the Oxon information about group emailing of locum GPs.**

## Responsiveness of MK/Northants Cluster Leads

PHR reported that it appears that his emails to John Parkes (Cluster CEO) of early August and September had been misinterpreted by his PA. They were meant to start an LMC/Cluster relationship, rather than be issue specific (maternity reimbursement), yet she had passed the emails on to the Cluster Finance Director who has now moved on.

PHR has clarified that he wants to develop a relationship with the cluster that will now have to relate to two LMCs (a cultural change).

## Marianne Berry's paper on Data Quality in General Practice

MB spoke to this.

Guidance had been sent out earlier this year on data quality of practice records before uploading to the SCR.

MK PCT are working with the Summary Care Team at Northampton PCT.

LMC has commented on early drafts (workload and the voluntary nature of many indicators).

Items initially labelled as mandatory have now become guidance, permitting practices to check whether their records meet the criteria to upload information.

The appendices contain the checklists for various situations.

Before they can go forward with the critical upload, MB is asking practices where they are at the current time.

The paper aims to encourage practices to ask for help if they have not done so far.

The supplementary data had been very overloaded but this has now been thinned out.

If a patient wants their record uploaded the practice can look at that record and upload it individually rather than doing the whole practice.

PHR said that making it guidance makes it a lot easier for the LMC to 'sell the paper' to practices.

The workload involved must not be disproportionate to the benefits delivered by it.

PHR asked if every practice had a written policy document on information security.

RM said that most practices will have one as a requirement for QoF but how often they are updated and how readily accessible they are, was not known.

PHR was loathe to support a tick box exercise ("a document exists").

LMC said that the document still contained the wrong starting date for CQC registration of practices.

This has been deferred until at least 2013.

MB said that she would take reference to this out of the document before it was officially issued.

With this amendment the LMC were happy that MB took this document forward to practices.

## NHS 111

LMC asked where MK had got with NHS 111 planning. Each area had to have submitted a plan by 23.9.11.

GB said that the proposal went before the Unplanned Care Programme Board and the GP Healthcare Team regarding approval to pilot NHS 111 from April 2012 in MK (subject to a business case).

PHR was surprised that MK seem to have agreed to proceed with this from April 2012 (ie one year earlier than required nationally).

There are 2 potential providers, South Central Ambulance (SCAS) or NHS Direct.

The NHS Direct 0845 number will disappear in April 2013.

It is understood that as a pilot the DoH will reimburse £8 per call but that this will be phased out once it goes live in 2013.

The Unplanned Care Programme Board are looking to resource the project and will make a decision on whether to go with SCAS or NHS Direct in the next 3-4 weeks.

PHR said that in order to go ahead a lot of work was needed, the PCT would need to:

- Chose a provider and to ensure the right staff are in place
- Train people to use the NHS pathway algorithms
- Match local patient disposals (Directory of Services or DOS) to the pathways algorithm (Design the Directory of Services).

This all needs to be done between now and April 2012, a tight deadline.  
Oxfordshire is now considering not going this early as the workload is too great.

GB said that the Unplanned Care Programme Board is chaired by Nicky Smith.  
Jeannie Ablett and Andy Peeble are on it, along with representatives of the providers and Link.

NHS 111 is designed to deal with the people who currently ring 999 or go to A&E.  
PHR was concerned that in developing the DOS, there was a danger that the majority of dispositions would be to general practice, and this would result in a huge increase of work for practices.  
LMC needed to be involved with the development of the DOS so that general practice is not overwhelmed by activity that was currently dealt with elsewhere.

### New Medicine Service (NMS) from 1.10.11

HC said that this went live on 1<sup>st</sup> October 2011.

PHR said that this was fully discussed at the Bucks LMC meeting in September and was fully reported in those minutes.

See page 9 of <http://www.bbolmc.co.uk/bucks/lmc/bucksmin/bucksmin0911.pdf>

HC asked that GPs identified patients with a new patient medication to pharmacists, so that they can conduct an NMS.

This will involve seeing the patient 3 times in the first 4 weeks after commencing their medication.

It was suggested that NMS be written on the right hand side of the script sheet.

PHR said that in Oxon a similar suggestion has been put forward but this had been rejected.

Oxon LPC has now produced post-its for GPs to highlight a new medication to the Pharmacist.

The Oxon LPC has also developed a leaflet for patients which GPs can hand to patients when a new medication is prescribed.

