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MINUTES OF WEST BERKSHIRE LRC/PCT LIAISON MEETING Thursday, 8th July 2010 Room G28, 57-59 Bath Road, Reading, RG30 2BA

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Minutes of Previous Meeting

The minutes from 13th May 2010 were agreed as a correct record of the meeting.

Matters Arising

PCT Finances

PHR said that IP had not sent him a copy of the Financial Board paper.

Action Point: MM to follow this up.

Chart Upload Project

Chris Cook attended for this item.

The PCT's intention is to have a new (largely electronic) system to pass practice childhood immunisation information regularly to the child health information system (CHIS).

Enhanced Services data will be collected with the same system.

The ES data will be collected quarterly, whereas the childhood immunisation data will be collected monthly.

The practice will have to run either a monthly or quarterly Chart query.

The PCT intends that this will go live in September but wants to continue the paper submissions for a period of a few months to ensure that the new system is stable.

It is hoped that this IT solution will solve the historic problems that have occurred.

The PCT are looking at any data protection issues for childhood immunisations (the ES returns do not contain any patient identifiable information).

There may be slight delays in getting immunisation onto CHIS.

This might be a problem in cases where a child is immunised just after a chart enquiry is run.

Any delay will only be 4-6 weeks.

Despite this, the new system was considered useful as it would stop children from falling through the net.

PHR said that he had read the draft document and did not see any problems.

He saw it as a system that GPs wanted and would avoid the current manual systems with wasteful double keying and data errors.

It was recognised that there has been workload implications for practices in the past few months but these will disappear.

CC asked that the LMC circulate the summary paper to members. LMC agreed to do this.

Action Point: LMC to circulate CC's summary paper to members.

Rheumatology

Rosemary Croft email to PHR (15/6/10) has been contentious (see copy below):

Dear Paul,

I remember we had some correspondence many months ago about the Discharge of patients in remission from the Rheumatology OPD, back to 'usual care' with their GP. The monitoring of all patients on DMARDs on the DAWN system is now in place.

I (in my position as a member of the South Reading Consortium) have been working with Secondary care who are now planning to discharge patients back to their GPs – each time attaching the two letters above. Both are still in draft...and the Rheumatology dept are planning to do training sessions for keen GPs – but are aware that many will be unable to attend.

Is there anything that might cause concern here?

I have checked on the Choose and book system, and re-referral to the Flare clinic is now available – and has spare quick appointments.

I would be very grateful for any comments before all of the above is finalised.

It appears that RBH consultants have acted on this proposal and are discharging patients on DMARDS back to Primary Care.

LMC reps felt DAWN was not working well, and produced a disconnection between prescribing and clinical care/monitoring of patients.

One rep asked whether the DAWN nurses spot trends in inflammatory markers and know how to handle this.

CG said that he had received a letter from a consultant stating that the patient had been discharged as “it was PCT policy”.

LMC reps were unhappy about secondary care discharging stable patients just after the abolition of the LES. This was the opposite of funding following activity.

DB said that they were trying to reduce the number of follow ups but he was not aware that a formal agreement or process had been reached on rheumatology patient discharges.

DB said that he had hoped that other people would have been able to attend the LMC meeting today but they had not been able to.

DB had been sent examples of RBH Rheumatologists wanting GPs to monitor new DMARD patients immediately. He had investigated this, and it appears that 2 consultants were asking GPs to monitor the patient for 8 weeks. This was a surprise to DB as it was not what had been contracted between the PCT and the RBH. After highlighting the problem it was understood that it had been stopped by the RBH.

DB said that one of the PCT’s main objectives was to reduce the number of follow up appointments at the RBH.

First OPD appointments were at an acceptable level but follow up numbers were too high.

DB said the South Reading consortium had seen some mileage in this and the PCT had investigated this with GP representatives and leadership present.

RM said that not all practices in the South support this idea.

PHR said that whatever the role of PBC commissioners, they cannot represent the provider arm of general practice.

Initiatives involving moving work to general practice were an LMC issue.

PHR said that there was a joint meeting between LMC and PBC leads on 22nd July to ensure the interface between PBC and LMC worked properly.

LMC asked if there would be funding for looking after stable rheumatology patients.

They were concerned about transfer of work without resources.

LMC reps were not happy with DAWN monitoring patients and the GP then prescribing.

DB said that it was similar to the INR prescribing but GPs said that the difference was that the INR result was available to them.

LMC reps reported no feedback from DAWN at all, yet GPs were prescribing and held the legal responsibility.

