

LMC Secretariat Newsletter (January 2006)

Contents

(CTRL + Click to hyperlink)

Commissioning a Patient Led NHS (CPL-NHS)	1
Provision of Practice Held Clinical Information	2
Pandemic Flu Planning	2
Changes to the Misuse of Drugs Legislation	3
Hamish Meldrum's Letter to All GPs - 19.12.05	4
Barbara Hakin (NHS Employers) View of nGMS for 06/07	6
Enhanced Services Floors (ESF)	7
GMC GP Register	7
New Premises Directions	7
BMA Guidance on Jury Service	8
Dovedale Counselling	8
Flexible Career Scheme and GP Returner Scheme Funding	8
MURs (Medicines Use Reviews)	8
GPC Elections	9
PCTs who Delay Payment	9
Choice	9
Oxfordshire Issues	10
CALS (Clinical Advice and Liaison Service)	10
Buckinghamshire Issues	12
Buckinghamshire Alliance Board	12
Demand Management (Mid & South Bucks Health Economy)	12
Berkshire Issues	14
Berkshire Sessional GPs	14
AAA Screening (Abdominal Aortic Aneurysm)	14
West Berkshire PCTs	15

Commissioning a Patient Led NHS (CPL-NHS)

14 week public consultation over Thames Valley Reorganisation (CPL-NHS) began on 14/12/05 and ends on 21/03/06.

TVHA Consultation Document available on:

www.tvha.nhs.uk/cpl-nhs.html

Feedback by text messaging 07775 544974

Feedback by email cplfeedback@tvha.nhs.uk

TV SHA 01865 337000

The options for PCT numbers in the Thames Valley are either 5 or 4.

5 seems likely, keeping Milton Keynes separate from the rest of Bucks.

Oxon will form 1 PCT and Berkshire 2 (East and West).

Provision of Practice Held Clinical Information

Practices are increasingly getting requests from PCTs to provide specific health information. GMS (paragraph 77) and PMS (paragraph 73) regulations oblige contractors to give the PCT (or its authorised rep) access to:-

1. Any information which is reasonably required by the PCT for the purposes of or in connection with the contract.
2. Any information which is reasonably required in connection with the PCTs function.

Web addresses for regulations:-

GMS regulations: <http://www.opsi.gov.uk/si/si2004/20040291.htm>

PMS regulations: <http://www.opsi.gov.uk/si/si2004/20040627.htm>

Wessex LMC has developed the following code of practice TV LMC might also like to adopt:-

1. All requests for information should be made in writing (this would include email) by the PCT.
2. Requests should also include a brief explanation as to why the information is required and what the information will be used for.
3. The PCT will copy the LMC into any request for information.
4. The timescales for completion should normally be 28 days; exception may be agreed with the LMC subject to capacity issues at practice level.
5. The outcome of the information gathering exercise should be fed back to practices, because if this data is deemed to be important then comparative data would be valuable for practices to use in their practice development plan.
6. All requests for information from practices should be managed through a single source at the PCT; this will prevent duplication, assess workload being requested from practices and ensure the information cannot be obtained in any other way.
7. If practices do not have the skills or time to provide the data then they should accept the PCT employee assistance in obtaining the information, provided all issues of patient confidentiality are covered.
8. If there is a dispute, the LMC would suggest that practices first approach the LMC, rather than escalate the issues locally.

Pandemic Flu Planning

The whole Thames Valley and each County has set up planning Committees. Oxfordshire seems most advanced and involved the LMC early, especially on a clinical sub group.

Many issues are common to all civil emergency planning but there are some specific clinical issues.

1. Tamiflu eligibility and how to prescribe/dispense.
2. Discussion on whether most triage will be by phone or face to face.

