
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

12th July 2005, 2pm
At Easthampstead Baptist Church
RG12 7NS

CONTENTS

CTRL and Click to hyperlink

Minutes of Previous Meeting	1
Optician Referrals to Specialists	2
Referral to Private Hospital Capio	2
Capping on Referrals - Risk	2
Secondary Care Work.....	3
Flu Jabs for House Bound Patients.....	3
Leg Ulcers	3
Referral Hub	3
Recovery Plan.....	4
Service Level Agreement for Anti-Coagulation & Near Patient Testing.....	4
PCT Reconfiguration.....	4
24/48 Hour Access	5
Date of Next Meeting – 13 th December 2005.....	5

Minutes of Previous Meeting

Minutes of meeting on 12th July were agreed as a correct record of the meeting

Optician Referrals to Specialists

Work is going on across Berkshire.
It has been decided to approach cataract referrals in the first instance.
Consultants in the acute trust are opposed to opticians making direct referrals.
The PCTs are keen that this should go ahead.
It was agreed to revisit this in 6 months time.

Referral to Private Hospital Capio

If no response has been received from a GP within 24 hours it will be assumed that there is agreement.
This was felt to be unsafe and unacceptable.
The LRC felt that one week was more reasonable, however if a response had not been received, every effort should be made to contact the practitioner or their partner to get agreement.
Wendy McClure had spoken to PEC about this and it had been agreed that no response was not a positive response.
The issue is the turn around the referral once it has been received by the referral hub.

Capping on Referrals - Risk

The way the service will be handled is unclear.
What would happen to a cardiological referral once the cap has been reached?
There is recognition in plastic surgery that a number of referrals have been of a cosmetic nature, but there are a number of issues that are of great concern to the patient that are between cosmetic and cancer.
If there was any capping GPs should be supplied with an explanatory sheet by the PCT to give to patients explaining what is happening.
East Berkshire Commissioning Team is updating information relating to plastics and will be sent to GPs.
Practices will be receiving a list of what can and what cannot be referred to each specialty.
There should be an objective mechanism to manage referrals between primary and secondary care.
If a cap is reached and a patient has a genuine clinical need that will be met.

Action Point: The PCT agreed that a notice to put up in waiting rooms would be very good and agreed to work on this.

What is the mechanism once the cap is reached?
There is work going on around care pathway redesign, ENT have agreed to do telephone advice to try and avoid referrals being received, and this has now been increased from half an hour a week to one hour.
It is anticipated that ENT, T&O, Rheumatology, Cardiology and Oral Surgery are the danger areas that may reach the cap.

Secondary Care Work

Practices are concerned that work is expected to be done in primary care which should really be done in secondary care.

There has been no prior contractual agreement to do this.

GPs are cheaper than primary care and if an LES is set up it would be cheaper than commissioning this from the hospital.

CJ asked that details of this secondary care work be passed on to her.

Action Point: JS will email asking that this be done.

Flu Jabs for House Bound Patients

There is concern about the eligibility criteria as no vaccinations will be given without prior arrangements.

In other PCTs where the patient is on the workload for the DN there is no charge for that vaccination.

Only those patients who are housebound need to be identified.

Practices cannot be expected to provide the vaccine and its storage for nothing.

Vale of Aylesbury PCT have produced an LES which states that those patients on the DN's workload are not charged for.

There are elements of this that the PCT will be using, and elements of other areas.

WAM, Slough and Bracknell need to come up with one solution for this.

The PCT will sit down with the Head of Nursing and devise the best way forward which will go to PEC.

AO said that even if a patient was on the DN's workload the administering of the vaccine was extra and must be paid for.

The email stated that £7.51 would be deducted from the practice; however the PCT said that the cost of the vaccine and its storage would need to be deducted from this.

Action Point: CJ and JS will liaise over this issue.

Leg Ulcers

There are the simple chronic leg ulcers that the practice nurses are failing to heal and the complex ones that they are not qualified to deal with.

Currently there is no referral pathway.

Lucy Botting reported that a new LES would be coming out.

AO reported that this was about to be finalized.

Action Point: The PCT will supply a copy the new LES to JS in the first instance.

Referral Hub

A practice in Sandhurst had objected to this originally in March 2004.

RH reported that his practice still felt that this was a problem area.

The practice have agreed to pass referral letters through the hub but they insist that it is anonymised with either the EMIS number or the NHS number as the identifier.

They have accepted it on the grounds that there will be no delay to the referral although this is hard to see as the referral will need to be posted to the hub and then onwards to the hospital.
Any changes of pathway made to referrals must be brought back to the referrer before it is actioned.
RH asked that the PCT pass this information back to Diane Hedges.
The practice had been supplying the Hub with referral data in the past but had a confidentiality issue with supplying the letters.
The LRC recognized the need for the Hub as a demand filter mechanism.
The patient seems to be caught in the middle of this structure.
Currently the PCT needs to manage the budget and this is one solution.
Hopefully Practice Based Commissioning will take this problem away.

Recovery Plan

Negotiations with Acute Providers continue.
Some agreement has been reached with the providers and PCTs and others about how to address the financial issues.
Across the 3 PCTs, there are problems finding a solution for the last £3.5m.
Heatherwood and Wexham have agreed to reduce the SLA by £5m.
Savings across the 3 PCTs have been identified for £23.5m.
Heatherwood and Wexham have agreed a slippage on investment; they are holding non urgent vacancies as are the PCTs.
The Mental Health Trust are considering restricting the Primary Care Teams in WAM and Slough, Bracknell do not have one.
Most of the savings are being achieved by being more efficient about the way the PCT operates.

Action Point: The PCT agreed to supply JS with any plan for her to send on to other members.

Service Level Agreement for Anti-Coagulation & Near Patient Testing

The PCT decision was to pay at the top end of level 2 which would fund level 3 too.
The problem was that there was a perceived inequality of the service.
The PCT have put money into practices to pay for a phlebotomist however practices have been using this in a different manner.

Action Point: It was agreed that the PCT would pay level 3 at a cost of £110 per patient.

The PCT were asked if they could simplify the form for near patient testing as it takes the PMs an inordinate amount of time to fill this in.
PHR asked if the PCT could extract the data they needed from Aspire rather than using the form

PCT Reconfiguration

Proposals have been sent to SHA along the lines of an East and West Berkshire PCT.
The Board has considered these proposals and has also considered a Berkshire wide PCT.
The paper to the DoH is saying that this is still a possibility.
It is expected that this will go to public consultation around Christmas time.
The timescale is unlikely to be April; it is likely to be June-October 2006.
The SHA are merging with Hampshire and Isle of Wight as are the Ambulance Trust.

Within East Berkshire there will be strong locality bases.

HR and Finance will be centralized elsewhere.

The arguments in favour of fewer NHS bodies are clearly around scale but there are disadvantages as a lot of the knowledge and wisdom will be lost in a larger body.

PHR reported that Oxford are going out to tender for the management team.

24/48 Hour Access

AO reported that patients are often voicing concerns that they cannot see their GP within 24/48 hours. AO wanted to share the data that is collected from practices at the Overview and Scrutiny meeting and this was agreed by the LRC.

Action Point: It was agreed that the PCT would conduct a ‘mystery shopper’ exercise.

Date of Next Meeting – 13th December 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
	Hedges Diane	BF PCT
*	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

In attendance Stephanie Holland

Apologies: Drs Henman and Kade
Gill Major