

Annual Report 2007/2008

BARKING & HAVERING LOCAL MEDICAL COMMITTEE

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This Annual Report focuses on the LMC's achievements, negotiations and ongoing projects with both Barking & Dagenham and Havering PCTs. This has been another busy year for the LMC covering, amongst other things, level of care at BHR Hospitals Trust, Choose & Book, Healthcare for London, Midwifery services and Extended Hours.

LMC meetings continue to be held on the first Thursday of the month which are also attended by representative members of both PCTs and BHR Hospital Trust. Separate bi-monthly meetings with the PCTs and BHR Hospitals Trust also continue to be held. The LMC also has a representative attending the monthly Havering PCT Prescribing meetings and the LMC has also introduced a Prescribing Sub-committee and hold quarterly meetings, which are attended by Belinda Krishek.

The Annual Dinner, held on the 10 October 2007, was a great success. The guest speaker at the function was Laurence Buckman, Chairman of the GPC, who gave a very interesting and instructive talk. Besides GPs and their partners, guests from both PCTs, BHR Hospitals Trust and recently retired GPs were in attendance.

The new Consultant-to-Consultant Referral Policy was developed during the year in conjunction with Havering PCT, Barking PCT and BHRT and has been distributed to all BHRT and community consultants.

Our Website, www.barkingandhaveringlmc.org.uk has gone from strength to strength, with regular updates from both PCTs and the GPC. The "GP Notice board" also includes useful information for GPs.

The following donations were made throughout the year:

£100 to The Cameron Fund

£100 to The RMB Fund

£100 to Amnesty International in memory of Dr Jim Stiff

£ 25 to Brentwood Catholic Children's Society in memory of Len Smith, Chairman of Havering PCT

£ 50 to The Sick Doctors Trust

Thanks go to our Medical Secretary, Dr Madhu Pathak, for her invaluable support throughout the year. We also thank Sue Elliott, our Administrative Secretary, and congratulations go to Suzy Iskander, our Administrative Assistant and IT Support, on the arrival of her second son.



Appraisals Barking & Dagenham

During the year 2007/08 all GPs in Barking and Dagenham underwent their annual appraisal. Once again there was complete usage of the NHS Appraisal Toolkit. Not only did this make the collation of documents easier, it also allowed appraisers to access Forms 1, 2 and 3 at the touch of a button. Once the appraisal encounter had been undertaken the Toolkit allowed appraisers to complete Form 4 and the PDP. In addition, using this technique allowed the PCT Appraisal Manager, Ekuba Edjah, to oversee the whole process.

Two innovations were introduced this year. Firstly, all appraisees were asked to undertake at least one practice audit for the year and to write a case study, appropriately referenced. Secondly, the PCT funded 360 degree appraisal using an online resource. Such appraisal allowed appraisees to demonstrate an evidence-based approach to the section on 'Relations with colleagues'. The PCT will continue to provide access to 360 degree appraisal which, once revalidation commences, will be required once every five years.

All thoughts are now turning to revalidation with its components of recertification and reaccreditation. Revalidation commences in 2009 involving a more robust annual appraisal. Appraisers are to receive additional training in order to make meaning the revalidation process.

Finally, Barking and Dagenham PCT wishes to recruit additional appraisers. All Barking and Dagenham GPs have been sent an invitation to become an appraiser. For additional information GPs should contact Dr Eric Saunderson, Medical Director, on 020 8532 6357.

Eric Saunderson, Medical Director BDPCT

Appraisals Havering

Annual appraisal is a contractual requirement for all GPs working in the NHS. It is a formative and developmental process assisting GPs to identify their learning needs on an annual basis. The main aims are to improve learning and reflective practice to improve patient care. Responsibility for the appraisal process and its compliance lies with the PCT. The appraisal process has continued to see significant improvements over the last few years. There has been continuing improvement in the quality of form 4s which has become more detailed, and personal development plans continue to contain educational objectives.

A recent review of the appraisal processes across the former PCTs in London revealed significant differences in approach. Work is underway to agree a unified approach to the appraisal process across the London NHS.

Thirteen trained appraisers within the PCT undertook a total of 139 appraisals in 2007/08. This represented 100% of those that were eligible and those that requested an appraisal.

The London Deanery attended the 2007/08 workshop in June 2007 as part of a quality assurance visit and indicated overall good compliance with best practice and suggested areas for further development with the appraisers.

A half-day mandatory training was organised by the PCT in April 2008 with the support of the Deanery and all appraisers were offered appraisal training update for advanced practitioner. Three appraisers who were unable to attend have been asked to make individual arrangements to access this training externally. As this is a mandatory requirement appraisers would only be able to participate in the appraisals for 2008/09 once they have completed this training.

All appraisals were completed in time. More and more appraisals are now being type-written. The information recorded in each domain of Form 4 is becoming more detailed and more meaningful. All GPs had completed their PDPs. All GPs gave feedback on their appraisers. Feedback was positive. Negative comments were in areas of time needed to collect and present all the evidence.

A report identifying the development needs from the appraisees' personal development plan has been forwarded to the GP Tutor to incorporate into the GP PTI sessions.

Conclusions

The Havering PCT appraisal process has seen significant improvements over the past year. Form 4s have been of better quality and feedback has been given to those that were not. There are still significant improvement that can be made, particularly in relation to peer review and 360 degree feedback. A training update has already taken place. A full discussion of the process for next year's appraisal took place at the appraisers workshop in June.

Extract from GP Appraisals End of Year Report compiled by PEC

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Choose & Book

Barking & Dagenham:-

Most GP Practices signed up to a Commissioning Incentive Scheme, which has carried on being the incentive usage for 2008/09.

Practices are aware which services are excluded from the C&B menu. All the important community services are accessible online (12 specialities) and there is ongoing work to achieve the DoH target of making every service a 'Direct Booking', i.e. access to book all appointments on line.

