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Minutes of Milton Keynes LRC /PCT Liaison Meeting

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On Friday 31st March 2006, 2pm

At the Post Grad Centre

MK6 5LD

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Minutes of Previous Meeting

The minutes of 27th January 2006 were agreed as a correct record of the meeting

Matters Arising

Healthcare Commission Patient Satisfaction Survey

TW is still chasing John Derry for his interpretation

Choice and MK Website

James Wilks is leaving his particular post within the PCT and it is unlikely that this will be done. Due to the vacancy freeze it is unlikely anyone will replace him, John Lee Thompson will lead on Choose and Book.

Neonatal Check Specification

Practices have received the triplicate forms for use.

Flu Pandemic Planning

PHR has yet to contact Dee Morrison, however this issue has got tedious as the aspect of a pandemic is so far ahead, it is impossible to maintain enthusiasm; however he was still monitoring this.

QoF Visits

This will be addressed during the next round of visits

Policy Document on Demand Management to show Patients

TW said that the PCT has still to do this.

It was felt that this area moved too quickly to produce a specific document, TW wanted to wait until practices had signed up to PBC so the document could be addressed to specific areas where they were planning to reduce referral rates.

He felt this would be more constructive for GPs, rather than a general document.

GPs felt that the PCT only considered things urgent when they considered them so, not when GPs did.

GPs have received daily bulletins saying that A&E are full, GPs are expected to cope with patients being bounced back by the hospital and the walk in centre, but the PCT does not understand that demand is something that affects everyone.

GPs simply wanted something in writing from the PCT to show patients, stating that not all conditions could be treated on the NHS.

The PCT do not seem committed to working with GPs.

It was suggested that all the Priority Forum sheets be available on a MK website to enable GPs to show patients.

This would be a starting point and others could be added. **This was agreed**

Action: It was agreed to put the Priority Forum Statements on the MK website. TW and PHR will work together on this.

PBC MK Collaborative 'First Steps' Checklist v3

The PCT are only commissioning with the DES and are planning to use the BMA template as the appendix to the DES was too vague to enable practices to specify what they want to achieve and it could lead to problems with payments over achievement next year.

The intention is that the Collaborative will circulate the Plan to practices, already filled out, with areas left for individual practices to fill in.

TW has the first draft of the Plan filled in by Peter Birkin; once it has been finalised it will be circulated to individual practices for their input.

The Collaborative currently has a member of the PCT staff working with Peter Birkin.

The PCT feel the Collaborative is a GP led organisation.

How they fund it is down to the practices involved, the PCT are putting no funds into it.

The DES is very basic and this is what practices will provide, however this is not enough to get PBC off the ground and the only areas where it is working is where the PCT have invested money.

TW said that the SHA wanted to have one scheme across the Thames Valley and no PCT would be able to break with this.

The PCT have agreed that the plans will only be worth the money that is being input to this DES and will only take things so far.

The only way for practices to make changes is to use the savings, although they are unlikely to be made.

Funding needs to be up front in terms of a management allowance.

The other worry for GPs is paragraph 47/48 and the interpretation, regarding savings going to practices except in exceptional circumstances.

PCTs around the country are already planning on taking all the savings if there is a deficit.

PHR said that this only refers to the 30% which is accessible by the PCT and JD is aware of this.

TW reported that JD had sent copies of the questions and answers paper to all PCTs so they were aware of this.

New C&B, PBC, Access, IM&T and DES

All practices have been notified of these; everyone has signed up to everything except for 2, one has not signed up to C&B and another has not signed up to C&B, PBC and IM&T.

The IM&T DES is structured so that practices can take as much or as little as they want and a lot relies on the PCT providing the equipment to do things.

TW said he had supplied practices with the spreadsheet on the Access DES.

GPC are discussing the new patient questionnaire, although it has been reported that there are difficulties.

There is a big difference to the way questions are worded, with the response that is received.

With telephone access patients will compare this with the service they receive elsewhere and this will have an effect on the response.

There are some practices who are supplied with the telephone equipment by the PCT and it is pretty old, but the chances of getting it replaced is very unlikely so this will need to be taken into consideration.

Report from PC Commissioning Group 21/03/06

Physio and Counselling

The LMC position has not changed from last year, whatever services are available, each practice needs to be treated equally.

One practice has in-house physio, others have to refer patients into the General Hospital.

Counselling is available in-house to one practice; others do not have the service at all.

The PCT were going to ensure that there was equality to all practices.

Counselling is only £55K and it will be all or nothing; the Physio pot is £600K and the PCT want the PEC to reduce the pot by either reducing the follow up ratio, having one contractor and therefore one price, and also where the service is provided.

One of the in-house clinics has almost 50% of the cost for rental of the room, if another location could be found, it would save this.

It was asked if the current in-house providers were influential, would the PCT be prepared to follow this through and take the service away?

