

## **BARKING AND HAVERING LOCAL MEDICAL COMMITTEE**

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

<p><b>MINUTES</b> Part Two of the 219th LMC Meeting held in the Committee room, Administration Block, St. George's Hospital, Hornchurch, on 06 October 2005 <i>An OPEN Meeting</i></p>
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**PRESENT:** Dr A Mittal (Chairman)  
Dr A Aggarwal (Vice-Chairman)  
Dr M Roy (Treasurer)  
Drs H Ahmad, G Barclay, T Bland, J Kakad, GS Kalkat, RS Kalra, P Patel,  
S Poolo, P Prasad, S Subramaniam  
Non-principal: S De

**ALSO PRESENT:** Hilary Ayerst, Chief Executive, B&D PCT  
Ralph McCormack, Chief Executive, HPCT  
Robert Evans, Director of Special Projects, HPCT  
Eric Saunderson, Joint Medical Director, B&D PCT  
Madhu Pathak (Medical Secretary)  
Sue Elliott (Admin. Secretary)  
Suzy Iskander (Admin Assist/IT Support)

**APOLOGIES FOR ABSENCE:**  
Neil Smillie, Director Primary Care, HPCT  
J A Barbosa, A Deshpande, B Dixit, A Jabbar, J O'Moore, A Patel,  
M M Rahman, N Rao, G Saini, N P S Teotia

**35. MINUTES:** The Minutes of the Meeting held on 01 September 2005 were approved and signed as a true record of the meeting.

**36. MATTERS ARISING OUT OF THE MINUTES**

Enhanced Services: Dr Mittal stated that Simon James was dealing with this on behalf of the PCT.

Occupational Health: A letter was sent to the LMC by Jo Hagley, Associate Director of HR, stating that HPCT selected two practices for interview, based on their experience, to provide this service. HPCT have selected Dr Feldman's practice to provide Occupational Health as he has more experience. He has been running a similar service for several years. When available, details will be put on the LMC website.

Ralph McCormack advised that this was initially a joint PCT project as the original idea was that we got a mixture of Havering and B&D GPs, but as discussions were not finalised, Havering PCT decided to go ahead on its own. Dr Pathak confirmed that the invitation to tender had originally gone to all GPs in the district.

Anonymous Complaints: The LMC had discussions with Eric Saunderson after he submitted the original document and Eric has since submitted amendments for further discussion. After

discussions with various organisations, Eric Saunderson made further revisions and the document again went back to the LMC. It has been designed to look at anonymous complaints of a serious nature.

Dr Barclay congratulated Eric on a very ably produced paper and said that in the LMC closed meeting it was agreed and accepted.

Ralph McCormack stated that HPCT had been given the opportunity to look at this document. John Harvey, Theresa Berry and Dr Mannakkara have seen the document and all agree it is a sensible thing for Havering to adopt. Therefore it will be accepted as an HPCT policy.

Level of Care Oldchurch Hospital: Dr Mittal stated that Neil Smillie had suggested the LMC attend the next BHRT/HPCT link meeting. LMC Members have rejected this and suggest the LMC take it to consultants for discussion. This decision was accepted by Ralph McCormack.

Clinical Assessment Service: Robert Evans stated that HPCT has agreed to work with the CAS Office to ensure that any referrals come back to HPCT, not to GPs.

Dr De said the protocol started with the assumption that patients would have a central point of contact and feedback for appointments was a couple of weeks. So far, from the feedback he has received, the patients are kept waiting for several weeks with no further knowledge of when their appointment will be. Patients kept coming back to the surgery and asking when are they going to be seen and this does not shorten the GP's workload as it should have.

Robert Evans replied that if practices have this problem they have to make the PCT aware as it was agreed that patients would get appointments very quickly and agreed to work with practices to speed things up. If there are problems make the PCT aware of them.

Choose and Book: Robert Evans confirmed that from the booking and choice money there is a nominal amount the PCT are making available for training costs. The PCT have identified the training will take approximately two hours per practice and a nominal payment will be made to each member of staff attending to support this. This money needs to be claimed although no claim form is yet available.

B&D PCT Award Ceremony: Hilary Ayerst confirmed this will take place on the 17 November at the Cranleigh, starting at 7.30 pm. This is for B&D only. Dr Mittal confirmed that Dr Aggarwal will represent the LMC on the panel.

Ralph McCormack stated that HPCT had already finalised their awards although the presentations have not yet been made.