3. Supplementing a workforce depleted by illness.
4. Designating some surgeries and clinics as specialising in flu care.
5. Separation of premises into flu and non-flu areas.
6. Information provision for both patients and clinicians.
Secretariat view is that each county should develop a Flu Website.
7. Augmentation of telephone access to clinical triage by publication of selected mobile phone numbers when the situation demands it.
8. Criteria for hospital admission. Is age a stand alone criteria?
Will GPs be provided with pulse oximeters.
9. Impact of flu on delaying routine admissions.
10. Sickness certification, how will this be managed. Will the 7 day rule be suspended?
11. What arrangements may be needed for death certification and morgue facilities?
12. Will some aspects of the new contract be suspended without detriment to GP income?
13. Procurement of personal protective equipment.
14. Practicality and financing of mass immunisation.
15. Practices working in confederations and helping each other out.

Weblinks:-

Influenza Pandemic Plan -

<http://www.dh.gov.uk/PolicyAndGuidance/EmergencyPlanning/PandemicFlu/fs/en>

Health Protection Agency - <http://www.hpa.org.uk/>

Bird Flu Information Sites - www.bird-flu.me.uk/

GP Education - www.doctors.net.uk/pandemicflu

US Government Flu Planning - www.pandemicflu.gov/plan/tab3.html

Workshops for Practice Managers and GPs were held in Milton Keynes on 12/1/06 and in Oxfordshire on 10/1/06.

MK/Mid and South Bucks flu planning contacts are Nicholas Hicks (01908 243084), Clare Strong (01494 606646) and Catherine Woolley, Project Manager (01494 606661) catherine.woolley@chilternsb-pct.nhs.uk

Many PCTs are sending out helpful templates for business continuity planning during emergencies (including a pandemic).

LMC feels that completing these would be a useful exercise for all practices
We have examples that can be emailed if wanted.

Changes to the Misuse of Drugs Legislation

These came into effect on 14.11.05. There are 2 main changes affecting GPs:-

1. Removing the requirement to handwrite prescriptions for controlled drugs.

2. Introducing a statutory framework to permit electronic controlled drug registers.

CD prescriptions will no longer need to be written in ink but must be indelible.

This will permit prescriptions printed using a computer printer.

The requirement for words and figures continues, so clinical systems will need to be adjusted.

There is no requirement for a handwritten date; however the prescription must still be signed by the prescriber with his usual signature.

Hamish Meldrum's Letter to All GPs – 19.12.05

On 19th December Hamish Meldrum wrote to all GPs summarising the changes the GPC has negotiated to the nGMS Contract from April 2006.

More details are emerging piecemeal but some issues are still sketchy.

Written below are my summary and some comments

I have also looked at the equivalent NHS Employers press release and added their wording to compare the spin of the two sides

The second paragraph of the GPC letter sets the scene for negotiations and could be interpreted as warning GPs not to expect too much in the current NHS financial climate.

The NHS Employers version of the document says:

"The changes will be better for patients, fair to the profession and secure good value for money for tax payers' money"

General LMC Comments

- Another year of no inflationary rise to Global Sum or QOF pounds per point (latter rose by 60% last year)
- Vague warnings of difficulties in implementing the nGMS pension deal.
The DoH wants to limit the level of dynamisation that uplifts GP pensions in line with increases in average earnings.

Interim figures for 2003 - 2006 put this rise at 30% but eventually it could be greater than 40%.

GPC negotiators vow to force government to stand by 2004 agreement

QOF

- 166 points will be redistributed
- 138 points allocated to new areas and 28 points reallocated to existing areas
- There has been a culling of QOF areas considered easy to achieve. Gone are the 50 access points, Quality practice points and 80 of the Holistic Care points
- The NHS Employers version says:
"Fewer points are being allocated to holistic care, organisational indicators and a number of disease registers, recognising the shift to ongoing maintenance following initial work to set up the lists"

- Minimal thresholds will rise on all indicators.
- A detailed listing of what will have to be done for the moved 166 points can be found on our website www.bbolmc.co.uk
- The broad categories are:
Dementia 20, Depression 33, Chronic Kidney Disease 27, AF 30, Palliative Care 6, Mental Health 9, Obesity 8, Learning Disabilities 4, Ethnic Origin Recording 1.

