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MINUTES OF BERKSHIRE COUNTY LMC MEETING Tuesday 3rd November 2009 Berkshire Masonic Centre, Sindlesham, RG41 5DB

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Minutes of Previous Meeting

The minutes of 8th September 2009 were agreed as a correct record of the meeting.

Matters Arising

ISA Vetting and Barring Scheme

Berks LMC has previously discussed the ISA Vetting and Barring Scheme under “Contact Point”.
New obligation came into place on 12.10.09. See <http://www.isa.gov.org.uk/>

PHR has been trying to clarify one new aspect

From 12.10.09, it will be a criminal offence for a practice knowingly to appoint a barred person to a 'regulated activity' post. How does a GP practice check if a potential employee is barred from regulated activity? Is it enough to ask the potential employee, or does a practice have to run a CRB check using the TVPCA as an umbrella body (cost £61)

TVPCA have said that NHS Employers have advised that CRB checks should be obtained from 12th October, but PHR believes this is incorrect advice. Both the ISA and BMA have now confirmed PHR's view. The ISA has said that ISA registration will be required for new employees from November 2010 and this will involve a CRB check.

New ISA rules will be implemented in stages, with current GPs required to be registered with the ISA by 2015. GPC guidance is expected soon.

The process for obtaining ISA registration is currently unknown.

Members asked who would fund this. Would it be the employer or the employee?

This is not known.

See <http://www.bbolmc.co.uk/hottopic/hotall/hotall.html>

Patient Perception Survey: Better advertising in practices

See <http://www.bbolmc.co.uk/hottopic/hotall/hotall.html>

PHR has not heard of any successful appeals against QOF PE7 and PE8 (although some in West Berks are still to be heard).

He has emailed all Thames Valley practices encouraging them to advertise their access arrangements widely.

The hope is that that when patients are asked for their opinion in the national survey (now quarterly) their responses on the questionnaire will be favourable.

IM reported that even though her practice did not do extended hours they usually got a good percentage on this questionnaire however practices that were open longer and offered extended hours got a much lower percentage. IM felt this was very relevant in Slough.

PHR reported that if a practice managed to vaccinate 3% more patients with swine flu compared with the 08/09 seasonal flu vaccination programme they would be rewarded with the thresholds for PE7 and 8 being changed. The upper limit would be reduced 10% and the lower reduced by 20%.

The patient survey figures for the first quarter April – June have been delayed and are now expected in January 2010.

JR said that the BMA and GPC are lobbying Government about the survey but it was unlikely to change.

GPs asked if the LMC could produce standard advertising for practices to use.

PHR said that in his email he had asked practices for evidence of good practice but had so far received none.

He said he would email practices again and see if anything was forthcoming, following which he would try and issue guidance.

Action Point: PHR to email practices asking for examples of advertising and then issue a standard form of words for practices to use.

Dates for meetings in 2010

GH reported that 23rd February was difficult as it was a STEPS meeting and asked that it be changed.

Action Point: To change the February date.

Recent meetings with CAMHS Providers and Commissioners

As the CAMHS service was unable to attend the County meeting its reps had attended both LRC meetings instead. Issues discussed had been very similar, problems with the referral form and the fact that when patients are rejected clear advice was needed on what to do with them.

BHCT as current providers of CAMHS have agreed in future not to introduce new changes without dialogue with the LMC.

It was generally felt that Simon Forster was well intentioned, wanted to make the system work and ensure that the referral process was not an obstacle.

GPs felt that the presentations were influenced by CAMHS going through a tendering process and were worried that once the tender was complete the service may revert to its previous behaviour and attitudes.

It was not known when the tender decision would be made, but it was felt it would not be too far off.

PHR asked if the Committee would like a similar presentation from the Adult service.

GPs reported that if an adult referral was rejected by BHCT no other suggestions were made for the treatment of the patient and this needed to be addressed.

GPs also said that they felt they were the last people to be told what was happening with a referral.

BHCT also behaved inconsistently.

If a patient was refused by the service and told to approach voluntary organisations, the Berks Healthcare Trust has been known a few days later to send round a flier announcing a new service that would have been appropriate for the patient.

It was agreed to ask Pete Sudbury's successor to attend the next County meeting.

Action Point: To ask Pete Sudbury's replacement to the next meeting.

IAPT (Improved Access to Psychological Therapies)

GPs reported that they had found out by accident about a service called Talking Therapies (IAPT).

The service had approached practices asking if there was space in their practices for an IAPT worker to see patients.

If the surgery had said no, it was not informed about when the service would be operational.

The Talking Therapies service was being funded with new money to improve access to psychological therapies and is about to be implemented in West Berkshire.

PHR reported that in Oxon not every practice had an IAPT worker based onsite, but they were geographically spread across the county.

Practices that hosted the service were not being paid for room rental but received a contribution for heat and light.

The Oxon system requires the GP to refer using a standard form and the patient is given a questionnaire to fill in.

The IAPT service then contacts the patient.

The problem is that the service very quickly reached capacity and a waiting list now exists.

Reading GPs said that in their area, the service had been operational for 6 months.