DB had not sought briefing on DAWN issues as the agenda had only said Rheumatology.

DB said that he would look into this further and report back.

LMC enquired about the DMARD LES.

MM said that 6 practices had now signed up to this and they would be receiving a quarterly claim form to complete.

CG said that he had not seen this document but had seen one which related to Newbury patients going to Swindon. His PM had not signed up to this as the practice was not in Newbury.

LMC felt the number of eligible practices was larger than 6, and the under counting resulted from a poorly worded LES document.

LMC felt the LES needed to be written in a way that applied across West Berks and then all eligible practices would sign it.
MM agreed to check this.

**Action Point: DB to look into the prescribing issues and DAWN monitoring.
MM to look at the low LES sign up and the wording of the LES, then re-offer the LES to practices that had patients cared for outside the RBH.**

Revised QoF Process/ QoF Visits (pre and post payment verification)

MM wanted LMC views on the PCT briefing paper proposing changes to QOF monitoring in 2010/11. This proposed:

- a reduction in the number of prepayment visits to a maximum of 10, down from 17 in 09/10 (with the aim being to visit 7 or 8)
- a light touch approach to Practices not visited with a significant reduction in the amount of documentation to be submitted in relation to the organisational domain and
- an increase in post payment verification from 5% to 10%.

The PCT felt it would be beneficial to conduct more visits as post payment ones.

PHR said that he understood that it was a national requirement to conduct post payment verification visits on no more than 5% of practices and that he would check this.

MM felt that there was no ceiling on the %.

MM believed that in Portsmouth, Southampton and the Isle of Wight 10% of practices were visited for post payment verification.

PHR said that he could see no problems with the PCT visiting the 5% (3 practices) and then visiting others that concerned them (ie targeting).

The LMC said that they would not sanction the PCT visiting 10% of practices for random post payment verification but would not raise objections if the PCT visited practices causing concern on top of the 5%.

DB reported that the PCT needed to make savings and that they had clawed back income following the post payment verification visits this year as people had made claims that were inappropriate.

Action Point: PHR to check whether the 5% national figure for post payment verification visits could be increased at PCT discretion.

Progress Update on email Contact with Locums

PHR wanted the PCTs and TVPCA to move from agreeing that an email system was necessary, to actually implementing it.

Although Penny Thorpe has sent PHR an email, he was concerned that things only happened when he pushed. The agreement had been made in principle 4 months ago but nothing had happened.

He said that he had tried to speak to Jeniene Scott about this but not got an answer.

It was agreed that MM and PHR would follow this up.

Action Point: MM and PHR to follow this up.

8-Month Baby Checks/Child Health Surveillance – clarification of new schedule

It appears that only in Reading is the 8 month check still occurring.

CG reported that his health visitor had approached him saying that all planned visits by HVs had been down graded to targeted visits only.

Unless the child is identified as at risk there would be no visit.

This seemed to contradict the CHS policy LMC was given on 11/3/10.

JM said that the investment needed to deliver the new CHS policy was about £200K and the PCT were reluctant to commit this until any national policy was known.

The PCT would continue with the old policy and Reading would need to continue with their 8 month checks for the time being.

LMC was unhappy that this change of direction after 11/3/10 had not been communicated to it.

Action Point: PCT to note LMC unhappiness with its communication on the issue.

Carbon Reduction Strategy for the NHS and GP's Role in Carbon Foot Printing Scheme

Janet Maxwell attended for this item.

She recommended papers by the NHS Sustainable Development Unit (SDU), dealing with saving carbon and improving health, and giving an overview of what GPs can do.

http://www.sdu.nhs.uk/page.php?page_id=167

A national carbon footprint carried out on the NHS from 1992-2004 came up with the figure that the NHS was using 18.6 mega tonnes of carbon dioxide which is 25% of the public sector emissions in England.

59% of this is procurement, mainly of pharmaceuticals.

The report says that the NHS has to reduce this figure by 10% in 2015, 34% in 2020 and 80% in 2050.

Work is ongoing on explaining the breakdown of this footprint and the effect the changes can make to health care in the country.

From the health point of view we need to look at health benefits of walking, healthy eating etc.

The SDU is producing a series of useful leaflets and a guide to commissioning.

These look at some of the areas which could be improved.

West Berks PCT is working with East Berks and BHT.

BSS has employed a sustainable development manager to work on this across the 3 Trusts.

He has a financial action plan which will be taken to the Board of the 3 Trusts.

There is a need to work on a wider basis especially with GP commissioners.