New Access DES

£6250 per average practice

Few details from GPC

The NHS Employers version says:

"Changing the way practices are rewarded for improved patient access including advanced booking, telephone access as well as being able to consult a GP within 48h"

Child Vaccine Targets

MMR waiting on childhood vaccines reduced to 25%.

Practice Based Commissioning

1y DES for PBC @£1:90 per patient

Precise specification not yet known.

Possibly first 95p for a plan of budgeting and committing to demand management tasks and second 95p for making savings when none available from PCT.

Choice and Book

95p per patient for offering choice of hospital and booking (not necessarily electronic)

Choice will be assessed by patient survey and booking by referral statistics. Funding of each of these will involve 50% for aspiration and 50% for achievement.

Locum Reimbursement

53% increase in discretionary maternity, paternity and adoption leave reimbursement, raising the weekly ceiling from 979 to 1500.

IM and T

1 year ES priced at £1.30 per patient for implementing electronic prescribing, GP to GP record transfer and NHS care record system.

Dispensing Doctors Review

I have contacted the GPC but they have no more details to give

The following extract came from Barbara Hakin (NHS Employers) financial briefing to PCTs.

A significant change in dispensing doctor arrangements is that relating to VAT. With effect from 1 April 2006, the PPA and DH will no longer reimburse Dispensing Practices for the equivalent VAT costs relating to the purchase of

drugs. To receive such reimbursement, practices will be expected to register for VAT purposes with HM Revenue and Customs (HMRC).

A second paper says:

A new 'fee per item' pay system is to be introduced from 1 April, which removes the link between pay and the cost of drugs and improvements to the system of reimbursement for VAT costs on drugs. This will ensure that the reimbursement for VAT incurred is equal to the actual amount of VAT paid.

The VAT changes only apply to dispensing GPs who will need to consider registering for VAT from 1 April 2006. HMRC will provide further details about the application process in early 2006. General guidance on registering and accounting for VAT is available on the HMRC website www.hmrc.gov.uk

The container cost allowance for dispensing doctors is being abolished.

Comments so far

Outcome of negotiations described by Hamish Meldrum as far from ideal but could have been worse. Negotiations were dominated by government belief that GP pay has soared under nGMS.

GMS bill was £1.5 billion higher than expected. Government had wanted more than the 8% efficiency saving held by NHS employers.

Some GPs feel that new indicators contravene the principal of no new work without pay.

25 points for assessing the severity of depression by an unknown validated tool also criticised.

Barbara Hakin (NHS Employers) View of nGMS for 06/07

- No indexation of global sum and QOF represents a cash releasing efficiency saving.
- Recycling of QOF points and a more demanding Access DES represent productivity gains.
- MPIG to be phased out.
- Reminds PCTs that all locum costs are discretionary and "set in the context of ensuring continuity of local access to healthcare, whilst recognising the GPs remain independent practitioners".
- Future annual negotiations covering nGMS will be subject to the same efficiency requirements and Gershon implications (see URL below) as all over commissioning arrangements across the NHS.

http://www.hm-treasury.gov.uk/spending_review/spend_sr04/associated_documents/spending_sr04_efficiency.cfm

- Deal represents considerably improved overall value for money position across the nGMS contract.
- Reminds PCTs that similar efficiency gains are expected through local negotiation of PMS contracts.

Enhanced Services Floors (ESF)

Hamish Meldrum (HM) has said increasing numbers of PCTs are suggesting that they will not spend to their ESF and instead will use this under-spend to help offset their financial deficits.

LMC has asked the GPC about the status of the ESF and whether it is enforceable. HM recognises the conflict of obligation of PCTs both to spend to the ESF and live within budget. Neither are legally enforceable, but managers see greater threat to their careers if they ignore living within budget. The GPC will continue to press the DoH to encourage and performance manage PCTs to spend to the ESF.

