
BERKSHIRE LOCAL MEDICAL COMMITTEE

Chairman
Dr John Rawlinson
Radnor House Surgery
25 London Road
Ascot
Berks
SL5 7EN

Tel: 01344 874011
Fax: 01344 628868
rawlinsonjohn@hotmail.com

Treasurer
Dr Gurdip Hear
Crosby House Surgery
91 Stoke Poges Lane
Slough
Berks
SL1 3NY

Tel: 01753 520680
Fax: 01753 552780
gurdiphear@yahoo.co.uk

Secretary
Dr Paul Roblin
Secretariat of Berks Bucks & Oxon LMCs
Mere House
Dedmere Road
Marlow
Bucks SL7 1PB

Tel: 01628 475727
Fax: 01628 487142
paul.roblin@bbolmc.co.uk

MINUTES OF WEST BERKSHIRE LRC/PCT LIAISON MEETING Thursday, 13th May 2010 Room G26, 57-59 Bath Road, Reading, RG30 2BA

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Minutes of Previous Meeting

The minutes from 11th March 2010 were agreed as a correct record of the meeting.

Matters Arising

New Communication System with Locum GPs

PHR understood that this had been agreed verbally by PCTs, but he was unaware of how it would operate.

How would the TVPCA compile an emailing list and chose which documents to send out?

MM suggested he spoke to Jeannine Scott.

Action Point: PHR to speak to Jeannine Scott.

Safeguarding Children Meeting

PHR said that he would be attending this meeting on 25.6.10.

He asked reps which elements of the Safeguarding Children process were of concern to them.

Is the workload of responding to social services requests getting out of control?

MM said that she had been discussing this issue with other PCTs

Birmingham PCT believes that the DoH is going to look at this again.

MM said she would ask the SHA what is happening.

Action Point: MM to approach the SHA about changes to Safeguarding.

Items from Berks LMC Minutes

Shared care Rheumatology and the DAWN system

CG spoke to this issue.

There are 3 groups of patients:

1. those covered by the DAWN system
2. those covered by the LES
3. those who are not covered at all.

GPs have been getting letters from consultants saying that they have started the patient on DMARDS and want the GP to look after them for the first 8 weeks until they can be put on the DAWN system.

With the abolition of the LES, this was unfunded work.

DB said that he was unaware of this; CG said he would send him evidence.

CG asked how the PCT intended to do a search for those patients who are not covered by DAWN and whose care continued under a LES.

MM said that the PCT had not run a search yet as it was too early but thought that there was a procedure in place; she would check this out.

DAWN will apply to any patient with a rheumatological problem.

It will not apply to patients on the same drugs for skin conditions.

DB said that from his figures there were only 3 patients in the whole PCT area who were on Methotrexate for Crohns Disease.

The protocol for patients on Methotrexate for a gastroenterological condition is monitoring every 3 months whereas for rheumatology patients it is every month.

DB said that the PCT had yet to decide a way for GPs to claim for non-rheumatological use. It may be that another LES is developed.

CG has checked his records and feels that in 2004, Methotrexate for the treatment of psoriasis was in the NES so the feeling was that this was not part of core services.

PHR said that elsewhere it was the medication that was paid for not the condition it was being used to treat.

**Action Point: CG to send DB evidence that the Consultants are asking GPs to look after patients for the first 8 weeks after being put on DMARDS.
MM to check that the relevant LES search will be run when it is due.**

Responsible Officer

PHR has recently asked all TV CEOs about their plans for Responsible Officers.

This is also being looked at nationally.

DB said that PHR's email to Charles had raised a number of valid points.

The plan is to take this to the Board on 22nd June.

DB asked the LMC to think of what points to raise with the Board.

DB confirmed that he had been appointed as Medical Director.

The problem is that in a lot of PCTs there is no one on the staff other than the MD who could fulfil the role.

LMC is concerned about a potential conflict of interest.

PHR saw problems where the PCT regarded a GP as difficult rather than a bad performer.

