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MINUTES OF EAST BERKSHIRE LRC/PCT LIAISON MEETING Tuesday 13th October 2009 The Manor Park Practice, Slough, SL1 3XU

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Guest Item - CAMHS meeting with Commissioner and Provider reps

Simon Foster (Medical Director of CAMHS in Berkshire Healthcare Trust) attended for this item. SF reported that all 3 East Berks localities have Teams which provide CAMHS. The service was split into tiers with tier 1 being the service that was delivered by GPs, schools etc.

Trevor Keable (TK) as a lead commissioner of the CAMHS service, said that it was recognised that CAMHS has not provided the service it should have. EB PCT is actively working with Linda Woolham at the SHA to see how it can be changed to ensure it does work.

It was felt that in Bracknell the service did work better; all referrals went to a hub where they were assessed and any that were inappropriate diverted elsewhere.

The problem is that Slough and WAM do not have this system.

A new specification is being worked on which will be introduced over the next 6 months and then each area will have a hub and work in the same way.

So far the changes introduced in WAM are working, but this was not so in Slough and this was being looked into.

The new changes have halved the number of children who have been referred to CAMHS. It has received positive feedback from the Children's Trust.

GPs expressed concern over the high number of rejections of GP referrals but were hopeful that the hub will solve this.

A lot of the current referrals to CAMHS are being told to try other services without the patient even being assessed.

The hub will have assessment criteria for each referral.

Katie Simpson is involved in this redesign; she is the mental health lead and a GP.

SF assured GPs that it was not his intention to turn children away. He wanted to see people who needed to be seen and it is difficult to get this right every time.

He said that he would welcome feedback should anyone be unhappy.

The service is in the process of setting up a website and contact details would be available on that site.

GPs reported that the CAF form was a very long winded document which incorporates information that GPs may not have and would not feel was relevant to the referral.

Traditionally GPs have completed a referral letter stating all the facts they knew and sent this off.

Now these referrals were being rejected if they did not have the CAF form attached.

PHR said that in other areas he had negotiated that provided relevant parts of the document were completed and accompanied by a referral letter this was acceptable

SF said that discussion would need to occur on what was needed as the CAF form was a national requirement to collect demographic details which needed to be fed back to the commissioners.

GPs suggested that they could send in their traditional referral letter and accompany it with a computer print out including the information the service needed and that GPs held.

Currently the data from the form was being input manually by CAMHS and as long as it was accessible within the printout it should be acceptable.

GPs said that one stumbling block was the requirement that the patient and parents sign the form.

In some instances the patient does not want to sign or does not want their parents to know about it and this was causing delays with the referrals.

SF said that a regular review with the LMC would be useful.

GPs reported that once they could get into the service, it was very good.

Action Point: PHR and the Business Manager responsible for the CAF Form to work together.

Minutes of Previous Meeting

The minutes from 7th July 2009 were agreed as a correct record of the meeting.

2010 Meeting Dates

The following were noted:

12.01.10

09.03.10

11.05.10

06.07.10

05.10.10.

Swine Flu Vaccination

The national agreement for vaccinating the housebound is that this is not a task expected of GPs and should be performed by DNs.

In his letter Ian Dalton has stated that the £5.25 that will be paid to practices is for all patients on their list vaccinated irrespective of who administers it.

DNs will have to be paid by the PCT separately, thus PCTs would end up paying twice.

The PCT were concerned about this as it would impact on their finances.

National clarification on this issue is awaited in the next week.

The PCT said that they had asked practices to provide them with the numbers of housebound patients who would need vaccinating.

GPs said that the numbers concerned would only be very small and felt that the PCT should be concentrating on issues which would save a lot more money.

PHR said that his view was that the GPs needed to step up to the mark with swine flu and he would be encouraging GPs to ensure that practices' role in vaccination is successful. This was an issue of clinical delivery and GP reputation.

In recommending the figure of £5.25 the GPC was not anticipating GPs making profits but had negotiated a cost neutral service.

The PCT said that practices could use their extended hours to vaccinate patients if they needed to.

PCT Funding in a Recession

Although nothing has been announced nationally, the PCT were working on a £100m per annum reduction in spend over the next 5 years. This is approximately 20% of its budget.

Over the next few months work must be undertaken to minimise the impact of this.

Hard decisions will need to be made on what services to maintain and what to change.

It was accepted that the Government needed to educate patients on what to expect in the future.

When asked the PCT felt they may not have commissioned the Darzi Centre if they had known about the recession but felt that extended hours were acceptable as it was about seeing patients in the surgery rather than them attending A&E at a far greater cost.

Areas that need to be looked at are:

- The significant outliers in out patient referrals.
- Clinical areas where the contract would suggest more activity than planned such as surgery, (recognition that this could be patient driven).
- Address some of the work that is currently being done in hospital which could be done elsewhere.
- Look at mental health services in terms of whether they are value for money.

The PCT assured the LMC that there would be no sacred cows exempt from consideration for change or cuts.

Conversations were needed early on regarding where to make changes.

PCT suggested that initial discussions could take place at the LRC meetings.

The PCT needed to define core services and would be working on this with the LMC.

AG felt that it was important that the secondary care consultants saw that it was not just secondary care that was feeling the pain but that primary care was too.

GPs said that whenever a change was made it always impacted on the services GPs provided.

The PCT will be looking at referral rates, prescribing costs etc.
GPs needed to develop systems to control this in-house.

