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Minutes of South Oxon LRC/PCT Liaison Meeting

Thursday, 17th May 2005
at Marcham Road Family Health Centre
OX14 1BT
1.30pm

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Minutes of Previous Meeting

The minutes of 3.3.05. were accepted.

2004/2005 ES Underspend

LRC felt it had been agreed at the last meeting that this should be divided out to practices.

The LRC argument depends on the concept of relative underpricing and agreement to this earlier in the year. Where there was an underpricing for goodwill GPs are looking for a return of goodwill.

If items had been priced more reasonably GPs would have earned this money during the year. The basket and minor injuries were priced below the estimate needed to deliver the work

The SHA have told the PCT this not an option.

CT did not want to divide the money out to practices.

There is a general PCT acceptance that giving out £101,000 to 32 practices is not acceptable.

LMC member felt that the SHA advice had to be wrong

The agreement with the GPC is that roll forward can only occur with the agreement of the LMC. It absolutely requires a position where the LMC does not agree to roll forward money and alternative ways of spending have to be found in year.

Discussions have taken place between RG, PHR and JD about how to avoid GPs earning the funds twice.

The easiest way is to re-price the 05/06 basket.

The Basket continues to include things that should have been taken out (eg breast screening list validation) and it has been reduced to 40p.

There are a total of 280,000 patients in the area. Dividing the underspend by this figure gives 30p/pt

Raising basket price to 75p it would consume the overspend.

CT has been looking to use the underspend for training.

Equipment purchase has been discussed with a wider range of GPs but CT did not get very positive feedback.

The LES for “meeting with specialists’ pathway development and review” will cost £53,000.

A draft LES for insulin conversion is being considered.

A number of practices already do insulin conversion without payment.

Training is an issue for those who do not.

Insulin conversion is a recurrent spend.

Recurrent spend should not come from any 04/05 underspend.

LRC hesitation on the proposal for training is that there is a cost to the practice

If a partner takes time out to attend a training session there needs to be a locum.

This is the same as earning the money again.

Therefore the PCT should pay the locum costs when the GP is out of the practice.

How has an underspend been used in other areas?

Kent have come up with equipment supply solutions. CT said that Oxon practices were not keen on the equipment options.

Basket was only envisaged to last 1 year

eg by making a separate LES for services such as Zoladex.

The breast screening and waiting list validation was only accepted by LMC for last year. If it was included in this year it should be for extra money. One solution would be to say the basket price will increase to include breast screening which will drop out next year and the cost will go down.

CT would rather compromise and add the dermatology into the underspend and not contest this.

CT suggested putting the underspend into the pathway training, equipment to support GPsWI and payments by results and to back up the insulin conversion LES to give to all practice staff.

The LMC were unhappy with this. This is not money that practices should earn again.

CT disagreed.

PR said that the LMC could recommend that practices did not accept the basket if it was priced as it was.

CT agreed to take the training less out and add dermatology in and to increase the price of the basket to 60p.

Late Payments for Cost Rent, Improvements, QOF

Practices were apparently not paid properly in April but this has now been resolved. LRC felt the solution required quite a lot of calls from practices before the PCT realized there was a problem.

CT said he had only received one phone call. RG had received many.

PCT explanation was that for the first time the TVPCA wanted PCT confirmation before paying the cost rent but they did not tell the PCT this.

Once the PCT knew about the issue it was rectified within a week.

Dermatology GPsWI

LRC are not convinced that the post constituted a proper GPwSI in 04/05.

GpwSI should be independent doctors working in the community.

The current doctor sees overflow patients from Reading.

The £19,000 in the floor to pay for this should not be there.

The clinic should be opened up to direct access by GPs

The doctor has been asked to define what administrative support is needed to give open access for 2005/06.

LRC felt the £19,000 should be added to the underspend making the total £101,000.

QOG Goalposts Shifted after Preliminary Visit

Several practices in dispute feel the goalposts were changed after the QOF visit

PCT view is that they always adhered to the original guidelines.

There are only 6 disputes out of 32, usually over 2-3 points.

All the requirements were written but may not have been explained to practices.

A letter was sent to practices on 21st February 2005 detailing some areas that needed looking at.

They were then reminded again 2 weeks before the end of the year,

One practice said that the latter email included items that were not in the February list.

Some of the problems were vaguely described

ES Contracts 05/06

CT said that the problem was that LES were sent out and comments came in from all angles

He would appreciate having a named LMC person for comment.