The latest PCT targets for C&B referrals are:

Month Ending	BDPCT	RedPCT	HavPCT	BHRT	Weekly slot problems
Aug	74%	61%	88%	59%	Average 400-
Sept	70%	62%	86%	55%	500 unavailable
Oct	72%	60%	85%	56%	slots

The percentage of bookings for all three PCTs can only improve when the main provider improves the ongoing capacity issues.

The DoH would like London Hospitals to also start implementing 2WW Specialities online, which would account for a further 8% of referrals.

Local patients have the assurance of a wide choice of community services available versus long waits of the main hospitals to fast track Spire Roding and ISTC.

Supplied by the Commissioning Office, BDPCT

Havering:-

NHS Havering are pleased to announce that they have been ranked in the top 10 PCTs in the country in relation to Choose & Book usage. Their local Choose & Book officers assist Havering patients with booking appointments in their chosen Hospital. As they have such a high utilisation of Choose & Book, it allows them to monitor GP referral patterns more closely. Maximising the Choose & Book reporting mechanisms helps them to understand the requirements within their health economy and plan future provision. They are planning to train a number of staff to become 'Super Users' which is the term given by the DoH to expert Choose & Book operatives.

Supplied by Alison Murray-Richman, Head of Service Redesign

Consultant-to-Consultant Referrals

During the year the LMC worked tirelessly with BHR Hospitals Trust to solve the problems GPs were experiencing with Consultant-to-Consultant Referrals. Dr Bland kindly agreed to get involved and produced a new strategy to help solve this problem. This was approved and signed by all four organisations involved:

CONSULTANT-TO-CONSULTANT REFERRAL POLICY

June 2008

INTRODUCTION

Over the last 12-18 months there have been several policies and much confusion on the matter of consultant-to-consultant referrals. Before this policy was finalised there was much discussion between BHR Hospitals Trust, the local Primary Care Trusts and the Local Medical Committee of GPs. The outcome of these discussions has been an agreed policy, endorsed by the chief executives of these four organisations. This document outlines the policy.

1. To eliminate needless complexity in each patient's clinical care pathway.
2. To eliminate potential for patients 'slipping through the net'.
3. To reduce unnecessary and unreasonable demands on GPs.
4. In all cases of doubt, where an exceptional situation arises that is not covered by this policy, consultants are expected, and given authority, to take whatever decision they feel is right in the patient's best interest clinically.

The policy applies to:

- All BHRT consultants and their representative junior staff, *Policies 1, 2 and 3*
- All BHRT anaesthetists and their representative junior staff, *Policy 2*

Key points of the revised policy:

- Consultant-to-consultant referrals are now allowed.
- The previous ban on consultant-to-consultant referrals is overturned.
- There is a lot of 'small print' in the policy, but this 'small print' is important and needs to be understood by all relevant parties.

POLICY 1 – INTERNAL SECONDARY REFERRALS

1. Where a patient is referred to a BHRT consultant about a particular problem, and that problem requires internal referral to another BHRT consultant, the first consultant has full authority to make that internal referral without any need to send the patient back to the GP to make the referral. Indeed the policy determines that where such internal referral is considered necessary the initial consultant should make that referral.

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This policy covers the following categories:

- i Acute GP referrals to any specialty where subsequent onward referral is considered necessary. Acute GP referrals cover the following categories: referrals to MAU for admission and referrals to MAU where admission does not result. Such onward referral by the consultant's team could be acute or elective, and the policy would apply in both cases, for example:
 - A patient attends MAU with chest pain, does not need admission but subsequent outpatient cardiology referral is considered necessary by the consultant's team; this referral should be made by the consultant's team, not by sending the patient back to the GP to do so.
 - A patient is admitted under a general physician, and upon discharge it is considered necessary to have outpatient follow up with a chest physician. This referral should be made by the general physician and not by sending the patient back to the GP to do so.
- ii Elective GP referrals to any specialty where subsequent onward referral is considered necessary.

The internal referral letter should in all cases be copied to the GP.

This policy supersedes all previous policies on this matter.

- 1.2. This policy does not cover the situation where a referred patient mentions a condition that is coincidental or irrelevant to the reason for initial referral by the GP. In such cases the patient should rightly be referred back to the GP with instructions to ask the GP's opinion regarding his/her management.
- 1.3. However, there are some important exception categories to the policy in 1.2.. These are as follows:
 - Any patient suspected of having a malignancy should be internally referred to BHRT's 2-week-wait cancer referral office. All consultants and their junior staff should be familiar with the existence and function of this office and how to refer a patient to it. Each clinical firm should have access to the 2-week referral forms.
 - Any patient whose coincidental condition is severe or otherwise clinically urgent. In such cases internal referrals can, indeed should, be made without sending the patient back to the GP to do so.

As in policy 1.1 all internal referral details or letter should be copied to the GP.

POLICY 2 – REFERRALS FROM ANAESTHETIC PRE-OP ASSESSMENTS

Where any consultant anaesthetist or his/her representative junior staff consider that a patient is not fit for operation they have authority to refer that patient directly to another BHRT consultant, e.g. cardiologist or chest physician, if they think it is necessary. They should not send the patient back to the GP to make this referral. However, they should copy the internal referral details to the GP.

POLICY 3 – TERTIARY REFERRALS

Where any BHRT consultant or his/her representative junior staff consider that a tertiary referral is necessary, the following directives apply:

- 3.1. Where acute tertiary referral is needed, the consultant should make that referral and also copy the referral details to the GP.

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- 3.2. Where sub-acute tertiary referral is needed, i.e. an inpatient waiting to go to a specialist unit, the consultant should make that referral and also copy the referral details to the GP.
- 3.3. Where an unrelated elective tertiary referral is considered necessary, the consultant should communicate with the GP in order to inform the GP and to seek his/her decision regarding the matter. The GP, in his/her capacity of commissioner and budget holder, has power of decision here. After discussion with the consultant, the usual GP options will be one of the following:
- To ask the consultant to go ahead and make the elective tertiary referral
 - To do the referral himself
 - To veto the said referral
 - To request delay in one form or another, e.g. 'wait and see'

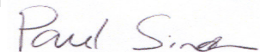
In all unrelated elective tertiary referrals the consultant has to communicate with the GP.

