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Minutes of Bracknell LRC/PCT Liaison Meeting

8th March 2005
AT Easthampstead Baptist Church, RG12 7NS
At 2.00 pm

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Minutes of Previous Meeting

Mary Henman asked that her name be added to the list of attendees, otherwise they were agreed as a correct record of the meeting.

MMR Catch-up

This is satisfactory.

Access

Have the PCT had an opportunity to consider this.
It was felt that £5,000 was paid for access.

Enhanced Service Floor

A more up to date table was tabled.
Is the GpwSI the GP that provides the ward for the Heatherwood old people beds? No, it is intended to support the beds at the Bridgewell Centre, currently the post is vacant.
The tabled paper was for month 10.
There does not appear to be much of an underspend looking at the current spend pattern.
The desirability of the acute sector overspend had been discussed and the need for a flexible health economy to be developed and one of the most powerful levers is enhanced services. The LRC hopes that the next meeting will look at an enhanced services floor which will be bigger with some sums against them.
Last year there was an GMS Practice Group which looked at this, will it be reinstated this year? Yes it will and the LMC will be invited to attend.
The LMC will be notified of the Enhanced Services by 20th April 2005.

ECGs

Assume this is concerning the ECG machines that the PCT have supplied to practices which, once 500 reports have been printed out, say they need another £1,000 to continue. What is the PCT doing about this?
A letter has gone to practices and those who needed them have approached the PCT.
The PCT are replacing these ECG machines for the practices as it is cheaper for them.
The option was that once the new machine has been purchased it is the Practice's responsibility to maintain.

Action: A letter to go to practices from the PCT.

Practice Based Commissioning

The work that should have been sent by Diane has not yet been received.
There is a working party to decide what the PCTs view on PBC should be. The guidance is that GP need to have ownership of it and not what the PCT want them to.
Practices cannot be involved at the moment as it is impossible to get any realistic data.
It is difficult to know what support there will be for practices in terms of usable data. This needs to be available before it starts.

From fundholding it was learnt that preparation was needed before it started.
It must not be pushed through too quickly, it will be folly.
Bracknell had a high proportion of fundholders in the past, there is a practical caution at the moment to go forward without sufficient information.
The technical guidelines from the GPC via the LRC is that the latest technical guidance is not very technical and it is not guidance. There is the allied matter of choose and book which will probably be part of PBC. The LMC guidance is not to do this at the moment.
Reimbursements are not clear.
Dawn Irons is leading PBC for the PCT but has been off sick recently. AG has been invited to the meeting on Friday.
Outcome from the GP council meeting on Friday was waited. The PCT does not have a fixed view on whether to go with localities or individual practices.
The PCT did not know what the funding was yet. The PCT has to find the money and get it back from the savings made, the PCT also has a statutory duty to break even at the end of the year.
If you look at the baseline budget and have an overspend of £2.3m you will have to cut your referrals by 20% before you start so your savings will be cut too.

GP Council – Relationship with LMC/LRC

The LMC does not have a monopoly with the relationship with the clinical professionals and the health authorities such as the PCT.
It does have certain statutory obligations where both parties have a basis for a relationship; this will stand regardless of what else happens. The LMC will look at making sure the constituent's interests are looked after.
The Council's role will be how GPs try and help develop services for patients that GPs can take ownership of. PBC is one way, the use of PCT funding another way, such as phlebotomy.
They want to lead the agenda not support it.
The GP Forum of the PCT is a PCT led information forum. More could be gained if all the PCT GPs got together and sent information up the line.
The future of the GP Forum is what?
This could be scrapped, given a new name, or could remain. It could be that there would be an early part for all GPs and Practice Managers, as it was in the past, with other clinicians which would be like the present GP Forum, then there would be a latter part, which could be part of the 'build' workshop and cover issues which has a mutual agenda. Things the PCT would put on and the profession would put on. There would be partnership on this point.
Things could come on from the patient and the PCT could think about commissioning services.
There may be a need for more frequent PCT Council meetings rather than the 'BUILD' frequency.
Will this replace build? At the moment BUILD is a lot of people together and part of this may be used for PCT propaganda if they wish.
If the Council works there needs to be a mechanism to have meetings with the PCT on service developments to try and improve the way things run and patient care.
All that may be needed is an ideas forum; currently it is a client/provider agenda.
General Practice will change in the next 5 years; the current PCT relationship will probably change in the future.
GPs need to be able to speak with one voice.
It is important that there is an information giving session and there is no need for a further meeting to be developed.
Will Practice Managers be invited to the GP Forum meetings and then the PMs will leave and the GPs will discuss future issues in the Council
The PCT to consider this proposal.

