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MINUTES OF BERKSHIRE COUNTY LMC MEETING **Wednesday 9th November 2011** **Berkshire Masonic Centre, Sindlesham, RG41 5DB** **2:15 pm**

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Minutes of Previous Meeting

The minutes of 13th September 2011 were agreed as a correct record of the meeting.

Matters Arising

COPD Referrals

The area of concern was the protocol that stated that an ECG report needed to accompany each COPD Pulmonary rehabilitation referral. CG said that he has not contacted the Pulmonary Rehabilitation Team directly. In an effort to contact the authors of the guidance he contacted the PCT and spoke to Maureen McCartney who had passed him on to someone else but so far he has not had a reply to his queries.

TVPCA Issues

JK reported that he had not received any significant feedback from practices relating to the Dispensing Review or the List Cleaning process and practices appear content with these initiatives.

Hospital Issues

Wexham Park Black Status: JK reported that he has e-mailed Charles Waddicor as PCT Chief Executive twice, copying the Primary Care Leads for the East and the West into the second communication. To date he has not received a reply.

LMC felt this is probably an issue the CCGs should be taking up, especially if the Hospital is having problems delivering as evidenced by Black Status and Pressures on A&E

Jackie McGlynn is the PCT manager looking after the Wexham Park contract whilst commissioning responsibilities are being passed to the CCGs.

Wexham Park report that the problem is caused by the number of admissions from South Bucks but LMC pointed out that they received funding for these admissions and that any workload shift from High Wycombe could have been anticipated.

LMC Reps are keen to see actual data on patient flows into Wexham and will seek these through their CCGs.

JL said that from the statistics issued it appears more patients are self referring to A&E and when patients are sent to A&E from CDU they may be counted as self-referrals.

PHR said from April 2012 the new QoF sections QP6-14 will deal with referrals and admissions with QP12-14 dealing specifically with A&E. Practices will have to analyse activity going to A&E that are not emergencies.

Currently GPs are trying to clarify if the practice at Wexham is to charge twice, once when the patient attends A&E and again when they get admitted to the ward.

LMC opinion is that CCGs need to analyse these statistics and identify if and where double payment is occurring.

Practices will also have to compare the referral data they receive from the hospital to their own internal practice data for QoF next year. If there is a large difference the CCGs will have the evidence to push for change.

There is a financial incentive to collect the data and tools are available for practices to use.

LMC note that Philippa Stringer's move to Wexham Hospital as acting Chief Executive, may assist improvement.

Royal Berks 2WW Letters:

The issue centred on patients referred under 2WW arrangements who for personal reasons choose to have an appointment that fell outside the 2WW window.

RBH had sent letters requesting the referring GPs write a letter stating that because the patient could not attend the offered appointment their referral was not in the 2WW category.

LMC raised concerns at last County LMC and these were picked up by a PULSE article.

This led to Dr Fielden, Medical Director RBH, contacting PR who communicated the LMC's concerns that the referrals were indeed 2WWs but it was appropriate for the patient to exercise choice as to when they arranged their appointments.

No further RBH letters have been received by GPs since that conversation.

CG reported he had written to Jonathan Fielden, Medical Director RBH, to express LMC concerns on 7th September who had said he would get back to him, but no communication has been received. However when PULSE published their article on this issue Dr Fielden contacted CG and the LMC saying that communication was important. CG reported he had again emailed Dr Fielden on 27th October and asked for a response to his original email but is still awaiting a full reply.

Action Point: It was agreed that JK would follow this up and get a response from the Provider.

Mental Health Update

CG reported on the ongoing issue of the Mental Health Team (MHT) requesting GPs carry out investigations such as ECG and blood tests for MHT patients on certain medications.

GG and JK met with the MHT to discuss related issues but no further action on this subject has yet been reported from MHT.

CG will continue to follow this.

Now that Philippa Stringer had moved to Wexham Hospital, Julian Ems is acting Chief Executive of the Mental Health Trust.

