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MINUTES OF BERKSHIRE COUNTY LMC MEETING Tuesday 12th February 2008 Berkshire Masonic Centre

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Minutes of Previous Meeting

Page 2, ECG, the response from the Trust was it would conduct an audit or ECG need and then decide whether to contract for the service.

The amended minutes of 4th December 2007 were signed as a correct record of the meeting.

LMC Constitution

TM asked whether the constitution was available on www.bbolmc.co.uk.
PHR wasn't sure but felt it could be if members thought this was desirable.
If members wanted to see a copy they could contact Pauline Green at the Secretariat.
(PHR checked after the meeting and the constitution is already on the website.)

Matters Arising

New MUR Form

A new 2 page national form is available and being used.
It is simpler to follow and scannable.
GPs will only receive a copy if there is something to report.
Otherwise, GPs will receive a list of names of those reviewed.

PMS Contract Variations (both PCTs)

The document on adjusting PMS contract sums as list size alters has caused problem in East Berks.
LMC was not shown the final document sent out and which had significant differences from an earlier draft.

GH reported the PEC had not seen or approved the final version.
The description of changes listed under version control seems trivial but they are far from that.
The PCT have apologised for the omission, which was due to "pressure of work".
PHR is to attend a problem solving meeting with the PCT and one concerned practice.

In West Berks the PCT redrafted their letter to practices suggesting a PMS variation.
The main issue concerns supplements to the contract sum to reflect actual superannuation employer contributions.

It is not known how many practices will sign the variation.
PR asked the LMC to consider if it was fair that PMS practices got better deals on superannuation than GMS, all from a finite local pot.
The Committee felt that there would be winners and losers with two contract types.
Members (even GMS) did not resent what PMS had negotiated.
PHR was surprised at this and felt the two PCTs would opt for equal treatment of both contract types.
PHR will let the LMC know of developments.

Imposed Changes to the GP Contract

PHR apologised for the amount of emails from LMC on this subject.
The situation was changing constantly and on such an important issue members needed to know the facts.
The ability of the Government to alter the GP contracts unilaterally is legal according to GPC lawyers.

Background to the Dispute

In the 2006/07 agreement between GPC and NHS Employers, issues of GP over performance and value for money were supposed to have been dealt with once and for all.
Last year GPs received another 0% pay cut.
During 2007 (and with covert government support) the media have frequently portrayed GPs as "overpaid and under-worked" and promoted the concept of extended hours services for patients.

The GPC view is that GPs will not get any sympathy from the other political parties.

The Deals and Offers on Extended Hours

In October/November the GPC had agreed with NHSE a solution similar to (but more flexible than) imposition A.

£158m from the Access and C&B DES would come to an extended hours DES at a price of £2.95 per patient.

In December Government interfered with negotiations and substituted Imposition A, which was debated by the GPC On 20th December.

This proposed DES was felt a lot more onerous because it had to be delivered in blocks.

38.5 QoF points earmarked for new clinical areas would be moved to a QOF Access domain and an inferred 1.5% uplift to Global Sum was illusory. They decided to ask the profession rather than accept/reject immediately.

On 21st December the GPC were told accept Imposition A or Imposition B would be imposed.

The poll paperwork will probably come out on 18.2.08. with the closing date on 29th February.

As a result of this the date of the Reading meeting has been moved forward to 22nd February (7.30pm) at Palmer Building, Reading University.

Under Imposition A, Extended Hours have to be delivered at 30 minutes per 1K registered patients, in blocks of 1.5 hours after 6.30pm and 1 hour before 8.00 or at weekends.

The frequency of appointments has been increased to 9 in 2 hours.

The opening hours of the practice must be “genuinely additional” suggesting government intention is to create extra capacity not better access.

The DES has not been written yet so its precise details are vague.

The PCTs have been told, via the SHAs, to perform an audit of practice baseline opening hours and individual GP time. They will then compare this data with hours that are offered in the future.

GPs present felt that the PCT already held current data; it had been included in the PPP submission, although this had not been doctor specific.

The GPC has calculated that not doing extended hours under imposition A will cost the average wte GP £6K.

If the profession does not agree to Imposition A, Imposition B will be imposed.

This will mean that £158m will go straight to the PCTs for them to use in any way they like.

This money is unlikely to come back into the GP contracts.

PCTs may use it to fund APMS practices.

Under Imposition B, the number of points taken from QoF will also be increased to 135 making the maximum achievable permanently 865.

The money that will be taken from practices roughly equates to what is needed to establish a Darzi practice in each PCT area.

If imposition B is imposed the financial hit will be £12K per wte GP.

Might the government prefer GPs to reject A and go for B?

Extended hours is voluntary in both options but the financial penalty to the practice is greater in B.