**Action Point: The LMC and PCT to work together on this.
To encourage GPs to put in place systems to allow them to feed back to the PCT on issues such as referral rates and prescribing costs.**

PE7 and PE8 Appeals

There have been no formal appeal hearings; all appeals had been dealt with in writing.
No appeal had been successful.
The main criterion which practices failed was “conducting an alternative survey at the same time as the national one”.

The LMC will be encouraging all practices to improve their advertising of their access arrangements so that when patients are asked to fill out the next national questionnaire this is fresh in their minds.

TV HPA Guidance on Infection Control

Re Guidance on Infection Control and Communicable Disease for Primary and Community Care within the Thames Valley: August 2009.

LMC had major reservations about this TV HPA document that had gone to the GP Commissioning Group. It describes standards in infection control in general practices which appear relevant only to the hospital environment.

LMC has had difficulty identifying the author.

A TV HPA lead identified with the document admits there has been no involvement with GPs in its development!!!

This person had advised that it was expected that the PCT would apply common sense about what is applicable in ordinary consulting rooms.

When building new premises, PCTs should use the guidance to install the most appropriate infection control.

IM had asked that this document went to the Contract Group.

The PCT had not accepted it as policy.

PHR agreed to deal directly with the HPA.

Action Point: PHR to deal with the HPA.

Role of GP Contract Commissioning Group

PHR asked that if the PCT had issues that would affect Primary Care, that they spoke to him in advance.

It appears that there are issues which are bypassing this route and only discussed at the GP Contract Group, eg the consultant to consultant referral LES.

The PCT said that such issues were being discussed by the PBC groups; the LMC asked that they be informed of such initiatives at an early stage. This was to avoid wasting time and resources when early LMC input could have corrected things that were wrong.

Action Point: The PCT to alert the LMC to issues affecting primary care.

Seniority abatement and the contract safety clause

PHR has been approached by a BE practice for help with its seniority payments and abatement after income assessment, apparently by the TVPCA. The latter say they only do this after consultation with the PCT. However, PHR is concerned that the abatement decision never gets to those in the PCT with knowledge of the contract safety net described below

<http://www.bbolmc.co.uk/> contains a document originally written by PHR in 2007 part of which is copied below:

The negotiators of our new contract put in a safety net clause

Seniority – pay thresholds

We have therefore agreed that those GPs who believe that they are not receiving the seniority payment to which they are entitled can apply to the PCO which, together with the LMC (or equivalent), will examine the entitlement to ensure the GP is not disadvantaged and correct it upwards where evidence supports this. The intention is that seniority payments should reflect doctors' time commitment to general practice and not simply their earnings. Only the GP would be able to initiate a review. PCTs would not have the power to do so.

JW said that the TVPCA did speak to finance but then spoke to someone in primary care. PHR asked that the PCT took notice of the contract safety net.

Action Point: The PCT and LMC to work together to reach resolution.

Acute Medical Pathways: contacting the HWPB Medical Registrar

PHR said that he would be dealing directly with HWPB and if there is no resolution he would bring it back to the meeting.

Action Point: PHR to deal with Healthierwood and Wexham on this issue.

QoF and Contract Reviews

The paper has been sent out which describes the process that will be applied this year. If a practice has not been visited in the previous 2 years they can expect a visit this year; in total 23 practices will be visited.

The visiting team will remain the same as in previous years.

Diabetes Capacity

CK spoke to this issue.

Under David Dove's shared care protocol only the Diabetes Centre can start a patient on Xenetide after which general practice can take over for on going care and monitoring.

However the Diabetes Centre seems not to have the capacity to perform this role and is returning GP referrals. DD is saying that he has no funding left.

GPs asked what mechanism the PCT had to improve the capacity of the Centre.

The NICE guidelines actually state that the drug is safe for a GP to initiate but because of the shared care protocol EB GPs felt they could not do this.

The PCT agreed to take this issue up and review the guidelines that are appropriate for primary care.

Action Point: The PCT to process this issue.

Date of Next Meeting – 10th March 2009

The meeting closed at 3.10 pm.

Present	Name	Organisation
*	Arora, Kanchan	Bracknell LMC
*	Birchall, Carol	LMC Minute Secretary
*	Crampton, Anne	Bracknell LMC
*	Greig, Adam	East Berks PCT
*	Halliwell, Roger	Bracknell LMC (Co-optee)
*	Head, Paula	East Berks PCT
*	Hear, Gurdip	Slough LMC
*	Kade, Chauke	Bracknell LMC (Co-optee)
	Kumar, Hemantha (MLH)	Slough LMC
	Llewellyn, Lise	East Berks PCT
	McGlynn, Jackie	East Berks PCT
	Mitchell, Eleanor	East Berks PCT
	Mower, Isabel	WAM LMC
*	Nabi, Ajaz	Slough LMC (Co-optee)
*	Nelli, Prash	Bracknell LMC
	Parker, Julius	Slough LMC
*	Rawlinson, John	WAM LMC
*	Roblin, Paul	LMC Chief Executive
*	Skilling, Anthony	East Berks PCT
	Tong, William	East Berks PCT
	Trivedi Jitendra	Slough LMC
*	Walters Jacky	East Berks PCT

Apologies: Drs Mower and Parker

In Attendance: Simon Foster, Trevor Keeble and Tota?? (GH brought her)

Dates of Future Meetings

12.01.10 09.03.10 11.05.10 06.07.10 05.10.10