The RCGP has taken an active lead in this and Tim Ballard is the RCGP lead.

The Theale practice has signed up to be part of the pilot.

As a health economy there is a need to look at commissioning services in terms of carbon costs in future.

GPs also raised the issue of not being able to sterilise their equipment as they used to do but having to use disposables. This was felt to be carbon intensive.

JM said that the financial plan would be going to the September Board; after this there would be meetings with the PBC leads and she said she would like the opportunity to present this to the County LMC.

PHR and JM will liaise about attending the County LMC meeting.

Action Point: PHR and JM to liaise about attending the County meeting.

Extended Hours Utilisation

LMC said that it had seen the paper.

LMC shared PCT concerns about practices claiming full Extended Hours DES payment yet having poor slot occupancy figures.

The PCT had proposed a sliding scale system of payment pro-rata to slot occupancy.

LMC had reservations about this solution.

Poor % uptake has two possible causes:

1. practices where the patients do not want the service so are not using extended hours slots;
2. practices that are not advertising sufficiently the extended hours services.

LMC sympathised with the first scenario but not the second.

If a practice finds that its population does not want the service, it could re-time the service with PCT permission.

A practice should not be penalised because a well timed and advertised service is not wanted by its population.

MM said that last year the unfilled slots cost £87K.

Most practices have had a review to ensure that have done everything they can.

It is probable that the patients do not want the service.

One practice that had scored badly at 11% also had high OOHs and A&E attendance.

The PCT have worked with them and they are now scoring 69%.

LMC said that if it could be proven that the practice was not putting any effort into supplying and advertising extended hours slots, then it would support the PCT withdrawing the DES.

Operating Framework

MM read an email received on 23rd June from the SHA regarding access and the patient survey.

“The survey will continue as will QoF PE7 and PE8”.

The PCT advised practices to continue with 48h access arrangement until the White Paper said otherwise (due out next week).

LMC felt there was some confusion over this.

In some of his speeches, Andrew Lansley has said that the 48 hour access will disappear immediately.

LMC recognised patient survey results were still part of QoF.

MM said she would send PHR a copy of the Operating Framework for him to read.

Action Point: MM to send PHR a copy of the Operating Framework.

Revalidation

LMC has seen the PCT Board paper about the appraisal and Responsible Officer pilot being undertaken by WB PCT.

PHR was surprised the Steering Committee had membership from the Deanery and Executive Committee but not the LMC.

This Committee will deal with future evidence requirements and Responsible Officer (RO) governance issues.

GP appraisal requirements are part of the GP contract Regulations and Performers' List Directions and their interpretation should involve LMC.

DB said that he chaired the Committee and he would come back to PHR quickly with an answer.

Action Point: DB to respond to PHR quickly on LMC membership of the Committee.

Patient Survey Appeals

PCT has used national guidance to inform its policy on patient survey QoF appeals.

This seems to increase the confidence interval threshold for an appeal from last year's 7% to 10% and 15%.

The GPC had not seen the guidance before it went out.

PHR feels that paragraphs 4.1 (CI of 7%) and 4.3 (CI of 10 or 15%) contradict themselves.

PHR has asked the GPC to investigate this contradiction.

MM said that under the higher CI thresholds, 1 practice would lose its appeal eligibility for 48 hour access and 12 for advance booking.

Date of Next Meeting – 7th October 2010

The meeting opened at 2pm and closed at 3.15 pm.

Present	Name	Organisation
*	Birchall, Carol	LMC Minute Secretary
	Brock, Nicola	Wokingham LMC
*	Buckle, David	West Berks PCT
	Cave, James	Newbury LMC
	Foster, Nigel	West Berks PCT
Chair*	Gallagher, Charles	Wokingham LMC
	Harris, Mark	West Berks PCT
	Hyde, Maria	Newbury LMC
*	Lade, Jeremy	Wokingham LMC
*	McCartney, Maureen	West Berks PCT
	Mittal, Rab	Reading LMC
*	Morando, Sarah	Newbury LMC
*	Naran, Kish	Reading LMC
	O'Keefe, Hugh	West Berks PCT
	Owen, Anne	West Berks PCT
*	Roblin, Paul	LMC Chief Executive
*	Smith, Rod	Reading LMC
	Waddicor, Charles	West Berks PCT
*	Westcar, Paul	Newbury LMC
	Winfield, Cathy	West Berks PCT

Apologies: There were no apologies received

In Attendance: Chris Cook, Dr Janet Maxwell