(Review Date: June 2009)

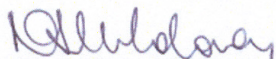
SIGNATORIES TO THIS POLICY:



.....
Ralph McCormack
Chief Executive
Havering PCT



.....
Paul Sinden
Director of Commissioning
Barking & Dagenham PCT



.....
Neill Moloney
Director of Planning & Performance
Barking, Havering & Redbridge Hospital Trust



.....
Gurdev Saini
Chairman
Barking & Havering LMC

Enhanced Services / QoF

Barking & Dagenham:

Enhanced Services

An enhanced service was introduced in 07/08 as a pilot scheme for extended opening. Practices were able to provide up to 1.5 hours of extended opening outside of core hours (8.00am – 6.30pm) per 1000 patients. There were entry criteria for this enhanced service and only those practices that were providing an agreed level of GMS services during core hours were able to participate in this scheme. This enhanced service was taken up enthusiastically by 29 practices initially and 40,601 additional appointments were offered to patients. The Barking & Dagenham Extended Hours Scheme, developed with the PCT's PEC, received much attention and praise nationally and has been used as a basis for aspects of the national DEC introduced in 2008/09.

Towards the end of the year work began on auditing all enhanced services being offered by practices currently, to ensure complete care packages are being offered to their patients. There are also plans to introduce further enhanced services in 08/09 for phlebotomy and ADHD.

The Access Survey for 07/08 showed that there was an overall improvement of 3% for the practices that were partaking in the extended hours scheme. Those not offering extended hours had an overall decrease in satisfaction by 1%. We will be reviewing the access data with practices who have not improved and those who have an overall score below the PCT average of 80%.

QoF

The average QoF score this year was 970 points. There have been no changes to the QoF indicators for 07/08. Due to the high levels of exception reporting that was highlighted in Barking and Dagenham practices, in addition to QoF visits, practices with the highest levels of exception reporting were visited by the PCT's Medical Director, and action plans were drawn up to address this.

Information supplied by BDPCT GP Contracts

Havering:

IM+T

46 practices signed up to provide this service during 2006/07. The service was extended for 2007/08 and has been further extended to 2008/09. This service requires practices to take part in the Connecting for Health programmes such as electronic transmission of prescriptions and patient data between practices (GP2GP). This includes practices achieving data accreditation for high standards of data quality in their patients' records.

Practices that did not sign up to this service initially will be offered the opportunity to provide this service as a LES during 2008/09. Five of the remaining six practices have indicated that they wish to provide this LES.

Information supplied by Havering PCT Primary Care Service

Extended Hours Barking & Dagenham PCT

1. Portfolio

The PCT piloted an extended hours scheme with local PMS and GMS practices between July 2007 and March 2008.

Building upon the success of this pilot, in 2008/09 the PCT launched a new local scheme in line with the national DES requirements but offering additional levels of opening hours up to 8am-8pm Mon/Fri and Saturday opening with no afternoon closing. The extended hours scheme in Barking and Dagenham for 08/09 now has three levels:

Level 1	DES	0.5 Hours per 1000 patients
Level 2	LES	Up to 1.5 hours per 1000 patient
Level 3	LES++	8-8 Mon-Fri + Sat AM (no afternoon closures)

The PCT has also strengthened its market management/performance management role setting entry criteria for LES Level's 2 and 3

PBC's, the PEC and LMC have been involved in both the development and evaluation of this pilot and have supported the changes.

90% of practice's in Barking and Dagenham now operate extended hours arrangements.

Obstacles have included:

- General practice workforce capacity – 'underdoctored' area
- Evening and weekend security
- Access to diagnostics
- National opposition to the changes

Four key catalysts for change:

1) Practices responding to increasing competition (new APMS practice)

In July 2006, the PCT introduced a new APMS practice with Care UK to provide general practice and walk-in centre services. The APMS contract stipulated 8am-8pm and Saturday morning opening for the General Practice.

2) Patient feedback regarding existing opening hours

Whilst the majority of Access survey respondents in 06/07 were satisfied with opening hours a large proportion of the population wanted to see more Saturday and evening clinics.

3) Review of A&E activity

Practice Based Commissioners undertook an audit review of A&E activity and identified that approximately 50% of attendances could be handled in primary care. To tackle this imbalance the PCT extended hours in general practices and extended WIC provision.

4) PCT in a healthy financial position

Barking and Dagenham PCT has received significant growth in funding for primary care services in the last 2 years bringing its funding position from 11% below capitation to the current 3.5%. In 07/08, there was significant resource for investment and £1million was set aside for the extended hours pilot scheme.

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Day 2. Impact

Impact on Practices:

- 68% of practices signed-up to provide extended hours in 2007/08
- 90% of practices signed-up to provide extended hours in 2008/09
- 252.5 additional GP hours per week now provided in 2008/09 compared with 178 in 2006/07 baseline year
- 34571 patients attended extended hours sessions in 2007/08 and 113625 are expected to use this service in 2008/09
- A small number of practices have recruited additional salaried GP's with the extended hours funding. Extended hours sessions are GP-led but a number of practices also run nurse/HCA sessions alongside.
- Local primary care clinicians have reported that they are seeing different patients during extended hours sessions and that they are pleased with the patient feedback they are getting. The LES gives them the flexibility to plan their own sessions and workforce delivering sessions at times that suit their patients and capacity. For example one practice near to central Barking station has opening early morning commuter clinics in response to patient demand.

Impact on A&E and WIC Attendances:

The PCT estimated in April 2007 that there would be an increase of +0.6% in A&E attendance in 07/08 compared with the previous year in the contract with our main acute provider (Barking, Havering and Redbridge Hospitals Trust):

	A&E Attendances	Movement from Outturn
2006/07 Outturn	58,507	
207/08 Plan	58,865	+0.6%
Month 7 Plan	34,500	
Month 7 Actual	34,222	
Month 12 Forecast	58,390	-0.2% (straight line forecast)

A recent review of A&E attendance data shows that for the period of July and October the number of attendances at A&E were significantly below plan by 5.2%, whereas previously from April to June A&E attendances exceeded the plan by 5.1%:

	A&E	Attendances		
	Plan	Actual	Var	Var%
Month 7	34,500	34,222	-278	-0.8%
Month 3	14,633	15,379	+746	+5.1%
Month 4-7	19,867	18,843	-1,024	-5.2%

There was a slight decrease in walk-in centre activity between July and September 2007 activity then increased as the PCT launched a marketing campaign advertising WIC services.

