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# BERKSHIRE LOCAL MEDICAL COMMITTEE

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## Minutes of West Berks LRC/PCT Liaison Meeting

Thursday 8<sup>th</sup> May 2008

Room G29, Reading PCT, RG30 2BA

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### Minutes of Previous Meeting

The minutes of 6<sup>th</sup> March 2008 were agreed as a correct record of the meeting.

### Matters Arising

#### **PMS Variations**

Practices have been sent forms to sign. Some are still outstanding,

It is not known why they have not been returned, but the PCT are of the opinion that the revision has taken place for all practices.

### **TVPCA Patient Removals**

The Agency had issued an excellent bulletin outlining the process involved. Practices cannot just delete the electronic FP69 from their clinical system. The bulletin outlines clearly the steps that need to be followed.

## **Access/Extended Hours**

The LMC has received a draft LES from Helen Clark and circulated this to LMC reps for comment but no circulation any wider.

The paper has not been formally put before the PCT Directors or the PEC.

MM reported that following comments received HC will be sending a second email responding to the various issues raised.

The key issues are:

- Pre-bookable as opposed to urgent slots: The majority of extended hours will be for routine, pre-booked appointments.
- GP Concurrence: 2 GPs will work concurrently for practices of 10K patients or more.
- Nursing Hours: Initially the draft did not make mention of nursing hours; however this will be reviewed in light of the comments that have been received.  
Nurses likely to be considered are nurse practitioners rather than practice nurses.  
The LMC felt that practice nurses would generally run the cytology, contraception, asthma, hypertension, diabetes clinics etc during in hours, so there should be no difference for patients who work during the day and want to consult routinely during extended hours.
- Baseline audit: LMC did not want in hours schedules to be cast in stone for ever more.
- Consortia approach: The PCT has indicated that if practices wanted to work together they will consider proposals.

The PCT said that they wanted to be as flexible as possible and deliver services that are good. However, at the same time they did not want to be punished by the Government for being too flexible.

The LES is being put in place to allow practices who want to offer extended hours to do so prior to the DES being issued. Once the DES has been issued the two will overlap and run concurrently.

The draft refers to 18<sup>th</sup> May as the date that practices should start to offer the service.

The PCT was asked if this still applies as it is only 10 days away. The PCT said that the paper needed to go to the Directors and the PEC and it may be that this date is extended.

The aim of the document was to get something that was workable to allow practices to offer the services.

MM and JL have discussed the issue of switching the phones over at 6.30pm to Westcall and the general opinion is that as the appointments will all be pre-booked there would be no need for the telephone to be live and practices could switch over to OOH mode.

The cost of an extra line for extended hours bookers would be an extra unnecessary expense for the practice. If patients did not turn up for their extended hours appointments the GP would have some spare time.

GPs foresaw a problem in the future when patients became aware that the surgery was open and would walk in expecting to be seen. Locking the door would be difficult.

The solution would be that if a patient wanted to be seen and there was an appointment available, then that slot could be booked. Otherwise the receptionist would have to tell the patient how to contact the out of hours service.

If a genuine emergency presented to the surgery then the GP would have to deal with that in the appropriate manner as part of their duty of care.

The service delivered will be audited. If there are a lot of unfilled slots the PCT will not hold this against the practice, especially if they have proven that they are running a service at a time that patients indicated they needed it, i.e. in the GPAQ survey or in practice individual surveys.

The PCT are expecting 30 minutes of extended hours per 1K patients. LMC wished to see the facility for practices offering less than this if this was the level of patient demand.

This would attract a pro-rata reduction in funding and save the PCT spending unnecessarily.

**Action Point: The PCT, GPs and LMC to work together to try and agree a LES that suits patients, PCT and practices.**

### **DDRDB and GP Contract Uplift 2008/09**

The DDRB has recommended a 2.7% uplift to the global sum but a 2.7% reduction in MPIG which effectively means a 0% increase in resources for the third year in a row.

PMS practices do not have an MPIG so they in effect would be receiving a 2.7% rise which GMS practices would not.

The PCT agreed that this needed to be discussed.

The SFE states that the global sum and MPIG should be subject to the same rise.

The Government seems confident it can make this change but GPC disagrees and is seeking legal advice.

**Action Point: PHR to keep everyone informed of developments on this.**

### **Locum Reimbursement Policy**

The latest PCT proposal contains 2 elements:

- Only 10% will be paid if the PCT are not predicted to be in financial balance at the end of the year.
- Payment will be tiered according to practice scoring against a list of performance targets. (maximum payment would be £1500 per week)

The second part is only relevant if the PCT are in financial balance and at the start of the year it would be difficult for them to know what state they will be in 12 months later.

PCT was told that the first part of the proposal would not get LMC support.

MM said that it was important to remember that the payments were discretionary and the SFE states that each application must meet the PCT criteria and what level to pay is up to the PCT.

The PCT expects to come out in financial balance but if they are not and they made full payments senior members of the PCT would lose their jobs.

With the performance related payments, practices that are meeting the criteria will receive the maximum payment of £1500, currently the maximum being paid is only £975.

In the past the PCT has paid practices the same. Now they are going to reward those who are working hard to achieve targets.

The first part is the stumbling block; the LMC agreed that the second part was acceptable.

**Action Point: Members to email PHR with suggestions for a solution to the first part.**

### **Sickness Reimbursement**

The LMC asked what the PCT position was when a GP was off sick and had insurance, but the insurance company had decided that they were off with a pre-existing condition so would not pay out.

