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Minutes of West Berks LMC/PCT Liaison Meeting

Thursday 2nd October 2008
Room G26, Reading PCT
RG30 2BA

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Minutes of Previous Meeting

The minutes of 10th July 2008 were agreed as a correct record of the meeting.

Two Week Urgent Referral Forms

Richard Ellis (WB PCT) attended for this item and tabled examples of draft two week wait template referral letters on which he welcomed feedback: Richard.ellis@berkshire.nhs.uk

The aim is that the form should be easier for GPs to complete and be structured in such a way that all clinical data is captured.

The form is side of A4 per specialty (Colorectal Cancer, Breast, suspected Sarcomas, melanoma and Squamous Cell Carcinoma).

GPs asked that if information was somehow missed off the completed form, then they be rung and questioned rather than having the form returned.

This is an irritating practice prevalent in other parts of the NHS.

LMC suggested that a phrase be put on the form to ask consultants to do this.

RE felt that it would be extremely unlikely that any referral would be returned.

LMC asked for the final form to be placed on a website that GPs could access easily.

LMC also asked that the final version be sent to them in an electronic format.

Practices could then populate it automatically with each patient's details.

Action Points:

To feedback comments to PHR or RE on his email address.

To put the final form on an easily accessible website.

To tell hospital departments to contact GPs direct rather than return the form (should any information be missing).

Matters Arising

Suturing ES

This is meant as a replacement for the Minor Injuries LES.

Currently the PCT are trying to get activity levels from the RBH but are encountering problems at the moment.

Phlebotomy ES

August GP Commissioning Group was not happy with the current proposal.

HOK has met with DB and JC and will be meeting with MM to try and progress this.

Currently there is no ceiling and all activity is being funded.

Practices are paid per procedure not the cost of the Phlebotomist.

There have been problems with the validity of the data that practices have been supplying.

Child Health Surveillance Schedule

LMC would like to ask the PCT to alter its local CHS schedule to bring it into line with national recommendations.

PHR explained the problem.

The contract performance return to the PCT asked the question "What steps have you taken to ensure that children receive their 3 ½ year check" or words to that effect.

The GP Contract Regulations say:

Child health surveillance

(b) the examination of the child at a frequency that has been agreed with the Primary Care Trust in accordance with the nationally agreed evidence based programme set out in the fourth edition of "Health for all Children"[58].

The system should be that each PCT has a local CHS surveillance schedule reflecting current national guidance.

Last year Health Visitors stopped performing the 3 ½ year check and the task was not transferred to GPs because in 2004 an important change took place.

The Children's NSF substituted the Child Health Promotion Programme for the Child Health Surveillance Programme.

This change removed the requirement for a physical examination between the 6 week check and school entry, a fact that seems not to have been recognised by WB PCT.

Action Point: MM to ask Mark Harris to issue a statement to GPs, copying in the LMC.

Vascular Disease LES

Paper supplied to LMC the previous day. Few had had time to read it.
PHR found Appendix A was very confusing.
How is the target group of at risk patients to be defined?

Proposed 2009 Meeting Dates

8 January 2009, 5 March 2009, 7 May 2009, 9 July 2009, 8 October 2009.
All were agreed.

New DESs

See <http://www.nhsemployers.org/pay-conditions/primary-893.cfm>

The PCT are aware of the 5 new Clinical DESs and have done some initial work to assess their implications for the PCT.

Once the draft specifications have been written they will go to the GP Commissioning Group.

PHR said that they had come from the GPC with a warning that the remuneration may not be worth the effort.

They seem to have been priced in such a way that practices will not want to take them up.

The Ethnicity DES is priced at 5.6p per registered patient.

The cost of a second class stamp is 26p. This hardly provides an incentive.

Practices could get this data via a questionnaire that patients fill in opportunistically at registration or appointment.

DB reported that he collected ethnicity data at his flu clinics and found that very few patients refused to give it. More patients had refused permission for their notes to be loaded to the national spine.

It was recognised that spoken language was often difficult to assess.

One GP reported that the necessary codes were not always there so he had to make 'guesses'.

Learning Disabilities DES requires practices to use lists from the local authority (LA).

In East Berkshire the LA has said that under the Data Protection Act, it would only be able to release information with the permission of the patient or carer.

There is also a requirement for three practice members of staff to attend training (a GP, Nurse and a Practice Manager).

HOK said that in Wokingham they had created a training course when they devised a LES for Learning Disabilities. This LES was more user friendly than the new DES.

The PCT is going to raise the issue of training with the GP Forum.

In Wokingham Mary Codling, the Learning Disability Nurse, had worked with practices and the Local Authority and only those patients who were not on the practice lists were approached and asked to consent to their information being transferred.