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Impact on Patient Satisfaction

In Barking and Dagenham we saw improvements in satisfaction with opening hours for those practices that were opening for longer in 07/08.

% change in satisfaction with opening hours

England -2%

Average for B&DPCT practices that were offering extended opening from July07 +2%

% reporting dissatisfaction that practices were not open on a Saturday

England -2%

Average for B&DPCT practices that were offering Saturday opening from July07 -10%

The PCT has seen a **reduction in the number of complaints** from patients regarding access to appointments. The feedback from patients has been overwhelmingly positive.

"This is an excellent step for elderly patients and patients with long-term conditions who rely on working carers to bring them along to appointments"

"The early morning clinics are very popular with commuters"

"Hopefully the funding will be there next year - we'd like to offer 7am-8pm Monday to Thursday and 7am-5pm on Friday"

"Being a teacher I can fit this in to my schedule more comfortably"

'The response to this service has been very positive and patients are pleased'

"Patients seem happy with the service and I feel that these sessions are easier to manage - I can often offer them quicker appointments"

"Grateful to Dr Arif for providing this service to the community- it would be good if it continues"

"I got a quicker appointment and am happy with the quality of service"

"Saturday mornings are a really good idea"

3. Innovation and good practice

In 2007/08 there was no national DES for extended hours arrangements. The PCT introduced this scheme as a new pilot in response to patient demand and the pressures on A&E. The PCT was not aware of any similar schemes in existence elsewhere. In December 2007 Alan Johnson, Secretary of State for Health asked for an evaluation report of the Barking and Dagenham pilot and in 2008, a national DES was launched.

4. Planning for the future

The scheme was evaluated in 2007 and rolled-out in 2008/09. The PCT has invested £900k in 07/08 and £1.5m in 08/09. A national DES scheme has also been introduced in 08/09.

The next step for the PCT to consider will be offering transition arrangements to APMS contracts for practices in suitable premises with the appropriate workforce and good patient satisfaction / health outcomes already offering 8-8/weekend opening.

Extended Hours Havering

As part of improving patient access for routine appointments, Havering PCT introduced a Local Enhanced Service pilot in January 2008. This pilot was intended to run until 30 April but was then extended until 31 May.

Under this pilot practices were able to bid for funding to provide up to an additional 1.5 hours per week per 1,000 patient list size. Any additional hours needed to be offered outside core hours of 8.00 am to 6.30 pm. This pilot was a GP led service and a minimum of 75% of all appointments had to be with a GP and the remainder, up to 25%, could be with a nurse or nurse practitioner.

Thirteen practices took part in the pilot and a patient survey of the pilot was undertaken between March and early April 2008.

The survey asked patients who were using the service if they were satisfied with the extended hours being offered and if they would like the service to continue.

Each practice was provided with 25 copies of the survey and asked to return the completed surveys to the PCT for analysis. Of the 302 surveys returned, 95.7% of patients were satisfied with the new hours and 95% indicated that they would like the service to continue.

Following national negotiation, a variation to the GMS/PMS contracts has been introduced which includes a new Directed enhanced Service (DES) for Extended Hours. Havering PCT has taken the decision to offer a more flexible approach by developing a Local Enhanced Service (LES) for Extended Hours that allows practices more flexibility when planning their extended hours provision. This LES is available from 1 June 2008 to 31 March 2010.

The intended outcome is an increase in patients' access to GPs outside current contracted hours, while standard of access and availability during the core contracted hours are maintained or improved.

Under this LES the practice provides extended hours clinical sessions on a regular basis each week outside its core contracted hours of 8.00 am – 6.30 pm Monday to Friday. These extended hours need to be in line with the two areas where patients were most dissatisfied, as reported in the National Survey. Practices can apply to provide an additional minimum of 30 minutes and up to a maximum of 45 minutes per 1000 size list.

This is a GP led service but, similar to the pilot, there is flexibility around including some nurse appointments, with the ratio of GP to nurse consultations being 75% to 25%. Practices are funded on a sessional basis with each session equating to 1½ hours. In addition an aspiration payment is paid to each practice signing up to this LES based on the practice list size at 31 March 2008.

Currently the PCT has received applications from 44 out of 52 practices to participate in this LES. To date, 42 applications have been approved, of which 37 practices have already commenced offering extended hours.

The PCT intends to undertake an evaluation of the service offered in respect of this LES.

Future Strategy Barking & Dagenham PCT

From the Board of Barking & Dagenham PCT:

This past year has been another exciting and challenging one for Barking & Dagenham PCT as we have continued to deliver ever-improving services to our local population. Many innovative plans have been implemented and we expect to see even more significant change over the next few years as a result.

The PCT's progress was recognised when the Healthcare Commission published its performance ratings for NHS organisations in October 2007, rating Barking & Dagenham in the top five in the country for 'use of resources' with the highest rating of *Excellent* – a leap from the *Fair* rating the previous year. This indicates that our financial reporting and management are of the highest standard, achieving excellent value for money for the residents.

Overall the progress on tackling health inequalities is good, although there are variations within the borough and between different communities. We are working with the London Borough of Barking & Dagenham and other local partners, through schemes such as the neighbourhood management programme and the local area agreement, to develop a variety of programmes and initiatives targeted at the individual communities in the borough.

The PCT has consistently met all the mortality targets relating to suicide rates, cancer, cardiovascular disease and infant mortality. The target associated with teenage conception rates continues to prove challenging but we are developing a tool to help health and youth workers to understand better the factors that lead young people to become young parents and continue to develop our services to make them more @young people-friendly@.

