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Minutes of Bracknell LRC/PCT Liaison Meeting

10th May 2005

Easthampstead Baptist Church

RG12 7NS

At 2pm

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Minutes of Previous Meeting

Minor Ops Ceiling: The minutes suggested that everyone had stopped doing minor ops, this was not the case, some practices are still doing them.
The amended minutes were agreed as a correct record of the meeting

Practice Based Commissioning

Dawn had submitted a paper which will go to PEC.
It is a little short on detail and it needs further discussion.
The next meeting is 17th May and all practices have been invited to attend this.
12 out of 13 have expressed interest and the deadline for submissions is 30th May.
Activity and budgets need to be in place before things can proceed.
The Health Service is moving to payment by results.
This links in with demand management where PCTs work jointly with PBC could construct an ES which looks at the demand side rather than just the supply side of what the public wants.
Payment by results looking at leg ulcer management, cost per case.
A lot of Pilonoidal sinuses are coming to primary care recently and could be a cost per case issue.
Post-operative care being taken away from the secondary care and placed in primary care where it could be done more appropriately.
The care of patients in nursing homes could also be looked at.
This illustrates how PBC is on the edge of other topics being discussed. It is an important way of joint working.
The Steering Group has been looking at indicative budgets.
Some practices that have been working hard and making few referrals will have a smaller indicative budget than those who refer a lot so there is an inequality here. These have not been properly addressed yet.
Budgets are worked out on 2 year old data from the Trust. GPs know how inaccurate this data has always been.
If practices are taking on PBC, they need to read code their referrals properly to be able to extract the data at a later date.
Work is being done around plastics concerning activity.

MMR Catch Up

This issue has been resolved.
Everyone should have received a letter from GK about how to source the vaccines.

Access

GPs were not clear about access payments for this financial year.
The balance of the payment has been paid.

Enhanced Services Floor

Bracknell have not always put items into the Floor.

What is the contracting procedure for this year?

When do you sign off your intent on ES per practice?

Only new ones have gone to practices, no one knows what is happening with the existing services.

AO to take this back and will email JS.

JS asked that the Secretariat be put on the mailing list for things that are sent to practices.

JS and PR to be added to emails

Best practice is to look at specifications and adjust pricing so the contract is clear and it is clear what practices have signed up and this is relayed to the TVPCA.

A lot of PCTs fell down in year 1 and clarity is needed in the current year.

This is taking longer and Katherine is looking to make things clearer for practices.

A meeting is scheduled for 27th May to discuss these services.

What will the uplift be? Inflation runs at 3.2%.

Will the basket be varied?

Enhanced Services 04/05

Is there an over or underspend? Is the year signed off?

The PCT are in the middle of this and things should be known in a week's time.

It is likely it will be an overspend.

The LRC asked to see a copy of the spreadsheet for the final year.

Some PCTS have expected an overspend but in fact have come out with an underspend as practices have not spent up to the floor.

Implanon Costs

Will this be covered by the basket? It is a useful service to a small number of patients.

The clinical work around this issue is greater than the basket pays.

The idea for the basket was to run it for a year and then review it with a view to developing LES.

JS reported that most PCTs have dismantled the basket and Implanon and Zoladex have come out.

There is a relentless pressure for other drugs to be included in Near Patient Testing.

Guidelines need to be looked at.

AG suggested that practices be given a sum of money if they agreed to provide a list of services. This would do away with the need for ES. If you did not decide to provide all the services the practices could be paid less.

Bradford PCT have already done this.

The PCT will set the clinical agenda and practices can sign up to do what they want to.

Residential Home Problem

A practice is in dispute with the provider which has led the Practice to say they will deregister all patients, currently 42 out of 50 residents.

PR reported this line will probably break the GP's Contract.

They could say that future registrations should be pro rata between the local practices. This will put the home to some inconvenience.

The LMC would act as a broker if needed.

Another option would be to have an enhanced service or a GPsWI who could provide this service.

ECGs

This issue has been resolved

Practice Managers Meeting

Katherine Johnson now attends the meeting at the PMs invitation.