Action Point: CG to continue to follow up the issue of investigation request for MHT patients.

LMC Elections

PHR reported that the period for receipt of self nominations starts on 1st December, although he has already received a few, with a closing date of 20th January.

GPs reported the nomination form on the website appeared incomplete, PHR agreed to check this.

PHR advised all sessional, employed and locum GPs, on the Performers Lists who are LMC members are being contacted to make them aware of the elections.

JL asked if the OOHs doctors were being approached.

PHR agreed to write to JL who would then pass the communication on to the OOHs doctors, he will similarly write to the East Berks OOHs organisation.

It was agreed to use the PCT email list of sessional GPs.

**Action Point: PHR to check the nomination form on the website is complete.
PHR to write to JL and the East OOHs organisation for onward transmission to the OOHs doctors.**

Community Pharmacy Contractual Framework – Service Developments

Carol Trower, Chief Executive of the LPC, attended for this item.

CT was seeking feedback following the implementation of the NMS.

Pharmacists are finding it difficult to identify patients who have commenced new medications.

3 GPs present had received feedback forms from the Pharmacists.

CT said the aim was not to feedback information to the GP unless there was a problem with the medication but JR said that the form he had received had reported on a positive outcome.

Pharmacists are having problems getting patients back in for their 14 and 28 day review in person but are instead contacting patients by phone at these review dates.

PHR reported that in Oxon the LPC had supplied GPs with a supply of “post-its” to attach to new medication prescriptions to flag them up to the pharmacist and patient.

CT said that Berks had adopted the same policy and would be dropping off “post-its” to practices shortly.

LMC raised the problems with weekly prescribing and Nomad boxes.

The change in the regulations means that GPs should be prescribing for 28 days and only issuing 7 day prescriptions in specific limited circumstances.

RM said his practice was still issuing repeat dispensing 7 day prescriptions and the pharmacist therefore receives 4 x 7 day prescriptions.

One pharmacy chain has offered to provide NOMADS if no one else will.

CT said that dispensing fees for weekly prescriptions does not cover the pharmacist’s costs of preparing NOMAD packs but it does help.

CT said that preparing MDS is a significant workload for pharmacists but they do it for patients’ benefit.

LPC, LMC and PCT agree that GPs must only be requested to issue 7 day prescriptions when the patient meets the agreed criteria for such scripts.

It is not a necessary or appropriate prescribing mechanism for many patients who require adherence support and its overuse might place GP prescribers at risk.

GPs can still do weekly prescribing provided they feel it is appropriate.

CT said that there are other compliance aids apart from NOMADS.

If someone requires a compliance aid under the DDA the pharmacist will provide an appropriate compliance aid but it does not necessarily mean a NOMAD.

If a patient has a cognitive impairment pharmacists can deal with their request under the DDA.

In a significant number of cases patients have NOMADs because their carers have requested it.

Carers in most of the UK have been trained in assisting patients with their medications.

The problem in Berkshire is that it appears only the Royal Borough Social Services have trained their carers on how to dispense medications from blister packs.

JK agreed to reproduce for the East the discussions that have taken place in the West.

CT stated the LPC and PCT have agreed to move away from weekly prescribing from 1st January 2012. LMC said that they understand that it would stop by 1st January.

JK reported the East PCT was considering adapting and issuing the joint communication from LPC, LMC and PCT developed in the West.

This had been issued to pharmacists, GPs and patients in the West and advised all parties of a 3 month “grace period” in which to move to 28 day prescribing.

LMC asked if the LPC could produce a proforma on which the pharmacist could indicate to the GP what compliance aids they were providing to the patient.

Pharmacists and GPs together could share information to identify patients where family or carers are competent to assist the patient with their medications.

In the West GPs report a significant number of patients are being discharged from the RBH with MDS, the hospital pharmacy is not always able to prepare their MDS in the short timeframe before discharge so they are referred instead to community pharmacies for MDS provision.

There are also cases of patients going into the RBH with a NOMAD but being discharged without one.