If there were then problems with revalidation, the RO may be less objective.

His view might be coloured by PCT issues.

PHR saw that there could be problems for anyone fulfilling the RO role if they wore more than one hat.

DB said that he would discuss this issue with the Project Team.

The LMC would like to be part of the RO appointment process and have input to the selection criteria and person specification.

Oxon PCT is planning a RO Team.

DB said that there needed to be someone who could take Board level responsibility.

His plan is to have a Deputy Medical Director and an advert is shortly to go out for this role; this person will be dealing more with primary care work.

Vetting of Central Alerts by BW Public Health

PHR has concerns that no one is filtering the Central Alerts that are sent to practices.

He has been told that this function sits with BW Public Health.

They have told MM that they only vet the alerts that relate to them.

MM thought the alert PHR had highlighted came from Berks Shared Services.

PHR said that the most recent alert had referred to anaesthetic machines which is of no relevance to General Practice.

Action Point: MM to take this back to Penny Thorpe.

Physiotherapy Review

Jackie Lonsdale attended for this item.

The PCT feels that the physiotherapy service needs reviewing; the contract should have gone for tender 2 years ago.

A group has been formed to look at the issue.

It comprises the 4 providers, Steve Madgwick (a GP representative), and a project management team.

They will be looking at alternative ways to provide physio rather than face to face appointments.

Physios support this and are looking at group treatment sessions as well as face to face contact.

Not every provider will provide both types of physio options.

It has been agreed that the best way to progress this is through the "any willing provider" route.

One essential criterion is that the service specification must be delivered for £35-45 for one to one appointments.

The drawback for the provider is that they will only be able to guarantee activity and attract business by giving good quality services.

To control total activity, it has been suggested that either indicative or real budgets are held by PBC consortia.

Discussions continue at the end of the month with the PBC Consortia.

The providers will be asked to provide rapid good quality data; currently activity data is being provided 2 weeks after the end of the month.

A service specification will be provided and the provider will be asked to provide services against this, without guarantee of activity.

LMC asked if the use of community physio by the Orthopaedic and Fracture Clinic was identified.

Gill Gillespie has been asked.

It is unclear what secondary care should provide under PbR tariff following surgical intervention.

GPs reported that they were receiving requests asking them to arrange physiotherapy either before or after surgical procedures. DB said that he was unaware of this and asked for evidence.

From April 2011 the PCT plan to have a new service in place.

The plan is to take this to the Clinical Executive in either July or September.

The PCT is about to send out information to all GPs, PMs, current providers and stakeholders about an event that will be held on 10th July.

DB said that he was fully aware that if physio volume was increased to practices, it would be utilised. This might save the PCT secondary care costs, but cost pressures prevented more funding being put into physio.

Berkshire West was one of the best counties in the country for the conversion of referrals to Orthopaedics into some type of intervention, the current figure being about 40%.

Practices that want to start up an in-house physio service can bid for it as long as they meet the quality criteria and can obtain accreditation.

In terms of containing the costs of treatment, physio would be limited to a maximum number of appointments, after which time the patient would need review.

The patient might then be offered an extension in session number.

Self help leaflets would form part of MSK help.

LMC said that it was important that any documents written should be readily available on the PCT website. JL said that they would be.

JL said that she had found a very informative leaflet but it was only available at a cost of £1 and asked if GPs could charge their patients for it.

GPs said that they were unable to charge patients for anything concerning NHS care.

See paragraph 24 of GMS Regulations

<http://www.opsi.gov.uk/si/si2004/20040291.htm#24>

Action Point: CG to provide DB with anonymised copies of letters from Rheumatologists.

Legislation regarding Prevention of Healthcare Associated Infections

Helen Mackenzie and Sarah Bellars attended for this item.

A consultation document has been available since 26th March.

The consultation ends on 26th June.

From April 2012 every practice will have to register with the Health Care Quality Commission.

It is not known whether the change in Government will affect this.

Some of the infection control implications are significant.

PHR said that the LMC was unaware of its existence.

