

Chairman: Dr. M. Wells | Vice-Chairman: Dr. P. Whidborne | Secretary: Dr J Macpherson | Executive Officer: Maggie Edwards

DECEMBER 2011

CARE QUALITY COMMISSION

West Midlands LMCs were invited to meet representatives of CQC to be kept up to date on the process of CQC accreditation of Practices. The salient points are;

- The process for General Practice is currently being refined. GPs can input into this process by joining the Provider Reference Group which can be found at; <http://www.cqc.org.uk/organisations-we-regulate/get-involved/join-our-online-communities-providers> Being a member of this may enable Practices to be part of pilots and thereby have a head start on registration.
- Pre-registration opens in July 2012
- Registration begins in September 2012
- Registration to occur from September 2012 to April 2013
- The vast majority of 1st assessments will not involve visits. All re-assessments, no less than 2 years after registration, will involve visits
- Branch Surgeries will NOT need to be registered separately
- Only clinical and senior management will require CRB checks. For doctors GMC registration will be accepted in place of a new CRB check.
- Paperwork should be largely 'tick-box'
- Practices will not fail due to things like carpeted floors etc

Practices should NOT employ Consultants to facilitate CQC Registration. Additional IT software should not be necessary.

NEW MEDICINES SERVICE (NMS)

LMC Officers met with the Local Pharmaceutical Committee to discuss this scheme which is already being implemented. Pharmacists are going to be paid to offer this service to patients who are started on repeat medication for chronic diseases such as Diabetes, COPD and Hypertension as well as patients starting long term anti-coagulation. The idea is that patient compliance with the medication will be improved if there is discussion of the importance of taking the medication, benefits and side effects of drugs followed up by a check in 2-3 weeks that the patient is adhering to the medication. Problems will be fed back to the GP, patients will have to consent to this.

We emphasised that it should be made clear to patients that NMS should not replace the normal GP review to assess the effect of the medication.

Pharmacists are obliged to inform Practices when they are offering this service. We agreed that rather than having a conversation a joint letter from the LMC and LPC would suffice as de facto notification.

Following these discussions it was agreed that the Officers of the LPC and LMC should meet on a quarterly basis to discuss areas of common interest.

CLINICAL COMMISSIONING GROUPS

The two CCGs in Coventry continue to cooperate, along with Rugby, in developing Commissioning Pathways. There will be an umbrella organisation in Coventry. Both CCGs will be sub-groups of this.

Recent discussions between the GPC and DH have established that;

- CCGs are in shadow form and are not statutory bodies and have no legal rights
- CCGs are defined in the Health and Social Care Bill 2011 as a 'membership organisation', the members being Practices, and Practices should approve a constitution and governance framework. These should not be imposed.
- It is not expected that CCGs will be able to expel 'failing' Practices
- The GPC believes that CCGs should not hold Practice Contracts and that any formal action taken against the Practice should be independent of CCGs and should involve the LMC.

This follows attempts by some CCGs to take draconian action against Practices and have Practices sign up to unacceptable conditions of membership.

LMC ELECTIONS

13 LMC member positions will be up for election in March. We are keen to get members from all sections of General Practice on board. At present both Sessional and Women GPs are underrepresented on the LMC.

General Practice is going through fundamental changes. LMCs remain the only statutory representative bodies for General Practice, and they are likely to remain so. CCGs are going to increasingly be driven by dictat from the DH, NHS Commissioning Boards and Clusters. Election papers will be issued to all Coventry GPs during January with full details of the election process.

Please consider standing and making an important contribution to safeguarding General Practice.

GODIVA BOARD ELECTION

The LMC Officers are pleased that this election was carried out in line with GPC Guidance with all GPs, whether Principals or salaried, able to vote and stand. Nationally there is a drive to engage salaried GPs in CCGs as their numbers are increasing and their input is vital.

PMS RE-NEGOTIATIONS

These are all but complete. They have been scrutinised by Lockharts Solicitors and we have sought the opinion of a local accountant who is testing the contract against the previous PMS contract.

TERMINATION OF PMS PRACTICE CONTRACT

The recent high profile termination of a City PMS contract was not done as a result of 'Change of Name' as has been rumoured. The PCT has assured us that it has no intention of using 'Change of Name' as a reason for terminating PMS contracts.

PCT DIRECTOR OF PRIMARY CARE

The Arden NHS Cluster has decided to not appoint an Associate Director of Primary Care but Alison Walshe assures us that she will continue to be closely involved, She has appointed 2 assistants;

Kerrie Woods who will be responsible for General Practice and Optometry
Margaret Johnson who will look after Dentistry and Pharmacy

FREEDOM OF INFORMATION REQUEST

The LMC has asked the PCT for facts and figures around the contract implementation and financial impact on the local health economy of the EAPC (Darzi) GP Practices, the Walk In Centre and the Tile Hill APMS Practice.

