minutes

Meeting	RUSHCLIFFE MUTUAL SELECT COMMITTEE
Date	Monday, 25th September 2006 (commencing at 12.30 pm)

Membership
Persons absent are marked with `A'

COUNCILLORS

Edward Llewellyn-Jones (Chair)
Mrs K L Cutts (Vice-Chair)

	John Allin	A	Andy Freeman
A	Martin Brandon-Bravo OBE		Ellie Lodziak
	Richard Butler		Parry Tsimbiridis
A	Steve Carr		

C0-OPTED MEMBER

Barbara Venes

ALSO IN ATTENDANCE

Dr Holmes) Rushcliffe Mutual
Dr Short)

MINUTES

The minutes of the last meeting held on 4th September 2006, having been circulated, were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

None.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

RUSHCLIFFE MUTUAL – EVIDENCE AND RESPONSE

Councillor Edward Llewellyn-Jones stated that there were a number of issues which had come upon which it would be useful to have further clarification. These were around finance, the services to be provided by the Rushcliffe Mutual and the question of employees.

Dr Holmes explained that Directed Enhanced Services (DES) budgets were for a variety of schemes practices may be paid above and beyond what was expected was designated. These would be things which had not been done before and were national. Locally Enhanced Services (LES) were locally agreed incentive practices. One Directed Enhanced Service was practice based commissioning. He stated that GPs and their staff would have to carry out work to make practice based commissioning happen. All GP practices which were part of the Mutual had signed over their funds from the DES practice based commissioning to the Mutual. He added that there were other Directed Enhanced Services for example for immunisations but the funds from this were separate. He explained that elsewhere funds from the DES practice based commissioning were going to GPs to pay staff for doing the work. He indicated that the Clifton GPs would no longer be a part of the Mutual. In response to a question from Councillor Mrs Cutts, Dr Holmes explained that the money from the DES practice based commissioning was only for management and not for the provision of services. That was what these funds were designated to do. In response to a question from Barbara Venes, Dr Holmes stated that targets, for example, for immunisation were separate from the DES for practice based commissioning. These funds came from the centre and it was all the funds could be spent on. Targets were unrelated to the DES for practice based commissioning.

In response to a question from Councillor Parry Tsimbiridis, Dr Holmes stated that the Mutual company would do what the Primary Care Trust did in commissioning. He added that from the patients' point of view they should see seamless services. Commissioning in the past had failed to engage primary GPs and patients into how all services were provided. They should all be involved in designing services for patients, looking at costs and accessibility. That was the intention of the Mutual where the GP representation was small and the public's large.

Councillor Mrs Cutts asked where services would be delivered. Dr Holmes stated that this would be in places which could provide the quality of care. They would work towards a high quality service as near to the patient as possible and convenient; for example the GP practice, the patient's home and larger buildings e.g. using Lift buildings. Councillor Mrs Cutts raised the problems over transport. Dr Holmes stated that concerns over transport issues would need to be talked through with the public to see how they could best be dealt with.

Dr Short referred to the article in the Nursing Times which had been considered at an earlier meeting. He explained that the DES for practice based commissioning was a national allocation which could not be vired elsewhere. There was no ability to impact on other areas of activity. The other area of budget was commissioning. This was an indicative budget based on historical spend on primary and secondary care. It was the intention by the Government that they would move to an allocation which reflected need, based on deprivation and social factors. The re-distribution would be in 2008/09 when a valid formula had been calculated. The Mutual brought 18 practices together and would use this to influence service delivery methods. This was historically a Primary Care Trust responsibility and would still remain with the new Primary Care Trust. He added that a practice which did not operate within budget would have the practice based commissioning removed from them. Dr Short stated that if any money was left over at the end of the year it would be re-invested in an extension to the range of services. It would not be used for anyone's personal advantage. Seventy per cent of freed-up resources would be given to the company

to develop services; and 30 % would be retained by the Primary Care Trust. The funds could only be spent with PCT approval and it all had to be spent on patient care. The 70/30 split was for year 1 and the 30% for the PCT would go towards balancing its books.

Barbara Venes asked what happened if a patient needed for example treatment at Great Ormond Street. Dr Short explained that the PCT had agreed that it was prudent to pool risk around specialist services so the money for practice based commissioning was top sliced to cover this.

