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DRAFT

MINUTES OF BERKSHIRE COUNTY LMC MEETING
Tuesday 16th February 2010
Berkshire Masonic Centre, Sindlesham, RG41 5DB

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Minutes of Previous Meeting

The minutes of 3rd November 2009 were agreed as a correct record of the meeting.

South Central SHA Policy on DNACPR

DNACPR stands for “Do Not Attempt Cardio-Pulmonary Resuscitation”.
Mark Rowland (Respiratory Consultant in Portsmouth, with responsibility for end of life care at the SHA) and Tracey Courtnell (Senior Resuscitation Officer for Oxon PCT) attended.
MR spoke to the issue.

The issue of who should be offered CPR was raised by South Central Ambulance Service (SCAS) in 2008. SCAS were exposed to lots of similar documents outlining advance decisions across the region.
The SHA had contacted all the Medical Directors of the Acute Trusts and PEC Chairs in September 2008. A suggested programme with timescales was produced, with the aim of having a definite policy by October 2009 and dissemination to all involved by March 2010.

One acknowledged omission was that the TV LMCs had been missed out from this consultation. Through lack of knowledge of the structure of general practice, MR had assumed that consulting with the PEC Chairs would constitute consultation with GPs.

The process was started in October 2008 with a letter being sent out to all Chief Executives asking for nominated individuals to represent the organisations during the process.
Over 100 people were nominated over the course of the year, including patient representatives, representatives from cancer network, social care and domiciliary care, the ambulance, fire and police services, coroners and GPs.
5 working groups were established and the Adult policy group was led by Tracey Courtnell from Oxon PCT.

The existing TV documents were reviewed against the Resuscitation UK template document.
It was agreed that rather than using existing documents a new one (with associated process) should be developed.
Lothian have a policy (written by Juliet Spiller) which is being launched as a live document, and MR had several conversations with JS before starting the process.
The South Central will have one form and one policy for the region.

A lot of resuscitation decisions are made in the 24-48 hours following admission to hospital and many feel that historically some of these decisions have not been in the best interests of the patient.
The policy hopes to include any conversations about resuscitation within each individual's end of life care plan.
This decision must be captured and it is essential that this is respected.

A document was sent out to Chief Executives in December 2009 with a view to launching it in March 2010.
Tracey Courtnell sent PHR the document for comment. It was forwarded to all TV LMC reps, and produced a lot of responses. Unfortunately the reply to these was that the policy was no longer capable of change, and this provoked objections to the process and a request for the SHA team to speak to LMC.
All feedback received (including that from the LMCs) has now been incorporated in version 8, which was sent out on 15.2.10.

Currently there is no policy for children and adolescents. The plan is to concentrate on adults first.
This policy document is the first of its type in the country and may be rolled out nationally.

These resuscitation decisions are being made every day in secondary care.
It is felt important to communicate them with Primary Care, but currently they are not because to do so is too complicated.
A large number of acute trusts in the Thames Valley have now signed up to this policy.
Rather than a document launch in March, there will probably now be a celebration of its existence.

PHR said that he had passed back comments from Dr Godlee (Oxon LMC Chair), but not all of the grammatical suggestions seem to have been incorporated (eg use of 'to whom' in paragraph 10.1). One bullet in 8.8 appears to be a duplication.

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TC said that Dr Godlee's comments were very welcome and that the team took on board the omissions.
They were anxious to get GP/LMC input into section 8.8 of the document as it was felt that this was a very complex area.
Having spoken with Anant Sachdev (the most heavily involved GP up until now) the team has established that there is a Read Code which can be used to document the existence of a DNACPR decision but further work is needed.

From his clinical practice, PHR described two scenarios:

- A patient was receiving terminal care.
- A patient who is recurrently admitted to hospital with conditions such as arteriopathy or severe COPD, making them liable to cardiac arrest during an exacerbation.

It was easier for a GP to have a DNACPR discussion with the first category of patient.

MR said that 90% of patients on practices' GSF (Gold Standards Framework for terminal care) register were cancer patients with a prognostic pathway. It is with the failure (CCF) patients that a relationship needs to be built up before a GP can approach them and draw up a plan for when they do not want to continue with hospital admissions.
The aim is to get 50% of patients on the practice's GSF register with non-malignant conditions.

The plan is that a new DNACPR form will be produced on tear off lilac paper and sit in a pad containing a permanent white paper duplicate. The A4 form will have a tear off slip which needs to have written on it where the completed form can be found within a patient's home. This slip will be kept in a bottle in the patient's fridge with a label displayed clearly just inside the front door to warn the ambulance crews of its existence.

PHR felt the form could be clearer and highlight the 3 reasons for signing it.
These seem to be:

- CPR will not succeed.
- CPR might succeed but is predicted to be followed by a very poor quality of life.
- The patient does not want CPR.