Practice Based Commissioning: Dr Mittal confirmed that the LMC discussed the document with Paul Sinden and objections were raised. Paul Sinden has provided the LMC with an amended document, which has been more or less accepted, but there are two or three changes:

Page 8, second paragraph, top slicing - at the end of three years, the top slicing belongs to the consortia who have made savings and is not just to be used to prop up consortia who have not reached target. Hilary Ayerst gave the LMC a general principal response. The intention is for the PCT to have a contingency should anybody overspend. The PCT has to break even and can't see how, if the PCT ring fenced 5% for particular consortium or GP within a year that we will be in a position of breaking even if there are overspends elsewhere so the position at the moment is that Hilary agrees the 5% belongs to practices and certainly should not be used elsewhere in the PCT but at this stage she cannot agree that each individual bit of 5% would belong to the consortia arrangements that are in place next year.

Dr Mittal stated that those practices who have done the hard work and saved may be propping up their colleagues who have not worked so hard and therefore not getting the benefit of their hard work. Hilary Ayerst imagined these discussions would be in the following year on how

practices might put forward a case for claiming those additional savings back but the PCT has to break even and will use whatever savings are being made. Effectively it would be a rolling three years.

Robert Evans stated it is to support the potential of overspending across the PCT and it is only 5% of the budget every year. Any savings that this makes beyond this will come back to the practice.

Dr Mittal asked if the PCT is taking into consideration that it might be more than 5%. The PCTs are expecting the consortia to make a saving of 10% to stay below their own level and prop up someone else.

Hilary Ayerst replied that the top slice stays at 5% throughout the period. When 5% has been ring fenced to start with then that stays at the same amount of money. As the PCT has to break even it cannot keep the money, it has to be spent within the system and would imagine that, as we get closer to months 10 or 11, if there is no overspending, and we are confident there will not be, the money goes back into the system to the consortia.

Dr Mittal asked, what if the risk pool is spent or exhausted 10 months down the line, what happens then? Where will the money come from? Hilary replied that effectively the PCT are only allocating budgets at 95% and as the PCT cannot make a surplus at the end of the year this has to be reallocated back to the consortia.

Dr Bland stated that if the budgets are correctly set in the first place and top sliced by 5% to cover overspend, would we not expect some consortia to be 5% overspent because they have had 5% top sliced at the start. Top slicing from a correctly allocated budget seems to be a self-defeating process and the 5% will be used to fund what has been taken away in the first place. Hilary Ayerst replied that if you look behind the policy of PBC the intention of making decisions closer to home by clinicians will effectively reduce some of the costs that are currently going into the acute hospitals. Savings will be made because practices will be better, with more community based services to stop people going into hospital.

Dr Bland said that it needs to be recognised that this is going to take time. It is like saying that the PCT knows that PBC will take time to develop but practices are expected to deliver from day one. Would the focus of the consortia be, from the beginning, cost saving rather than patient care?

Ralph McCormack replied that the only point of reference he has is what happened previously when GPs had budgets, the fund-holder didn't have difficulty in getting the efficiencies out of the system.

Hilary Ayerst stated that the PCT had picked up the point that the LMC want to move quickly to fair shares and allocations. Dr Mittal commented that it is taken for granted that there will be savings. It does not allow for flexibility.

Ralph McCormack replied that PCTs year on year have a statutory requirement to break even.

Dr Bland stated that from the LMC's point of view the greater reality is that the NHS is here to provide care that is needed free at the point of care and if consortia are starting 5% down on what is needed this is not the reality of what the Health Service is all about. Do the PCTs want consortia to focus from the very beginning on making savings or more appropriately improving the level of care to the population.

Ralph McCormack answered that whether we like it or not that is the reality.

Robert Evans stated there has to be risk pool support and the Directors of Finance are getting together to try and get some sort of agreement on the level it should be set at. This is what the PCT are looking for and it is expressed in the document.

Dr Barclay asked why the PCT have decided to go against National Guidance on savings.

Dr Mittal stated that the 75%-25% split has been abandoned, it is up to the consortia and practices how to spend savings. However PEC has to approve their plan

**37. GPC NEWS M2**

GMS Contract Review: The GPC and NHS are meeting to review the contract. Some changes to QOF are being implemented from April 2006. An allocation formula review group will produce a report during 06/07 and funding for initiatives such as PBC and patient choice is being discussed.

