Private and Confidential

BARKING AND HAVERING LOCAL MEDICAL COMMITTEE

M I N U T E S Part Two of the 238th LMC Meeting held in the Committee room, Administration Block, St. George's Hospital, Hornchurch, on 05 JULY 2007

A n O p e n M e e t i n g

PRESENT:

Dr G Saini (Chairman)
Dr M Rahman (Vice Chairman)
Dr T Bland (Treasurer)
Drs H Ahmad, G Barclay, A Deshpande, V Goriparthi, A Jabbar, A K Jawad, J John, R Kalra, A Mittal, J O'Moore, A Patel, P Patel, S Pervez, S Poolo, I Quigley, O M Sanomi, S Subramaniam, I Sudha, N P S Teotia
Non-principals: Drs S De, S C Hora, R Kumar
Madhu Pathak (Medical Secretary)
Sue Elliott (Admin. Secretary)
Suzy Iskander (Admin Asst./IT Support)

Robert Evans, Associate Medical Director Primary Care, HPCT
Paul Sinden, Director of Commissioning, B&D PCT
Eric Saunderson, Medical Director, B&D PCT
Steve Rubery, Director of Emergency Care/Hospital Director, Queens
Peter Blessington, FHS Services for NELSHA
Lisa Browne, FHS Services for NELSHA

APOLOGIES FOR ABSENCE:

Hilary Ayerst, Chief Executive, B&D PCT
Ralph McCormack, Chief Executive, HPCT
Simon East, Director of Finance, Performance & Commissioning, HPCT
Drs A Adedeji, J Barbosa, C Claoue, B Dixit

6. MINUTES: The Minutes of the Meeting held on 05 July 2007 were approved and signed as a true record of the meeting after correction to page 1: Enhanced Services, 2nd paragraph, line 2: "…….submitted *within* 4 weeks……..

7. MATTERS ARISING

Meetings with BHRT

The next meeting has been postponed until the 25 July. Dr Bland, Dr Kumar and Dr Saini have agreed to attend.

Enhanced Services

Havering – All the letters have been sent out. In a meeting with the LMC secretary Robert Evans shared the cost of the payments for last year's DES AND INFORMATION HAS BEEN CIRCULATED TO ALL MEMBERS.

B&D – Dr Mittal stated that in the last meeting Jemma Gilbert said that clinics offering phlebotomy will not affect practices but it has not yet been offered.

Paul Sinden said there is a proposal going forward at the next Primary Care Contracting meeting. Paul gave the following breakdown of funds for 2006-07:
PBC £258,000
C&B £113,000
IM&T £ 49,000

Dr Saini asked if Paul could let us know which parts have not yet been paid and Paul said that C&B would not have been paid.

Anti-coagulation

B&D – Paul Sinden said that in the last meeting it was asked if there could be a clinic in the Marks Gate area. There are two options:

1. The PCT can ask an existing provider to change their venue.
2. The PCT could ask a new provider to go through a bidding process.

Havering – Robert Evans said that he had received formal notification from BHRT that the way the service is currently provided cannot be done by them. They have given the statutory six months' notice and the PCT is considering options for the future of this service.

Choose and Book

Havering – Dr Bland said that sometimes when referrals are made through CAS, those referrals are diverted to the musculoskeletal service although the original referral was to orthopaedics. What is happening in some cases is that the PCT based musculoskeletal service is assessing the patient and after a period of physiotherapy they are deciding that an onward referral is required and is passing the patient back to the GP. Our concern is twofold. The first is patient care, when the patient is sent for a consultant's opinion and after a few months it is decided that a consultant's opinion is required. In real terms there has been a significant delay. Secondly, clinical responsibility; If something goes wrong someone has to be held accountable and the concern is that the clinical responsibility may fall on to the GP. Our request to HPCT is could they provide us with a list of doctors, by speciality, who assess referrals made via CAS so that if an individual GP has questions about a referral that has been diverted he has a named clinical colleague whom he can approach or does the Medical Director assume clinical responsibility for any referral that is diverted by CAS because If there is nothing to fear there is no reason why the Medical Director would want to avoid this responsibility.

Clarification needs to be given by the PCT in writing.

Robert Evans said the LMC has already been told that the PCT takes responsibility. Assessing referrals – there is no problem in making this information available. A meeting of the LMC and someone from the musculoskeletal service would be welcome to clear up some of the issues.

