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MINUTES OF OPEN CHILTERN & SOUTH BUCKS LRC MEETING 28TH JANUARY 2005, 2PM AT RECTORY MEADOW SURGERY, AMERSHAM

CONTENTS

CTRL and Click to hyperlink

MINUTES OF PREVIOUS MEETING.....	1
THE FUTURE OF THE BASKET OF SERVICES	2
OOH REVIEW	2
A&E CRISIS	2
PRACTICE BASED COMMISSIONING	3
COMMUNITY MENTAL HEALTH SERVICES.....	3
QOF GUIDANCE FOR PRACTICES ?AFFORDABILITY FOR PCT	3
COMMUNITY HOSPITALS	3
ACCESS LES.....	4
CRB CHECKS	4
ISTC	4
DATE OF NEXT MEETING.....	4

MINUTES OF PREVIOUS MEETING

The minutes were agreed as a correct record of the meeting. PCT was asked if the agendas could be more fully laid out so that the PCT knew what was required of them. It was agreed that the PCT would ring PR if there were any areas that needed further definition.

THE FUTURE OF THE BASKET OF SERVICES

For 04/05 the service had been agreed in June. What was happening for 05/06?

LMC asked PCT about plans to break the basket down into more LES for 05/06

The PCT did not currently have any plans for change. Discussions needed to take place. The LMC would be invited to these. PR said that he needed local GP input for this.

He reported that other PCTs were extracting things into a hospital support LES or list validation LES. He agreed to email good ideas around. The fact that hospital consultants expect GPs to do a lot more work for them was raised. The PCT said that they needed to be kept informed of such issues.

OOH REVIEW

LMC asked if the PCT received feedback from Harmoni. They said that there had been discussions about OOH in general. Where service delivery is not up to standard there was a need for GPs to let the PCT know TW said that he had received complaints from GPs and had emailed these to Harmoni. Anecdotal evidence is not useful. The PCT needed specific events.

GPs were not aware of the Harmoni complaints manager. TW said he would email the name to the PR. PCT felt Iver issue was a temporary database problem. Currently patients in Iver are seen in the Ruislip base. This was not always convenient for them. LMC view that all practices in Bucks should receive a service from the same provider was raised. There was a change from the old service to the new one and understandably it had not gone completely smoothly. The PCT wanted Harmoni to spend time getting things right rather than developing new areas. It was agreed that the time had now come to ask questions about standards. PCT would be asking about response times etc and would expect information to compare with the national standards. The PCT are interested in how rotas will be met at expected peak times such as Easter and Christmas

HM felt that Harmoni might be using A&E as a triage. TW said that over Christmas this had happened. The PCT had tried to sort this out. JC asked that the relevant patient names be given to the PCT so that they could listen to the relevant conversation and take action as appropriate. It will be necessary to ask the patient for permission to give their name to the PCT but this information usually occurs within a patient interaction anyway. The consultation record forms for could also be used as a source of evidence if the patient was sent to A&E.

It was agreed to ask GPs to record names and details to feed back to the PCT

A&E CRISIS

JC reported it had been another bad week in Wycombe, Stoke and Wexham. The PCT were trying not to give GPs the daily crisis alerts they received from the hospitals.

The A&E Service want to involve a GP in the A&E Services. They want GPs who want to admit a patient to telephone Peter Peitre for advice prior to admitting. It is hoped to implement this shortly. The data collected will prove whether inappropriate GP referrals are part of the problem or not. Not admitting one or two patients could make the situation easier.

GPs wondered whether there would be a need for GPs to make a second telephone call. LMC regard this as undesirable.

PR reported that Oxford had done a similar survey but had abandoned it very quickly as the figures for inappropriate referrals were very small. Referral without admission is not necessarily a bad thing. Patients do need tests carried out that cannot be done in a surgery. It is the hospital admitting policy that is wrong.

LMC felt that the proposed change would irritate a lot of GPs.

One GP had personal experience of Wycombe A&E over New Year. There was blood, urine and swabs on the floor and the whole department was being run by HCAs with no nurses present. The question was raised how would Peter be accessed. The PCT said that his line would only be available at certain times. It would not be manned 24 hours. The concept of talking to a GP about a hospital admission could raise medico-legal issues. Some felt a consultant would be better.

It was agreed to pilot the service giving precise start and end dates with the timescale being very small. It was also pointed out that there would be GPs who would not comply with this.

PRACTICE BASED COMMISSIONING

PBC was cautiously welcomed. The PCT reported they had visited nearly every practice. Generally practices seem interested but more detail was needed. PBC will start on 1st April although probably in a shadow form. The types of services to be included still need to be discussed. It is hoped to have a project person and a budget in place by April. Practices can join in at any time during the year and in any proportion. This needed to be talked through.

