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MINUTES OF BERKSHIRE COUNTY LMC MEETING
Tuesday 22nd June 2010
Berkshire Masonic Centre, Sindlesham, RG41 5EA

DRAFT

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Mental Health Services in Berkshire

The LMC told the Mental Health Service that they had specific issues around:

- The prescribing and management of patients with ADHD in particular when the patient leaves the child service and joins the adult one.
- Access to a psychiatrist and the referral process into the Mental Health Service.
- GPs being able to communicate directly with a psychiatrist.
- Drug and alcohol services.

IM said that previously in WAM there had been a named psychiatrist who had left and there were then a succession of locums fulfilling this role.
It appears that there is a newly appointed consultant, Dr Joshi, but no GPs knew about this.

Katie Simpson (KS) said that in Slough, Diana Wise had produced an excellent flow chart showing which psychiatrist covered which sector.
There is also the facility to call in to the switchboard and be put through to a named person's mobile.
KS asked why such systems did not exist in other areas.

CAMHS have developed a list of contacts which is available on their website.
Simon Forster (SF) said that CAMHS were taking on 2 new consultants in the next 2 months.

Philippa Slinger (PS) said that she would ensure that a flow chart was developed for each area.
It was agreed that this would best sit on the Mental Health Services (MHS) website or the Doctor's Desktop.
GPs also said that they would find details of the architecture/structure of the service useful.

The NSF requires Mental Health Services to be set up with dedicated teams to take on specific work.
This was not a model that worked well (source of this comment unclear to PHR).

Justin Wilson (JW) said that the number of locums was being reduced; when adverts were placed they were now getting more applicants for posts.
The BHT was working hard to make quality improvements.
The single point of access has a financial advantage for the PCT.
GPs will be surveyed to ensure that the service is seen as an improvement and if it is, then payments will be made.

The MHS said that they had a GP representative for East Berks in KS but this position was not filled in the West and they tended to use the PBC lead to fill this role.
They would welcome a West Berks GP if one was available.
GPs said that the PBC role was different to that of a practising GP.

GPs said that with the adult service, there used to be a consultant that they trusted and whom they could contact directly about patients; this is now not the case.
The old age service was not such as problem; GPs tended to know who the consultants were.

Moving consultants around areas was seen as a problem.
It was suggested that the team worked their way around practices introducing themselves to GPs and building up good working relationships.
They could also attend the educational events set up by Dr Chauke Kade from Bracknell.

A few years ago practices in Slough had been allocated key workers; this system had worked well but unfortunately when the key worker left they were not replaced and the system had fallen apart again.

GH said that despite working across the road from his local MHS, he was unaware of who the staff were; it seems to have been run by a succession of locums.
There also appeared to be too many layers to the service.
GH said that GPs tended to manage at least 99% of patients within their surgery and only referred 1%.
If that 1% was seen by a consultant, and the advice was that they were inappropriate for referral, then GPs would accept this.
However, in many cases decisions are being made after a 10 minute patient assessment by a counsellor.
GPs felt psychotic patients would invariably refuse the offer of help despite plainly needing it.

GPs said that despite addressing letters to the consultant psychiatrist, patients were not being seen by them.
GPs reported that counsellors were often telephoning patients, and asking if they had a problem and needed to be seen by the service.

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In a lot of severe cases the patients were saying that they did not, so the service then discharged them without them being seen.
In some cases, this has ended in the death of the patient.
GPs were very frustrated with the system.

GPs said that for patients over 75 who were very muddled, faxes were sent back suggesting that the patient be started on medication.
The problem was that this fax would come from someone the GP did not know, and there would be little indication of whether the patient would be seen again.
Medication suggestions were sometimes on the red list, and needed to be prescribed by a specialist

Schools were also advising parents that there were issues with their children and telling them to go to their GP and get referred to CAMHS.
Schools needed to be reminded that they could self refer into the service, not use the GP.

The CAF form was discussed.
Referrals to CAMHS were being returned to GPs because the form had not been filled in properly or signed by the child.
The need to have this form signed at all before the patient was seen was queried by GPs.
There are problems for those who are illiterate or unable to sign any form.
There were also issues with some children who wanted to be seen, but did not want to consent to their information being passed to other agencies.
GPs said that in no other speciality was there a requirement for the patient to sign a consent form to enable them to be seen.
It was suggested that the form could be signed when the patient was seen.
This would help those patients who were unable to sign on their own behalf.

