

Private and Confidential

BARKING AND HAVERING LOCAL MEDICAL COMMITTEE

'The Willows', St. George's Hospital site, 117 Suttons Lane, Hornchurch, Essex, RM12
6RS

☎ 01708 465400 & 5046. Email: LMC.BDH@haverinpct.nhs.uk.

Fax: 01708 465579. Courier 103

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

MINUTES Part Two of the 218th LMC Meeting held in the Committee room,
Administration Block, St. George's Hospital, Hornchurch, on 01 September 2005
An OPEN Meeting

PRESENT: Dr A Deshpande (Acting-Chairman)
Drs H Ahmad, G Barclay, T Bland, V Goriparthi, J Kakad, J O'Moore,
P Patel, G Saini, O M Sanomi, S Subramaniam and I K Sudha
Non-principal: Dr S De and Co-opted member: Dr B Dixit

ALSO PRESENT: Ralph McCormack, Chief Executive, HPCT
Robert Evans, Director of Special Projects, HPCT
Eric Saunderson, Joint Medical Director, B&D PCT
Paul Sinden, Director of Commissioning, B&D PCT
Graham Blowes, Head of Corporate & Primary Care Performance, B&DPCT
Madhu Pathak (Medical Secretary)
Sue Elliott (Admin. Secretary)
Suzy Iskander (Admin Assist/IT Support)

APOLOGIES FOR ABSENCE:
Hilary Ayerst, Chief Executive, B&D PCT
Neil Smillie, Director Primary Care, HPCT
Drs A Mittal (Chairman), A Aggarwal (Vice-Chairman), Dr M Roy (Treasurer)
M Asadullah, J A Barbosa, A Jabbar, RS Kalra, P Prasad, M M Rahman and
N P S Teotia

25. **MINUTES:** The Minutes of the Meeting held on 4 August 2005 were approved and signed as a true record of the meeting.

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

Enhanced Services

There is a further meeting next week with Graham Blowes, B&DPCT.

Occupational Health

Ralph McCormack stated that the most up to date position was that HPCT have had all representation of interest that they are likely to get from GPs and are now in the process of making a decision on how to award the responsibility to carry this out.

Anonymous Complaints

Eric Saunderson stated that the second draft has been very complicated to do but is pleased to say it is almost complete. Hopefully a copy will be available during the early part of next week. It can then be discussed at the Officers Meeting or at the next LMC Meeting.

Level of Care Oldchurch Hospital

Dr Pathak told the meeting that a list has now gone to Neil Smillie to enable him to arrange a meeting. When the LMC knows the date of the meeting she will update the Members. The LMC are still collecting data.

Clinical Assessment Service

Robert Evans advised that it seems to be going quite well. Early indications are that most GPs are working well with the service. The best example is orthopaedic care where patients are getting prompter and more appropriate treatment on Primary Care rather than going on a list for Secondary Care. CAS has been running since the 1 June. An evaluation will be done.

HPCT have changed the basis of the system to make it more robust. Within the next few weeks the PCT are hoping to generate reports to give GPs more clarity on how it is working.

Dr Bland stated that he has heard from a colleague that an orthopaedic assessment through CAS had been done by someone "not appropriate". At what level in the PCT should information come back to the GP? This colleague stated that he was contacted by a physiotherapist to say x-rays were needed and the referral could not be passed on until the x-rays were done and expressed the view that this should come from the Medical Director of the PCT or a senior manager and not an unknown physiotherapist.

Ralph McCormack stated that this is not an 'unknown physiotherapist' but a specialised practitioner and it is perfectly reasonable for her to have a clinician to clinician discussion with the practice and did not think it was for the Medical Director to do. The difficulty may be that there is a lack of awareness of the level of expertise of the individual the GP is dealing with. It may be good for her to attend a PTI session to say what she does and how she does it.

Dr Bland stated it is good to know it is a specialised practitioner but it was expressed to him that this was a second triage. Ralph McCormack said that all he can tell the LMC is that we are talking about a specialised practitioner in physiotherapy and this is a perfectly adequate way to handle a request for referral, and that is evidence based, and he will take Management responsibility for this. PEC knows what the PCT is doing.