LMC will raise this issue with Jonathan Fielden (Medical Director RBH).

LMC will raise these issues with CCGs and ask them to address them with the RBH contract department, but recognises that CCGs are stretched to manage the workload transferring to them.

Action Point: JK to reproduce the discussions that have taken place in the West on this area.

LPC to produce a proforma of compliance aids available so that pharmacists can indicate what is provided for patients.

JK to raise with Jonathan Fielden the issue of discharge medication for patients.

JK to write to the LPC and PCT to propose 1st January 2012 is the date by which the change to 28 prescribing will be completed.

GP Contract Changes for 2012/13

Communications have been sent out from NHS Employers and the GPC on the arrangements for the GP Contract for 2012/13:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130951.pdf

- There will be no increase in GP pay but there will be an uplift of 0.5% to cover increased costs including practice staff under £21K who will receive an uplift in their pay of £250 per annum
- This will be met through an increase in the value of the QOF points from £130.51 to £133.76.

QOF

- Changes to take into account some of NICE's recommendations (the depression indicators will be remaining in QOF until NICE develop alternative indicators)
- An increase to some upper and lower thresholds
- New clinical areas available in QoF.
- Revision of points attached to existing QoF areas.
- A continuation of the emergency admissions and referrals indicators in QOF
- The prescribing indicators being retired and replaced by 3 new indicators which aim to reduce avoidable A&E attendances

Practice boundaries/choice of GP practice

- Patients registering with more than one practice: a pilot is being run in 3 cities to understand cross boundary registration, GP issues and feasibility.
- Practice boundaries – when patients move to an area just outside their practice's boundary the practice can agree to retain the patient on their list but they do not have to take on patients from that area as new registrations.

Directed Enhanced Services

- An extension of the alcohol reduction scheme, the learning disabilities health check scheme and the extended hours access DES for a further year
- The osteoporosis DES to end in March 2012 as this will move into QoF.

Other

- Agreement in principle that subject to the successful passage of the Health and Social Care Bill all GP practices in England would be contractually required to be a member of a CCG.

LMC recognise there will be considerable pressure on GP budgets, costs and staff and GP income.

Berkshire PCT Cluster Developments

Cluster Chief Pharmacist

JK reported that Maha Yassaie has been appointed as the Chief Pharmacist across the Cluster.

It is unclear exactly which PCT management staff and clinicians were involved in making the appointment.

It is crucial the Cluster Chief Pharmacist consults the LMC appropriately and is conversant with GPs' obligations under the contract.

Erectile dysfunction prescribing

GPs reported that in the East the Medicines Management Team had recommended the prescribing of only 2 Erectile Dysfunction (ED) tablets per month and had advised that patients needing more should be prescribed these privately, possibly by a GP other than their registered GP.

PN said that in Bracknell GPs had been told by their CCG that patients already established on ED medications would be permitted to have 4 tablets per month but newly diagnosed ED patients should only be prescribed 2.

JK reported there were a few key issues around this advice.

- Clinical guidance from NICE or a local organisation is advisory, not obligatory.
- GPs have a duty under their terms of service with the NHS to provide appropriate medication based on the patient's needs.
- GPs have professional obligations to act in their patient's best clinical interest.
- There is an obvious inequity if two patients with the same ED condition receive different quantities of treatment determined by their date of diagnosis and initiation of treatment.
- Obvious inequities will quite rightly attract media interest.
- GPs can only be restricted from prescribing drugs on the NHS Black and Grey Lists.
- GPs need to prescribe what is appropriate for the patient's need, bearing in mind they may only prescribe on the NHS if the patient has one of a small set of clinical conditions.

Management Team Appointments

The Chief Executive, Directors and Assistant Directors are now all in post. Mid level management are now going through the appointment process.

The PCT Primary Care Team have clustered but will continue with an East and West base and staff will have portfolio responsibility across the area.

In total the PCT have reduced the team of about 40%.

In late 2012 there will be another round of reorganisation as the NHS Commissioning Board will take on responsibility for GP Contracts and premises (and the management staff that will administer these functions).