Reference is made to GPs who have not taken out insurance or cannot get it but there is no reference to this scenario.

**Action Point: The PCT to revisit the policy.**

### **PCT Strategy for Primary Care**

(Meeting dates 23.05.08, 10.06.08, 18.07.08 at 12.30-2.30)

PHR reported that he was unavailable for the next 2 meetings but that Rab Mittal would be attending in his place.

DB reported that he had invited anyone who was interested to attend the first meeting.

There was a good attendance from GPs in the locality.

The aim is to achieve a short document that gives everyone an understanding of PCT strategy.

For example if GPs are considering investing in a branch surgery they could look at the strategy document.

### **PCT not Buying Hardware Support from System Suppliers**

LMC has been alerted by Finchampstead Surgery and Andy Ferrari already contacted.

The contract for the hardware is with Berks Shared Services (BSS) but software problems remain with the system supplier. This has always been recognised as a bad arrangement because each blames the other for the problem and practices are caught in the middle.

GPs also reported that despite contacting BSS, either the equipment was still in the surgery or there were concerns about the removal of sensitive data from the hard drives.

The PCT said that there is a clear process in place for the destruction of data.

Practices were advised to contact the GP IT helpdesk to arrange for equipment to be collected.

DB reported that he had had discussions with Andy Ferrari about these issues.

There is also a problem with the installation of new equipment in the surgery and DB is proposing that this should take place when the surgery is closed to allow the practice to have as little disruption as possible.

DB said that the PEC was trying to recruit a member who had an interest in IT, possibly someone from the IT Steering Group.

**Action Point: Practices to contact the GP IT helpdesk to arrange for redundant equipment to be collected.**

**PHR to pass any IT issues to DB.**

## PCT Communications with GPs

Previously practices (GMS and PMS) had nominated a partner and the Practice Manager to receive matters relating to contracting.

The PCT have had some reports that the nominated partner was not passing information on to colleagues.

PHR said that there would be very few occasions when consent would be needed by every member of the practice.

If practices nominated a lead person to receive the communications failure to communicate with practice colleagues is an internal matter.

Practices must agree that the nominated person has the consent and trust of all the contractors.

## Darzi Practice Developments

The site has yet to be sorted out but will be in the Centre of Reading.

Expressions of interest have been received from 11 parties and a specification is being drawn up which will be sent to all 11 parties.

Everything has to be signed by December 2008.

How walk in patients are to be dealt with will form part of the specification.

The PEC has had long discussions about this but this is new uncharted territory.

The bidders may wish to provide their own site, or the PCT may provide one.

The PCT is interested to hear from anyone who might have a prospective site.

If Reading GPs have patients who are registered with them but they then turn up to the new service with a problem and ask for further investigations to be performed e.g. smears, it may be that the PCT will be paying twice for the service; LMC asked how this will work.

The new centre will have a very large practice boundary and will have a walk in facility and must provide as many services as possible.

The original specification from the Government mentioned 3 doctors, 9 nurses and 2 receptionists but this will need to be considered by the bidders.

The PCT is finding it very difficult to get the specification right regardless of the price.

The DoH has not yet issued guidance about how to pay for the walk in element.

The PCT may go for a fixed priced contract but this will depend on how it is negotiated.

## Low Molecular Weight Heparin

The RBH have a policy that drug addicts are not warfarinised and are now asking GPs to give Low Molecular Weight Heparin (LMWH) which costs 3 times more in the community.

LMWH is also red on the traffic light system.

The PCT said that the policy had not been agreed and they would be looking into this.

**Action Point: The PCT to investigate.**

## Referral Obstacles

There are problems with the 18 week wait, patients are ringing into the RBH to book appointments and are being told there are no appointments and to ring back; this is repeated several times and they are then told to go back and see their GP.

PCT staff member dealing with C+B asked to come to the meeting and explain the rules.

The 18 week wait officially starts when the patient books an appointment, not when they phone and fail to book anything.

With referrals that are sent into the hub not using C+B, the 18 week wait starts once the letter has been stamped.

GPs felt that the RBH was game playing and asked that the PCT investigate.

**Action Point: The PCT have a meeting planned with the RBH at which this will be raised.**

**Date of Next Meeting –Thursday 10<sup>th</sup> July 2008**

The meeting closed at 3.05 pm.

Present	Name	Organisation
*	Birchall, Carol	LMC Minute Secretary
*	Brock, Nicola	Wokingham LMC
*	Buckle, David	West Berks PCT
	Cave, James	Newbury LMC
*	Foster, Nigel	West Berks PCT
*	Gallagher, Charles	Wokingham LMC
	Harris, Mark	West Berks PCT
*	Hyde, Maria	Newbury LMC
*	Lade, Jeremy	Wokingham LMC
*	McCartney, Maureen	West Berks PCT
*	Mittal, Rab	Reading LMC
*	Moneim, Tarek	Reading LMC
*	Morando, Sarah	Reading LMC
*	Naran, Kish	Reading LMC
*	O'Keefe, Hugh	West Berks PCT
	Owen, Anne	West Berks PCT
*	Roblin, Paul	LMC Chief Executive
*	Smith, Rod	Reading LMC
	Solomon, Jane	LMC Director of Development & Liaison
	Waddicor, Charles	West Berks PCT
*	Westcar, Paul	Newbury LMC
	Winfield, Cathy	West Berks PCT

Apologies: Anne Owen & Jane Solomon

In Attendance: Kath Haversham