We met most of the top national priority targets by the end of the year. For example, the cancer waiting times were consistently met month-on-month and our performance relating to patient choice has been one of the strongest in London. For the first time the PCT met the smoking cessation target, due to a range of focused initiatives such as the opening of the 'For the health of it' shop in Barking Station and the implementation of mobile phone technology in GP surgeries to raise awareness of support services. These initiatives were supported by a targeted campaign to promote the stop smoking service in the borough.

The targets relating to the maximum referral-to-treatment time for patients (18 weeks) and the maximum wait in A&E Departments (4 hours from arrival to discharge or admittance) have not been met this year and we continue to work closely with the local hospital trust on both issues. We are making greater use of the local independent sector treatment centre, the independent sector diagnostic centre and the newly established clinical assessment treatment service to reduce the referral-to-treatment times. We also know that many patients attending A&E do not need to be seen by specialists in emergency medicine, but that they are unaware of, or unable to access, alternative services. Towards the end of the year we started the 'Walk this way' campaign to raise awareness of the walk-in centres in particular, supporting the earlier extending of their opening hours and to promote other alternatives such as GP services, the role of pharmacists and self-care. Last summer we established a pilot project to extend opening hours at GP surgeries to enable patients to see their GP or practice nurse in the evening and/or weekends. Three quarters of practices took part, patient feedback has been very positive and we are looking to extend this further this year.

At the same time as working towards providing more services outside hospitals, in more convenient locations, we have also been working to improve the quality of health care premises in the borough. Many primary care refurbishments and improvements took place during the year and work on two new health centres – Barking Town Centre and Porters Avenue, progressed well with both expected to open towards the end of 2008. We have also made progress with the plans for the redevelopment of the Barking Hospital site and expect to start work on the site later in the year.

As ever none of these achievements would have been possible without the commitment and loyalty of staff working for, and in partnership with, the PCT, such as our colleagues in the local authority and those working in primary care services.

Future Strategy Havering PCT

From the Directorate of Havering PCT:

The PCT is keen to develop a forum with local GPs and other key stakeholders such as the Borough Council, where strategic issues that impact on the health and social care of the community are discussed.

The first event was held at the Holiday Inn in Brentwood on the 3 June. The session covered:

- *Aligning health needs and primary care resources*
- *Quality and standards in primary care*
- *Shifting care closer to home*
- *Group work determining alternative approaches to patient care with a greater focus on care outside hospitals*

The key messages that came from this work were:

- *Primary care will need to be able to offer a critical mass of services for assessment diagnosis and treatment to handle the larger volume of care that will be undertaken outside hospital.*
- *The model of care may require fewer GPs but they will be leading larger teams of health professionals who will increasingly be working autonomously.*
- *PBC groups will start to work with colleagues in local authorities to explore the potential for service solutions that address patients' whole needs.*
- *Relationships between GPs and the PCT need to improve to support joint working, both in commissioning and service provision.*
- *PBC and PCT commissioning from BHRT would need to be far more assertive. BHRT can also play a role in shifting care closer to home and should be encouraged to provide more activity in community settings.*

A second workshop is planned for the Autumn with a tentative date of 10 September. It is intended to run the session from mid afternoon ending with early supper.

GP-Led Health Centre – Havering

The interim report of the NHS Next Stage Review gave a commitment that the NHS will establish at least 150 GP-led health centres. These centres will provide access to GP services from 8 am to 8 pm, 7 days a week. They will also need to be co-located and integrated as far as possible with other community based services, including social care.

The key features of a GP-led service are:

- *Core GP services*
- *Maximising opportunities to integrate and co-locate with other community based services, including social care*
- *Easily accessible locations*
- *Open 8 am – 8 pm, 7 days a week*
- *Bookable GP appointments and walk-in services*
- *Registered and non-registered patients*

The procurement of these services will be undertaken using the national procurement framework. The PCT is intending to advertise in late September/early October for these services. It is anticipated that contract will be signed in early 2009 with a view to services commencing in late Spring. There has been a lot of interest shown locally and many GPs have requested further information about the procurement process. The PCT therefore held a procurement information day on the 14 August.

The PCT is currently considering a range of other care models that could work well if co-located with the GP-led health centre. Areas that are currently being considered are diabetes, stroke and long-term conditions, using the Individual Care Plans as the key to managing patients effectively. The PCT is also keen to develop a robust approach to health and well being for the residents of Havering.

A new APMS General Practice

In addition to creating the GP-led practices there was a commitment that the NHS will establish at least 100 new GP practices in areas with the greatest needs. On 23 November Ministers announced the list of 38 PCTs that will receive additional funding to procure these new services. Havering PCT has been fortunate to secure additional funding for a new general practice that will increase the number of GPs available to Havering residents. It is intended that this practice will be located in the Harold Wood area. The procurement for this practice will be undertaken via national procurement and run in conjunction with the GP-led procurement. The key factors of the new practice will be:

- *Core GP services – full range of NES, DES, LES*
- *Maximising opportunities to integrate and co-locate with other community-based services, including social care*
- *Easily accessible locations*
- *Open 8 am – 8 pm, 7 days a week*
- *Bookable GP appointments and walk-in services*
- *Registered and non-registered patients*

PCTs will be encouraged to maximise innovation by integrating and co-locating health centres with other services and locally the PCT will be designing services that respond to the local need of the residents of the Borough.

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BARKING & HAVERING LOCAL MEDICAL COMMITTEE

Mentoring Update September 2007 – August 2008

Aim

The aim was to see the uptake of Mentoring in Barking, Dagenham and Havering and to ensure a team of trained mentors was in place.

Objective

To ensure Mentoring was available for all GPs in Barking, Dagenham and Havering.

Discussion took place with both PCTs and it was agreed that Mentoring was a good idea. Funding was secured from both PCTs and Cygnus Mentoring and Professional Development provided training.

Fourteen GPs showed an interest in becoming Mentors and attended four training sessions, all run by Cygnus. After these sessions it was felt by Cygnus that all fourteen GPs were ready to mentor their colleagues.