It currently appears likely that the NHS Commissioning Board will have a Thames Valley organisation.

Rental Arrangements

JR reported that rent reimbursements will be able to go up and down in the future.

The notional rent could go down to zero but it would be unlikely as it will need to be based on market valuations.

GPs said they would welcome sight of the new Cluster PCT structure.

JK reported that the LMC had asked the PCT for this at the LRC meetings but only LRC members appeared to have received this.

PN suggested that including it in a GP Bulletin would ensure that GPs saw it.

Action Point: JK to ask PCT to send the new PCT structure to GPs in a bulletin.

Clinical Commissioning Group (CCG) Developments across Berkshire

There are 7 CCGs in Berkshire which now have Boards in place in a shadow form until April 2013. There are increasing negotiations between the CCGs on how to work together.

A meeting, chaired by Rod Smith from the West, has looked at a Federation across Berks.

The CCGs are looking at groups and individual Board members taking on portfolio responsibility for areas such as mental health or acute long term conditions across all or a large part of Berkshire.

PHR asked how each CCG is performing.

In Bracknell GPs reported that the 4 Board members are reimbursed £90K each a year from a total annual budget of £365K.

In other CCGs Board GPs are reimbursed £100 per hour if they are employing a locum and £75 if they were not.

The WAM Board reimburse an hourly rate of £75 which is equivalent to the locum rate.

In Slough the Board have not yet agreed to pay themselves.

It was assumed that the information on Board payments would be available under the FOI Act and the LMC agreed to ask for this.

In WAM JR reported that the GPs involved had managed to secure funding of £40K from the SHA for education to assist more clinicians to become involved in clinical commissioning.

WAM intend to publish a report on how much they are spending and on what, to ensure that the whole process is open and transparent.

LMC asked how long the mandate the Bracknell CCG Board had with its constituent GPs would last for.

GPs felt that no changes are proposed or expected in the Bracknell CCG Board.

LMCs have a clear directive to ensure that elections take place for membership of the CCG Boards.

Lawrence Buckman has written that LMCs must ensure that CCGs are democratic and accountable.

A joint GPC/DOH document on the responsibilities and accountabilities of CCGs is expected soon.

JR said that Peter Holden (GPC Negotiator) is producing a record of work being passed onto GPs without the relevant funding and asked that GPs send him anonymised copies of letters when such instances occurred.

The Negotiators can use such data in their negotiations with the NHS Confederation about the increase in GP workload.

Action Point: The LMC to obtain financial information under the FOIA on payment to CCG Board members'

Flu 2011/12: Latest Advice

Paediatric versions of Flu vaccine have been withdrawn. There are no local Berkshire reports of any problems with this withdrawal.

JR reported that work is in progress to produce a vaccine to give life long protection against Flu.

Berkshire 111 Developments

Oxon are going ahead with this rapidly.

Berks are progressing more slowly and hope they will learn from the Oxon experience.

PHR reported his involved in this initiative and has attended many national and local conferences.

Pilots have run in Durham and Darlington, Nottingham, Lincoln, Luton, Derby and the Isle of Wight and PHR is emailing them about their experiences.

There are specific instances in the III protocols/operational guidance where the GP may be informed they have 1 hour in which to contact the patient.

PHR said he has now seen the III triage software and it could take up to 6 minutes to get from the patient whether they need an acute ambulance or not.

The initial contact point for patients will be non-clinician triagers/call handlers. There will be a clinical advisor as a second line but these will be mainly emergency care practitioners (paramedics and nurses) rather than GPs.

PHR felt that the patient disposal will inevitably be very frequently to the GP either in or out of hours.

JL said that in the West the OOH service could not engage the Ambulance Trust to work with them on a joint proposal for 111 as the Ambulance Trust is already committed to working with Oxon, Milton Keynes, Hampshire and hopefully Bucks.

In 2 years time when the West Berks service comes up for tender the Ambulance Trust may bid for it but they then may or may not be successful in their bid.