A texting service (similar to the one used by Chlamydia screening to communicate the results of tests) could be considered by the CAMHS as a means of communicating with young patients.
PS said that they currently used services such as Facebook, and were exploring this further.

GPs raised the issue that the adult service was sending patients to them to have ECGs, bloods etc performed.
GPs said that they were not skilled in interpreting ECGs and certainly did not know what to look out for in terms of psychiatric medication. It was suggested that these requests should be made to the Cardiology Department rather than GPs.
GPs also said that their contract did not require them to take bloods; this service was also funded differently in different areas.
It was suggested that the person requesting the bloods should complete the relevant form and the patient could then go to secondary care for phlebotomy (not all practices were funded for this service).
This would enable the result to be sent back to the requester.
GPs reminded the service that if they prescribed for a patient they were taking responsibility for the patient.
If a patient needed medication urgently the person seeing them should raise the prescription.
If this could wait, then the GP would do this on receipt of a letter stating what to prescribe, for how long and what the follow up arrangements were.

For children with ADHD, CAMHS were working (with KS) on a new shared care protocol.
This protocol will look at how to wean patients off medication once they reach the age of 14 and how they will be managed if this is not possible.
SF said that ADHD comprised a large workload of approximately 2.5K patients which had not existed 20 years ago.
Currently there is no up to date shared care protocol for ADHD.

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It was agreed to invite the MHS to the September LMC meeting for feedback on developments.
GPs said that they wanted to work with the MHS to develop a service that worked for all.

Action Point:

1. **PS will:**
   - **develop a flow chart of services available and who delivers them for each area and put this on the website.**
   - **encourage the teams to visit Practices and introduce themselves to GPs.**
2. **MHS will feedback to LMC at its September meeting.**

Minutes of Previous Meeting (27.4.10)

The minutes of 27th April 2010 were agreed as a correct record of the meeting.

Matters Arising

DNACPR
Practices reported that they had received their packs of lilac forms.
Along with the forms was a re-order form stating the prices practices would have to pay for new stocks which GPs felt was inappropriate for a service such as this.
PHR has already given the SHA team a LMC view that no charge should apply.

BBOLMC Medical Director
Dr Jim Kennedy (JK) has been appointed to the position and will be starting on 1st September.
He has previously been a Medical Director for the OOHs organisation that employed Dr Ubani and his name might appear in press reports about this.
The BBOLMC Board were impressed with his application and interview.
IM said that she was due to interview him on behalf of the GPC in relation to another OOHs doctor in July.
He has also worked as a GP in East Anglia, having trained in Ireland.

JK will be working part time as a GP in Wargrave, West Berks and 2 days for the LMC.
He has indicated that he would prefer to not work in the area in which he practices and so it will probably be that he covers Bucks.
There is a 6-month trial period for both sides.
PHR has indicated that he intends to retire in the next few years.
It was asked how this appointment fitted into the succession planning at the LMC.
JR said that revalidation would mean it would be virtually impossible to have a GP working full time at the LMC but JK was only in his 40s so it would help PHR plan his retirement.

LPC Details
These were included in the papers for the meeting and were noted.

GPC Sessional GPs Report June 2010

A GPC working Group has reported on the representation of sessional GPs within the GPC and LMCs.
A survey has been conducted to determine the number of sessional and salaried GPs who are currently on the GPC and it has been discovered that this reflects the number of sessional/salaried GPs in the UK.
The MPU had originally spearheaded a breakaway group to voice the concerns of sessional GPs to the GPC.
A solution has been put forward to enhance the Sessional GPs' sub-committee.

As a result the LMC needs to look at sessional GP representation.
GH said that Amadeep Guell would be a good person to co-opt to the Committee.
SM said that there was an issue of communication with sessional GPs which the TVPCA were addressing but nothing further seems to have happened.

Action Point: PHR to continue to chase up the communication issue for salaried/sessional GPs and Locum GPs.

GPC Letter re Contract Uplift June 2010

This was self explanatory.
JR reported that in the budget, workers in the NHS faced a 2y pay freeze which was something to be welcomed as it would mean that there would not be a further pay cut.

