OXFORDSHIRE LOCAL MEDICAL COMMITTEE

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Minutes of NOPP LRC/PCT Liaison Meeting

Wednesday, 27th September 2005 at 1:30pm
Board Room, Banbury Business Park
OX17 3NS

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Action Point: It was agreed the PCT will submit agenda items to Michelle in the office for inclusion.

Previous Minutes (26th July 2005)

The minutes of 26th July 2005 were agreed as a correct record of the meeting.

Enhanced Services

Following the last Liaison meeting, NB had sent a response back to the PCT to ensure that all adjustments to ES specs were as clear as possible.

Smoking
This had been sent out without any LMC involvement despite unresolved Read coding issues. QOF uses different codes.

Basket of Services
In CV the 50p per patient paid last year has been reduced to 40p this year with the removal of patient transport.
NE were paid 80p and it proposed that this is reduced to 40p.
LMC felt practices will not want to do the same amount of work as last year for half the amount of money.
In NE it could be worth removing things from the basket and commissioning them separately.
The LMCs response to the drop would be to write to practices asking them if they wanted to continue providing the services or whether they wanted to pass them back to the PCT and get them to commission them from elsewhere.
It was suggested that if practices did not want to continue providing the service they give the PCT 3 months notice so that patients were not left without the service.
A difficult precedent was set in the NE by paying 80p last year.
The PCT are trying to be consistent and have one price across the locality.
PCT felt NE must be made aware that CV are providing the service for the lower price.

LMC asked how the PCT would handle payments to date for practices withdrawing from the ES.
The PCT will pay practices for the 3 quarters they have worked at 40p per patient.
LMC felt that practices have provided the service for a fee which was previously 80p per patient and would expect to be paid at this level. Anything else would be a betrayal of trust when practices were asked to work to a contract that arrived 6 months late.

The PCT have always said that the basket was time limited and it was felt that from April 2006, there would be a separate LES written for each area in the basket.
This was agreed.

Alcohol
It has been agreed to continue with this in NE
A proposed specification will be sent out to practices.
A copy of a draft letter to be sent with this specification was tabled.
The letter states that the there will be a cap of 150 cases across the NE PCT in 05/06
Each practice will have a pro rata retainer and share of the 150 cap.
Practices will be asked to demonstrate that they have met the specification which has been based on the national specification.
Practices will need to provide more than core GMS to these patients.
Next year the arrangement will cease from 31st March 06 as the specialist service will be up and running.
NES will not be offered to CV practices.

JG tabled a paper was tabled showing how much alcohol abuse cost the NHS and showing how tackling alcohol abuse could be part of a Spend to Save policy.
People with alcohol issues must have more aggressive management.
Felt one particularly keen NE practice should be supported to provide this service.
If the PCT plans not to commission a service next year, practices should be informed as soon as possible so that they can adjust their plans.

Anticoagulation
The ES expects the monitoring of Warfarin to involve practices using the hospital RAID system. One practice approached the Horton Hospital and tried to get their patients on the system but were told that they could not take on any more practices despite it being commissioned.
The PCT agreed to liaise with EH on this issue.

Inclusion in the ES Floor
The PCT tabled a projected spend against floor.
LMC expressed concerns over including payments to practices for medical cover for community hospitals.
Roll over contracts are specifically excluded under Paragraph 2.79 of the Investing in General Practices.

Counselling
There has been disquiet about the equity of the provision of counselling to practices.
LMC felt strongly that if this is part of the ES Floor the provision needs to be made more equitable.
The PCT proposed to look at an Oxfordshire wide provision and with the future merger in mind this was the way to go.
LMC felt the Oxfordshire wide proposal would take too long to reach a conclusion and a local decision was needed sooner.
The inclusion of counselling in the ES is debatable.
If LMC and PCT are to agree its inclusion, then LMC has to ensure the service is equitable available to all practices.
LMC cannot see why the PCT find this change so difficult.
If counsellor cannot move then patients could travel to where the service is provided.
It could also become a locality based service, rather than centring on one practice.

It was agreed that the PCT would do a mapping and funding exercise and report back to the next meeting.
NB agreed to participate in this exercise on behalf of the LRC and reminded the PCT this is not about GPs getting a better service it is about patient care.

