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Minutes of Bracknell LRC/PCT Liaison Meeting

27th June 2006, 2pm

At Easthampstead Baptist Church
RG12 7NS

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Minutes of Previous Meeting

Minutes of meeting on 18th April were agreed as a correct record of the meeting.

Matters Arising

eGFR

Slough have written to the 3 Trusts in the area and confirmation has been received from the labs that this has been running from the end of April.

Smart Cards

The PCT has asked that those practices who are requesting them should have them. The authorities say that they cannot be handed out until training has been given, however practices will not be using them for C&B so this should not be an issue. A decision is awaited from a meeting held that morning.

Enhanced Services 06/07

Although the GP Forum says that practices will not be worse off it seems that they will be. The PCT have not taken into account the different needs in each practice, one may have a higher population of Warfarin patients than another and the workload would not be equal to all. The Development Team has not consulted with practices on how they feel about the new 'bundle' although they have approached the LMC on this. There was also a feeling that to go to capitation was a step backwards, capping services like last year would be preferable. This would enable practices to do some work until the cap was reached with a capitation based system the PCT were relying on GP's goodwill to continue to provide the service. GPs did not feel that there had been enough consultation with them as a body and there were not enough options on the table and the 'bundle' was imposed rather than consulted upon. When this went to the PEC, CJ was reassuring that the LMC had seen the development of this, and 3 of the 4 PEC members available were all in agreement that the LMC involvement would ensure acceptance by local GPs. The Primary Care Development Group has been re-established with new terms of reference and other GPs and PMs have been invited to attend the meetings. Comments have been made about the phlebotomy service and these have been taken on board by the PCT, i.e., the service is not equitable or reliable. If practices had their own phlebotomy money it would ensure a more reliable and flexible service, any remaining money will be divided to practices and would give them a set budget which they will receive upfront and this can be used to help with PBC. To say that the LMC are aware of this does not mean that local GPs agree to it, PR had not seen the final version. It had been discussed whether practices wanted to commission phlebotomy as a whole. The feeling was that no GPs were consulted on this; it would just be imposed on them. One practice felt they would be happy to not take the money and walk away from the workload. Practices would just about break even without considering phlebotomy costs. The PCT proposed to pilot this to BF and roll it out to WAM and Slough from April 2007. The idea of a high trust, low monitoring scheme was welcome by the PCT and some practices. The control of workload had not been considered. CK will be emailing practices and PMs asking for their opinion and pass the results on. If there was a mass resistance to this the PCT would reconsider this, however phlebotomy needed to be looked at as it was a problem area of inequality. GPs felt that the system operated last year worked very well and could continue. The workload at the practices and PCT was very large with this capped system and this was why a one off payment would save time monitoring on both sides. If the majority of the practices feel the same, the PCT would revisit this. It may be that GPs could commission a GP phlebotomy service with the PCT and this would help the smaller practices too.

Action: CK will email practices and PMs and get the views of the GP Council too.

PBC

The PCT hope that practices will receive their indicative budgets next week along with a practice pack which will include information.

Practices have already been told how to access data on the website, although this only goes up to June 2005, it appears it is better than in other areas of the TV.

Fair shares calculations have been done too but the figures are not reliable as deprivation has not been taken into account, GPs are being invited to a meeting to try and work this out.

The East Berkshire Collaborative have 2 Slough practices, most of WAM and only Sandhurst in BF has not signed up. There has also been interest from Chiltern and South Bucks in this too.

The PCTs have negotiated with the acute trusts a stepped blocking, if they commission 1000 procedures and go over they will pay no more, however if there are less, the PCT will save on the PBR structure. There will also be an invest to save scheme that practices can sign up to.

The plan is that there will be a 20% payment up front, 40% if BF deliver the locality target and another 40% if the EB target is met.

The DES will pay out 95p on production of the plan and 95p on delivery of the plan.

This scheme, if successful will bring the books into balance and when this happens there will be savings for practices.

The invest to save scheme will pay out £800K but will save £3m and will balance the books, after this 70% will be allocated to practices.

It was thought that the DES specified 70% of savings should be paid to practices, if practices reduce the referrals and the costs come down, what is the point of one area working very hard and other areas not?

This idea came from practices who felt that peer pressure on the others would encourage its success.