The PCT have a GP who three times a week gives a clinical oversight to this issue. The Director of Public Health is involved and Ralph McCormack is content with how the PCT are doing things. If there are issues GPs want to bring to him he will be happy to deal with them outside this meeting.

Dr Pathak agreed that a small meeting could be arranged to resolve any issues.

Choose and Book

Dr Deshpande asked if there was any funding for staff training. Ralph McCormack stated that HPCT were anticipating getting £100,000 capital but was not sure how many hoops the PCT had to go through to get it. Robert Evans stated there was very limited flexibility in how the money can be used. The more positive news is that it has been potentially recognised and there is a nominal sum the PCT can make available.

Graham Blowes confirmed that B&DPCT were going down the same path.

Agenda for Change

Ralph McCormack feels that HPCT have got the expertise and resources in place for handling Agenda for Change. The PCT will lose the skill of those people relatively soon after October when the PCT anticipate the completion of the requirements but there is no obligation on practices to go down this route. If practices want to take advantage of Agenda for Change the PCT could agree how best to support them. Although Agenda for Change is not the route practices are obliged to follow, there are potential benefits in doing so, giving harmonisation to staff. Dr Pathak stated that Debbie is going to produce something for the LMC Newsletter asking interested practices to get in touch with the LMC.

LMC Annual Dinner

This is now booked for 19 October with Graham Gooch coming to talk.

B&D PCT Award Ceremony

Graham Blowes stated that there are three dates available in early November and will let the LMC know when a date is confirmed.

27. PRACTICE BASED COMMISSIONING

Paul Sinden is the lead within B&DPCT and stated that no sooner had the information pack gone to PEC a guidance came from the DoH and the time scale has concertinaed. B&DPCT were to start introducing PBC in April 2005 with the aspiration that every practice be involved by March 2008. The latest guidance indicates that all practices should be engaged in PBC by December 2006. This makes it a harder target for all practices.

A circular from the Strategic Health Authority about the suggested process says that by October 2005 the PCT should have agreed and approved policies on budget, savings and Management cost for practices.

All budgets should have been identified, allocated and agreed at practice level no later than March 2006 so that each practice, regardless of the level in which it is engaged in PBC, should have an indicative budget ready for the financial year 2006-07.

PCTs are mandated to supply monthly information to practices. B&DPCT will provide monthly information to those who want to be actively engaged in PBC. Other practices will get quarterly information. Governance arrangements also need to be in place by a date to be advised but it will probably be in line for October 2005 or by realigning existing PCT staff.

The PCT will need to have commissioning plans in place by November to allocate budgets to practices. The PCT have put £50,000 aside in this financial year for pilots and the LDP will put £150,000 into next year to support the infrastructure of PBC. If this goes through there will be £200,000 to support PBC. Any other Management costs will have to be found in savings.

In line with Havering, B&D would like the Locality to be the bedrock of PBC. Unlike Havering, B&D has not set a defined population limit for PBC but this is a route the PCT is interested in. This will come up at the next Practice Based Steering Group within the PCT. The paper states that where savings were accrued, 75% will come back to the Locality, 25% to the practice.

In terms of budget setting, within three years we will move to 100% fair shares budget historically based, so we will move by a third each year. It is the PEC role to oversee the use of Management cost, approve savings plans and business plans put forward by

practices and Localities, and as a last resort dispute resolution and also recovery plans. The paper suggests that where a practice goes over its indicative budget by 5% it has to put in place a recovery plan to get back down to target. Where referrals are more than 10% above plan, the PCT will have the right to withdraw the practice from PBC. Obviously in the early days, based on historical referral patterns with reference to where the pattern sits against averages, it will be subject to local review rather than hard and fast.

The initial role out will be based on acute services to go along with existing prescribing budgets and then over time we will move to enhanced services, community services, and partnership services. By December 2006 we anticipate that all practices will be involved at level one and then practices who want to be engaged in PBC will use their indicative budget savings and work through what services will be set up across the cluster.