She is working with her colleagues in Reading and Newbury with a view to finding someone to help practices, it is important that the local community work with practices to ensure that this works.

The **CCF and Beta Blocker DES** is a straight forward end of year audit.

The Alcohol DES incentivises GPs to refer to facilities that are currently non-existent. The PCT reported that work was going on to look at services alongside the Royal Berks. The service proposed needs to fit together.

The Osteoporosis DES: Bizarrely, Criteria One provides payment only for people with a positive DEXA scan rather than anyone who has been scanned. GPs reported that in WB they did not have access to a DEXA scanning service. DB said that service was very limited and the PCT Commissioners recognised the need to look at this.

MMR Catch up LES

This summer Government initiative asks the PCT and practices to identify all patients $\leq 18y$ with incomplete MMR and complete the course.

One interpretation of GP responsibilities under Additional Services is the obligation to ensure that the MMR programme is completed for those up to and including 15 year olds.

It is not part of Additional Services to seek out these patients systematically, or to call them in for the vaccination.

Any MMR work for 16-18y olds would be outside Additional Services and require a LES.

Public Health is leading on this and has said they want to put together a proposal. They will be discussing this with MM and DB, after which MM will feedback to LMC.

The LMC said that they were aware that the amount of money that had been allocated to the PCT for this work was small and felt the PCT may need to put some additional money towards it.

Because Oxon PCT has little confidence in its Child Health Computer Data, it plans to write a MIQUEST/CHART query.

This will get the vaccination information needed from practice systems without placing a workload burden on practices.

The PCT will be writing to those patients who need catch up immunisation.

Action Point: MM will speak with Public Health and feedback to PHR.

HPV LES for year 13 (17/18 year olds)

LMC received a draft HPV LES from Kath Haversham last night.

This offers practices a total of £25.02 for a three vaccine course (£7.51, £7.51, £10).

PHR explained his understanding of the national funding.

The PCT have received £91K from the DoH for a target population of 2923.

This works out at £31.13 per patient for the course of 3 vaccines and means the PCT has retained almost £18K.

Oxon PCT initially offered a similar sum, but was persuaded by LMC to increase the amount from £7.58 to £9.33 for each vaccination (ie £28 per course).

This was because of the size of call and recall work.

MK PCT is also paying £28.

The PCT said that the £18K may be needed for an advertising campaign.

The LES as written states it will terminate on 31.10.09.

LMC asked if this meant that no vaccine given after this date would be paid for.

Other PCTs have an 18/12 LES to take account of the fact that a course takes 6/12 to deliver, ie a course started on 31.10.09. actually finishes 6 months later.

LMC felt there was also a problem with the LES title which refers to patients 'not in school'.

Paragraph 2.1 also says "aims to offer the majority of vaccinations via a schools based programme".

Does this mean that both practices and the school nursing services will be offering vaccine to this 17-18 y old cohort?

Action Point: MM to feedback when the funding will stop and who will be delivering the programme.

Access

The official DES was issued a few weeks ago and offers little flexibility.

The PCT plans to review their LES by 2nd November.

The PCT feels that the DOH edict on LESs deviating significantly from the DES (eg nursing hours counting) not counting towards the PCT target of 50%, makes it difficult for the PCT LES to continue in its existing format.

It may be that the PCT could fund the nursing hours on top of the £2.95.

Currently 14 practices use nursing time.

Currently the PCT have 76% of practices who have applied to provide increased access although not all have started. Of this figure 51% are using GP time only.

The DES will run until April 2010. The meeting speculated that the Government expects that by this time patients will be used to extended hours, which will then become a normal service.

Primary Care Access Survey (PCAS)

MM said that in the July survey there had been 5 failures and she has to account to the Board for how this has happened.

One GP said that in his practice, a new member of staff had taken the call and had misunderstood the question being asked. Although an experienced member of staff had rung straight back with a correction, it was too late as the first information had been formally accepted by the PCT.

MM reported that PCAS will cease in March 2009, but until that time urged that practices informed all front line staff of the importance of this survey and how to give correct information.

LMC suggested that all practices (not just those who had failed) be informed of how important this survey was to the PCT.

The PCT said that they would raise it with the Practice Managers at their next forum.

Action Points: The PCT to review the LES with a view to paying for nursing hours separately from the DES.

The PCT to raise the PCAS issue at the Practice Managers Forum.

Primary Care Strategy

All 3 Forums had discussed this and each had come up with different issues. Public consultation is also needed.

The final Strategy document needs to be produced by the end of November.

In Wokingham the issues had included:

- Obligatory opening of practices between 8 am and 6.30 pm.
- In house benchmarking of appointments. Currently the Consortia are looking at the access surveys from every practice in Wokingham.
- The Pharmacy White Paper and Dispensing Practices income.
- The patient survey and the patient 'memory'. MM reported that this survey will be expanded to cover more access and choice.