JL raised the issue of CRB checks for the call handlers.

PHR said that nationally they were felt not to be necessary. LMC has significant concerns about this approach and will clarify if this is the planned position and if it is, LMC will raise its concerns with 111 locally and nationally.

JL said that 111 services will be paid for each call they handle.

It was agreed that PHR and JL would liaise regularly on developments.

Low Priority Referral Arrangements

This has come up across the Thames Valley.

The volume and spread of procedures covered by low priority arrangements is increasing.

The LMC has asked for clarification of low priorities arrangements and has written to the PCT to ask for:

- Terms of reference.
- Group membership.
- How many time it has met in the last 2 years.
- Data and activity eg the number of applications received/declined/appealed and granted with a breakdown of clinical areas affected.
- Cost of the decisions in terms of those granted and those not granted.
- Oversight arrangements and appeal arrangements.
- How the data is published, when and to whom.

This request addressed to Maureen McCartney has been passed to Eleanor Mitchell SHA lead for his area but no response has yet been received.

LMC reps also wished to ask what the running costs of the Group were; this was agreed.

**Action Point: To ask PCT what the running costs of the Group were.
JK to feedback to the February meeting.**

New Chlamydia Testing at RBH

There is a new method of testing for Chlamydia that will be introduced from 1st December 2011 after which the old test devices will not be accepted.

SoS letter to L Buckman re status of LMCs

The Secretary of State for Health has written to the Chair of the GPC.
The letter affirms that the LMC will still have a role with the CCGs.
This will be incorporated in the Health and Social Care Bill.

Historical LMC Minutes (keep or shred)

This has arisen as there is no space at the Marlow office to keep these records that go back over many decades.
JR suggested holding on to these records until 28th February 2012, the LMC's 100th birthday.
It was suggested that Reading University History department should be approached to find out if they might be interested in adding them to the Universities historical archive.

Action: PR to explore alternatives to destruction (such as donating to a historical archive).

Day of Action – 30th November 2011

JK agreed to circulate information received on this from the GPC and BMA.
Pharmacists asked the PCT how they will be able to handle the workload if GPs or their staff are absent on the day of action.
PHR had canvassed surgeries and none anticipate any impact on service provision on the day of action.

Palliative Care in the Community

JK has been in communication with the PCT to clarify arrangements for obtaining oxygen.
If a patient needs oxygen they can access it via the Respiratory Team at the RBH but GPs can get faster access via a community based respiratory nurse for palliative care patients.
JK agreed to circulate the details.

Action Point: JK to circulate the details of the nurse who could assess respiratory patients.

Dates of future meetings

Due to clashes with CCGs etc it was suggested that the County meetings be moved to a Thursday, keeping the starting time of 2.15.
JK to follow this up and propose dates.

Action Point: JK to follow this up.

Date of Next Meeting – February 2012

The meeting closed at 4.30 pm.

DRAFT

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
	John, Megan	Sessional GP
	Kade, Chauke	Bracknell LMC (Co-optee)
*	Kennedy, Jim	LMC Medical Director
	Kumar, Hemantha (MLH)	Slough LMC
*	Lade, Jeremy	Wokingham LMC
	McCartney, Maureen	West Berks PCT
*	Mittal, Rab	Reading LMC
	Morando, Sarah	Reading LMC
	Nabi, Ajaz	Slough LMC (Co-optee)
*	Naran, Kish	Reading LMC
*	Nelli, Prash	Bracknell LMC
Chair*	Rawlinson, John	WAM LMC
*	Roblin, Paul	LMC Chief Executive
*	Ruffle, Simon	
	Skilling, Anthony	East Berks PCT
	Smith, Rod	Reading LMC
	Thorpe, Penny	TVPCA
*	Trivedi, Jitendra	Slough LMC
	Waddicor, Charles	West Berks PCT
*	Westcar, Paul	Newbury LMC

Apologies: Drs Brock, Hyde & Hear

In Attendance: Carol Trower Chief Executive LPC