Robert Evans then stated Havering's position on PBC:

Obviously there has been a slightly different approach from HPCT and have been sharing information with the LMC for several months since establishing the Steering Group last year. After the establishment of this the principals were agreed, and a process was agreed with PEC on how PBC would be implemented in Havering.

HPCT then arranged an OPM simulation event and had good feedback from this, which helped in terms of supporting the PCT's developing plan. Two clusters of practices went live on the 1 July. There is a lot of work involved in ensuring the availability of data and confirming the budget setting forces, all of which the PCT will do in light of the new timetable that has just been issued.

HPCT are working with a range of clusters and recommendations will be made to PEC in September for more clusters to go live in October. If everything goes according to plan, HPCT will then have 75% to 80% of the population covered by clusters of practice based commissioners.

HPCT have gone down the road of trying to get practices to work together within the principals we have established rather than necessarily giving it directly to Localities. The clusters as they have emerged are geographically contained within the current Localities. The other progress we have made is again prior to the recent additional guidance. Guidance issued a few months ago was in terms of the PCT tool kit, which included a state of readiness, which we have been regularly looking at and updating. Across the sector we are making progress but it is the detail that we now need to work out in terms of activity, budget setting and the process of taking this forward.

Dr Deshpande thanked Paul and Robert for their input.

Dr Saini stated that this document, as an information pack, is more a directive. There are a lot of areas where the LMC have concerns with this document. The first question is, the PCT is saying to the practices we are going to give all the budget to you. The practices have not yet had the chance to look at their budget and activity plan for the next year and they have already had a lot of obstacles put in their way.

Paul Sinden stated that the PCT have sent out historic data on activity patterns, referrals for all acute activity and then had a first stab at providing indicative budgets for that activity which went out to practices at the August Locality. One of the difficulties is getting information on a practice based level before we look at acute trust providers in a particularly robust manner so before the PCT could send information out to practices, quite a lot of screening of that information took place to make sure it was fit for the purpose. The PCT have not sent out all the information that they would have liked to practices but there have been two rounds of information going out on acute budgets.

Dr Saini asked, on Page 9, do you mean Locality as a consortium of a group of practices or the Locality as defined by the PCT?

Paul Sinden replied that what has happened is that subsequent to this document going out the PCT received expressions of interest from clusters of practices, so this will get amended to say that practices can work on a cluster basis. Some of B&D's clusters go across Locality boundaries so the PCT has got work to do building in flexibility for practices to work on a cluster basis.

Dr Saini said the question of savings then arises because, as the national guidance says, the savings belong to the consortia or group of practices and they need a management type data base to develop proper services. If the PCT is already putting in a clause giving 25% to the practices and 75% to the Locality, that restricts the practices in building up services. Secondly, because a lot of Secondary Care is going into Primary Care, if practices have not got the flexibility to use their savings they will not be able to build up the services and this proportioning of savings needs to be removed. It is up to the practice to put in a plan on how they will use savings and this has to be approved by PEC. If PEC says it is not right the practice has to go back and look at it. If the practice only has 25% for primary care and 75% goes to locality and there are three or four practices in the locality with one making savings and the others overspending, it is not fair.

Paul Sinden agreed that it takes away the flexibility of what the cluster wants to do and will take this back to the Practice Based Steering Group to see what flexibility can be built in. Going back to the budget, the guidance does indicate that budgets are set initially on a historic basis and we do not always have the information on a practice basis to move to fair shares immediately so the PCT recognises that a historic basis is not the best way to start off and that is why the PCT has moved to fair shares within three years. It is very much like prescribing but there has been a pace of change over a number of years.

Dr Saini stated the issue then is that in three years time the practices may not be able to balance their books and will be told that they cannot carry on in PBC.

Paul Sinden felt that when he spoke about it he gave it more flexibility than was in the document by saying that when the PCT use the 5% and 10% triggers, they were there as a rule of thumb and recognise that if a practice is a historically low referrer the PCT would need to take that into account.

Dr Saini asked what is there stopping the PCT from giving a fair share budget now, showing what the difference is to a historic budget, so that practices can then at least see what is going on now and see how they can manage in three years time.