Work is ongoing on how to communicate hospital decisions to GPs.
It should be noted on discharge summaries but these often take a long time to be produced and received. GPs could either be telephoned or a message sent electronically.
LMC suggested wristbands could be used. Apparently these are not allowed as they could be transferred to someone else.

TC said that the plan was to provide each practice with a book of 50 duplicate forms.
Reps said felt they would not be readily available when GPs wanted them
Many GPs would prefer to obtain the form online and then file it in their clinical system as an attachment to a patient's record. This would preclude printing it on lilac paper, the only purpose of which was easy identification by SCAS staff.
The meeting discussed alternative ways of demonstrating authenticity to ambulance crews.
Suggestions were an immediately recognisable logo or a watermark.

The SHA team hoped that in future, GPs who look after patients in nursing homes who were dementing or in a poor state of health would consider initiating a DNACPR decision. Where personal capacity was impaired, GPs would be building up relationships with family members and then asking them if they had any views on resuscitation.
The family need to be told that if they have made this decision and they call the ambulance they are asking for the patient/family member not to be resuscitated.
A leaflet is available which explains the process for family members.

PHR said that in the Oxford Radcliffe Trust, a lead acute take physician at the Oxford Radcliffe was unaware of the policy development.
TC said that the Medical Director (a neuro-histopathologist) had signed this policy off and that it was then to be cascaded through the organisation.

MR said that this had been a valuable learning experience on how to consult within the region.
In future, should a similar piece of work be undertaken, the LMC would be consulted from the outset.

Action Point: **MR to consider how to make an electronically available form immediately recognisable as legitimate by the ambulance crews.**

Matters Arising

ISA Vetting and Barring Scheme
PHR asked if practices had seen a GPC Guidance on ISA registration and CRB checks.
See **http://www.bbolmc.co.uk/vetbar1209.pdf**
The LMC office had also sent a hot topic email to practices last week.
http://www.bbolmc.co.uk/hottopic/hotall/hotall.html
It describes when to do CRB checks and on which staff.
Members did not recall seeing it possibly because it went to practice managers.

Action Point: PHR to email this around as a separate document.

Swine Flu Vaccination
JR felt that the profession should be congratulated for doing a good job during 2009.
Reps felt the vaccination up take for children from 6 months to 5 years seemed poor.
In East Berks, the advertising by the PCT was considered inadequate. Patients were still expecting to receive a letter inviting them to come in for vaccination and not self presenting.
East Berks PCT has said that the Walk in Centre will be also be providing a vaccination service.

KA said that within nurseries and schools it was being advertised that parents should present children to the GP for vaccination.
Vaccination during extended hours has been better on Saturday's than at evenings.
EB PCT has funded extended hours nursing clinics for this purpose.

Annual Appraisal

PHR asked if there were any problems now that the toolkit website was down on security grounds.
Appraisers said that it would cause problems for them as they would not be able to perform the required number of appraisals by the end of the financial year.
All hoped that PCTs would extend the time limit to complete this year's appraisals.
It is possible to complete the form manually but a lot of the appraisees had uploaded their evidence which was consequently un-retrievable.

It was hoped that the website would be operational again in 3 weeks as the DOH has indicated.
If it was not PHR said he would be taking the issue to PCTs asking for an extension to the deadline.
PHR has been surprised by the Oxon PCT stance that they will not extend the deadline.

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JD said that if a GP was to be struck off the Performer's List for non-appraisal in these circumstances, they could appeal to the NHS Tribunal with the likely result that the PCT would have to pay costs and reinstate the GP; it was not reasonable that any GP should be penalised because the national IT system had let them down.

MLH asked about an article in the local press about East Berkshire participating in a pilot about revalidation.
JD said that the National Pathfinder Pilot had approached South Central and the proposal is that MK PCT and Foundation Trust and the Isle of Wight will try enhanced appraisals of every doctor in these areas.
It will be 2013 before this will be rolled out nationally and this date will probably slip.

It was asked what would happen to GPs should remedial training be required after enhanced appraisal?
One view was that:
If this training was needed due to maternity or illness then it was inappropriate that the GP should be expected to pay for this. However if it was because the GP was performing poorly and had neglected CPD, then it should be up to that GP to pay for it.

Communication with Sessional GPs

Currently this relies on practices cascading information to the practice workforce.
PHR felt that the PCT had a responsibility to ensure that peripatetic locum GPs received the right documentation and paperwork.
The Performer's List held by the TVPCA has details of GP Contractors, Registrars, Armed Forces Doctors and 'others'.
The 'others' category could be identified as a sub-set and a special emailing list established.
Permission was needed from these GPs that they were happy to receive random emails.