In Newbury the issues were:

- Lack of interaction between primary and secondary care. An example of good practice elsewhere was a meeting held regularly in Basingstoke where GPs meet and share information with consultant colleagues.
- The transfer of data from the new GP Led Health Centre.
- Clarity of what the PCT means by Significant Event reporting,

In Reading the issues were:

- The original drafts talk about a minimum practice list size of 6K.
- The wording needs to be looked at again.
- The PCT wishes to ensure patients have access to a complete range of services.
- If a single handed practitioner retires it is unlikely that that provision will be replaced.
- Open lists.
- Lighter touch monitoring for better performing practices.

Further thoughts were welcomed.

Action Point: To feedback comments on the Strategy to MM.

Visits to Practices Achieving Low Rates of Cytology and Immunisations

A schedule of visits has been set up for those practices who have not reached their targets for cytology, immunisations or access.

Public health is involved in the visits concerning cytology and immunisations.

So far one visit has taken place where issues have been talked through with the practice.

PCT hopes to develop a benchmark for urgent and non urgent appointments per unit population. Unless practices offer close to this, they will never meet access targets.

This appointments figure should be broken down by doctor/nurse/telephone appointments;

LMC was happy with this.

GPs that did not employ locums but covered the work between them said that it would be difficult to calculate these figures. An average figure was what was needed.

PHR said that in previous enquiries he had found there was no nationally accepted figure available.

The PCTs in South Central have asked to look at benchmarking.

KC53/QoF Discrepancies

LMC was aware that John Derry has previously written about the unexplained discrepancy between KC53 and QOF cytology data even when exception reporting is taken account of.

MM said that in October 2006 PMS practices were given 6 months to clean up their cytology data and no one has raised the issue since.

GPs reported that although their data was cleaned up it was the Exeter system with the KC53 data that was still a problem.

Jonathan Miller has raised this issue with the LMC and has constructed a very good argument to demonstrate that the practice's figures are correct.

MM agreed to look into this and said that the PCT would look at appeals from individual practices if they could prove their data was correct and KC53 was not.

Action Point: MM to look into the matter of KC53 data from individual practices.

Update on ES Review

2 are still ongoing, it is hoped to be able to report back by Christmas on the Near Patient Testing and Minor Surgery ES.

Pharmacy White Paper

The LMC asked if the PCT would be giving feedback as part of the national consultation process, particularly on possible changes to the control of entry to the Pharmaceutical List.

The Pharmacists, Maha Yasaie and dispensing practices, all feel the status quo is the best option but it may be that the PCT does not have this view.

Another part of the consultation is on Pharmacists performing healthy living checks.

GPs felt that to be able to do this, pharmacists needed to do an holistic risk assessment of patients, especially if health services money is being used to pay for them.

The PCT said that PEC will be discussing the issue.

Darzi Centre Update

The dates that are being worked to have not changed.

Practice Rates Reimbursement

Practices were concerned that since the change to practices paying their rates and then claiming back reimbursement they were experiencing cash flow problems.

HOK said that the PCT were now more closely following the 2004 Premises Directions.

Practices must get approval for reimbursement of the rates prior to submitting a claim.

HOK said that if practices paid the rates on a monthly standing order the PCT should be able to reimburse them on a monthly basis before the next instalment came out.
GPs were also concerned that the word 'discretionary' was now being mentioned.
PHR felt this only applied to new reimbursements, and existing deals (and uplifts) were protected.

Action Point: Practices to seek approval for rates reimbursement from the PCT prior to submitting a claim.

Les for Deponeuroleptics and Zoladex

Deponeuroleptics – The LES in Wokingham has stopped and GPs asked what they should be doing with patients who were being referred to them by the MHT for depo administration within practices.

Three options are possible: practice to administer depo for nothing, the GP to refer back to the MHT, or the PCT to pay for it via a LES.

DB said that there were such few numbers involved this was why it was decided to withdraw the LES.

If GPs could prove that the numbers had significantly increased the PCT would look at it again. There was a finite amount of time at the PCT and it was felt it would be better spent on other, larger issues.

The PCT had no problems with patients being referred back to the MHT for the administration of this drug.

Zoladex – GPs in Newbury used to be funded to administer this to patients with endometriosis but it is now limited to patients with cancer of the prostate; the work was the same for both categories.

Action Point: HOK to look into the Zoladex issue.

Date of Next Meeting –Thursday 8th January 2009

The meeting closed at 3.25 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 |
| * | 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 |
| | Moneim, Tarek | 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 were received from Drs Brock, Cave, Lade and Smith.

Dates of Future Meetings

8 January 2009, 5 March 2009, 7 May 2009, 9 July 2009, 8 October 2009.