Last week, the GPC overwhelmingly accepted the motion that “Option A would be less damaging for general practice” and it would appear that this is a way of recommending GPs vote for Option A, whilst still registering a protest at government behaviour.

The poll questions are likely to provide a protest facility.

GPs felt it would be helpful to have greater clarity around the £6K: how should they work this out?

PHR felt the £6K comprised the loss of the C+B and Access DES income (£2.95 per patient) plus the 58.5 QOF points. The £12K was bigger by virtue of losing 135 QOF points.

Practices would have the option of voting for option A, but not doing the DES.

PCTs could offer a LES in addition to the DES.

The problem is that a LES would be easier for the PCT to alter in future, especially if our relationship with them alters.

Mark Britnell letter of 30th January implied that practices opening for Extended Hours could not close during the day to compensate. Similar constraints would apply to individual doctor hours. Concurrence of GP Extended Hours would not be allowed (ie the surgery could be open 1.5 hours in the evening with 2 doctors running surgeries but this would only count as one block of 1.5 hours).

GPs reported that some practices closed at lunch time for administration and could not be contacted to book appointments; they also closed at 6.00 pm so could not be contacted.

It seems that some Red Book behaviour has been retained by practices and many considered this was unacceptable. It is easier for government and media to push for Extended Hours if some GPs are not delivering the In Hours contract properly.

There is an option to reject offer A and have offer B imposed.

What sanctions would GPs then use to develop the dispute?

Most agree that mass resignation would never happen.

It would be portrayed badly in the media and would lose GPs public support.

It would also not stop Government coming back with another imposition next year.

However, the profession does have a battle to fight: the apparent desire of government to make the APMS contracting route the only option in the future.

When practices become available for re-tendering the PCT will put it out to APMS.

When the new Darzi centres are up and running, the threat of competition will be much greater.

APMS practices generally only offer 6% employers pension contributions to a private (not NHS) pension.

Commissioning a GP workforce under such contractual terms would help solve the problem the Government has with a £35 billion pension shortfall.

Some members voiced the view that some practices have not recycled enough of their income into patient services. GPs needed to live in the real world experienced by ordinary people, with redundancies and unemployment and private pension provision.

Unless GPs gave value for money in the eyes of the public and politicians, the profession would succumb to APMS.

GPs need to make themselves unique and different to APMS.

The real problems started when GPs gave up their 24 hour medical cover; this ended their unique position.

Members felt that MPIG would be the next target that the Government would hit.

AMPS Primary Care Centres in Berkshire

Each PCT has to have a contract in place for a new Darzi practice by December 2008.

The new practice will provide list based and walk in services, for 7 days a week 12 hours a day with a nurse to doctor ratio of 3:1.

Nationally the average cost estimated by government is £800K.

In West Berkshire, this is likely to be in Central Reading, possibly introducing an element of competition to existing practices.

Local practices are aware of the potential threat this brings.

One member felt the PCT were looking at premises in the new Tesco site.

With the development of the Tesco site there will be a population growth of approximately 8K in the associated housing.

In East Berkshire the likely location is Upton Hospital in Slough.

GH reported that the aim was to continue to use the staff employed by the PCTMS and walk in centre.

Members wondered whether TUPE would apply to all existing members of staff.

How would pension arrangements be handled?

Action Point: PR will keep an eye on developments.

Difficulty in Referring Patients (both PCTs)

The C+B DES ends in March.

Some practices may continue to use C+B, but not every GP supports C+B.

Referrals may be sent to other agencies such as GRACE and the TVPCA referral management centre, who would then offer Choice.

The GPC view is that PCTs cannot insist that C&B is the only referral route.

LMC has recently received criticism of GRACE; the decision making and triage is not consistent and use of the UBRN (Unique Booking Reference Number) is confusing.

Peter James has just been appointed as the medical director at GRACE.

When GRACE was established GPs were told it would be an educational tool, but this has not materialised.

GPs generate a C+B UBRN to refer a patient to GRACE, which is then cancelled by GRACE and replaced by another when patients are referred to hospital.

Apparently if the patient does not contact the hospital to book an appointment after the GRACE/patient dialogue, the hospital are writing to the patient asking him/her to contact them quoting the new password and UBRN which they say the practice will have.

Because GRACE changes the UBRN and password, the practice cannot supply them.

In West Berks there is a capacity issue at the RBH.

Patients being referred for routine breast lumps are being told to ring back in 2 weeks as the service is full and this is repeated again 2 weeks later.

As a result routine patients are being referred inappropriately under the 2 week wait system.

Action Point: To invite representatives from GRACE and the EB PCT to the next EB Liaison meeting.

LMC Elections

The closing date for receipt of submissions was 5pm on 8th February.

Of the 6 Berkshire constituencies, there will be elections in Bracknell and Slough.

