
BERKSHIRE LOCAL MEDICAL COMMITTEE

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

Tel: 01344 874011
Fax: 01344 628868
John.Rawlinson@GP-K81655.nhs.uk

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 MCs
Mere House
Dedmere Road
Marlow
Bucks SL7 1PB

Tel: 01628 475727
Fax: 01628 481173 or 01628 474731
paul.roblin@bbolmc.co.uk

Minutes of Bracknell LRC/PCT Liaison Meeting

28th February 2006, 2pm
At Easthampstead Baptist Church
RG12 7NS

CONTENTS

Minutes of Previous Meeting	1
Matters Arising	2
ES Spend Against Plan 05/06.....	2
ES Plans for 06/07	3
East Berkshire Commissioner Visibility	3
East Berkshire Referral Screening.....	3
East Berkshire 'Choice'	4
Information Request Policy	4
Flu Pandemic Planning (East Berks).....	5
District Nurses and their New IT Systems	5
Future of the LRC.....	5
Gateway.....	6
Date of Next Meeting – Tuesday, 18 th April 2006	6

Minutes of Previous Meeting

Minutes of meeting on 13th December were agreed as a correct record of the meeting

Matters Arising

Minor Surgery SLA

The PCT have still to provide this.

Future for Build?

AG is looking at inappropriate referrals and GPs need to look at how to learn from this.

GPs believe that Build is educational and GPs need to do more locally and refer less and these sessions could be seen as a risk assessment.

It was asked if the PCT would consider funding this in the future year.

The PCT said that 3 meetings were planned for the next year but for clinicians not admin staff.

The health economy will not provide funds to finance this further.

With PBC it may be that this is a decision that needs to be funded from savings.

The sessions could be used to develop referral guidelines.

Build should be across East Berkshire, Slough and WAM certainly have this funded more and if the PCTs are going to a unified budget how do these PCTs fund it and BF cannot.

BF have made more efficiency savings in the year.

The PCT have had discussions about monitoring uptake of these sessions with GPs and practices, if the PCT fund cover for practices and only 3 of the GPs attend the PCT will be asking why out of hours cover is provided.

What build is for needs to be looked at and it needs to be based on clinical need, if it produced guidelines on separate referral pathways the practices could take them away from the meeting.

Specialities where there are problems will need to discuss at these sessions.

Action: The PCT agreed to take this back.

ES Spend Against Plan 05/06

The PCT tabled a spreadsheet of spend against budget.

The format is the same as last year, each item is listed with the planned and actual spend.

The planned spend was £1.1m, pro rata for 10 months this should have been £918K but is £839K.

It is anticipated that the spend will be to the budget of £1.1m, last year's underspend was only £20K.

The Primary Mental Health Care Service will be continuing, although there were problems after Christmas and New Year with them reaching capacity for referrals, now they have worked through these and the waiting time has improved.

Practice Shared Initiatives relates to some expenditure that the PCT are not clear about but are investigating.

Some GPs raised that money is being received in the practice with no audit trail, so they were unaware what they were being paid for.

AG agreed to provide examples, as the TVPCA send a statement.

It was felt that the paperwork was very vague and it is difficult to know where it has come from.

A TVPCA member will be attending the PMs meeting to discuss this further.

The TVPCA have requested pension contribution data by 28th February for tax calculations.

It was found that 3 practices had not sent their forms, but these have now done so.

Action: The PCT to investigate payments to practices

ES Plans for 06/07

The PCT have not yet been notified of the floor, however the PCT are planning no change. It is not yet known whether the LES can be rolled forward because of the DES that are coming are for PBC, Choice and Access.

The discussions have been around funding PBC and how much of nGMS funding goes to the PBC indicative budget, will it be MPIG or the whole lot?

There is a meeting on Friday to discuss this. MPIG will be coming down to PBC.

Action: The PCT will supply JS with a copy of the details after Friday's meeting

East Berkshire Commissioner Visibility

Following the full Berks LMC, East Berkshire GPs had asked who the commissioners were and how they could be influenced and the Secretariat had had a useful meeting with the commissioners.

East Berkshire Referral Screening

In the past Sandhurst has resisted going through the referral hub.

DH has said last year that they should go through the hub and the practice had written back to her with some questions and highlighted that any referral through the hub would result in a delay as all letters go directly to the hospital and there is no collection from the practice so the referrals would need to be posted; they wanted reassurance on the confidentiality issues and would provide the referrals with the only identifier being the NHS number.

No reply was received to this letter but they received another letter in mid February telling them that they must send all their referrals to the hub from 1st March or the hospital will not be paid.

The practice have had another meeting and written another letter to DH dated 17th February, no reply has been received to this either; the PCT said that DH was on leave last week.

RH read the letter that had been sent to the PCT.

The practice has also drafted a letter to patients stating the changes in the referral process.

The need to have all referrals go through the hub is as a result of the growth at Frimley Park and future SLAs and indicative budgets for PBC, also the data the practice had supplied was a month in arrears.

The SLA needs to be set that the only referrals that will be accepted by Frimley Park are those that have gone through the hub.

The practice have accepted this but want reassurance that any referral diversion etc will become the responsibility of the PCT and any problems that arise from this.

Only low priorities and dermatology referrals are being redirected at the moment.

It is accepted that there needs to be greater transparency about the screening of referrals.