Dr Saini said that if the GP has referred the patient to orthopaedic surgery which has been directed to the musculoskeletal service and things do not go the right way and the outcome is not exactly what is required, it is for that service to refer the patient to what the GP thought was right in the beginning. If the GP wants musculoskeletal service they will direct the patient to them but if he writes to an orthopaedic consultant it should be directed to him.

Dr Bland thought It is more of a clinical governance point of view that the Medical Director takes responsibility so that patient welfare is safeguarded by having a doctor responsible for their care between GP and consultant.

Dr Sudha said it should be made clear to the consultant that the patient has already lost six months since the original referral. Steve Rubery stated that all referrals to orthopaedic surgeons are dealt with by their clinical urgency and not how long ago they were referred.

Robert Evans acknowledged the LMC's concerns and will report back to us.

B&D – Dr Hora stated that CAS sees patients within 7 days. If the patient cannot be treated through a community referral CAS refers the patient to a hospital specialist. So far there have been no complaints and GPs are happy with the service.

Practice Based Commissioning

Havering – Robert Evans will send the LMC a document regarding appropriate referral to plastic surgery. The PCT has made progress in terms of how cluster leads will be reimbursed and what level of support will be available to practices. An internal review is being done and hopefully there will be some positive feedback next week.

Dr Mittal asked why another 0.5% top slice is required. Robert Evans stated there is no top slicing of the national budget at all now. A further proposal has been received which Robert thinks will give a way forward.

B&D – there are 12 pilot sites for unique care. There is still some concern about the time GPs will have to put into this scheme. At this point in time the PCT has not put any resources into the pilot for GPs' time and agreement has to be reached on how it will impact on GP time. Dr Mittal said that only committed GPs should apply. Paul Sinden said that obviously the PCT want this to go ahead so do not want it to fall at the last hurdle.

Counselling

Havering - Robert Evans confirmed that Sannibel is taking new referrals whilst trying to clear the backlog.

B&D – The PCT thinks it is time to retender the counselling service and will be asking Dr Kumar to find out what patients are getting from it and what they need. Patients are being asked to donate and are afraid they will be asked to donate at every session. Dr Saini said patients should be told they may be asked for a donation rather than finding out at the last minute. Paul Sinden said it has been made clear that it is inappropriate to ask for donations.

Professor Darzi's Model of Health Services for London

Eric Saunderson said that polyclinics are in a very rudimentary stage at the moment. Prof. Darzi's final report is not yet published so it is not known exactly what it will mean. It is actually a 20-year programme for the future of healthcare. Prof. Darzi is going to propose his Health Maintenance Organisation model, e.g. smaller hospitals, larger primary care units.

8. LIST CLEANSING EXERCISE

Peter Blessington and Lisa Browne from FHS attended the meeting. They explained that the PCTs in the North East London sector are commissioning the FHS Consortium to undertake a comprehensive sector wide list validation exercise. Peter and Lisa explained the background to this and the context of the paper, which had been circulated to the LMC. It was made clear that this should not be viewed as a purely financial exercise but the PCTs are keen to ensure that the quality of the registration data is as accurate as possible given the links to so many other developments within primary care.

FHS explained that list validation can be undertaken at any time and in a number of ways but the outcome is likely to be more successful if practices are engaged in the process. LMC endorsement of the process would be a critical step in securing support from practices. Active participation from practices would also minimise the risk of genuine patients being removed from practice lists although FHS did confirm that should this happen back credits would be payable providing supporting evidence can be provided.

Adopting a cooperative approach would enable the validation exercise to be focused and refined and would avoid the need to write to all registered patients.
The preferred methodology for validation was outlined, the key components being;

- Practices to supply details of patients who have not attended surgery in previous 12 months
- FHS will write to these seeking confirmation of continued registration
- Non-responders after 2 letters will be referred to the practice with a request that further information about attendance in the previous 3 years be provided.
- Once a list of residual query registrations has been established FHS will work with practices to identify those who are no longer considered live patients using a truncated FP69 process. Those practices not wishing to sign up to this would have the FP69 process as a default but FHS would not be able to offer support in those circumstances to manage queries.