The 20% up front payment could be clawed back if the PCT felt no effort had been put in by practices.

The nGMS says if any savings were made the practice would be entitled to 70% and GPs felt that the goal posts kept moving away.

This had been led by East Berkshire clinical leads and it is up to these leads to take the messages back to the PBC groups, the PCTs have not been driving this forward but facilitating it, most practices are represented at the meetings and should be feeding information back.

The subcommittee of the GP Council asked that PCT communicate through them rather than directly to practices.

It was agreed that CK would email practices and ask if they are happy with the proposal.

The DES will still be offered but the PCT need to be in balance before the 70% savings can be paid and the PCT will find the wording that says they have to be in financial balance before payment can be made.

Action: CK to email practices

The PCT to find where it says that they must be in financial balance before paying savings

Drug Misuse

A LES has been developed across East Berkshire for GPs and pharmacists; the original 4-way agreement was not working from a GP point of view.

A new payment of £220 per patient will be paid and £250 per patient if the patient is from another practice.

BF have 8 practices doing this work and one practice is in negotiation at the moment as there is only one clinician and the worry is what will happen during holidays. With the New Hope service it is hoped that they will provide cover when this happens.

The basic requirement is level 1 and it is assumed that GPs will have attained level 1 RCGP, there will be extra funds available for level 2. It is hoped that one GP per area will have the level 2 qualification.

Finance

The PCT tabled figures around the LES funding.
The PCT went through this table.
Payments for the first quarter are based on an average of last year's activity.
The PCT assume 90% uptake of the new DES.
The total money available is the ES floor rolled over from last year with no uplift and the QoF Access points have been added.
Total money available is approximately £1.1m; currently it is a working document.
The PCT tabled 05-06 spend which is in the same format as last year and shows approximately £25K underspend, although there may be some invoices that still need paying. This has not been rolled over due to the deficit situation.

QoF

It appears that the population manager for Mental Health for EMIS practices has many patients who have been read coded with a problem many years ago but are being picked up due to this code.
Practices are not sure how to change this as it is illegal to change the read code, but the patients do not have a severe or enduring mental illness.
One option is to exception report these patients, what will the PCT say if this happens?
It was suggested that this be raised with John Derry as he has a lot of input with QoF.
CK said that if the patient was coded as E135 it excluded the patient from the register.

Action: JS will put an item on the GMC/BMA website and the PCT will raise this with John Derry.

Minor Surgery and Diane Hedges email

The plan was to run this as a pilot; this is over the ES tier of work.
Initially the PCT told it would be run solely for Slough practices; however EB practices are being told their patients are being referred there too by the referral centre, without the GP's knowledge.
The pilot has been re-instated but commissioning will be contacting BF practices to ask how they want to commission this.
BF practices could decide the specification and it would then be put out to tender and those who wished to tender could do so.
The PCT agreed to supply JS with a copy of the SLA.
The procedures that are planned will be in the SLA too.

Action: The PCT to supply JS with a copy of the SLA

Local Savings Team

DH wanted GPs to be aware that there is a Local Savings Team in EB, similar to the Turn Around Team in other areas.

It has external support and the clinical lead is Peter Jones and they have asked for an East Berkshire LMC meeting with representatives to promote the savings plan for this year and come up with some ideas.

Action: None

Health Visitors

Continuity of care was raised as HVs are being split between practices.

The worry was also with the current problems with MMR with breaking care pathways this may drop further too.

The DoH policy is to develop children's centres and try to consolidate services for 0-5 year old in one place.

HVs are in short supply so it was agreed to consolidate services.

The HV lead has written to practices informing them of this change.

It was agreed to take this back to the Head of Nursing and Anne Owen and ask for further communication to practices.

Action: The PCT to take this back

NHS Reorganisation

The PCT will know who the new Chief Executive is by the end of July and the new Chair by 20th July.

Everything will go ahead on 1st October.

Once the new Chief Executive has been appointed, a location for the organization will be decided.

Date of Next Meeting – 19th September 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
	Ann (I don't know her surname)	BF PCT
*	Siddique Salim	BF PCT Deputy Director of Finance

Apologies: Drs Crampton & Halliwell
Paul Roblin
Catherine Johnson & Anne Owen