It was very good, with patients being seen within a month of referral and few DNAs.

It seems that this service is not available in all parts of the West Berks PCT area.

Slough GPs reported that their service was extremely bad.

If they asked for an urgent assessment of a patient they would receive a visit at the surgery by a very inexperienced worker who would usually assess the patient and state that a routine referral was all that was needed. In one instance this was incorrect and the patient had gone on to have serious problems.

Action Point: PHR to raise the question of inequality of the IAPT service within West Berks.

Payment of LRC Chairs

It had previously been agreed a year ago that in recognition of the work the LRC Chairs do, remuneration should be made to them.

However, the level of remuneration had never been agreed.

PHR said that he had emailed a draft job description for the roles of LRC Chair, County Chair and County Treasurer to members for their consideration.

GH reported that as Jane Solomon had left BBOLMC and not been replaced, there was a pot of money to be spent equivalent to the Berks share of her cost.

BBOLMC has failed to recruit a new Medical Director.

Should one be appointed, the role of the LRC Chair would change.

Currently LRC Chairs were supporting PHR when he was unable to attend a meeting due to a clash of commitments. LRC Chairs would try to attend in his place.

PHR said that he felt the role of LRC Chair was important in vetting information that came from PCTs. Often he was left off the distribution list and he valued having someone in local general practice who could pass emerging issues to him.

Graham Jackson (Bucks Treasurer) has told GH that Bucks fund their LMC Chair at 2 hospital practitioner sessions per week per year and were close to hitting the limit for their levy.

PHR queried whether this was an accurate description of the Bucks position.

Berks were happily not in this situation.

JR said that historically the position of the LMR and LRC Chair in Bucks had been filled by the same person but they had changed to pay one session for each role.

There was discussion about what rate should be paid, a clinical assistant rate at £5,100 or a Hospital Practitioner at £6,014.

West Berks currently has no LRC Chair.

PHR said that he did not see the role of chairing the actual LRC meetings in West Berks as an issue.

The main problem was that he had no one to deputise for him when he had a clash of commitments.

He felt that to offer remuneration for the post might attract a GP to come forward, if not for all of the role then for part of it.

PHR also felt it was important to have a local figurehead for each LRC.

CG expressed an interest in looking at the position now that his duties within his practice had changed.

IM reported that it was not her intention to continue in the post of Chair of the East Berks LRC indefinitely, but that she had been promised remuneration when she undertook the role.

PHR said that it was also important to remember the matter of succession planning for when he retired.

It is possible that in future his current full time role might need to be covered by more than one part timer.

If LRC Chairs were in place, they might provide a pool from which his successors could come.

GH raised the issue of what to pay the County and Secretariat Treasurer: both roles were quite onerous.

Lengthy debate took place.

A motion was proposed that the LRC Chairs and Treasurer should be remunerated at the rate of £6,014 per annum.

This was proposed by Dr Kumar and seconded by Dr Mittal. It was carried unanimously.

Action Point: To pay the LRC Chairs £6,014 per annum (the higher Hospital Practitioner's rate).

Swine Flu Vaccination

Practices will have received a spreadsheet devised by the DoH and sent by each PCT, which advises them when vaccine will arrive.

Each practice will receive 500 vaccines which will be the approximate size of a shoe box. It was decided to only deliver this amount initially to ensure that surgeries would have sufficient storage space in their vaccine fridges.

The Baxter vaccines will be available on demand for patients with an egg allergy, or for pregnant women who do not want the Pandemerix product (contains Thiomersal).

There is an issue with those over 10.

National guidance (Green Book and CMO letters) is to offer only a single dose but the SPC (Summary of Product Characteristics) describes a 2 dose course.

PHR said that he was trying to resolve this nationally.

JR described research done in Australia that if a patient had one dose they developed 98% antibody response but after the second dose this dropped to 96% across a range of ages.

Children under 10 do not have a well developed immune system and would need two doses.

GPs were concerned that if they deviated from the SPC and gave a patient only one vaccination they might be sued if a patient went on to develop swine flu.

The Committee felt that this was unlikely after a national directive.

WB PCT have contacted practices and asked them if they would be prepared to vaccinate social care staff.

The LMC advice is that it is up to individual organisations to decide whether to take on the work and how much to charge.

If practices agreed to perform this service, the vaccinations would be taken from their initial stock of 500.

PHR said that only GPs and nurses (not receptionists) counted as frontline staff within a practice.

HVs and DNs would have to contact their own employers to organise vaccination.

Under the DES, practices should supply the PCT with a list of their housebound patients.

The PCT would then organise for DN staff to visit and vaccinate them.

This would be done at no cost to the practice (please note this is not the case for seasonal flu).

Currently it was not known whether the vaccine for the housebound would have to come from the practice stock of 500. As it was the PCT who would be paying, they may also be providing the vaccines.

PHR said that if practices achieved 3% more swine flu vaccinations in the clinical at risk groups than the equivalent figures for 2008-9 seasonal flu, then they would have their PE7 and 8 targets reduced.