Cygnus Mentoring & Professional Development, a training company specialising in mentoring, ran a full-day training session on Saturday 7 July 2007 and a half-day session on 26 September 2007, after which it was agreed that the mentors were ready to see local colleagues. A letter was sent to all GPs informing them of the service that was now available. A further half-day session took place on Tuesday 18 December 2007.

Evening meetings were also held so that mentors could discuss and build on what they had learnt.

Procedure

The LMC is responsible for the day-to-day management of the project so the GP will not hesitate to use the service. A GP who identifies the need for a mentor telephones the office and speaks to the Admin. Secretary, who then sends them a list of the Mentors, following which the GP contacts the mentor direct or the office asks the mentor to contact the GP.

Uptake of Mentoring

<i>Total number of mentors</i>	<i>14</i>
<i>Total number of mentees seen</i>	<i>23</i>
<i>Total number of sessions undertaken</i>	<i>34</i>

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Mentoring Update.....Page 2

The mentors' and mentees' experience of the issues discussed during mentoring, of which we are aware, has been in supporting professionals during time of transition:

*Joining a new partnership
Developing a new role in the partnership
Being involved in more specialist work
Running professional life as a non-principal
Taking on management roles
Mid-career (where do I go from here?)
Coming up to retirement*

Mentoring is not aimed at doctors not coping with their practice work but can be helpful in sorting our specific issues before they become a problem:

*Partnership issues such as communication and integration
Getting life-work balance
New horizons in mid-career*

Conclusion

As funding has been secured for two years, a further two half-day sessions will be held during the coming year to update and refresh the mentors. This will also give them the opportunity of discussing any problems with the trainers.

End of Year Report from the LMC Office

Paperlight Accreditation Process

Barking & Dagenham:

This process is for practices that only use EPR to record information during consultation (all Clinicians in the surgery) and have stopped using manual notes altogether.

Barking & Dagenham PCT has set guidelines, which the LMC has agreed, and they can now give accreditation should they fulfill the requirements within it.

The Good Practice Guideline document is the bible for EPR and covers everything that the practices and the PCT needs to know about EPR, in particular point 6.2 on Shredding. The PCT gives the following advice to surgeries:

The surgery needs to keep the documents until they have a validated back-up that includes the scanned document. This means that documents are kept for up to one year/six months depending on the validation cycle. However, for those with a managed service the PCT does not have clear guidelines but suggests that three months seems reasonable.

Rashid Aleem, I M & T Facilitator

Havering PCT:

Havering PCT do not have a written policy. However the Good Practice Guidelines for electronic records includes guidance on retaining paper records once scanned.

The recommendation is to keep all scanned documents until a back-up which includes the scanned document has been validated by the system supplier. Therefore practices who have an annual validation, documents should be retained for up to one year.

The PCT recommends practices should retain documents for three months if they have a managed server.

Shirley Case, GP Contract Performance Manager

A copy of the Good Practice Guidelines can be viewed on the LMC Website

Practice Based Commissioning Barking & Dagenham

41 out of 43 practices are signed up to PBC and are working together in three clusters. The PCT was part of the Improvement Foundation wave 1 Collaborative for PBC in 2006/7 and has continued to build on the learning from this programme. A new PCT management structure was put in place to support PBC in January 2007 and this report reflects on the progress that has been made by practices and the PCT in developing PBC for the financial year 2007/08.

Finance and Information

Practices were issued with PBC budgets in May 2007 that covered Payment by Results activity for elective, outpatient, non-elective and A&E attendances. PBC budgets also include some other primary care services which have influenced a reduction of activity in secondary care, i.e. Anticoagulation Services, Unique Care and the Clinical Assessment and Treatment Services. Each practice was issued with a budget statement that detailed their PBC budget and also set out an indicative budget for services that the PCT continued to commission on practices' behalf.

The PCT provides patient-level activity information to practices for patients registered with them for the purposes of analysis, validation, audit and checking that billing is appropriate. A process has been put in place for the validation of data.

The supply of monthly PBC financial and activity reports to practices has been problematic. The accuracy of monthly activity reports was undermined by concerns about data quality and by underperformance on the BHRT Service Level Agreement. As a consequence the PCT was unable to provide monthly financial and activity reports to practices. It has been agreed that in 2008/09 activity and financial reports will be issued quarterly following the freeze date.

Incentive Schemes

The PCT offered a PBC incentive scheme ("Commissioning Incentive Scheme") to all practices in 2007/08. This replaced the Direct Enhanced Service for PBC and the Prescribing Incentive Scheme, which had been administered in previous years.

The CIS rewarded practices for undertaking a range of activities that supported the PBC Clusters in achieving their overall goals for reducing inappropriate hospital admissions, developing primary care Clinical Assessment and Treatment Services and supporting cost-effective prescribing.

42 practices signed up to the scheme. Evaluation of the scheme was completed in June 2008.

The Direct Enhanced Service for Choose & Book was continued into 2007/08 and 42 practices signed up to the scheme. Utilisation of the Choose & Book system by practices has continued to increase and reached 93% for first outpatient appointments in April 2008.

Governance

The development of PBC is overseen by the PBC Steering Group, which meets monthly and reports to PEC.

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BARKING & HAVERING LOCAL MEDICAL COMMITTEE

Practice Base Commissioning – Barking and Dagenham.....Page 2

The PBC Clusters and PCT have agreed to a Memorandum of Agreement that set out the responsibilities of the clusters and the PCT in the management of PBC, including budget management and PBC business plans.

Each cluster has developed an inter-practice agreement setting out risk sharing arrangements and their policy on sharing of savings.

A process has been agreed for the approval of PBC business cases through a Part 2 meeting of the LDP/Operating Plan Group. Arbitration arrangements have been set out in accordance with the pan-London policy.

Support to Practices

PBC Managers attend all three PBC Cluster meetings. All practices have been offered a quarterly visit with their PBC Manager at the PCT to review their activity data and achievement if CIS targets. 22 visits were made by PBC Managers during 2007/08.