Paul Sinden replied that it was not fair shares in total but the first time the PCT sent information out the historic practice referral level was sent and the PCT then used benchmarks of referrals of 1,000 people so that practices could see where they sat against the Locality and PCT output. It did not take into account demographics so was a fairly blunt instrument and was an attempt for practices to see where they sat and where a move to fair shares would take them in the future.

Dr Saini stated that, under Section 6, which excludes the purchase of a car for personal use, there could be, for example, specialists in the consortia who ask for transport. How is a practice going to fund that part of it if they are restricted and cannot use savings for transport? Also, a practice may decide it wants transport for patients because ambulance transport is too expensive. The PCT need to give the new organisation some sort of footing to work from and say we need a better service than we are delivering now, here's your budget go and do it, instead of putting so many restrictions in. It is going to cause problems.

Paul Sinden replied that his initial reaction is that he does not think the savings are restrictive about what you can reinvest in. The PCT will take that restriction away but it is a standard point and he would have to be convinced to take it out.

Dr Barclay stated the PCT are putting in restrictions already, which are unnecessary because any savings have to be overseen by PEC.

Paul Sinden replied, yes that's true but the PCT needs to follow the guidelines on how savings are used.

Dr Saini said that under section 7.2, the PCT is looking at Enhanced Services and are already saying 20% to 50% to be taken for out-patients and put into the Primary Care side and if there are restrictions on how to use the savings, you cannot deliver that. What is the target, what is the time-scale and what date are you looking at? We need to have something specific.

Paul Sinden replied that the PCT have agreed to take out funding from acute trust in line with the additional services that are being provided in Primary Care.

Dr Saini said that half the problem with these points is that the PCT go to the consortium saying, you are a new organisation, these are the things we should be looking at, this is a requirement, sign on the dotted line that you will deliver it. The consortia cannot promise they can deliver it. This should only be a guideline. Practices are not prepared on day one to say they can deliver, because that's going to be in the business plan.

Paul Sinden replied that what you will be signing is the business plan so where this document talks about the 20% orthopaedic and 50% of dermatology, the business plan would have a phase of change to get there.

Dr Barclay stated that PEC has looked at this. The LMC is a group of very experienced GPs and they have come up with these questions, which PEC have either failed to acknowledge or not realised. On Page 13, Point 7.2: Business Plan Targets 2005-06, Access, this should read "100% of patients who want to see a GP or a primary care professional in 48 hours" because there is triage going on, and nurse practitioners, in practices.

Ralph McCormack stated in Havering it is 24 hours for a practitioner, 48 hours for a GP.

Dr Barclay asked, under 7.1. "Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services", how will you measure it and who will measure it? And under "Management of long term conditions", with the increasing age of the population there will be an increased number of patients with long term conditions and there is no way that we will ever be able to reduce hospital admissions. You may improve care of long term conditions which will continue to have acute episodes that will need admission. It is ignoring a fact of life that we have an aging population. Also, "Reduce prescription spend on nutritional supplements". This comes out of Secondary Care, mainly dieticians initiate it, not Primary Care. Nutritional Supplements is something for prescribing advisors to take up with Secondary Care.

Paul Sinden replied that the PCT will be signing up to provide information to support the infrastructure and the whole thing is not set up to provide fall guys. This is not what it intends to do. Dr Barclay stated that the PCT should therefore remove the whole paragraph.

Paul Sinden stated that he will take on board what has been said but the tenure of this is not to create fall guys.

Dr Deshpande stated that he feels the whole document needs to be completely revamped. He did not know how PEC has approved a document that has so many fallacies and so many targets before practices even embark on PBC. For example, the reduction in outpatients. What the PCT are restricting here is the savings. 75% has to go back to the

Locality, or PCT, and 25% to the practices. How are practices expected to offer any kind of service? This is not what the National Guidance says. I think we need to look at it carefully before we embark into this sort of draft.

Paul Sinden replied that he will take the LMC's comments back to the Practice Based Steering Group for debate.