GPs said that the problem was that all over 65s were routinely vaccinated against seasonal flu but not with swine flu.

PHR agreed that these differences in target populations needed to be taken into account when making the calculations.

GPs reported that there were several lists being circulated which put different patients as the top priority for vaccination.

PHR agreed to issue the list he had helped devise with the TV HPA.

(Thames Valley HPU recommendations 26.10.09)

The following groups are particularly vulnerable and appropriate to immunise early in the setting of limited initial vaccine availability.

Patients with steroid dependent asthma, or asthma related hospital admission

Pregnant women at 20 or more weeks of gestation
Children with neurocognitive or neuromuscular disorders
Children with other severe lung disease (cystic fibrosis etc.)
Immunosuppressed individuals.

PHR alerted reps to the statement issued by BBOLMC encouraging all clinicians to be vaccinated.

It was not known what the further supply of the vaccine would be.

Obviously if a practice only had a small list the 500 doses may be sufficient but for larger practices a further supply would be needed.

GPs were having difficulties deciding who to vaccinate from the first batch.

It was recommended that pregnant women in their third trimester and those with immune suppressed illnesses should receive the first vaccines.

There was a worry that only 500 could be vaccinated and if the 501st became ill the doctor could face major problems.

PHR agreed to research the issue of further vaccine supply.

Action Point: PHR to research whether two or one dose was needed for children over 10.

PHR to post the issue of further vaccine supply on the national list server.

Annual Appraisal

PHR reported he had sent an email on 21st October that stated that the PCT have the potential to remove from the Performers List those GPs who have not had their appraisal performed.

See <http://www.bbolmc.co.uk/hottopic/hotall/hotall.html>

PHR view was that although most PCTs allocated appraisers (and dates), it is up to the individual GP to ensure that they have an annual appraisal performed.

Otherwise they are risking their professional and financial livelihoods.

The TVPCA want to have a trickle of appraisals performed throughout the year and intend to inform GPs in the month of their appraisal.

GPs said that they would like more notice and felt that quarterly appraisal allocation would be the best solution.

PHR praised the West Berks solution of allowing one appraisal to count for two years in their attempt to achieve even spread of appraisal over any year.

JD reported his advice to PCTs that it is not necessary for doctors to have more than one appraisal in any one year period as part of catch up.

Rather than have every GP have an appraisal at the end of March it is intended that they be spread out across the year and he agreed that a quarter's notice would be adequate time to arrange for an appraisal to be performed.

PHR said that the LMC could advise people experiencing Performers List and appraisal problems following a career gap through choice, sickness or maternity.

Action Point: To advise people returning to the profession to contact the LMC for initial advice.

Childhood Vaccination System (SHA Study)

The SHA plans a study to look at improving the childhood vaccination service and have contacted BBOLMC for support. PHR has given this. Two broad questions are being asked:

- Are too many computer systems coding this information?

- Are the standards for education and training of health professionals sufficient to ensure that nurses practice the best vaccination standards?

In West Berkshire the PCT are apparently looking at asking GPs to use only the childhealth computer system and to stop using the Exeter system.

In Oxon, a computer based interrogation had reconciled the practice and childhealth computer data to produce one useful list.

Implications of a Recession for GPs

PCTs have stressed in recent LRCs that they are required to save 20% of anticipated costs within the next 5 years. PCTs are saying that savings will not only come from secondary care.

IM stressed that practices also need to examine their income and costs.

GPs are now performing coil fitting but it was asked how many GPs realised that they were performing this task at a loss.

The PPA does not reimburse the full cost of the coil, or the cost of the disposable equipment.

The IUD and Minor Surgery enhanced services are NESs, and so the payment rates will be set by the PCT.

It is rumoured that rental reimbursement may be dependent on GPs performing some extra services.

Meeting discussed whether notional rent could ever come down.

PHR said that he was under the impression that this could not happen under the Premises Regulations.

IM said that she thought it had already happened to one practice and agreed to supply PHR with the details.

Action Point: IM to supply PHR with the details of the practice who had had their rent reimbursement dropped.

Report from GPC Rep

JR reported that the abolition of practice boundaries is looming and the implications of this change are being worked on.

Date of Next Meeting – 23rd February 2009

The meeting closed at 4.10 pm.

<i>Present</i>	<i>Name</i>	<i>Organisation</i>
	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
*	Kumar, Hemantha (MLH)	Slough LMC
	Kade, Chauke	Bracknell LMC (Co-optee)
	Lade, Jeremy	Wokingham LMC
	Llewellyn, Lise	East Berks PCT
*	Mittal, Rab	Reading LMC
	Morando, Sarah	Reading LMC
*	Moneim, Tarek	Reading LMC
*	Mower, Isabel	WAM LMC
*	Nabi, Ajaz	Slough LMC (Co-optee)
*	Naran, Kish	Reading LMC
	Nelli, Prash	Bracknell LMC
	Parker, Julius	Slough LMC
Chair*	Rawlinson, John	WAM LMC
*	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 Smith and Penny Thorpe

Dates for Future Meetings

27.4.10 22.6.10 7.9.10 9.11.10