Dr A Patel said that if the FHS remove patients who do not reply the practice population will be skewed to those who are more demanding and practices are supposed to have a mix of patients. Peter Blessington said that the FHS would not automatically remove non-responders, they would go back to the practice and say they have not responded and ask if the practice has information as to where these patients are. Dr A Patel asked where is the support for the staff who will have to do this work? Peter Blessington said the FHS would firstly be asking the practice to put it through their computer system, which does not incur support. He has been assured that the information required is easy to get from the practice system. The FHS would first of all focus on the patients whose registration with the practice is questionable. The FHS will then put its own people out to work with the practice to identify whether these patients are still there. There is a risk of removing people who are live patients and if it can be demonstrated that they have been removed inappropriately they will be reinstated.

Dr Saini stated that it is a documented fact that a practice will see a patient every 3 years. If the FHS say they will provide the resource to deal with this that is fine, but if you say you will come and work with practice staff, this will not work. If there is 10% of the population who are not being seen the practices have to provide evidence that this person is still a patient. Peter Blessington said that this is being carried out with the support of all 7 NEL PCTs. The FHS would prefer to carry this out with the cooperation of the practices as their information can refine the procedure. FP69s for patients would make a huge amount of work. Peter cannot commit any other resources to provide additional staff time because he does not have any resources to give, however, the workload associated with the FHS proposal would be considerably less than having to deal with potentially hundreds of FP69s and practices need to consider this balance.

Dr John said that in his practice he has a huge population of immigrants who do not speak or read English who would not respond. Who is going to deal with that? The cleansing exercise needs to have some sort of consultation on what is needed for this exercise to be done.

Peter Blessington stated that what is going to supplement this paper, which is almost ready to be issued, is a series of procedures the FHS will follow and this will have in it samples of the letters the FHS will be sending out for different types of queries we would wish to make. There is a steering group working with the FHS consortium and we have used that to decide the best way to do this.

Paul Sinden said he would take this back to the PCT's Primary Care Contracting Group.

Robert Evans stated that not just in London but also across the country there is evidence that this list cleansing is an absolute necessity. What is being picked up is all the negatives and the problems and issues, lets work together to find the best way of doing it.

Dr Saini said that this needs to be properly discussed. Lisa Browne said there would be a list cleansing sub-group and this is where the LMCs can be involved. Dr Teotia felt that the public should be made aware that this exercise is going to be done in general practice. It should be well advertised to help the patients to answer the questions and send the letters back.

Peter Blessington said that this meeting is the starting point of these discussions and recognises that if the LMC endorses this there will be a much more reasonable way to getting this work done. If the LMC goes to the GPC the advice would probably be that there is no obligation to cooperate with the FHS, which is why this would be far better achieved with cooperation. The FHS will go through the process in any case and will get the job done but it will not be as effective a process as we would want. Peter Blessington said it would be better for practices to do this with us than have it done to them as they will have more control over the outcome. He will take our comments back.

There was also a comment suggesting that there may be medico legal implications for FHS of removing patients in this way and Peter Blessington said that there are unlikely to be any medico legal implications for FHS as patients would either be removed through a truncated process agreed with practices or through the FP 69 process which is already enshrined in regulations.

There was recognition from the LMC that list validation needs to be undertaken and Dr Saini said that the FHS now has the views of the LMC regarding process, which should be taken to the next steering group.

9. ANY OTHER BUSINESS

Practice Advertisement in CaretoSay

Dr Barclay stated that this is an advertisement for Broad Street Practice and he is wondering if the PCT will allow every practice to advertise for patients in the same brochure. There is enough evidence to show that patients are being asked to switch doctors when they visit the Walk-in Centre. It is unethical and also a GMC matter. Paul Sinden said the PCT will definitely take up the second point for informal review. If there is any evidence he would be grateful if this could be forwarded to him. It would be more explainable if it was just for the Walk-in Centre and he will make sure nothing like this happens again.

Dr Barclay said that if the PCT is having quarterly meetings with Care UK it is unfair and the PCT should invite all practices to the meetings, or not have the meetings.

10. DATE OF NEXT.MEETING: There being no further business for discussion**,** the Meeting closed at 4.00 p.m. Members agreed that the next Meeting will take place on 02 August 2007.

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Chairman

ANY QUERIES OR MATTERS ARISING FROM THESE MINUTES SHOULD BE DISCUSSED WITH THE LMC OFFICE