He had not previously had sight of this document, and would now assess it.

PHR had concerns about local and national guidance on infection prevention in primary care.

In the past, similar documents treated GP consulting rooms more like operating theatres than an environment to talk to patients.

He felt this was based on a lack of author knowledge about what GPs did.

Did the DoH want to standardise environments across all health care sectors?

There would be a downside to outlawing carpet flooring in GP surgeries.

It would be a significant cost pressure on practices.

It would make the environment less appropriate for talking to patients.

Would the CQC have the power to penalise practices for failure to comply with imposed standards?

PHR said that he would put this on the National List Server and see what response he received.

Choose and Book LES

DB has sent all practices a letter about the proposals for C&B from July.

This has been discussed at the Reading GP Forum and Practice Managers group.

PHR was happy with the arrangement for the 1y LES, but concerned about this being the final year.

DB said that he had persuaded the Board to put more into the LES this year.

A third person is being employed to help practices with C&B problems and training.

He envisaged that there will become a time when it is standard practice to use C&B in every practice and he wanted every practice to be in a position to do this.

In other parts of the country PCTs are not funding this at all.

PCTs Finances

In Nigel Foster's absence, Indira Patel (IP) attended for this item.

This is the last year for some while that the PCT will receive growth money.

This has been used to fund inflation and investment.

For the current year the PCT plan to make a £1.5m surplus.

The PCT have to make £60m worth of savings over the next 3 years. They have identified £30m but have not managed to identify the remaining £30m, which equates to £10m a year.

The contract with the RBH has been set that if activity goes over a certain level they will only be paid 30% of tariff.

GPs were concerned that because of this, they would see areas of C&B inaccessible for use.

DB felt that the only reason that C&B is greyed out is to allow the Trust to meet the 18 week target.

It was asked if the Darzi Centre expenditure could be saved.

DB said that the Walk-In Centre in Reading was something that patients liked and he felt it was proving value for money as there were access issues in Reading.

LMC wondered whether the productivity of community matrons justified their cost, and whether this area needed looking at.

The list cleaning exercise has saved £400K but other ways to save money are needed to meet the £10m required each year.

IP agreed to send PHR a copy of the Board paper with the financial details.

Action Point: IP to send PHR a copy of the financial Board paper.

H1N1 DES coverage and Easement of QoF PE7 and 8

MM confirmed that the PCT has this in hand.
She has a list of practices that have achieved the easement target 50.7%.

Mental Health Services in Berkshire

Mental Health Services have been discussed again at Berkshire LMC, and PHR has invited key players to the June meeting.

In West Berkshire it is the child and adolescent service rather than adult services that cause most GP concern.

CG felt that the service seems to have been redesigned into subspecialties with a loss of holism.

Each area has their own tiny clinical area that they deal with.

Once a patient has been through treatment in that area they are sent back to their GP despite the fact that they still need further help from the Mental Health Services.

GPs then have to refer them again.

PHR to speak with Justin Wilson the new Medical Director of BHCFT.

Action Point: PHR to speak with the Medical Director Justin Wilson.

SCR

Following the recent edict from CfH about deferred uploads, PHR will be liaising with Andy Ferrari to ensure that sufficient patient consultation has taken place before any upload.

CES (Commissioning Enablement Service)

PHR has been approached by the SHA lead on this

PHR assumes Thames Valley PCTs want access to GP data.

CES plans to commission a data providing system, run by a company Tribal.

DB said that this has been to the Clinical Executive and will be going to the PBC Leads.

PHR has stressed that any data sharing needs to have rigorous safeguards.

GPs need to know when data is to be extracted, what will be extracted, and have the ability to say "NO" when appropriate.

Date of Next Meeting – 8th July 2010

The meeting opened at 2pm and closed at 3.30 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	Reading 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: Drs Brock, Cave and Smith and Nigel Foster and Janet Maxwell

In Attendance: Jackie Lonsdale, Helen Mackenzie, Sarah Bellars and Indira Patel