HM predicts GP anger over this but feels argument is weakened by overspend on GIG (Gross Investment Guarantee).

Barbara Hakin's recent financial briefing letter to PCTs says:

"the GIG will cease from April 2006 and ESF will reduce in emphasis to indicative monitoring levels only. PCTs must still offer as a minimum the funding levels indicated to practices choosing to provide DESs."

GMC GP Register

On 31.03.06 the GMC will introduce a register of doctors who are eligible to work in general practice in the NHS. From that date all doctors working in general practice other than GP Registrars will be required to be on the GP register. The plan is to populate the register by drawing data from the medical performers list held by PCTs. By the middle of February all GPs will receive a letter explaining the new system and asking them to confirm the accuracy of data. Provided you wish your name to go forward to the GMC GP register, you need do nothing more. If you do not wish your name to go forward (which will mean you will be unable to practice as a GP in the NHS after 31.03.06) you will need to let the GMC and your PCT know.

If you have not received a letter by the end of February 2006, please contact the GMC by email using gpregister@gmc-uk.org

The GMC will write to all GPs when the new GP register goes live to confirm individual inclusion.

New GPs can apply for inclusion on the GMC register (free of charge) by downloading an application form and fact sheet from www.gmc-uk.org

GP Registrars are required to be on the GMC registrar only when they have completed their training and hold a CCT.

New Premises Directions

The lead PCT for premises in the Thames Valley has recently written to all practices on fixed cost rent reimbursement. They asked whether or not practices have renegotiated their loans to a lower rate of interest. The new premises directions allow PCTs to recalculate their cost reimbursement and

thereby reduce PCT expenditure. The reference to the regulations is paragraphs 39 and 40 of the directions NHS GMS Premises Costs 2004.

Access via:

<http://www.bma.org.uk/ap.nsf/Content/focusonpremisescosts0104>

BMA Guidance on Jury Service

Reference www.bma.org.uk/ap.nsf/Content/jury-service05

Dovedale Counselling

A free Mental Health Service for Oxon and Berks GPs, families, and practice employees.

Monthly utilisation reports for both November and December show:

	current month	year to date
Berkshire	0	0
Oxfordshire	0	0

Access to service via www.dovedale.co.uk/GP-CARE

Then click On-line Self referral

Flexible Career Scheme and GP Returner Scheme Funding

GPC is concerned that no funding has followed devolvement of these functions to Deaneries

The GPC is aware that some PCTs maybe proposing that Primary Care Development Scheme (PCDS) monies be used to fund FCS and GP returner schemes. The GPC objects and quotes the DoH own PCDS guidance that PCDS money is not to be used "as a substitute for other funding schemes".

Any practice facing withdrawal of FCS funding, contrary to SFE obligations on PCTs should contact the LMC.

MURs (Medicines Use Reviews)

The Secretariat will be discussing pharmacy issues (including MURs) at a meeting with local LPC Secretaries and the TVSHA on 17.01.06.

The evidence base for MURs providing added benefit over prescriber review is said to be limited.

PCTs do not have discretion not to pay for MURs although case selection and volumes are unclear.

Copperfield in Doctor on 10.01.06 said "Fan-bloody-tastic. We have an NHS downing in debt so the Department of Health decides to pay Pharmacists to duplicate what we already do but badly".

Does anyone have experience of receiving MUR paperwork from pharmacists?
Please let the LMC know of any problems.

GPC Elections

Eric Rose's 3 year term of office as the Berks & Bucks Regional Representative ends this year. Election is planned for 13.04.06.

The criteria for those able to stand and vote are;

1. Listed on a Thames Valley performers list.
2. A Contractor GP or Sessional GP from a practice paying the voluntary levy or paying the voluntary levy personally
3. Sessional GPs also need to register with the LMC using forms recently sent to practices (the existing workforce) and PCT agencies (new workforce).

GPC nomination forms are available at www.bma.org.uk or via 020 7383 6617.

