BERKSHIRE LOCAL MEDICAL COMMITTEE

Chairman
Dr John Rawlinson
Radnor House Surgery
25 London Road
Ascot
Berks
SL5 7EN

Tel: 01344 874011
Fax: 01344 628868
rawlinsonjohn@hotmail.com

Treasurer
Dr Gurdip Hear
Crosby House Surgery
91 Stoke Poges Lane
Slough
Berks
SL1 3NY

Tel: 01753 520680
Fax: 01753 552780
gurdiphear@yahoo.co.uk

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

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MINUTES OF BERKSHIRE COUNTY LMC MEETING
Tuesday 10th February 2009
Berkshire Masonic Centre, Sindlesham, RG41 5DB

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Minutes of Previous Meeting

The minutes of 4th November 2008 were agreed as a correct record of the meeting.

Matters Arising

Secretariat Medical Director
The BBOLMC Board has approved a new 4-6 session Medical Director.

The paperwork is with an HR consultant who is looking over it from a legal point of view and to ensure it enables the best appointment.
The appointee will look after 2 of the 5 PCTs in the Thames Valley currently all covered by PHR.
PHR will manage the organisation and this person will report directly to him.

PHR felt that lack of an NHS pension could be a recruitment issue.
The appointee would probably have to reduce down from full time practice to part time and this would affect his NHS pension contributions.
Members said that it would not be an issue if the person appointed had already taken their NHS pension. However, the cost benefit of training someone at this stage of their career needed to be considered.
PHR reported he had already received some informal enquiries.

Darzi Centres
Berkshire East PCT has not appointed a provider and is believed to be going through the process again.
West Berkshire has made an appointment but the name is not yet in the public domain.

BE only interviewed one interested party but did not feel able to offer the contract.
It appears that the ATOS contract experience may have made the PCT nervous about awarding the contract to a private company.
LMC hoped that PCTs realised that the best providers of these services were GPs.

Members felt that the PCT had set a very short time for the initial expression of interest and that the process favoured private organisations. They tendered in many UK areas and used their core application documents in all areas.
Just a first stage tender costs GPs £10K.
BE PCT had not published its bid scoring system which might have guided tenders.

MLHK said that he had put in a bid but not been asked for interview.
When he had asked the PCT for an explanation they had sent it to him.

The Shinfield practice apparently had 15 bidders and has been awarded to a single handed GP.

Extended Hours
BE PCT has still not issued the Extended Hours DES.
This issue had figured high in the Commissioning Group meeting.
PHR had warned PCT colleagues about a possible LMC complaint to the SHA.
Before DES issue, BE PCT wishes LMC to agree a definition of "reasonable availability during core hours".
LMC has suggested practices might be allowed a maximum of 1.5hr closed doors per day based on the difference between 52.5 maximum core hours and the old QOF standard of 45 hours per week.
The PCT want to see all practices open from 8 am – 6.30 pm with telephones on, a receptionist in place and the doors open before issuing the DES.
LMC has asked the PCT to take this proposal back to the Board and if it was necessary, PHR would attend and argue the case.

Apparently Slough has the second worst access score in the country.
This explains the PCT position.
Slough GPs felt their patients had different expectations and this fed into the patient survey results.
When Slough practices held open access surgeries, patients had not complained, but this system was not acceptable to the PCT.
When the system became appointments only, patients came in demanding to be seen immediately.
If they were asked to wait until the afternoon it was not good enough and threats to contact an MP were common.

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An Asian GP felt this attitude was typical of first line Asian immigrants.
Once their children get to late teens/early 20s they want to be able to book an appointment time so the issue disappears.
Others felt that this was not just an Asian problem but also applied eg to Polish patients.
It seems that it was a problem when the patient was used to a different health system.

It seems that BE PCT is unable to grasp the concept that not insisting on a rigid definition of core hours might actually get better sign up to Extended Hours.
BE PCT is anxious that practices do not close for half a day a week. PHR supported this but not all members did. Patients of smaller practices often preferred to trade such opening arrangements for continuity of care.
Currently in Slough there are 2 or 3 practices that close for half a day each week.

GPs said that the latest questionnaire from the DoH for patients to complete about access is very difficult to complete unless you have an excellent command of English and a lot of patients are visiting their GP asking for help completing it.

In West Berkshire the Extended Hours DES has been supplemented to include nursing hours.

Funding LRC Chairs

PHR enquired how the LMC wanted to fund LRC Chairs.
In Bucks the Chair of the county had been paid 2 sessions but it was recently agreed that the position of the Bucks Chair and both LRC Chairs (Bucks and MK) would be paid separately at one session each.
This has added a one session cost to Bucks LMC (two has become three).

PHR suggested that Berkshire might like to consider the same arrangement and offer a retainer to both the county Chair and the Chairs of the 2 LRCs.
Currently only BE had a Chair (IM). WB LRC does not currently have anyone filling this position.
PHR felt that having an LRC Chair was important in adding local credibility.

Members felt that this was a solution worth considering.
GH stressed that this would have an impact on the accounts.
It may be that with the appointment of the Medical Director a local LRC Chair may not be necessary.

