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Minutes of Vale of Aylesbury LRC/PCT Meeting Wednesday 8th March 2006, 1:30pm Meeting Room, Verney House

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Minutes of Previous Meeting

The minutes of 8th November 2005 were amended.
With Joint Committee of 3 PCTs and Relationship with LMC, CBP said that the VoA were not leading lights in Pharmacy and the plan is to merge primary care support services across Thames Valley. Otherwise the amended minutes were agreed as a correct record.

Matters Arising

Leg Ulcer Issues

There has not been much progress, the PCT are hoping to invite Fiona? to the next Primary Care Development Group.

Fiona has been asked to define what competencies are needed.

LMC stressed that PNs are not community nurses and are employed by GPs to do delegated work within GMS or PMS contract.

The issue has always been what type of wound management is funded within these contracts.

There is a national nursing document which implies that any wound <6 weeks old as being the responsibility of practices. Its conclusion is not shared by the GPC, hence the current problem. Practices may give notice that they are no longer going to provide this service.

If a patient is ambulant should they be looked after by PNs or a specialist nursing service?

Some practices have a complex leg ulcer clinic run by DNs within the practice.

LMC felt a specialist service should be set up across Bucks.

A wound management leg ulcer pathway needs more input than DNs. All stakeholders must be involved; it needs to have GP primary care input.

Community Matrons

LMC asked PCT about audit of the service and assessment of value for money

The service needs to be evaluated and the results should be made known.

Caseloads data exists for the last quarter.

The problem with interpretation is how to link the work of matrons to altered demand for acute admissions.

LMC asked what was the real driver for the matrons service.

Response was that if the Government had not insisted on them the PCT would only have employed one and then seen what benefit resulted.

However there are now 6 matrons, 2 COPD, 2 Heart Failure, 1 diabetes and 1 generic.

The majority of referrals to them come from the acute side.

When the PCTs merge will the posts be merged too?

The problem is that one person will not be able to cover the entire new PCT area.

Their cost effectiveness will be looked at.

Enhanced Services Review

ES specs and prices are being reviewed by the 3 PCTs together.

The people involved with the reviews are Tim Jones from Wycombe, Caroline Langley from C&SB and Tom Wilson from MK together with CBP.

The main reviews should be completed by April; some will be easy others not.

There may be variations in the services between localities for legitimate and transparent reasons.

CBP will be writing to PR asking him to join a review group.

Due to the above, practices will be advised to continue providing existing ESs.

Once changes are decided upon, practices will be given adequate notice (eg at least 3 months).

Areas where there are potential problems include protected learning time, anticoagulation and phlebotomy.

Action: PCT to write to practices notifying them of no change in ES for the moment but give them plenty of notice of any future changes.

Enhanced Services 05/06 Underspend

Extract from preceding LRC Minutes

PCT has suggested that they should use the ES underspend (approximately £400K) to offset their deficit.

GPs on the Primary Care Development Group have suggested that the whole ES budget should be spent before the end of March.

It was felt that compromise should be attempted eg GPs could have a proportion of this back on 1st April to support PBC. The payment will be seen as a one off payment to set up PBC.

Practices felt to be generally supportive of this approach.

Practices regard the ES money as GP money and are not happy with the idea that the PCT should use this to offset their deficit.

However, many felt it important that the money for PBC should not be badged as ES.

Practices feel that a figure of £200K would be acceptable but there must be a number of guarantees attached.

Should PBC fail to deliver savings or not proceed this money need not be paid back.

It is important that the ES floor is sorted out earlier in 06-07 so a similar situation does not happen next year.

The TPBC DES states that it must not be funded from within the ES Floor 06/07.

To qualify for inclusion within ES Floor activity should be clinical not administrative.

LMC advice to practices and PCTs must be that no funding means no activity; GPs will not deliver the service.

PCT View

The letter from CBP went to all Practice Managers by mistake; it was intended for PEC members only.

The PCT would find it difficult to make cuts in commissioned services yet keep the ES money back; it was felt it must be used towards the overspend.

If the PCT were to invest it, it must be invested soon in something like PBC.

J Newton and CBP hoped to draw up ideas on how the money could be spent on PBC.

The PCT deficit is very large and they hoped that a large proportion of the underspend could be used to meet this.

The PCT could devise a list of tasks that practices might provide for the money.

The proposal which had been discussed with practices was to use the ES underspend to fund the PCT deficit. A substantial sum could come back to primary care on 1st April 2006.

Any agreement needs to be watertight on both sides and done before the PCTs merge.

A lot of mutual trust is needed to ensure this happens.

80% of the practices have agreed this as a way forward.

If the PCT used the whole £400K to fund their overspend, their overspend for 06/07 would reduce by £400K too.