These have to be with the GPC by 16.02.06.

PCTs who Delay Payment

There were reports in the media that PCTs from outside the Thames Valley may be delaying payments to GPs to lessen their end of year deficits.

Another LMC Secretary has suggested using the commercial debts regulations 2002 (si20021674) if practices experience problems.

see www.opsi.gov.uk/si/si2002/20021674.htm

Choice

From 01.01.06, government expects PCTs to offer patients the choice of at least 4 providers when they are referred to hospital.

The DoH has said PCTs must provide details on Trusts, Specialties, Consultants and Clinics either electronically or manually.

The GPC view is that GPs have always offered clinically appropriate options to patients as part of good practice.

GPs have no Choice obligation under their terms and conditions of service.

Choice is currently solely an obligation on PCTs.

Within the Thames Valley, travel distances involved in some choices make the option meaningless. Choice which is not clinically appropriate or illusory will not help patients.

Each TV PCT is handling this differently.

- CSB has advised adding routine text to all GP referral letters indicating that the GP has offered Choice.
- WAM PCT has provided all practices with a stamp to the same effect.
- Oxfordshire Choice will be offered by Referral Hub staff

The recently announced DES may change all this

Oxfordshire Issues

CALS (Clinical Advice and Liaison Service)

Just before Christmas, all Oxfordshire GPs received a bundle of papers about CALS

This is a new venture and will inevitably have teething problems.

Many GPs have already contacted LMC with their views on the development, particularly referral restriction, confidentiality, medico-legal responsibility and uncertainty about what to tell patients.

The LMC is keen to make sure GP concerns and problems with CALS are recognised and dealt with.

Please let Secretariat know of any difficulties you encounter.

Summary of CALS

From 23.12.05 all outpatient referrals are to be addressed to CALS at:

Level 1, Block 2

Radcliffe Infirmary

Woodstock Road

Oxford, OX2 6HE

Tel: 08454 084143

Fax: 01865 224125

oxon-cals@nhs.co.uk

Monday to Friday 08:00 - 20:00

Saturday 09:00 - 13:00

Referrals excluded from CALS are:

- Cancer 2 week waits
- Rapid access chest pain clinic
- Mental health
- Learning disability
- Maternity
- Community based services e.g. podiatry, counselling

LMC Secretary View

CALS has arisen because the Oxfordshire NHS is living beyond its means (£34 million deficit). Government targets now mean that all referrals to hospital have to be seen and must be paid for within a fixed budget.

PCTs continue to argue for more government funding but Oxfordshire is not seen as an electoral priority.

I have supported the CALS concept because it is probably "the least bad solution" to living within budget. Practice Based Commissioning, particularly peer review within practices may eventually prove better.

CALS is not yet fully functional because the screening workforce is yet to be built up. Initially all letters will be logged but not all will be triaged. It is crucial that screeners have the confidence of GPs and that their decisions divert the correct patients away from hospitals.

The algorithm in the bundle describes several alternatives to an out-patient consultation including:-

1. Advice to GP on additional/alternative primary care management.
2. Return of the referral because it does not comply with lavender statements.
3. GP referral to community services, both current and new.

Choose and Book at practice level has been temporarily suspended. Where screeners are not in place (or if the screener doesn't divert a letter) a CALS based choice advisor will now contact all patients. GPs may be contacted by a CALS screener if dialogue about alternative care is necessary.

My suggestion about what to tell patients assumes most GPs will have few referral diversions.

Possible wording is:

Referrals in Oxfordshire are now screened by other clinicians in CALS before going to the specialist. I am suggesting that you see "Dr Specialist" but if CALS has other suggestions I will get back to you.

Views on confidentiality vary, just as they did with QOF visits. My feeling is that NHS referrals have always been read by more than the referrer and the specialist because this was necessary to provide UK patients with the best affordable care. In the new NHS of PbR (Payment by Results) referral screening is necessary to avoid patient care deteriorating dramatically at the end of the financial year if funding runs out prematurely.