Action Point: GH, IM and GJ to liaise and to revisit this at the March LMC meeting.

QOF and NICE: National Consultation

See http://www.dh.gov.uk/en/consultations/liveconsultations/DH_089778

It proposes major changes to the QOF from April this year. The consultation period ended on 2.2.09.

Main features:

- NICE to collate, work-up and prioritise new indicators, and review existing ones, rather than the QOF expert panel, from 1 April 2009
- QOF should continuously evolve, with indicators being replaced when they have become part of standard practice and no longer need to be incentivised

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- Focus QOF on clinical and health improvement indicators, removing most of the organisational and patient experience indicators
- More emphasis on patient outcomes and cost effectiveness
- Pilot new indicators to test that they are workable before introducing them with a ‘cohort of representative practices’
- Eventual choice of which indicators to be adopted and at what price to be part of GPC/DOH negotiations
- Paras 40 and 41 are contentious and many people disagree with the concept described
  The concept seems to be that once the work is being done by practices the funding for this is then withdrawn so practices then have to do more work for the same funding.

> 40. The purpose of QOF should be to provide the initial incentives to embed within general practice the best evidence-based care that will continue to improve patients’ care
>
> 41. We therefore propose that, in assessing cost-effectiveness, NICE should regard the costs of providing the interventions in question as being met from overall GP contract funding, not specifically from the individual QOF payment for that indicator.

- Plan is to review 20-30 of the existing 88 indicators over first 3-4 yrs, ie annual changes for this period, then perhaps biennial
- PCTs will have the flexibility to choose local indicators from a national menu
  The NHS Alliance is keen on this but GPC is not.

The BMA has responded robustly.
It has asked:

- Why do any changes have to be made to the undoubtedly successful QOF development process
- If changes really have to be made, is NICE the right organisation to take this on
- Is NICE really independent?

PHR hoped the BMA would be successful: GPs did not want QOF to change every year.

PHR stressed that in 2004 money was taken from the global sum to fund QOF.
This was why management indicators were included in the QOF.
QOF cross subsidises the global sum: if you change the QOF, then the inadequacies of the Carr-Hill formula become more apparent.
The GPC is apparently wary of renegotiating the Carr-Hill allocation formula, through fear of opening up a can of worms.
JR (GPC rep) said that the outcomes of GPC negotiations might not be what GPs may want but they were the best solution that could be achieved in the circumstances.

Income Threats: QOF Prevalence and MPIG Erosion

The 19ths formula was the best deal that the GPC could negotiate.
It gives some hope of extra practice income but does erode MPIG Correction Factor.
See **http://www.bbolmc.co.uk/latest/latest.html** **(21.11.08)**

The Carr-Hill formula takes into account age, deprivation and morbidity.
It weights different ages for GP workload: 15-24 year old males rate at 1.04 where as males over 65 rate at >6.
However, experience shows that the workload for 65 year old plus man is not 6 times more than a young man.
PHR felt that this is an area that the GPC need to renegotiate.

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Funding weightings need to be upgraded to reflect real GP workload.

With the changes to QOF prevalence, only one BE practice will gain.
The rest will lose with one practice losing £43.5K in the second year
In Reading one practice loses as much as £64K in the second year.

Some non student GPs felt that those practices looking after university students did not have the workload when the students returned home.
Student practices tell LMC that nowadays more students tend to stay in the area.
With the changes to University funding, many students come from abroad and do not return home during vacations. The workload therefore varies very little over the year.
PHR view was that if a practice can show the PCT that it is carrying out work that is not covered under Global Sum, then the PCT can be approached to provide compensatory LESs.
To be fair to all, this LES would have to be offered to all practices.

West Berkshire has sent PHR a list of practices' predicted income changes, but so far nothing has been received from Berkshire East.
From the WB list it appears the PCT will save £578K a year from the second year.
PHR advised practices to be conscientious in Read Coding all diagnoses, so their prevalence was correct and high.

Action Point: To get the list of predicted QOF loss figures from Berkshire East PCT.

Pandemic Planning

GPC and RCGP have produced a 57 page paper on Pandemic Planning for GP practices.
PHR's PowerPoint presentation from the Oxon practice managers' conference can be found at:
http://www.bbolmc.co.uk/pandplnpr0109.ppt

PHR has asked each of the five Thames Valley PCT Chief Executives what they plan to do to implement the guidance.
Meeting discussed the recent snow difficulties as a guide to what might happen during a pandemic.
GPs reported that the emergency plans had been put in place during the past week when it was not possible for staff to get into the surgery during the snow.
One PCT (outside the TV) had suggested that if the GP could not get into the surgery they should arrange to sleep there at night.
No practices in Berkshire had reported closure during this period but in many cases it had been patients who had not been able to get to the surgery.

Action Point: PHR to press the Chief Executives on their plans.

Prescription Exemption for Cancer Patients

Not all GPs had received the new certificates.
There were concerns amongst GPs that there was not a clear definition of what cancers were included. It seemed cancer had to be active physically, therapeutically, or psychologically.