Practice Manager's Meetings

From the Practice's point of view these meetings are funded from the global sum and are practice time and should have a practice driven agenda.
There is an important way in for the PCT to this meeting, but it needs to be driven by the Practice Managers as this is how the group was set up.
Risk Assessment will be for all practices to do and there is an opportunity for collaborative working.
The PCT must not take over the meeting.
There had been a breakdown in the relationships between the PCT and the Practice Managers.
The LMC expect to see a strong relationship between the PCT and Practice Managers.
The feeling was that the meetings were being hijacked by the PCT and they felt that there needed to be a demarcation between PCT business and Practice Managers business and these needed to be separated.

Leg Ulcer Management

There is a lack of clarity for patients with leg ulcers.
4 years ago guidelines were drawn up based on national guidance and it was thought this would enable all patients to be treated in a similar way.
There are different models employed now. Some practices refer all leg ulcer work into the Health Centre. Others send their work to the acute trust or do it in the practice or with the District Nurse visiting housebound patients.
There is a specialist clinic held in Bracknell but some practices have always referred into this continue to do so and the service is now blocked. Patients are now having to go to the Acute Trusts for treatment, the proposal is that patients need to have an assessment first before anything is done on them.
Part of this assessment involves Doppler studies and people are nervous about this process. The training for this remains mandatory in Nursing.
Some practices do not have access to this care. AG and NW attended a vascular out patient clinic and the consultant agreed he did not know why some of the patients were referred and he was sending them back but did not know where they were going and they then ended up being sent back. He was prepared to continue his vascular clinic in out patients and the leg ulcer clinic will be run along side this so an expert opinion is readily available.
Do patients need to be seen in the clinic before a vascular referral is made?
A model is needed to achieve care for all patients.
What is specialist treatment? If a patient has treatment in line with specified pathways, unless they have diabetes etc, the patient should have a leg ulcer healed within 12 weeks with Dopplers happening at the relevant times. This is what every registered nurse should be able to deliver as should GPs.
All practices would be supportive of a care pathway.
Most practices would have problems if some practices dumped all their workload on this service.
The PCT needs to work out ways around this.
Practices could cope with the leg ulcer for the first 6 weeks and then if they are not healed pass them on to the specialist service. Most ulcers would have healed within this time period. Could this format be considered?
The problems for practices are those ulcers that take a long time to heal and these are the ones that need specialist advice.
No one should be followed up in specialist clinics, they should just be reviewed by them.
Perhaps a LES needs to be developed to encourage practices to hold on to their chronic patients with recompense made to them along the same lines as asthma and diabetes.

The PCT will work through the pathway and a specialist assessment will be made in the clinic and an LES will be developed. This was agreed as a discussion point.
Action: JS to provide other area leg ulcer protocols to the PCT for their consideration.
The protocol to be re-sent to all Practice Nurses
The PCT to report back to next meeting.

Insulin Requiring Diabetics

There is a one off payment of £150 which will presumably be uplifted in the next contracting round. It is still a requirement that these people are looked after in practices.
There is some software coming which those who have done the necessary training will be able to set a LES for 05/06.

Practice Premises

Peacock Farm is about 1700 the Staff College has risen to 1000 and the Met Office site has risen to several 100 with infill.
Practices will not able to accommodate this within the surgeries available.
There is now a sense of urgency and what is the mechanism to get more surgeries. All practices need to know this.
There have been discussions with the Council for a health and social care facility. There is section in the Building Regulations that the builder has to provide certain things free of charge. This has not been successful but negotiations are continuing.
The process is in the SSDP but the process of bidding is not clear.
Practices need to increase floor space to provide extra services to patients.
David Millman is the Chairman of the Primary Care Development Group.
With PBC you can now use savings to finance premises.

Blood Tests

Patients are being sent to practices by secondary care with blood forms and asking for their blood to be taken.
There is no funding for this.
The PCT asked for a copy of the list of patients to be sent to Catherine Johnson.

Minor Ops Ceiling

From September all procedures on patients are being sent to Plastics, Dermatology etc for the removal of things that practices could do themselves. They would like the ceiling to be raised to allow practices to do this in house.
This would be cheaper than using the secondary care route.

Exeter Problems

Practices will have received a letter from the TVPCA highlighting difficulties with the Exeter System. Some practices have been paid too much, most too little.
An agreement has been reached that the TVPCA will inform the PCT that there have been problems as they happen rather than getting them in feedback from the practices.

Date of Next Meeting

Tuesday 10th May 2005

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
*	Nicky Wilson	BF PCT
*	DeGruchy Helen	BF PCT
	Hedges Diane	BF PCT Chief Executive
	Kassianos George	BF PCT PEC Chair
*	Owen Anne	BF PCT
	Taylor David	BF PCT