It was agreed in future to send these to LS. LS agreed to do this.

It is not for the LMC to agree contracts; they can help the PCT to develop a contract that practices would be likely to agree to.

Access ES has been changed in light of LS comments.

Once LS has seen it and agreed, it could go out to practices.

What happens if practice managers raise queries? LS is the first person to receive the documentation. When she is happy with it, she could then distribute them to the practice managers group with a definite date for return and then this is fed back to the PCT.

Comments on current Contracts:

IUCD, what is the PCT policy on Chlamydia screening? The policy needs to be attached to the specification.

Access payments. Access should be paid as an implementation and achievement payment but practices are being paid monthly. The specification states two payments.

Since November last year all practices except one have achieved the targets so it was agreed to pay monthly. The specification would be changed to reflect this.

Will practices be told if they are dropped a point. Practice managers are warned if they are about to drop a point.

Near Patient Testing This should be an NES. The Blue book says it is an NES and list can be adjusted. Monitoring of this should be the month following the end of the quarter, not preceding. Practices are also required to send an audit report to the Pharmacy Advisory Team. Could the PCT send this in? If the PCT want an audit it should be specified.

It was agreed that the specification be changed to say that if the PCT wants to do the audit there should be appropriate warning and clarity with a template. CT to take this back

CT was given a full list of Oxon amber drugs.

MMR The price is wrong it should be £7.51 which is £7.28 uplifted by 3.225%.

Minor Surgery payment under paragraph 7 should say there is a capping procedure for 12 cuts and 8 injections per 1000 patients.

Flu Will this SLA be re-issued? This was held back because of discussions at PEC with at risk groups and the John Derry letter. This is all written out in the Enhanced Services Directions 2005.

Under aims for the DES under paragraph 3 for flu and pneumococcal, should say pneumococcal disease and influenza and/or pneumococcal.

LS to send above written comments to CT.

PHR had additional issues itemised below

Minor Injury has been priced incorrectly at 0.45p and 0.65p per patient

The figure should be £0.45 per patient (ie it should be 45p.)

Diabetes Paragraph 1 talks about cost and volume agreement and paragraph 8 is cost per case agreement.

The specification infers a continuing obligation but the payment appears to be one off.

Continuing obligation is not about conversion.

ie The pricing does not conform to the specification.

The PCT should be encouraging practices to do this work but the LES does not deliver much incentive

In other PCTs there are retainers and cost per case.

There is no problem with doing insulin conversion and the figure of £150 is acceptable for a cost per case. Are PCT planning a retainer?

CT agreed £150 per case for conversion.

Baby Checks Not a contractual obligation under nGMS. It is priced as £50 per annum in last years prices and needs to be uplifted by 3.225%.

The specification refers to Oxford, however practices refer to other hospitals.

Would be better to just state hospital.

MIU in Abingdon

Discussion about inclusion within ES Floor

LMC felt only staff costs could be included (2/3 of the cost).

The LMC would like the planned spend for this year. CT gave a copy to RG.

Staffing could only be within 8.00 am – 6.30 pm as out of hours is excluded by guidance

CT to look into this further as he felt it should be included. He will take it to the National Steering Group.

Practice Based Commissioning

A paper around option 3 is going to the Board on Thursday week

Once it has been approved, then it can be discussed.

The document as it exists today is incomplete and would give a very small part of the picture.

Greater clarity will come shortly.

Appraisal Funding

Peripatetic locums is sorted

Is Appraisal funding in PMS contract sums? No it is kept separate.

GMS practices receive this in their global sums.

MSU Pots – Reading

PCT also find the unilateral change by providers unacceptable and will take it up with the Royal Berks.

If problems continue, inform the PCT.

Application to amend Hours of Availability

A paper was given to each member to review.

Date of Next Meeting

Thursday 7th July 2005 at 13.30

Present	Name
	Gavin Bartholomew
*	Prit Buttar
	Paul Coffey
	David Copping
*	Rick Godlee
	Christopher Langley
	Julia Milligan
	Simon Morris
	Ian Neale

	Michael Robertson
*	Lisa Silver
*	Paul Roblin
*	Jane Solomon
*	Carol Birchall
*	Jane Dudley
*	Ian Mackenzie
*	Stephen Richards
*	Colin Thompson
*	Kate Gale