It was discussed how much of the ES underspend could come back to general practice in the next financial year. It was agreed that 50% should come back, regardless of what the figure is.

The specification needs to be devised for practices to receive this funding.

The PCT agreed to take this proposal to the Primary Care Development Group for further development.

It is important that the money coming back is not badged as ES, but labelled as PBC pump priming.

The Primary Care Development Group need to devise a way of spending the money in an appropriate way within the year so there is no underspend this time next year.

The problem is that all ES will be across 3 PCTs so development may take longer.

Action: The PCT to take the proposal to the Primary Care Development Group for development.

Draft MUR Referral Form

Pharmacists are providing medication use reviews as part of their new contract and this is funded by PCTs.

Is value for money being delivered?

If a GP identifies patients who would benefit from an MUR, is it useful to have a GP to pharmacist referral form to use?

The PCT agreed to take this back to Jane McVea.

Pharmacists are being encouraged to speak to GPs about how MURs are done.

Action: The PCT agreed to take MUR issue back to Jane McVea

Referral Screening

The LMC felt the emergence of James Mapstone's guidelines was more of a shock to practices in VoA than in other areas.

How they were developed is not clear.

It seems that guidelines have been developed by a very small group.

LMC felt that commissioners needed to get wider input from general practice

JM also gave a commitment to involve GPs in future development of care pathway.

Despite many reminders no invitations have been received so far.

It feels as though VoA interests in demand management is not as strong as the other 2 PCTs.

Practices had been visited and demand management had been discussed but the 25 page document which was received by practices was very different.

The implication of the document being presented as a policy document is that referral screeners will use it as a rule book for passing referrals through or rejecting them.

Meeting discussed the medico legal situation.

Once a hand back conversation has taken place, responsibility lies with the GP.

If before hand back there is a delay within the hub, then the responsibility lays with the PCT.

PHR is the recipient of any problems with the hub in Oxford and offered to feedback problems identified by Bucks practices.

He asked for a named person to forward these problems to.

The PCT to identify a named person for PHR to contact with such issues.

The referral hub could produce a leaflet for patients, giving a telephone number and indication of timescales for them receiving appointments.

There are 2K referrals going through the hub on a weekly basis and the PCT commitment was that hub did not slow up any referrals by more than 5 days; urgents are not slowed up at all.

These targets are being audited and few deviations form target have been identified

It was agreed that the PCT would supply results of this audit to the next meeting.

Meeting discussed apparent loss of letters

Booking of the referrals takes place at the hub level with staff using the C&B software, the original letter is then sent to the hospital.

The worry was that hospital is saying that letters have not been received by them. They seem unable to access the C&B software. This could be a training issue which needs to be addressed as the hub are being blamed for every delay in the system.

When a letter has been received by the consultant, the booking is attached to it together with the UBRN.

2.5% Top Slicing of next year's PCT allocation

PR has heard that 06/07 PCT allocations have been top sliced by SHA
PCT confirmed this.

Action: LLS to forward a copy of the relevant document to PHR.

Reconfiguration of the PCTs

Consultation ends on 22nd March and a decision is expected from the Secretary of State on or soon after 8th May.

The SHA Chief Executive and Chair will be announced first.

Discussions are taking place about whether PCTs can be formed before 1st October if they are ready earlier.

The PCTs are already working towards one mid and south Bucks PCT.

Acute Medical Care at Stoke Mandeville Hospital

There are concerns about the quality of service being delivered across the acute trust.

When SMH are closed (with no beds), patients are having to go Wycombe.

Because patients do not want to travel there, they often stay at home where the GP is left caring for people inappropriately

PHR said that GJ was the representative from the LMC and was trying to get a meeting together with the provider to discuss GP/Trust interface issues.

Action: GJ and LW to take these issues to SMH at a joint meeting.

**Date of Next Meeting - 3rd May 2006 at the Fairford Leys Practice,
Aylesbury**

Present	Name	Organisation
*	Beck Gill	Member
*	Beesley Helen	Member
*	Jackson Graham	Member (Co-opted)
*	Lilley John	Chairman
*	Peacock Tim	Member
*	Quiney Iain	Member
*	Roblin Paul	LMC Chief Executive
	Solomon Jane	LMC Director of Development & Liaison
*	Birchall Carol	LMC Minute Secretary
*	Blakeway-Phillips Clare	VoA PCT
	Brogan Shaun	VoA PCT Chief Executive
*	Lake-Stewart Lynda	VOA PCT
*	Robinson Graham	VoA PCT PEC Chair
*	Lee Whitehead	VoA PCT Director of Commissioning
	Carol Watkinson	VoA PCT

Apologies: Jane Solomon
Carol Watkinson