Significant medico-legal responsibility has always stayed with the GP until the patient is seen. I am clear that if a screener diverts a referral without GP agreement then they take responsibility.

As predicted unforeseen issues have emerged since CALS went live on 23.12.05. Some of the new questions are listed below;

1. What should happen to urgent referrals arranged by phone between GP and a hospital doctor? (eg TOP, TIA, any issue where hospital doctor agrees by phone to rapid OPD assessment)
My view is that the referral letter should be copied to CALS making it clear the appointment has already been triaged by phone and giving the date and time agreed
2. Should referrals to peripheral clinics and to GPs with special interest referrals go through CALS?
3. Letters to Consultants seeking clarification of follow-up arrangements for patients.

I am sure this list will be added to. Please let LMC know about any issues that need clarifying.

Buckinghamshire Issues

Buckinghamshire Alliance Board

This project board is leading the development of the new Buckinghamshire PCT. It comprises of Chief Executives, Chairs, PEC Chairs and DPHs of the current PCTs.

Katie Donlevy is Project Director with support from Michael Jones.

Regular information available from:-

- ❖ www.buckinghamshire.nhs.uk
- ❖ changing.times@bssmail.nhs.uk

Register at this address for 2monthly newsletter and a fortnightly update by email

- ❖ PCT Comms leads:-
 - C&SB - Sarah Flynn
 - VoA - Richard Burton
 - Wycombe - Sarah Adent

Demand Management (Mid & South Bucks Health Economy)

On 13.12.05 all practices within the 3 PCTs (C&SB, VoA & Wyc) were sent:

- Version 5 of a paper on Demand Management authored by James Mapstone, Director of Public Health of C&SB and Wyc PCTs.
The latest version 7 can be found on: www.buckshealth.nhs.uk/csb
- A covering letter from the 3 PEC Chairs explaining the reasons for demand management and requesting that all working GPs are made aware of the documents to avoid referrals being sent back to them for review.
The initiative has been dictated by NHS financial pressure and escalating referral rates both elective and emergency.
Bucks needs to reduce work done inappropriately in hospital

The paper describes various referral processes and policies, some contentious. It will alter continuously, guided by a new Clinical Reference Group comprising James Mapstone, 3 BHT doctors and 3 PEC Chairs.

To give feedback on content of document contact Dr Mapstone's PA on 01494 606050 or via Judy.Standring@chilternsb-pct.nhs.uk

The Demand Management Program Board meets weekly.

The LMC Secretary is now attending.

This Group reports to a fortnightly Recovery Plan Program Board.

Proposed Follow up Policies

BHT has higher follow up rates than many other areas.

The following follow-up rules are proposed by commissioners;

1. No follow-up for day case surgery
2. 1 follow-up for inpatient surgical procedures (cancer and major surgery excluded)

3. No 6 month SHO follow-up
4. No follow-up solely to give negative results which could be communicated in other ways
5. Maximum of 2 follow-ups for medical patients with new problems unless agreed with the GP
6. These rules may alter as care pathways are developed
7. Hospital doctors wishing follow-up outside above rules need a signed confirmation slip from the patients GP
8. Hospital doctors required to seek written GP permission for follow-up outside the norm.
9. These PCT proposals are contentious and still being negotiated with BHT. Rules will eventually be enshrined in developing care pathways.

Intra-Hospital Referrals

- Details of policy have been difficult to develop.
- Such referrals must be sanctioned by the team consultant.
- Considered justifiable only for management of the primary problem.
- Incidental problems should be referred back to the GP.
- Hospital doctors encouraged to make recommendations to the GP on further referral.
- Normally casualty officers would send advice letter to GP rather than refer within the hospital.

Immediate Initiatives

- Review of patients listed for varicose vein surgery because historical compliance with low priority policy thought to be poor
- Specialist physiotherapy assessment of patients already listed for hip and knee surgery.
- No hypertension referrals unless circumstances are exceptional.
- Minimal referral of new type 2 diabetics to hospital

Filter Structure

The Referral Filtration System (RFS) became operational on 5.12.05.