AS asked about patients who had attended A&E more than three times. Had the figures been analysed. TW said that they had delayed looking at the returns, but had now received 97 of the 300 sent out. As expected there were common themes such as unstable angina. In many cases the person would be a frequent flier no matter what input occurred. The people who have extended lengths of stay in hospital are usually the frequent fliers. More data will be collected and analysed. It was suggested that those practices who did not return the forms be sent some more forms as they were unaware that the deadline had been extended and it was felt important that data from across the wider area needed to be analysed.

COMMUNITY MENTAL HEALTH SERVICES

LMC were very supportive of the new proposals. Concern was expressed about funding. JC reported that the new posts were mandatory and that funding was in place. There was concern that the service would be swamped in the early days.

QOF GUIDANCE FOR PRACTICES ?AFFORDABILITY FOR PCT

Claims will be submitted on 2nd April and signed off by the PCT. TW reported that this had been discussed at the Practice Manager's meeting. 2nd April is a Saturday so the first working day will be Monday 4th April. Practices will then go on to QMAS and if they agree the figures will press the electronic button and send the data. If the PCT do the same, then authorisation for payment is passed to the agency. Problems will occur if either the Practice or the PCT disagree. It has been agreed to have a dry run of things by early March. Patient and organisational points need to be added before end of March. There is a national training day and 2 practice managers will be attending along with the PCT. To get the payment for end of April the PCT have to pass payment by 14th April so it was hoped to have some form of schedule for submission of the claims to enable this to happen. In the guidance payment must be made by end of June even if only on account.

COMMUNITY HOSPITALS

The idea of a GP Community based service was welcomed. LMC queried the high time commitment in the consultant specification. JC said that it was not just for ward rounds and included domiciliary visits. It was probable there would be 2 consultants doing 3 sessions each.

Possibly a geriatologist and/or a stroke consultant. Not known if any practice had yet expressed an interest in providing GP cover.

The £75,000 was for the GP part of the cover.

ACCESS LES

There was confusion as to whether the specification had been changed, Had the penalty to the users been scrapped? TW said that he had not taken anything out. The £60 penalty had not been removed. Practices who use the service will have £60 deducted.

TW said that this service was necessary because of the 100% access target imposed by government. The PCT needed to have a contingency plan even though every practice had met the 100% target. It is planned to have 2 practices receiving a £500 retainer each. GPs felt that they could always cope with a few extra patients. The problem would be when an entire clinic, probably 13 or more people was unexpectedly unstaffed. With the proposed LES the cost to practices would be prohibitive. It would be cheaper to fund a locum. Perhaps the PCT should keep a list of locum GPs and nurses who could be used instead.

Member pointed out that 24 hour access actually means if a patient wants to be seen at midday, the practice has until 24 hours later to see that person. PCT felt it was important to ensure that access remains at 100%. This year it had earned £250,000 which the PCT was going to put into IT in practices. Transport to other practices would be a problem for some patients. An informal buddy system would be more sensible.

In view of the likely usage described above, TW agreed that the charge might be unhelpful

CRB CHECKS

TW reminded the committee that these needed to be received by 31st January 2005. PR gave LMC view that the non CRB checked doctor should be put on 28 day notice to remove them from list.

INDEPENDENT SECTOR TREATMENT CENTRE (ISTC)

There is another wave of independent treatment centers being sought all round the country by government. A large amount of elective and diagnostic services must be from the independent sector. The Health Authority has been given a quota and they have devolved this to PCTs.

The diagnostic center in Cressex comes on line in August. The policy is supposed to help PCTs with the 18 week target. 15% of activity must go this way in a year's time. The situation is changing daily. Is the presence of this going to threaten the viability of hospitals?

DATE OF NEXT MEETING

Friday, 11 March. 2PM
Rectory Meadow Surgery

Attendees

Present	Name	Organisation
*	Corlett Helen	Member (Co-opted)
	Daily Simon	Member (Co-opted)
*	Mallard-Smith Rebecca	Member
*	McDermott Hilary	Chairman
*	Sapsford Andy	Member
*	Stoneham Mike	Member (Co-opted)
*	Thompson Simon	Member
*	Roblin Paul	LMC Chief Executive
	Solomon Jane	LMC Director of Development & Liaison
*	Birchall Carol	LMC Minute Secretary
*	Carmichael Jonathan	C&SB PCT
	Johnson Bart	C&SB PCT Chief Executive
	McVey Vivienne	C&SB PCT PEC Chair
*	Wilson Thomas	C&SB PCT