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# Minutes of Wokingham LRC/PCT Meeting

Thursday 24th November 2005, 2pm
Ground Floor Conference Room, Wokingham Hospital
RG41 2RE

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## Minutes of Previous Meeting

The minutes of the meeting on 22nd September 2005 were agreed as a correct record.
No comments had been received from DB on the minutes.

## Enhanced Services Specifications 05/06

Action point from 22/09/05 was a referral to the Drug Addiction LES needs to be revisited.
The drug addition LES uptake was not good, it would appear that the specification needs to be re-visited.
There is an element of specialism and training needed in the service and it was agreed to re-look at this specification and price.

## PCT Reconfiguration

The SHA will soon consult on the nature of the PCT.
The re-organisation is in the newsletter and the Berkshire supplement covers the Project Board bulletin that Berkshire have just produced.
It appears that West Berkshire will be going to one management structure before merger happens.
There will be one Chief Executive, 3 Area Directors and 4 Board Directors in place by 1st January 2006.
This assumes there will be 2 PCTs in Berkshire.
The SHA consultation process will be on the 2 options for Berkshire and will be for 90 days.
No change is an option as part of the consultation.
This is running in conjunction with the appointment of the SHA Chief Executive.
It is unlikely that the PCT changes will happen until Autumn 2006.
The view is to introduce an interim solution of one organisation with the hope that this is the final solution.

## Ineffective Referrals to Secondary Care

This is poor collaborative working between LMC and PCTs.
It came to PEC Chairs 3 weeks before the last LRC meeting and did not feature at that meeting.
This is disappointing.
The PCT acknowledge it came to the LMC very late but DB felt there was a lot of discussion locally with Primary Care.
LRC members felt this was not the case.
GPs received it very late and practices did respond, but have received no receipt or feedback.
Stakeholders have discussed this and it has been discussed at TIPS and Council.
The presentation at the Clinical Governance meeting was that a solution was needed and this was what had been devised.
Concerns were discussed but it was presented as a fait accompli.
DB felt there was no objection in principle to this.
Practices felt it was an opportunity for constructive debate to improve services and avoid wastage.
This has been squandered by the lack of debate, it has come across as being imposed and could be clinically unsafe.
The guidelines are being redrafted and will come out for consultation.
The worry was at what point would the LMC have some input?
PHR reported that he had written to DB twice and received no response.
It has become apparent that the PCTs are meeting regularly in various groups and the LMC did not know the membership or the functions of the groups who were making very important decisions.
He wanted to meet with PCTs and develop an improvement in communication.
It was accepted that the PCT needed to respond to the LMC.
A document has been received from DB and in this the stakeholders holding dialogue does not include the LMC.

If a referral letter does not show the guidelines have been adhered to it will be returned to the GP.
GPs needed to know who was making this decision.
To demand confidence the person making these decisions must be competent to do so.
This function should be led by a clinician.
The GPs who were involved were those with a corporate requirement to live within budget, whilst the LMC recognise the importance of living within budget; it would also consider safety and the requirements of referring GPs would be supported.
The LMC said that they want to work with the PCT on this and other issues being evolved.

**Action Point: MN agreed to feed this back to DB.**

## Patient Rights

This was not discussed

## Eye Camera Allocations

The PCT are trying to assess whether Brookside are getting a fair share of the allocation of appointments.
The system seems to be working better but it must be equal.

## West Berkshire PCT Collaborative and LMC

There are lots of Committees, which are joint committees of the 3 PCTs working together, that have no relationship with the LMC, and whose papers and agendas are not circulated where the LMC is round the table.
Working collaboratively seems to stop any route for communication.
Opportunities are there to streamline some of the duplications within the PCTs
A parallel communication system needed to be formed to deal with this.
The minutes of meetings should be public domain documents and the LMC should be able to access them, currently it feels that there is a 'behind closed doors' organisation.
It was felt that the PCT needed to liaise with the LMC to work on rationalisation with the PCTs.

## Future of LRCs

It was felt that an East and West Berkshire LMC as opposed to a county wide Berkshire LMC would be the best format to liaise with PCTs.
It was agreed to hold a meeting with the West Berkshire PCTS as a group and PHR said he would make himself available to attend at any time suggested by the PCT.

**Action Point: MN agreed to take this back to Janet Fitzgerald and organize a meeting.**

## Receipt/Analysis of updated Spreadsheet from PCT on ES Spend 05/06

The presentation of this document is good.
The predicted underspend is a worry at £288K.
Flu will change this position.
Quite a few are around 50% underspent.
Practices submit by Chart or by paper.
With Support for Vulnerable Older Adults was being paid in advance but 4 practices have not signed up for this and this is the biggest underspend.
Any underspend is unlikely to go back to the Treasury but will probably be offset against the PCT overspend.
Elderly Health Checks seems to have taken a while to get off the ground as it has been around for 18 months now and needs to be looked at.

## QoF Reviews 05/06

They have only just started.
The paperwork is a self assessment form which should be easy to complete.
They are not combining QoF Visits with any others.

## Alcohol Misuse Provision

The Reconfiguration of the substance misuse service means there is now a deficit for the provision of alcohol misuse.
GPs used to refer to the Community Drug and Alcohol Team in Reading but they are now saying is it Reading only, and it is now drug misuse.
The local service is only dealing with drugs not alcohol.

**Action Point: The PCT agreed to look into this issue.**

## Enhanced Services

A ‘Difficult Patient’ LES has been devised along the Bracknell system.
The PEC has agreed to pay practices £520 per quarter per patient.

## Date of Next Meeting – Thursday 26th January 2006

| Present | Name | Organisation |
|---|---|---|
| | Brock Nicola | Member |
| * | Gallagher Charles | Member |
| * | Milligan Debbie | Member |
| | Shaw Matthew | Member |
| * | Roblin Paul | LMC Chief Executive |
| * | Solomon Jane | LMC Director of Development & Liaiso |
| * | Birchall Carol | LMC Minute Secretary |
| | Buckle David | WOK PCT PEC Chair |
| | Fitzgerald Janet | WOK PCT Acting Chief Executive |
| * | Naji Mike | WOK PCT |
| * | O'Keeffe Hugh | WOK PCT |

Apologies: Drs Brock, Shaw & Buckle