This is based at the Referral Support Centre in Aylesbury.

The service is designed to identify GP referrals which might be redirected to other services or might be amenable to suggestions for further patient management in primary care prior to referral.

There are currently 3 tiers of filters:

(Specialty specific filtering will be added in the next few months)

1. Administrative
To detect omissions in patient demographic data or non conformity with low priority policies
2. Senior nursing staff select referrals to be forwarded to tier 3.

3. GP filter assessing possible redirection or alternative management.

If an assessing GP feels an alternative care pathway might be appropriate, they will telephone the referrer for a discussion.

PCTs hope GPs will regard such calls as a learning opportunity.

It is unknown what proportion of referrals will be passed to tier 3 GPs.

The current assumption is 5% (about 10 letters daily).

There are built-in quality standards and alarms, yet to be tested.

The quality standard is that the filtration process will not delay the processing of patients referrals by more than 3 days.

The new service will be evaluated to make sure it fulfils its purpose.

It is hoped that it will only be a temporary measure as its value will diminish as referral patterns change due to its influence and PBC becomes more widespread.

PCTs are seeking GPs to become tier 3 assessors. The pay is £70 per hour.

Interested doctors are asked to contact Peter Lowe on 01494 552200.

Impact on PCT Finance

PCTs will only commission GP referred outpatient activity for patients who have been through the filter process.

PCTs will only pay for activity conforming to agreed referral pathways.

More care pathways are planned, with the top 10 due for completion by the end of the first week in January.

Berkshire Issues

Berkshire Sessional GPs

The December/January addition of the NAS GP newsletter gave contact details for the Berkshire Sessional GPs Group. This currently has a membership of 40 with 8-10 members attending their monthly meetings in Wokingham. The Group is currently organised by Susannah Denny (sjd.enigma@ntlworld.com). She is standing down as organiser at the end of 2005 and her role will be taken over by Sarah King (sjking21@btinternet.com) and Lynette Bermingham.

NASGP details are:- PO Box 188, Chichester, West Sussex, PO19 1FP

Tel: 01243 536428 Email: info@nasgp.org.uk Website: www.nanp.org.uk

AAA Screening (Abdominal Aortic Aneurysm)

Pulse reports that the government is planning to introduce a national programme for AAA screening, but only for men over 65 years.

The statistics for AAA deaths over 65 are; men 1.36% and women 0.4%.

Surgery will be indicated if aneurysms with a diameter greater than 5.5cm are detected.

Muir Gray, Director of the National Screening Programme recognises that screening may overwhelm current treatment services.

West Berkshire PCTs

Prior to likely formal merger during 2006, Newbury, Reading and Wokingham PCTs have been working together under the Berkshire West Collaboration Project.

Senior staffing structures have recently been reorganised.

Interim Chief Executive and Accountable Officer	Janet Fitzgerald
Interim Associate Chief Executive	Sheila Hayes
Interim Area Directors, Reading	Jo Devanny
Interim Area Directors, West Berks	Jan Bartlett
Interim Area Directors, Wokingham	Helen Mackenzie
Interim Director of Finance and Management	Linda Morris
Interim Director of Service Improvement	Richard Mills
Interim Director of Public Health	Su Harnett
Interim Director of Clinical Standards	Sandy Tinson
Interim Associate Area Director, Reading	Mike Naji
Interim Associate Area Director, Older People Services	Jan Evans
Interim Associate Area Director, Community Care and Housing	Bev Searle
Interim Associate Area Director, Children Services	David Hogg
Interim Associate Area Director, Wokingham	Helen Waddams
Interim Associate Director of Finance	Edward Haxton
Interim Associate Director of Public Health, Reading	Monica Dent
Interim Associate Director of Public Health, West Berks	Jane Wells