TW said that the PCT will be putting the service out to tender and the PEC will determine the size of the pot that is available; it will be for equal access to all practices.

If practices already receive cost or notational rent from PCT they cannot charge the PCT again, and the PCT have highlighted this as an area that needs to be investigated.

Open but full Lists

This is a term for Practices who are facing a short term staffing crisis, which is defined in the regulations and contract; you can turn patients away provided it is done in a non-prejudicial way. It still exists as a route for GPs to use.

Selected use of open but full by practices will be defended by LMC.

Over recent months the PCT have had to ask practices why they have refused to take patients on and asked for a copy of the letter that should be written to them.

One area has one nursing home covered by 4 practices, however nearly all the patients are registered with one practice and the manager is reporting that it is impossible to get patients registered with certain practices, but not others.

The PCT have agreed it would be sensible to get the 4 practices to sit down with the nursing home manager and try and sort out a sensible solution.

PHR said he would work with TW around this.

It was agreed it would be better to assess practice workload as the total clinical workforce rather than the GP:patient ratio.

Action: PHR and TW to work together to solve problems.

Business Rates

It stated in the minutes that 'Increase in business rates for practices has been funded by the PCT for GMS practices this is through the global sum'. This is wrong it should be direct reimbursement.

TW agreed to raise this issue at the next meeting and get the minutes corrected.

Action: TW to raise this at the next meeting.

Enhanced Services Update

No further spreadsheets were available.

There will be a few further services included in the ES, but will probably be included in the allocated funds.

An overspend is currently predicted.

Figures are expected from practices for the last quarter so the situation will change.

With Minor Injuries, there is a large difference in the number of cases that are being reported, it may be that this is a read code issue, but it could be that the practices are just not doing the work but it is going to A&E or the walk-in-centre and the PCT will be investigating this further.

Psychological service in primary care may be an area that goes, the PEC say that £3m savings are needed. If counseling is to be cut by half it will make no sense at all as the service cannot be delivered for the price paid, so it is better to remove it altogether and it is an area with large inequality.

Update on MK Acute Trust Services

Emails are being sent suggesting cuts.

TW reported that there were no more decisions about what should be cut.

When practices receive indicative budgets what type of normalisation or scaling down will be applied as this has implications on whether savings will be made.

Work is going on across Thames Valley on unified budgets; practices will receive the appropriate indicative budget by June/July, which is delayed.

In the interim practices will receive an interim budget based on quarter 3 activity.

TW will feedback details to PHR.

Action: TW to feedback details to PHR of the scaling down and to advise practices what percentage has been given to them.

Cost Rent of GMS/PMS Practices

PMS practices are entitled to GMS directions and assuming they apply to all practices what degree of retrospection will apply?

If the terms of the practice loan changed before October 2003, can the PCT make any claw back or it is only from the start of the directions?

Beryl Anderson is dealing with this primarily and it appears that this issue may go to dispute.

ER reported that the GPC discussed this and the cost rent was based on costs and it was not intended that practices should make profits by changing the loan rate.

The GPC directive is that the GMS cost directions do not apply to PMS practices.

The ultimate decision is to get a judge to decide on the interpretation of the guidance.

The LMC is as anxious that the case is resolved properly as the PCT is.

It needs to be resolved in a clear legal way.

The LMC need to know what the PCT's position is based on.

The LMC asked that TW get involved in this issue as mistakes may be made by the PCT.

TW agreed to produce a view on this for the LMC.

TW said he had advised Beryl Anderson to get the LMC involved in this and PHR said he had tried to contact her, however she only works 2 days a week and it is impossible; it is a problem of accessibility.

Action: TW agreed to produce a view on this for the LMC.

EGFR Needed for QoF for Renal Failure

For the QoF, practices need to have the EGFR, a letter has been sent to the local laboratory and response is awaited, however the local hospital do not provide lipid profiles so it was not expected that they could provide this.

Action: TW will chase what the situation is with the lab

Date of Next Meeting – Friday 19th May 2006

TW sent his apologies for this meeting

Present	Name	Organisation
	Alifoe Hopeson	Member
	Carter Ron	Member
	Kenny Tina	Member
*	Labrum Tony	Member (Co-opted)
*	Rao Lakshman	Member
*	Rose Eric	Member
*	Suleman Abdulrahim	Member
*	Whyte Sian	Chair
*	Roblin Paul	LMC Chief Executive
*	Solomon Jane	LMC Director of Development & Liaison
*	Birchall Carol	LMC Minute Secretary
	Ablett Jeanie	MK PCT
	Clark Ruth	MK PCT Clinical Governance Lead
	Savage Michelle	MK PCT Primary Care Commissioner
	Jacklin Mary	MK PCT
	Kennedy Barbara	MK PCT Chief Executive
	Wilks James	MK PCT
*	Wilson Tom	MK PCR
	Murthy Satya	MK PCT PEC Chair

Apologies: Drs Alifoe, Carter & Kenny
Jeanie Ablett