Constituency	Vacancies after 8.2.08 deadline	Elected LMC Reps
Newbury	None.	James Cave, Maria Hyde and Paul Westcar
Reading	One	Rab Mittal, Tarek Moneim, Sarah Morando, Kish Naran and Rod Smith
Wokingham	One	Nicola Brock, Charles Gallagher and Jeremy Lade.
WAM	Three	Isabel Mower and John Rawlinson.

PHR suggest that, after the elections, those who have not been elected be considered for co-option on to the LMC so that enthusiasm is not thwarted.

Secretariat Annual Report and LMC Accounts

Copies of the Secretariat Annual Report were sent out with the papers.

The cost of the Secretariat to practices is 19.5p per patient but this comes with a caveat.

With Jane Solomon being on sickness absence (duration unknown), PHR is currently the only trouble shooter and negotiator at the Secretariat.

He is temporarily seeking Medical Directors to deputise for him when important meetings across the Thames Valley clash.

Long term, with increasing workload across the Thames Valley PR reported that the Secretariat needs to expand its workforce; costings were being worked out.

He hoped to have one part-time medical director for each area, East Berks, West Berks, Bucks, Oxon and Milton Keynes.

In the interim he hoped that by making the fee structure appealing, members would volunteer to help.

The Annual Report papers will be sent out to practices in the Thames Valley for comment and these comments will be discussed at the Berks LMC meeting (AGM) on 1st April.

The LMC accounts are now available and PHR expects to be able to circulate them after they are received from the LMC treasurer.

Practice Manager Listserver

This has recently been established.

PHR wants to establish a closer relationship with PMs in Berkshire.

A lot of operational issues go through them.

PMs were encouraged to join up by contacting Pauline.Green@bbolmc.co.uk

PBC in Berkshire (this year and next year)

East Berkshire did not do well last year as the funding did not materialise fully.

Some money was made available to attend locality meetings but this was only approximately £200K out of a total of £800K which had been proposed.

Next year the proposal is that practices will receive a budget when they sign up.

Some work will be removed from the PCT to try and work independently, but practices will also work with the PCT to move PBC and service redesign forward. Redesigned services should be more cost efficient.

One member reported that there is a national guidance on PBC budgets, describing movement to fair shares and pace of change, which appears to have been ignored in East Berkshire.

The PCT has said that they did not have adequate historical data available on which to base budgets.

Therefore, only a fair share budget is possible.

GH said that part of the problem was that at the PEC meetings financial information was often tabled.

This meant that it was not read thoroughly before being approved; this was unacceptable.

There seemed to be no major issues with PBC in West Berks.

Action Point: LMC will emphasise to EB PCT that movement from historical budgets to fair shares needs to conform to national guidance on pace of change.

Public Consultation on Healthcare in East Berks)

JR reported attending a presentation on:
Our NHS, Our Future - A Public Consultation, and
Right Care, Right Place (East Berks and Berks Healthcare Trust).

The consultation is in conjunction with the Mental Health Trust about the re-provision of services in East Berkshire.

To move services closer to the patient, the NHS Trust at Heatherwood and Wexham Park provide secondary care in the community at Upton, St Marks and King Edward VII Hospitals. However, in Bracknell there is no such provision.

Bracknell want £6m to develop such a provision (Healthplex).

There are possibly conflict of interest issues here as the Bracknell PBC lead is also on the PEC and the PEC Chair is an interested party.

There have been assurances from the PCT that this is not a problem.

The Healthplex will be self owned by local GPs in Bracknell (under a company named "My General Practice") and practices have signed up to put money into the venture.

Shares will be owned by local GPs, the PEC Chair, a PEC member, a local GP and locality leads.

The locality leads are Peter Roberts, John Rawlinson, Judith Kimber, Jim O'Donnell and William Tong.

Bracknell GPs said that there had been meetings on a monthly basis but there had been little on the background of "My General Practice".

Bracknell GPs have signed a document pledging funding of £500 each.

The percentage share ownership of individual GPs is not known.

Directors had been offered shares in lieu of payment. However, some felt that they should be paid a salary instead of extra shares.

The issue is not confined to East Berks.

The Healthplex will be in Bracknell but Wokingham is very close and the Healthplex is likely to want to attract Wokingham and West Reading patients.

It will contain an urgent care centre and will also have radiotherapy; patients will go there rather than the Royal Berks.

Sandhurst practices have apparently said that they are not interested.

The PCT have gone out to consultation with a closing date of mid-late April and GPs were advised to look at the document on line at:

<http://www.rightcarerightplace.nhs.uk/page.asp?fldArea=1&fldMenu=0&fldSubMenu=0&fldKey=309>

For mental health it is proposed that all adult in patient treatment will go to Upton and the Wexham Park facility will continue to provide acute mental health services.

From this consultation, practices in Windsor and Ascot have discovered that they will be moving to King Edward VII Hospital.