Dr Bland stated that the restriction takes away the very incentive and heart of PBC, which is that the consortia have the incentive to recommission care in a patient centred way and use the savings to snowball that and develop it. If 75% of savings are taken back towards a locality centre, away from the practice, it takes away the incentive as to why practices should get involved in this. Dr Bland full supports the Chairman and thinks the PCT should really listen to the views that have been expressed today.

Dr Barclay asked how does the PCT differentiate between Locality and Practice as Locality is simply a cluster, or group of practices.

Paul Sinden answered that the intention was that if there are four practices working in a cluster, when they put together their combined plan, 25% of any savings they make would go back to each of the practices and 75% would be used across the four practices.

Dr Saini stated that it is up to the consortia to decide how much they put into Primary Care and on what basis, and it has to be approved by PEC. There may be circumstances that in year two or year three consortia might have to put 50% in to Primary Care because they have not developed services that need to be resourced. We need to move away from these proportions. The consortia need to decide how they are going to use savings to develop services. The consortia have to put plans in on a yearly basis and these have to be approved by both PEC and PCT.

Paul Sinden replied that what he will take back is that 75%-25% is too rigid. Practices need to approve this within the next couple of weeks because of the timescale attached, which has to be agreed by October, so there a large amount of work to be done.

Dr Dreshpande stated that there is an B&DPCT/LMC meeting on 28 September and there is enough time to look at this issue. Paul Sinden replied it may not be a full report but what he will do is give bullet points of what has been mentioned today.

Dr Pathak asked if the LMC could have a revised paper before the meeting so that GPs who may not be attending the meeting on the 28 September have a chance to look at it because they have contributed today.

28. ANY OTHER BUSINESS

Child Immunisation

Dr Sudha received a letter from John Harvey regarding the Child Immunisation System. The current system is out of date and the new system is not yet up and running. GPs are being asked to keep a paper journal for input at a later date.

Dr Sudha has real concerns about this as, if there is no local system in the practices, it will fall on the heads of GPs to recall for immunisation. What does the LMC think of this?

Dr Kakad stated that if you are using computers it is OK but if you do not use computers the information will not be easily to hand. He could also see a problem would be with MMR four year and five year boosters.

Dr Sudha stated that no dates have been given for how long practices would need to do this recall.

Ralph McCormack replied it may be better to address the issue about why we are where we are. The new system Connecting for Health, is BT trading under the name of CCA. The commitments that were given in getting that contract as service providers was that they would have a number of offers available quite some time before now in relation to hospital based systems for replacement of patient administration systems and that they would also have available the IPS versions of GP systems, together with the replacement.

The regional health system had been given notice that their systems will move on from December 2004 which was extended to the end of June and then extended further, principally because CHIA should have been available almost three months ago and it has been quite an effort to organise and test what clearly is a less than adequate system, against the specification. What we have been trying to do for the last month is run the system, which we thought was going to operate and to allow us to do scheduling and recall, only to find in the last week or so that there is a major system problem stopping us from doing that.

In the short term it does not allow the PCT to do what John Harvey is referring to in his letter for registration and recall. The impact on practices, and the difficulties it would create, are understood. What the PCT need to do subsequent to this is for John Harvey to set up some dialogue between practices, and maybe the LMC will want to help the PCT work on that, to make sure there is a proper understanding of the support practices will need, and the opportunity to brief practices about when the PCT think this should be operational from and when they hope to have the system in place. This will help ease what the PCT agree are unsatisfactory circumstances, but at the moment unavoidable.

Ralph McCormack will talk to John Harvey today. B&DPCT use the same system and are unlikely to have any different circumstances to Havering. If the LMC nominates some colleagues to work with the PCTs, and we do this as a B&D/Havering activity, this would be fine.

Dr Pathak is concerned that some practices do not have health visitors going in regularly to inform the mothers of what to do and nominated Dr Sudha as LMC representative.

29. **DATE OF NEXT MEETING:** There being no further business for discussion, the Meeting closed at 3.32 p.m. Members agreed that the next Meeting will take place on 6 October 2005.

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Chairman