Choose and Book Update

Feedback from pilot practices is that the IT is not fit for purpose.
The worry is that practices might already have been put off and would be difficult to re-engage.

Practice Based Commissioning Update

The Government are desperate to introduce Payment by Results (PbR) and to achieve this PBC has to work.
They see PbR as the thing that will save the Health Service by providing contestability, speed and more patient choice but are worried that this will cause chaos.

The SHA are keen for PCTs to support and enhance PBC
Reaching the stage where budget and spend data is available needs to be accelerated

The PCT would let the LMC know if there were any issues that they would like help with.
PR view was that within Oxon the NE were the only PCT doing anything at the moment.
Sandy Bridden from the TVPCA is willing to meet with GPs and help develop PBC.

Meeting discussed CAL proposal involving referrals to JR and NOC being channelled through a Demand Filter.
This development is linked to the saving targets that PCTs and secondary care trusts need to meet by the end of the year.
The concern is that this will restrict GP freedom of referral through capping.

PHR felt that GPs should be encouraged to engage in the least damaging type of cut and CALs is part of this.
Studies in another PCT (CSB) have shown that up to 30% of referrals could be managed in a different way.
If diverting away from hospitals can avoid more damaging service cuts then something has been achieved.
CALs may encourage dialogue between primary and secondary care.
Consultants could email GPs and suggest alternative management.
In Berks and Bucks experience clinicians at the referral hub are looking at letters in order to bring spend back within budget.
Ant new way of working needs to provide maximum health benefit for the available funding.
The reality is that the system needs to live within budget and GPs need to play their part in this.

PCTs Reconfiguration Proposals

Almost certain that Oxon PCTs will become one merged organisation within 9 months.
This week Nigel Crisp and John Bacon met with all Chief Executives in the South of England to bring them up to date.
The timetable is still that the SHAs have to submit their response to the Department by 15th October.
An independent panel will assess these submissions against the DOH criteria.
All PCTs will have an answer by the end of November and will then go to 90 day consultation.
The idea is that the SHA will be sorted first and at simultaneously there will be a process for PCT Chief Executives.
The answers to the consultation will be available in March
A final local decision needs to be made, which will then have to go to the Secretary of State for approval.
The new PCT would be unlikely to be in place before April or May of 06.
The name of the new organisation is not known yet.
The new bodies will be required to hang on to their provider services until December 2008 at the latest.
Brackley likely to be going back to Northamptonshire when merger happens.

Have the PCTs thought about locality input to the organisation? Yes
There could be 3 localities which will be along the District Council boundaries.
Local Government want to get their hands on health.
They have spare capital which could be made available to the NHS. Other areas have made much more use of this.

Last Liaison Meeting 26/07/05

The purpose of the Liaison meeting was discussed.
NW commented that too much detail was being discussed that should have happened behind the scenes.
LMC felt this view was at odds with the historically understood purpose of the meeting

ie resolving issues of difficulty between practices and PCT.
Recently discussions have centred around Enhanced Services
Any change to this committee function needs discussion.
Much of the detailed work with ES is already been done by email and will continue.
Many areas of difficulty can be sorted by email but discussion is helpful.

PR reported that with the other 13 LRCs he attends in the Thames Valley, Chief Executive attended the meetings for special issues only because most issues were not of a CEO type.

It was agreed that a smaller group would be more appropriate consisting of the Primary Care Lead and the PEC Chair and would meet bimonthly.

Date of Next Meeting

22nd November 2005

Present	Name
	Dr Simon Bentley
*	Dr Neil Bryson (Chair)
	Dr Martyn Chambers
	Dr David Grimshaw
	Dr Emma Haskew
*	Dr Stephen Haynes
	Dr Kulwant Pandher
	Dr Helen Van Oss
*	Matthew Brown
*	Dr John Galuszka
*	Dr Hugh Gillies
*	Ginny Hope
	Pippa Ogier
	Karen Prestidge
	Nicky Wadely
*	Dr John Walton
*	Nigel Webb (Chair)
*	Paul Roblin
	Jane Solomon
*	Carol Birchall

Apologies: Drs Bentley, Chambers, Van Oss, Haskew and Pandher
Jane Solomon
Karen Prestidge, and Nicky Wadely