When asked how this will happen when there are currently problems accommodating staff and patients, practices have been told that the administrative staff will be moved to another location, yet to be sourced.

LMC Conference Motions

The date for receipt of motions is 14th April.

Members were asked to develop motions by the next county meeting on 1.4.08.

The formal conference agenda will be issued on 23rd May with the next county meeting on 3rd June.

Maternity Reimbursement in West Berkshire

The recent PCT paper has problems.

It is not clear what how the formula will operate or whether it is practical.

It needs to be refined in some way.

Because of the understandable difficulty in developing a formula, PHR would be inclined to divide up the finite pot by an approximation of the number of pregnancies in a year and reimburse uniformly this amount.

Once this formula is established in West Berks, the rest of the Thames Valley will want to adopt it.

Action Point: PR to work on this further.

Practice List Cleaning

The TVPCA are carrying out a list cleaning exercise on practices.

It appears that despite the practice telling the TVPCA that patients are current and the patients themselves responding to the letters they are sent, the TVPCA are still removing them from practice lists.

Action Point: AG asked that Practice Managers contacted him to discuss these issues.

GPSOC (GP Systems of Choice)

Practices will be asked to make a decision on this by the end of the financial year.

The default position is that funding for GP systems will move to GPSOC unless a practice notifies the PCT otherwise.

The GPC sees no threat in moving to GPSOC.

New system agreements will be put in place between the national supplier and CfH (Connecting for Health; the PCT will have an arrangement with CfH and also an agreement with practices.

The draft agreement can be found at <http://www.bbolmc.co.uk/gpsocdrft110208.pdf>

GP IT systems have ascending levels of accreditation. Systems have to be at level 2 before GPSOC can accept them.

Most software suppliers are at this level or above, with the exception of iSOFT Synergy.

GPSOC will not be coercing practices to change their supplier, nor will they be insisting on hosted systems.

Non-Patient Transport

The TVPCA are shortly tendering for non-patient transport to practices, and is seeking views on the current service as a guide to what should be purchased in the future.

Anton Glinski (TVPCA) would like to be able to tender for all services eg pathology and notes.

LMC suggested that PMs are better placed to provide views and should be contacted.

GPs in East Berkshire reported that practices had already received a questionnaire on this issue from Allison Rees, Site Services Manager East Berkshire, Berkshire Shared Services.

Action Point: AG to write something to be put on the PM List server.

Pathology

GPs reported that tests for potassium were having to be repeated due to the hospital not processing them quickly enough, and haemolysis producing high results.

It appears that the potassium will go up 10% for every 4 hours taking the sample is stored without centrifugation.

Wexham Park Hospital says they are often processing samples at 10pm.

It is known that the pathology department is having to ring the out of hours organisations to report these high results. This then causes problems for these organisations as they do not have access to patient home telephone numbers.

It would appear that the commissioners need to increase the pathology budget.

Action Point: PR to liaise with the Trust biochemist (Dr Ian Walker).

Date of Next Meeting – 1st April 2008

The meeting closed at 4.35 pm.

DRAFT

Present	Name	Organisation
*	Arora, Kanchan	Bracknell LMC
	Bindra, Harjeet	Reading LMC
*	Birchall, Carol	LMC Minute Secretary
*	Brock, Nicola	Wokingham LMC
	Buckle, David	West Berks PCT
	Cave, James	West Berks PCT
*	Crampton, Anne	Bracknell LMC
	Crawford, Margaret	TVPCA
	Derry, John	TVPCA
	Easton, Jim	South Central SHA
	Gallagher, Charles	Wokingham LMC
	Greig, Adam	East Berks PCT
*	Glinski, Anton	TVPCA
	Harnett, Su	West Berks PCT
*	Hear, Gurdip	Slough LMC
	Kumar, Hemantha (MLH)	Slough LMC
	Lade, Jeremy	Wokingham LMC
	Llewellyn, Lise	East Berks PCT
*	Mittal, Rab	Reading LMC
*	Moneim, Tarek	Reading LMC
*	Morando, Sarah	Newbury LMC (Co-optee)
*	Mower, Isabel	WAM LMC
	Nabi, Ajaz	Slough LMC
*	Naran, Kish	Reading LMC
	Parker, Julius	WAM LMC
Chair*	Rawlinson, John	WAM LMC
*	Roblin, Paul	LMC Chief Executive
	Rose, Eric	GPC Rep
	Sinclair, Don	East Berks PCT
	Solomon, Jane	LMC Director of Development & Liaison
	Waddicor, Charles	West Berks PCT
	Westcar, Paul	Newbury LMC

Dates of Future Meetings

01.04.08 03.06.08 09.09.08 11.11.08

Apologies Drs Derry, Kumar, Lade and Parker and Margaret Crawford and Jane Solomon