Referrals were not being redirected if they were cosmetic, the GPs were being told it would not be done, or they were going to the Low Priorities Group.

Some procedures did not need to go to secondary care; they could be dealt with in primary care by GpsWIs instead.

GPs were being contacted and asked about alternative care pathways.

The only referrals that were redirected were those that are sent to Capio.

The referral that was redirected to a GPsWI and the GPsWI did not want to deal with this should not have been sent back to the referring GP but to the PCT and this needs to be investigated by

the PCT; such referrals should not go to the bottom of the waiting list as the patient has already waited, they should be slotted in at an appropriate place.

GPs are not clear where patient complaints should be directed to.

The PCT said that complaints should be directed to DH at the PCT and it would be passed through the Patient Complaints System.

The referral letters need to contain as much information as possible to enable a sensible decision to be made.

If a referral is made to a named consultant the PCT should ensure that that consultant seen the patient, often referrals are being sent to clinicians who cannot deal with the problem and are then referring them on costing the PCT two out patient appointments.

GPs refer to consultants who have a named specialist as they are the expert they want the patient to see.

The LRC felt it was very important to name the person who was doing the assessment and this was accepted by the PCT to ensure transparency, clear reasons for the decisions were also important.

GPs did not realize the amount that would be reduced by screening and BF are not appearing in the list of referrals that need redirection.

It was assumed that if the PCT called GPs regarding referrals then the GP would change their behaviour but some GPs have continued to refer.

The number of practices who are not open when the GP calls them is very large and is an issue that needs addressing.

The way forward is to have a named GP and a consultant so a joint decision is reached.

Action: The PCT will look into this further

East Berkshire 'Choice'

In Dermatology there is no choice.

The only GPsWI is in Upton Hospital and patients from Sandhurst have to travel a long way when the consultant is based only 4 miles away.

Dr Sherry Consultant Dermatology at Amersham has asked to speak to BF GPs and it is accepted that Dermatology is a problem.

The Consultant is not a choice at the moment.

Action: The PCT will investigate this further

Information Request Policy

This is about the information that goes to surgeries and there is confusion whether a reply is needed or not.

There is a policy that Wessex have put together where there is a central point in each PCT where the information is vetted.

Reading are putting together a new communication system with an officer who will highlight want attachments are in an email so practices can choose what to open.

Once this is worked up, if it is useful it could be spread across the TV.

Flu Pandemic Planning (East Berks)

There has been a flu pandemic test across Berkshire and this was not very good.

Pro formas will be sent to practices with a draft plan at the end of the week.

Pandemic flu will be a mutation of avian flu and influenza A to give a different virus which will be transmitted to humans.

The practices will do as much as possible, but it may be if a whole practice is affected, other surgeries will need to cover their patients.

Repeat prescribing needs to be addressed whether it goes to 6 monthly or no need for repeats at all.

It is anticipated there will be two 12 week affected times, and across the PCT there will be 100 more deaths in any 12 week period as an absolute minimum.

It is about patient education and requests for home visits which produces an extra workload.

It is also about self-help.

The pandemic flu affects the lungs very quickly and it is usually young, healthy adults who are affected and complications can set in very quickly.

Where Tamiflu will be stored is still not known and how this is got to GP Surgeries or pharmacies etc, GP input is needed to this planning.

Death certification needs addressing too if GP numbers are reduced in the PCT area.

District Nurses and their New IT Systems

There is an increasing number of duplications occurring in surgeries as GPs are not aware of who the DNs are visiting and what procedures they are carrying out.

The DNs say that they are getting a new IT system and they can input data on to this and practices are asking if this can be linked to EMIS systems to enable the data transfer.

The PCT said that this system is an audit tool only to enable the PCT to record commissioning details for PBC.

GPs felt that DNs were not working as part of the team and a 'them and us' relationship was flagged up.

Concerns about the DNs need to be raised with Lucy.

DNs in practices are not using their terminal to input data to patient's records.

Action: The PCT to investigate this.

Future of the LRC

The LMC were considering changing the LRC structure to mimic the new PCT structure, however this is proving very difficult at the moment so the intention was to continue with the current planned meetings.

Action: To continue with the LRC meetings for the future.

Gateway

GPs can log on to the Royal Berkshire Hospital to get data on patients but this seems to be very insecure as if you know the patient's date of birth you can get any data on that patient. Heatherwood and Wexham are stating on A&E attendance sheets that any investigations carried out on patients are available on this system. To get on the system you need to enrol for it.

Action: The PCT will investigate this.

Date of Next Meeting – Tuesday, 18th April 2006

Present	Name	Organisation
*	Arora Kanchan	Member
*	Crampton Anne	Member
*	Greig Adam	Deputy Chair
*	Halliwell Roger	Member (Co-opted)
*	Henman Mary	Member (Co-opted)
*	Kade Chauke	Member (Co-opted)
	Murry Ian	Chairman (Co-opted)
	Roblin Paul	LMC Chief Executive
*	Solomon Jane	LMC Director of Development & Liaison
*	Birchall Carol	LMC Minute Secretary
	Hines Dawn	BF PCT
	Johnson Catherine	BF PCT
*	Major Gill	BF PCT
*	Melia Siobhan	BF PCT
*	Owen Anne	BF PCT
*	Siddique Salim	BF PCT Deputy Director of Finance

Apologies: Drs, Murray and Roblin
Dawn Hines and Catherine Johnson