Action Point: PHR to try and progress this.

LMC Conference and PHR Annual Report

PHR has sent his annual report to all LMC reps.
He hopes this will encourage thought on motions for Conference.
Motions have to be with GPC by 12th April 2010.

Reps could email suggestions to the office.
These could be partially developed (for PHR to convert into motions) or could be fully written (please!!).

The dominant issues this year seem to have been the:

1) Recession and the PCT Deficits
2) Swine Flu.

One suggestion was that the PCTs should recognise their responsibility to communicate with everyone on their Performer's List.

Action Point: To consider motions for Conference and submit them to the Secretariat Office by 12th April.

Conference Reps -1 Vacancy Remains
Currently the representatives are Drs Hear, Rawlinson and Trivedi.
There is one vacancy, expenses are paid at £400 per day with hotel expenses and a meal.
SM expressed an interest and will confirm with PHR.
The dates of the Conference are 10th and 11th June.

Action Point: SM to let PHR know if interested in attending.

Private Screening by GP Surgeries (NSC Guidance January 2010)

PHR said that he had sent out the guidance to all practices.
The regulations state that practices cannot charge for the use of the room if they are covered by notional rent but it may be reasonable to accept company funding for reception and utility costs.
However, if the patients are being charged by an outside company this might be seen as indirect charging of patients by practices.

Practices offering access to private screening services need too ensure they offer their patients genuine informed choice.
Many organisations who offer private screening rely on patient fear as a way to sell their product.

One rep raised a related issue of companies asking GPs to provide medical reports on patients considering entering a drug trial.
JR said that the process was that the surgery would be asked to invite patients to participate in these clinics and it would be up to the patient to contact the company, who would then enrol them on the trial. If they were accepted then the GP would be asked to provide a report similar to a Personal Medical Attendants report.
It is very much a patient led exercise and legal.

Charging for Vaccinations

GH asked about charging for combined vaccinations.

PHR responded.
Under the new GP contracts, vaccines that previously attracted an item of service in the old Red Book (eg Hepatitis A or typhoid), are funded via core block funding
Vaccines such as Hepatitis B or meningitis were never given on the NHS and can be charged for.
However problems occur with new vaccine combinations which often contain both NHS and privately funded components.
This is a grey area that PHR has been attempting to address nationally without a lot of success.
If the combined vaccine has an NHS element, PHR advises no charge is made.

Patient Survey and the 'Your Surgery Your Say' Campaign

This is a BMA campaign to encourage patients to say the right things when completing the national patient survey and maximise QoF income.

Last year, no appeal was successful for PE7 and PE8 of QoF in the Thames Valley.

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PHR view was that practices should concentrate on this rather than running their own surveys.

Summary Care Record 'Public Information Programme'

The SCR initiative will upload elements of patient records to a national database (the spine) which can be accessed by emergency services with the correct permissions.
The DOH support an opt out system which is contrary to the BMA view that patients should opt in.

All PCTs have been told that for 2010 only there will be central funding for a Public Information Programme (PIP).
Berkshire PCTs have opted for this but the arrangements have been very rushed.
Berkshire Shared Services have now identified that to upload elements of a patient record, complete telephone numbers with STD codes are needed on the practice clinical system.
There is also the problem that practices often note the patient's home and mobile numbers on the same line which again is not allowable.

Reps felt that this may be simple to solve by the software suppliers: if not it would be a considerable amount of work which the practice should not be expected to undertake without additional funding.

PHR said that he would support practices who said that this was not a task they would perform.

Action Point: To alert PHR of any problems as they emerge with this issue.

Report from GPC (issues not already covered)

JR asked if members would like to see a copy of the weekly Negotiating News from Laurence Buckman.
PHR said that when he received it, there was always a warning about forwarding it on.
He said that he would produce a précis of any points that needed communicating.

The GPC were often asking for local information on national issues.
PHR felt that obtaining the information was often very time-consuming, whereas his time was best spent trying to solve local issues rather than feeding them up to the GPC.
They had recently asked about issues where the LMC was not involved, such as PCT negotiations with PMS practices. Researching this for the GPC had considerable workload implications.

Action Point: PHR to produce a précis of the GPC News should there be any issues that needed communicating to GPs.

Un-discussed Issues

Issues from LRC Minutes (eg DAWN in West Berks).
PGDs and PSDs.
LMC Input into Pharmaceutical Needs Assessment.

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Date of Next Meeting – 27th April 2010

The meeting closed at 4.05 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	Newbury 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 Crampton, Gallagher, Hyde, Kade, Mower, Nelli and Trivedi

In Attendance: Mark Rowland and Tracey Courtnell

Dates of Future Meetings

22.06.10 21.09.10 09.11.10

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