Levy and LMC Rep Issues from BBOLMC Board

There was an issue with GPs who were on the LMC but not attending any meetings.
It was felt that if someone missed more than 3 meetings they should be asked to stand down.
Julius Parker has not attended any LMC or LRC meetings for a long time and as he was an elected member he should be asked to either stand down or start attending.

Action Point: PHR to follow this up.

LMC Conference

GH had had the chance to speak to 2 motions, one about PMS practices and the other that the patient questionnaire should be discarded.
Berkshire had done better at this year's Conference than they had in previous years.

Coalition Health Policy

This was noted.

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New WB Practice Profile 7/6/10

It was agreed to put this on the September agenda.

Action Point: To put this item on the September meeting agenda.

BMA and Revalidation

To be able to continue to work as a GP 100 sessions per annum must be worked over any 5 year period.
This will cause a problem for a GP who intended to take a 3 year maternity/paternity leave and then come back to work part-time.
If they are unable to meet this requirement they will probably have to retrain.
It remains unclear who will be responsible for the financial costs of this retraining and who will compensate the practice that they work for.

Andrew Lansley has currently frozen the revalidation roll out although local pilots are still continuing.
The toolkit is not available yet.
It is currently not known when it will be rolled out

There are concerns about the role of Responsible Officer, especially over recommendations that a GP needs remediation or re-training.
In East Berks the PCT have appointed a GP to the post of Medical Director who is no longer working in General Practice.
In West Berks this position is held by a GP who works in General Practice but only a very few sessions.

Issues from each PCT Liaison

There were none.

Issues from the GPC

JR reported that Andrew Lansley has suspended the SCR but more clarification was awaited on this.
CG said that for EMIS practices to rewrite patient telephone numbers on the practice system so they appeared without a space would take (for a practice of 22.5K patients) approximately 303 x 4 hour sessions at an estimated cost of £10K.

QoF Prevalence

GPs felt that the PCT may be trying to implement the new changes for this year to last year's payments.
If practices found this was happening they should be reminded that they have the right of appeal.

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The LMC would support practices who appeal.
Andrew Lansley has said that the intention is that the questionnaire will scrapped but it was not yet known what would happen to the money that was currently allocated to PE7 and PE8.
It may be that it will be distributed amongst practices or used by the PCT to help meet their budget deficit.

Date of Next Meeting – 21st September 2010

The meeting opened at 2:15 pm and closed at 4.25 pm.

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Present	Name	Organisation
	Arora, Kanchan	Bracknell LMC
*	Birchall, Carol	LMC Minute Secretary
*	Brock, Nicola	Wokingham LMC
	Buckle, David	West Berks PCT
	Cave, James	Newbury LMC
	Crampton, Anne	Bracknell LMC
	Derry, John	TVPCA
*	Gallagher, Charles	Wokingham LMC
	Greig, Adam	East Berks PCT
*	Hear, Gurdip	Slough LMC
	Hyde, Maria	Newbury LMC
	Kade, Chauke	Bracknell LMC (Co-opted)
*	Kumar, Hemantha (MLH)	Slough LMC
	Lade, Jeremy	Wokingham LMC
	Llewellyn, Lise	East Berks PCT
*	Mittal, Rab	Reading LMC
	Moneim, Tarek	Reading LMC
*	Morando, Sarah	Reading LMC
*	Mower, Isabel	WAM LMC
	Nabi, Ajaz	Slough LMC (Co-opted)
	Naran, Kish	Reading LMC
	Nelli, Prash	Bracknell LMC
	Parker, Julius	WAM LMC
Chair*	Rawlinson, John	WAM LMC/GPC Rep
	Roblin, Paul	LMC Chief Executive
	Smith, Rod	Reading LMC
	Thorpe, Penny	TVPCA
*	Trivedi, Jitendra	Slough LMC
	Waddicor, Charles	West Berks PCT
*	Westcar, Paul	Newbury LMC

Apologies: Drs Lade and Roblin

In Attendance: **Nick Buchanan, Justin Wilson, Trevor Keeble, Sally Murray, Katie Simpson, Simon Forster and Philippa Slinger**

Date of Future Meetings: **09.11.10**

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