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Un-discussed Issues from Liaison Meeting with the PCT

GRACE and Referral Pathways
Paula Head has yet to get this pathway to PHR.
GPs said that the PCT also undertook to provide GPs with the monitoring arrangements should a referral go wrong and this has not been supplied.

Action Point: PHR to chase PH for the referral pathway and the monitoring arrangements.

HPV and MMR Catch up LES
The HPV LES has been received but not the MMR equivalent.

New DESs
Please see the following web references for the long awaited Directions:

The Statement of Financial Entitlements (Amendment) Directions 2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_094166

The Primary Medical Services (Directed Enhanced Services) (England) (Amendment) Directions 2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_094165

Mental Health Issues
PHR reported he had spoken to Mark Allsop (Medical Director of Berks Healthcare Trust) and got the feeling that the problems LMC raised were too difficult to address.
PHR had stressed the fact that his predecessor had been working to try and improve the services from the Berkshire Healthcare Trust.
PHR aimed to work with MA and build a healthy relationship.

Contact Point

This new initiative arises from the Children Act.
Every child is on a database which will list all the agencies involved with the care of that child (including their GP).
To be able to access this data GPs will need to have 3 yearly CRB checks, which currently don't happen. Jackie Walters (EB) and Rachel Edwards (WB) were unaware that this was the case.
PHR asked what would happen if something went wrong in a case and it was proven that the GP had not accessed the child's database.
PHR has spoken with JD at the TVPCA.
His view is that that once a GP is included in a medical performers list he/she is obliged to notify any events to the PCT (within 7 days) that are relevant to their continued inclusion in the list - these include anything that might be detected by an enhanced CRB check, so in theory there is no apparent need for repeated CRB checks after inclusion in a list.

Performing 3 yearly checks on every GP is a very expensive process for the Agency and not something they want to do unless funded by PCTs.

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Berkshire LMC Accounts to Year End March 2008

These can be found at www.bbolmc.co.uk
The majority of the payments made are to fund the Secretariat and payments to the GPC, the rest are payments to members for attending meetings.
The reason there is a £6K deficit is because the final quarter's levy had not been taken as it would have left the accounts with a large surplus.
Although the LMC do not pay corporation tax, they do pay it on bank interest.

So far the levy has been kept down to 22-23p per patient which is the lowest in the 3 counties, and considerably less than in other counties where it was as much as 50p.

Consideration would need to be given to the payment of LRC Chairs as this would have an impact on the funds needed for the future.

Balanced Scorecard

Last year PHR, GH, IM and JR had amended/altered the proposed scorecard in Berks East to take out the most contentious issues.
The original PCT document was based on one from Tower Hamlets.
The World Class Commissioning initiative now requires all PCTs to have scorecards.

PHR felt that the problem with the scorecard is the scoring system.
This involves conversion of the indicators for each practice's result into a figure and a totalling up.
The definition of Traffic Light bands needs to be decided by the PCTs after they have populated their scorecard with data from all practices.
Deciding the scoring system in advance does not seem sensible.
It often results in a lot of practices being scored as red or amber.
This only indicates that the scoring system is probably faulty.

The purpose of the scorecard seems to be to identify practices that might be underperforming and need extra PCT scrutiny, visits and contract monitoring.

BE has employed an external consultancy to populate the database.
The maximum score is 56.
Two points are allocated for a green classification, one for amber and zero for red.

GPs felt that they should be able to explain to the PCT why their access is low, often down to the cultural issues of the patient population and should not be penalised for it.
GPs felt they should be not penalised if patients went to A&E, especially if they lived next to such a facility.

West Berkshire has a list of indicators, traffic lighted similarly.

Date of Next Meeting – 31st March 2009

Members were asked to think of motions for LMC conference and to send these to PHR to be converted to full motions.
The meeting closed at 3.55 pm.

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Present	Name	Organisation
*	Arora, Kanchan	Bracknell LMC
*	Birchall, Carol	LMC Minute Secretary
	Brock, Nicola	Wokingham LMC
	Buckle, David	West Berks PCT
	Cave, James	Newbury LMC
	Crampton, Anne	Bracknell LMC
	Derry, John	TVPCA
	Gallagher, Charles	Wokingham LMC
	Greig, Adam	East Berks PCT
*	Hear, Gurdip	Slough LMC
	Hyde, Maria	Newbury LMC
	Kade, Chauke	Bracknell LMC (Co-opted)
*	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
*	Mower, Isabel	WAM LMC
	Nabi, Ajaz	Slough LMC (Co-opted)
	Naran, Kish	Reading LMC
*	Nelli, Prash	Bracknell LMC
	Parker, Julius	WAM LMC
Chair*	Rawlinson, John	WAM LMC/GPC Rep
*	Roblin, Paul	LMC Chief Executive
	Smith, Rod	Reading LMC
	Thorpe, Penny	TVPCA
	Trivedi, Jitendra	Slough LMC
	Waddicor, Charles	West Berks PCT
*	Westcar, Paul	Newbury LMC

Apologies: Drs Brock, Crampton, Derry, Lade, Morando, Naran and Trivedi and Penny Thorpe

In Attendance:

Dates for Future Meetings

31.03.09 02.06.09 08.09.09 03.11.09

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