In addition to the management support provided by the PCT, Clusters were also invited to bid for additional funding to develop the cluster PBC infrastructure. Proposals were accepted for additional clinical and management support for business plan development and support to practices with data validation.

Information and guidance on PBC has also been delivered through the Protected Time Initiative (PTI). The July PTI provided a number of table-top sessions on PBC supported by the Clusters and PCT. The Practice Managers Forum has recently been reinstated and the first meeting of the new group was held on 1st April 2008.

The Improvement Foundation has supported three development sessions over the past 12 months. These have covered a number of areas including Out of Hospital developments, developing PBC plans and implementation of the diabetes strategy.

The PCT has performed above average in the national survey of general practices on the implement of PBC. The survey was intended to give practices a voice on PBC implementation and the support provided by their PCT.

PBC Commissioned Services 2007/08

PBC Clusters agreed joint commissioning intentions for three areas of service redesign:

Anticoagulation Service – *A specification was agreed with BHRT to ensure continuity of care across primary and secondary care. Quality standards were agreed for training and accreditation, near patient testing equipment, computer dosage software system and quality assurance. The PCT contracted with two primary care providers to deliver a primary care based service in January 2007. In the period April 2007 to March 2008 the primary care service had registered 430 patients and transferred 3663 attendances from secondary care.*

Unique Care – *Unique Care is a flexible approach to practice based management of older patients in the community who are at risk of a hospital admission. The key factor is to bring together Social Services and Health Care in order to jointly respond to the needs of patients and to avoid a hospital admission.*

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Practice Base Commissioning – Barking and Dagenham.....Page 3

Twelve practices signed up to the pilot scheme and four social workers were recruited by the Local Authority, funded through a Section 256 agreement with the PCT. Although funding was identified for three community matrons, the posts were not recruited to and some nursing support was provided from the existing workforce. This restricted the ability of the practice teams to fully develop the practice model. Community matrons have now been recruited. A review of the scheme with stakeholders took place on 8 May in order to inform the roll out of the scheme to another twelve practices in 2008/09.

Clinical Assessment and Treatment Services (CATS) – *A specification was drawn up for the provision of CATS for dermatology, gynaecology, ENT, headache, urology and minor surgery services to be provided from Broad Street Resource Centre. The new specifications addressed waiting time requirements and areas of dissatisfaction expressed by patients about outpatients services at BHRT.*

The PCT advertised for willing providers to submit proposals. Care UK was awarded a contract for the delivery of dermatology, gynaecology, ENT, headache and urology services. Gynaecology and dermatology services commenced in January 2008 and ENT, headache and urology services commenced in May 2008.

The preferred provider for minor surgery CATS withdrew from contract negotiations in February and the PCT is in discussion with two other providers for the supply of this service.

PBC Plans for 2008/09

Business plans have been approved for development of a community diabetes service and expansion of the pulmonary rehabilitation service and oxygen assessment service. The implementation of these services is being overseen by the Local Implementation Teams.

Funding has been identified to extend the Unique Care service to another 12 practices, which will increase the coverage of the service to 50% of practices.

Increased activity for CATS has been funded to enable full roll out of the services in 2008/09.

Sharon Morrow, Asst Director of Practice Base Commissioning

Practice Based Commissioning Havering

In 2007/08 a number of outpatient services were approved for implementation following assessment and approval by the PBC Review Panel. Contracts for these services, which include Ophthalmology, ENT, Orthopaedics, Gynaecology, Dermatology and Rheumatology services have been extended to March 2009, under the willing provider model, to allow for full evaluation and tendering where appropriate.

All clusters have submitted revised commissioning plans for 2008/09, which have been reviewed and approved by PEC. From the information provided it is evident that in addition to supporting the seven key priorities identified within the PCT's Commissioning Strategy Plan for 2008/09, a number of clusters have identified similar priorities which include exploring options for new services in Dermatology, Ophthalmology, Pathology, COPD, diabetes, Sigmoidoscopy, Pain Management, Counselling and Neurology.

The outturn position for 2007/08 identified an under-spend in 26 of the 52 practices against the combined budgets devolved to practice based commissioners (the acute and prescribing budgets). The ability to use these feed up resources innovatively for the benefit of patients is a fundamental element of PBC. Under the terms of the DoH guidance, and in accordance with local agreement, the 26 practices will be able to retain 70% of their under-spend as savings to be reinvested in patient care. These practices are now in the process of developing proposals for the utilisation of their savings, which are subject to agreement by the Review Panel and which must fall within the criteria established and agreed through the PBC Steering Group.

For 2008/09 budget setting the DoH released a revised Fair Share formula for the allocation of all acute service budgets. Following discussion with the Cluster Leads it was agreed to use this formula in establishing the 2008/09 PBC budgets with a (+/-) 2.5% movement capping. This will result in a small residual value which practices will be able to draw on subject to approval through the PBC Steering Group. A criteria and procedure for application to draw on the residual value is currently under development.

Debbie Baronti, Interim Associate Director of Primary Care

Prescribing Committee Havering

There has been a considerable amount of work completed by the Medicines Management Team during 2007/08, which has been shaped by the impact of both the Havering Prescribing Committee (HPC) and the LMC Prescribing Sub-Committee (LMC PSC). The introduction of the LMC PSC has led to greater GP input and interaction between the LMC and the Medicines Management (MM) Team. This has led to sharing of ideas and creative problem solving. The information below explains how the two Committees have worked together to ensure seamless decision-making in Prescribing and Medicine Management for GPs in Havering.

Frequency of meetings – *The HPC meets monthly and has an LMC representative. The LMC Prescribing Sub-Committee meets quarterly, or more often if required.*

QoF MM 2008/09 – *Following on from the success of the QoF MM 2007/08 the HPC agreed to a proposal of a new individually negotiable practice based QoF for MM. The LMC PSC agreed this in February 2008 and was ready for much earlier implementation than in previous years. The majority of practices had received a prescribing advisors visit by the end of June 2008. All practices had their QoF MM set by August 2008.*

Prescribing Projects – *There has been an ongoing focus on the use of antibiotics in Havering. The top 10 highest prescribers of antibiotics were visited HPC continues to monitor this area of prescribing on a quarterly basis. The antibiotic formulary is being updated and has been shared with HPC and the LMC PSC. All comments have been fed back to the working group.*

Other areas the HPC continues to monitor and make decisions on includes SIP Feeds, wound dressings, the diabetes care pathway and the new Warfarin service.