In response to a question from Councillor Llewellyn-Jones, Dr Short stated that they were trying to map the current level of secondary care and look within constraint what areas could be repatriated to primary care but would still meet the quality criteria. The aim was to spend less in secondary care and to develop local provision. There was a national tariff for outpatient visits. Their model showed that they could do some at less cost than in hospital. Seventy per cent of the savings would be the Mutual to re-invest. He added that the Primary Care Trust would continue to pay the provider of services and that these funds did not go through the company.

Councillor Edward Llewellyn-Jones asked a question about possible destabilisation of secondary care. Dr Holmes stated that the starting point was a certain amount of money was allocated to a group of patients. The objective was not to maintain hospitals for the service but to provide appropriate health services for patients. He stated that if funds were suddenly removed the service would possibly implode and this was in no one's interest. Changes had to be carried out in a way which did not destabilise the situation. He pointed out that it may be more appropriate to move services nearer to the patient which would free up resources. He gave an example of dermatology service where a GP had a special interest and received a lot of referrals and had good links with the hospital. The suggestion was that some of the dermatology surgery could move out of hospital as it did not need to be hospital based. It was acknowledged there was a need for proper training. He added that small, easy dermatology treatments could be done in the GP practice as an enhanced service. Dr Short stressed that the starting point was what was best for the patient.

Councillor Tsimbiridis asked whether the service would be better for patients. Dr Short explained that 18 practices had voluntarily combined to see how best to respond to practice based commissioning. They had come to a clinical consensus on the care model. They were giving genuine power to patients which was unique and he felt it would be a model that would be replicated elsewhere.

Councillor Mrs Cutts asked about the treatment of patients with incurable diseases. Dr Short stated that they would develop preventative work to support people in their homes. Dr Holmes stated that they could develop support for chronic illnesses which could avoid patients needing to go into hospital.

Councillor Llewellyn-Jones asked what employees the Mutual would have. Dr Short explained that the company would have no employees and that the staff would be PCT employees. They would continue with the same rights and a guarantee of a return to work for the PCT. This would continue until provider arrangements for Primary Care Trusts were resolved nationally. In 2008 Primary Care Trusts would not be providers but issues around this were not resolved at the moment. The

Primary Care Trust would employ all staff and they would be supplied to the Mutual on a similar basis to the hospital staff going to the Diagnostic and Treatment Centre. Local managerial control would be provided by the Mutual. They would be liberated from Primary Care Trust personnel issues and may be able to be more creative. They had worked with Unison who were supportive of this as a pilot.

Councillor Mrs Cutts asked for a practical guide as to how the arrangements would work. Dr Short agreed to provide this.

At this point Dr Holmes and Dr Short left the meeting.

Councillor Llewellyn-Jones stated that it was important that the Select Committee provided a preliminary view of the proposals as on 30th September Rushcliffe Primary Care Trust would cease to exist and the matter would then become the responsibility of the new Nottinghamshire County Teaching Primary Care Trust. He added that at the next meeting of the Select Committee a final view of the Rushcliffe Mutual would be agreed. Matthew Garrard from the Scrutiny Team reported that the Clifton doctors had withdrawn their interest in participating in the Mutual, and therefore the City Council's Scrutiny Panel were no longer considering the issue.

Councillor Allin felt that the proposals should be supported. He commented that in other areas doctors were waiting to group together. Councillor Tsimbiridis thought that there was a need to be aware of all the pros and cons of the proposals. Barbara Venes felt that no information had been given about the quality of GPs and their training. She wondered whether the standards would be the same as at hospital. Councillor Ellie Lodziak commented that this was the way forward if there was quality control. Councillor Richard Butler stated that initially he had been sceptical about the proposals but now supported them. Councillor Mrs Cutts agreed but emphasised that quality control needed to be there. Councillor Llewellyn-Jones agreed that the model seemed good and the way they hoped to practice seemed reasonable and good practice. He felt it was necessary to ask the Primary Care Trust how they would monitor quality. It was suggested that patients be asked to complete questionnaires at the end of procedures as a way of monitoring.

It was agreed that the Chair and Vice-Chair agree a preliminary response in line with the above comments. It was further agreed to invite a representative of the new Nottinghamshire County Teaching Primary Care Trust to the next meeting.

The meeting closed at 2.00 pm.

CHAIR

Ref: Rushcliffe mutual/m_25 sept06