Leg Ulcer Management

The PCT said that leg ulcer management was a core competency of the practice nurse, the Royal College of Nursing say it is not a practice nurse core competency on account of the very few patients who need this service in each practice.

It should be a specialist clinic run by nurses with expertise.

AO report that the College had thought the PCT wanted all nurses to do complex dressings, not an ulcer that could be treated in the practice.

It will be going to the PEC in 2 weeks.

A nurse who has to do ulcer work must be specifically trained to provide this.

The pilonoidal sinus post-operative dressing request is increasing.

It would seem that the hospital is sending these patients to practices for their dressings and this takes a lot of the practice nurse time.

Insulin Requiring Diabetics

There has been a shift of patients from secondary to primary care.

The practices have not agreed to the shift and there are no resources for this.

Patients are appearing in the surgery saying they are under the GP care.

The LES has an element of maintenance of patients once insulin has been started.

How do the hospitals know whether a practice has agreed to provide this service?

Practice Payments

What is the mechanism for practices to expand their premises or achieve new premises?

AO agreed to take this back to Katherine.

Blood Tests

These are on the rise.

The policy at secondary care is not working regarding DNAs or blood tests.

An email works for a matter of a few weeks and then falls down again.

GK said that he has discussed that and had put in place a system to stop this happening.

It is a clinical governance issue.

Some patients are unaware they have DNAd as they have not received the appointment.

Clinical Governance could write on behalf of the GPs and say that this must stop, it is bad practice and invite comments.

The new Medical Director of the Trust is Jonathon Jones.

0870 and 0845 Telephone Numbers

The GPC view and the LRC view is that this is not on.

There is compensation of £500 for each practice.

Attendance at Meetings

There was a lack of clarity whether there had been any payments.

Slough are paying attendees £150 for attending the meeting, reading the paperwork and disseminating the information down.

Currently attendees are paid £65 for each meeting and payment was been made at the end of the financial year.

The PCT would work with other PCTs to work out a level of payment.

Health Visitors

The lack of HV is causing a problem with the uptake of immunisations.

AO will take this back to Debbie.

IM to email AO with issues.

Exeter Problems

There were problems payments, some practices were paid too much some too little.

The PCT has sent a letter out.

OOHs between 08:00 –08:30 & 18:00 – 18:30

This has gone away now.

Statistics have shown a 30% increase in the use of OOHs. 50% increase quarter on quarter.

Some GPs doing OOHs are being told by the patient they were told at 4.30 pm to call back later.

This has always been the case in the past too.

The service is a victim of its own success. Patients can ring up on a Saturday and come along and be seen within 10 minutes.

Looking at statistics for practices who were with Bedroc there has been a 180% increase.

This should be fed back to clinical governance.

For the certification of deaths in nursing homes. The guidance is available from the BMA website issued in 1999 and still current.

For anyone who dies in a nursing home is unlikely that any useful purpose can be served by a visit from the OOHs unless there is doubt that the person is dead. The duty is to inform the registered doctor who will visit the next day and certify the death.

This will be circulated to all GPs.

QOF

The proposed details for the current year will be brought to the next meeting.

The Post verification visit will be carried out by TVPCA.

All practices were paid by 13th April.

Two practices achieved 149 points.

GP Council: Relationship with the LMC

The LRC continues to have statutory functions that the county LMC has given them. This will remain so.

This does not mean that the LRC feel they are the only forum for discussions.

The LRC are eager to formulate a discussion path with the Council.

It is important that the LMC/LRC maintains its role; the GP Council will try to achieve a bottom up approach rather than a top down.

It will try and be proactive to the agenda rather than reactive to the agenda.

It is hoped the Council can feed issues into the PCT.

Date of Next Meeting

Tuesday 12th July 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
	Johnson Katherine	BF PCT
*	Kassianos George	BF PCT PEC Chair
*	Owen Anne	BF PCT
*	Siddique Salim	BF PCT Deputy Director of Finance

Apologies for Katherine Johnson