Commissioning a Patient Led NHS: Hilary Ayerst stated that the position at the moment, on the part that is imminent, is reconfiguration of PCTs in London. The SHAs from five sectors will be meeting on Friday 14 October to consider proposals they wish to put forward to Nigel Crisp and are hoping to get agreement amongst the five sectors. They are looking at a range of options: one is staying the way they are but making significant changes in commissioning and provider services to one big PCT per sector, or possibly two or three PCTs, the two PCTs being an inner and outer one or possibly three although this is possibly not one of the favoured options.

The PCTs may know what is going to the DoH after the meeting. The DoH will take six to eight weeks to consider what has been proposed and this will go out for formal consultation and reconfiguration by the end of December or early part of January with the expectation of a decision at the end of March, the new organisations being in place by October at the latest.

Ralph McCormack added that there could be £250m of additional investment in new services. He said that there was never going to be any new money. Whether we agree or not, the reality is that when you get to the issue of the £250m it is very clear that it can only come from the PCTs and in reality it is about PCT management organisation configuration. They are obviously saying if there are different ways to achieve this, tell us what the options are. the allocation is on a capitation basis which is unfair for London on the basis that London has bigger PCTs. For London this is around £40m. You can put forward as many schemes as you like but this will only be acceptable if you save the £40m as well. That's the really difficult bit. No one thinks the reconfiguration can save £40m but they will look as though they will to begin with. Criticisms of leadership, whether you believe them or not, are there. These are big issues that are going to take significant change. Barking & Dagenham's share of the £40m is £97,000. Havering's share is slightly larger at £1.2m. 15% savings is the average they are talking about.

Dr Barclay asked, is there any specific way the LMC can help in this area. Hilary Ayerst appreciated the offer but it goes back to the fact that the PCT have to make these savings. The disadvantage is that the PCT have to find the savings within the organisation. It will be a very significant issue. At this stage lobbying won't help but the PCT appreciates that the LMC understands that the PCTs are going through a difficult time.

IT Update: Practices have been asked to make sure they are paid for staff training.

Immunisation Programme: This has been extended to include chronic liver disease without any extra points being allocated, main carers of elderly or disabled people, whose welfare may be at risk if a carer falls ill. Hilary Ayerst will let the LMC know what funding may be available.

**38. ANY OTHER BUSINESS**

PCT Committees: Dr Barclay stated that Members have been given a list of GP representation in PCTs. Hilary Ayerst will check the B&D list and come back to the LMC as she knows other GPs should be on the list. The LMC felt the spread of GPs on committees should be wider.

Red Alerts: Dr Bland expressed concern over the amount of red alerts, beginning in August when most of the population were on holiday and there were hardly any cases of flu around. Red alerts are going up consistently and the LMC wondered if the PCTs' share this concern. What would the situation be if there was an epidemic of Flu.

Ralph McCormack replied that the PCT shares that concern and has been talking to colleagues at BHRT regarding this. There were no days when Oldchurch was not on red alert and BHRT are also saying that elective admission flow is lower than had been projected. Redbridge Trust do not seem to be having the same problem at King George Hospital.

The only thing the PCT thought would help explain this was the 7 July issue when people were on major alert and about 130 patients were discharged on that day. About 20 were subsequently readmitted. In reality very little resources were called upon. Although we have not got answers to these problems the PCT had got places to look. All these factors make a difference on availability.

Dr Bland asked, do the PCTs think it is possible that with these red alerts day after day it is reaching a point where the PCTs will almost be forced to go public in order to let their population know that the acute provider is not actually able to provide the care they need? It becomes a situation of collusion between the PCTs and BHRT. Ralph McCormack answered that he would not advocate going public, we should be working with BHRT to solve the problems.

Patient Referral: Dr Mittal stated that a letter had been returned to one of the Members from Harold Wood Hospital saying they no longer accept consultants' letters for referral. Robert Evans stated that he knew nothing about this and he would check and let the LMC know.

Terms of Agreement: These have now been finalised with both PCTs. It was also agreed that the distribution of the document will be done by PCTs for both GPs and their own staff

District Nurse Dressings: What is the level of their responsibility after discharge from hospital? The District Nurses are saying it is not now their responsibility. Hilary Ayerst replied that she will get back to the LMC on this.

**39. DATE OF NEXT MEETING:** There being no further business for discussion, the Meeting closed at 3.43 p.m. Members agreed that the next Meeting will take place on 03 November 2005.

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**Chairman**