Interface Working – *The HPC receives a monthly report on both the BHRT and NELMHT Drug and Therapeutics Committees (DTC). There has been much discussion on the implementation of shared care guidelines. This had led to the agreement with the LMC to implement new shared care guidelines as an LES. The first of these will be for hormone implants, which is currently being finalised.*

Epipen Prescribing Policy – *The LMC PSC asked for some guidelines on the prescribing of Epipens. Guidelines were produced by the MM Team and discussed at the HPC. The finalised version was agreed at both Committees and shared with BHRT DTC. GPs were sent the agreed guidelines.*

Home Oxygen Service – *After discussions at the HPC, Dr Ahkye has agreed to provide an educational session on the oxygen assessment service at a forthcoming PTI.*

NICE Implementation – *The HPC agreed that the simplest way to ensure the implementation of NICE TAGs involving prescribing was to send a quarterly tick box form to all GP practices. Further education was offered, either at an individual practice level or through one of the Prescribing Forums. This approach was agreed at the LMC PSC.*

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Prescribing Committee Havering.....Page 2

NPSA – The HPC receive regular updates and make decisions on the implementation of NPSA Alerts and Rapid Responses. Areas that impact on GP Practices were discussed with the LMC PSC and agreement reached as to how to progress implementation. For example, the NPSA alert for Injectable medication requires an audit to identify high-risk injectables. The HPC had agreed that all GPs should be asked to provide a list of injectable medications that they administer in their practice so that the risk could be assessed by the MM Team. The LMC PSC agreed this action and the information was sent to all GPs. For the NPSA rapid response on Oral Anti-Cancer medications, agreement was reached by the LM PSC to contact a small number of practices to provide information on who initiated the medication, what the indication is, whether sufficient guidance was given when making the decision to take on the responsibility for prescribing, the dose and the length of treatment. Once this information has been obtained the MM Team will put together guidance, which would then be agreed at the HPC and LMC.

Appliances – An issue was raised by the LMC PSC around the supply of appliances by companies directly to patients where GPs are then asked to provide prescriptions. The companies see the nurses in BHRT, who order the products, and the company are then told to get a prescription from the GP. Therefore BHRT were contacted to find out what the procedure is for these patients on discharge to determine the next step to take.

Prescribing Budget – The Medicines Management Department has to do cost saving exercises for prescribing year on year to ensure that the Prescribing Budget is not overspent and to try to make savings wherever possible. Each area for savings has been discussed at both the HPC and LMC PSC. There was an agreement to focus on four areas that are not controversial and would save money this year:

1. Fosamax to Alendronic Acid (switch to generic)
2. Co-codamol Capsules to Tablets
3. Inergy tablets to Ezetimibe + Simvastatin
4. Ramipril tablets to capsules

These have been shared with all GPs through practice visits and PBC cluster meetings.

Belinda Krishek, Joint Head of Medicines Management

Acknowledgement

I would like to welcome the many new GPs who have moved into Barking, Dagenham and Havering during the last year and wish them well for the future.

Thank you to our colleagues from both Barking & Dagenham PCT and Havering PCT for working well with us throughout the year, and for their contribution to our Annual Report.

Dr H Ahmad resigned from the LMC in January due to pressure of work and I would like to thank him for all his assistance whilst a member, and welcome to the Committee Dr Kanika Rai from Barking & Dagenham and Dr Sarita Symon from Havering.

2007/2008 proved to be a busy and constructive year for the LMC and I thank all Members for giving up their valuable time to attend to LMC business and for all the support I have received from them throughout the year.



.....
Dr Gurdev Saini, Chairman 2007-2009

Annual Report 2007/2008

BARKING & HAVERING LOCAL MEDICAL COMMITTEE

List of Members 2008

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Dr S Symon

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BARKING & HAVERING LOCAL MEDICAL COMMITTEE

BARKING & HAVERING LOCAL MEDICAL COMMITTEE INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31st MARCH 2008

	2008 £	2008 £	2007 £	2007 £
Income:				
Members subscriptions from levy	107,946		87,728	
Members subscriptions paid in advance	(7,597)	100,349	14,089	96,817
Doctors contribution for dinner	1,952		3,320	
Receipts from Drug Companies	7,720		1,100	
Bank Interest	511		539	
HM Revenue & Customs internet filing rebate	150	10,333	150	5,109
		110,682		101,926
Expenditure:				
Medical Secretary Salary	56,064		51,356	
National Insurance	6,508	62,572	5,928	57,284
Admin Secretary Salary	23,855		22,692	
National Insurance	2,385		2,259	
Admin Assistant Salary	10,154		9,471	
National Insurance	632		567	
Maternity Leave Cover	-		2,401	
Maternity Leave pay claim from HM Revenue & Customs	(1,015)		(3,308)	
HM Revenue & Customs PAYE (refund) payment	(40)	35,971	(911)	33,171
Postage and Stationery	1,094		1,129	
Mobile telephone	384		315	
Office Equipment	61		103	
Training meetings	170		-	
Conference Dinner BMA	-		158	
LMC Annual Dinner	6,825		5,501	
Locum Cover for attendance at Conference:				
- Dr Aggarwal			700	
- Dr Mittal			1,340	
- Dr Bland	773		-	
- Dr Barbosa	490		-	
Contributions to charity	375		150	
Catering for meetings	440		370	
Accountancy Fees	787		764	
Payroll fees	487		470	
Bank Charges and Interest	114		124	
General Expenses	139		230	
Internet design	-	12,139	117	11,471
		110,682		101,926
NET SURPLUS/(DEFICIT) FOR THE YEAR		0		0



*This Annual Report is prepared as required by paragraph 5 of the
Constitution of the Barking and Havering Local Medical Committee*

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