If a patient has a new medication which is not on the list for NMS, the Pharmacist will conduct an MUR instead so the referral will not be wasted.

JB said how much GPs in MK appreciated the help and support that the PCT Pharmacy team gave them and thanked them for this.

HC said that there was consultation out at the moment about their role within the cluster and LMC asked that PHR write in support of the service.

**Action Point: PHR to write in support of the Pharmacy Team.**

### Prior Approval Workload

Ivo Haest attended for this item.

Angela Croxton has sent an email out on 15<sup>th</sup> September which stated that some referrals for low priority procedures are still being sent to the hospital before receiving prior approval.

PHR said that that he had replied by asking for contact details of who they should be sent to but had so far not received a reply.

PHR said that MK was the only area where prior approval was required for hip or knee replacements. In other areas GPs refer if they meet agreed thresholds.

IH said that the prior approval system has been in place since March 2010 where the GP had to write to the PCT to obtain prior approval before sending the referral to the Hospital.

This has now changed; MB has loaded templates onto every practice computer which the GP completes and if the patient meets the criteria, the referral can be sent directly to the hospital with a copy of the template.

PHR said that there was some confusion because the email from Angela Croxton stated that referrals should be sent to the PCT not the hospital.

IH said that a letter has been drafted to address this issue and was due to be sent out.

LMC asked that PHR have sight of this before it was sent; IH agreed to send a copy to PHR for his perusal before it was sent out.

**Action Point: IH to send PHR a copy of the letter that is to be sent to GPs.**

### Practices Sending Patients to Hospital for Phlebotomy

LMC passed on their views after discussing this issue in part one.

The local custom and practice (supported by LMC) is that practices do their own phlebotomy and will only send difficult cases (mostly children) to hospital.

LMC has heard recently that a practice has received a bill from the Trust for a difficult paediatric case and would not support this billing process.

If the Trust wanted to charge for the service they should bill the PCT not the practice.

The caveat to LMC support is that it only refers to phlebotomy generated by general practice.

Where the phlebotomy is generated by the hospital it is their responsibility to venesect.

PHR agreed to write to the Chief Executive of the Trust highlighting the workload issue.

Practices would perform phlebotomy on patients for the Trust when this work was covered by a LES but if the practice had not signed up to this then it was the requester's responsibility to ensure it was done.

**Action Point: PHR to write to the Chief Executive of the Trust.**

### Practices Sending Patients to WIC when Short of Staff

LMC passed on their views after discussing this issue in part one.

An MK practice is reported to have been sending its patients to the WIC.

LMC felt practices should comply with their GMS or PMS contract.

Activity that should be undertaken under these contracts must not be referred to other organisations, unless there are extreme circumstances which have been discussed and agreed with commissioners.

Having visited the practice, SW reported that there were exceptional circumstances.

However, the practice was a high user of the WIC prior to this.

LMC felt that practices needed to have contingency plans in place to be able to cover the cost of locums when staff were off sick and to ensure bank accounts kept a reserve.

LMC asked that with the variation in GMS/PMS funding that the PCT offer further support to practices who are struggling to improve their service.

Practices that run into trouble need to have early dialogue with the Commissioners or the LMC.

Date of Next Meeting – 20<sup>th</sup> January 2012

The meeting opened at 2pm closed at 3.10 pm.

DRAFT

## Attendees and Apologies

Present	Name	Organisation
	Alifoe, Hopeson	Milton Keynes LMC
*	Birchall, Carol	LMC Minute Secretary
*	Bradley, Julian	Milton Keynes LMC
	Brookes, Clive	Milton Keynes PCT
*	Ball, Graham	Milton Keynes PCT
	Derry, John	TVPCA
	Frost, Anne-Marie	Milton Keynes PCT
	Hicks, Nicholas	Milton Keynes PCT
	Kennedy, Jim	LMC Medical Director
	Mahendran, Muttucumarasamy	Milton Keynes LMC
*	Marshall, Rod	Practice Manager
	Moore, Darren	Milton Keynes LMC
*	Roblin, Paul	LMC Chief Executive
	Thorpe, Penny	TVPCA
*	Whiteman, Sarah	Milton Keynes PCT

**Apologies:** Drs Mahendran, Kennedy & Anne-Marie Frost

**In Attendance:** Sharon Firmin Northants LMC, Marianne Berry, Helen Chadwick, Ivo Haest

**Dates of Future Meetings:**

**20.01.12      16.03.12      18.05.12      20.07.12      19.10.12**