Members were concerned that, particularly in times of financial constraint, these Practices are attracting a disproportionate amount of resources.

ALCOHOL AND ADDICTION SERVICES

These will no longer be provide by Coventry and Warwickshire Partnership Trust but have been outsourced to a charity called AddAction. The LMC has been assured that services will remain the same for the first few months and then be reviewed with the objective being to improve them. Services will continue to be provided from the same premises.

The LMC had concerns that the Alcohol and Addiction Shared Care LES would cease to exist as there is a new provider meaning that Practices providing these services would be paid under a Service Level Agreement with AddAction, thereby losing superannuable benefits. After discussion between the LMC and PCT the PCT has agreed to continue with the LES under an agreement with AddAction. This means that income from providing this service will continue to be pensionable.

TRAVEL IMMUNISATION

There is some confusion around what travel immunisations Practices can charge for:

A charge **CAN** be made for;

- Yellow fever
- Japanese B encephalitis
- Tick borne encephalitis
- Rabies

Patients should be given a private prescription or vaccines provided from stock. Fees and a clear vaccination schedule should be provided from the start.

NO fee can be charged for

- Hepatitis A – first and second / booster
- Combined Hep A and B – 2-3 doses according to age
- Typhoid – first and second /booster doses
- Combined Hep A and Typhoid – first and second /booster doses
- Tetanus, diphtheria and polio given in combined Td/IPV vaccine

Vaccines that may be provided privately or NHS:

- Hepatitis B single agent
- Meningitis ACWY (quadrivalent vaccine)

If provided under NHS Vaccine prescribed on FP10 or from stock (which is reimbursable) then a charge cannot be made for administering the vaccine.

Practices **CAN** charge for issuing Certification of Vaccination

Practices **CAN** charge for issuing private prescriptions for anti-malarials.

QUALITY OF PATIENT NOTES

LMC Members have raised concerns that some patient records are not fit for purpose. This is highlighted when patients move Practices. There is also significant variation in the information being transferred between Practices. GP 2 GP transfer does not work well between EMIS and VISION computer systems.

The LMC has set up a small working group to address these problems. The group consists of Drs D Barrett, H Dosanjh, G Ingrams and S Bogahalanda. If you have an observation or concerns then please contact one of the group (email: senarath.bogahalanda@nhs.net, hergevendosanjh@gmail.com, gji@nhs.net or dave.barrett@nhs.net).

Coventry's Primary Care Research Network

We have been asked to include the article below by Dr Tara Al-Salihi from Warwick University;

When do abnormal liver function tests need to be repeated?

How can GPs be helped to make a diagnosis of heart failure and manage this common condition?

Which people with a cough are at risk of getting worse and may therefore need antibiotics?

What do these questions have in common?

- They are all questions we, as GPs, probably ask ourselves often and would like to know the answer to.
- Answers to these and similar everyday questions are being discovered by the studies on the "portfolio" of the Primary Care Research Network (PCRN).

What's the portfolio then?

- A list of high quality research studies answering important questions for primary care.
- These studies have full ethical approval and PCT registration.

So what's the PCRN?

- A component of NIHR-CRN (National Institute Health Research Network-Clinical Research Network) set up in 2007 with 8 regional networks.
- Coventry is covered by PCRN - West Midlands South (WM-S) based at Warwick Medical School, led by Professor Jeremy Dale.

Why participate in GP research?

- Patients who participate have better outcomes, even those in the control arm of research trials.
- Patients gain access to new therapies or new ways of preventing illness.
- Provides evidence for improving clinical care, and more effective commissioning.
- Informs prevention, diagnosis, treatment and management of illnesses in primary care.
- Enhances professional and personal development of clinicians involved.
- Remuneration to cover staff time and involvement in research.

So what does PCRN do?

- PCRN comprises of GP research champions, research facilitators and research nurses who are employed to promote participation in primary care research
- We assist practices in undertaking studies.
- Deliver training on specific studies.
- Ensure practice costs are met.
- Provide training and accreditation for research.

EXAMPLES OF STUDIES CURRENTLY RECRUITING IN COVENTRY

Cough Complication Cohort Study (3C)

- A study to help GPs identify which people with a cough might get worse.
- Data collection - simple on-line proforma and review of medical notes two months later.
- £ 35.73 per patient recruited by a GP, £20.91 for those recruited by nurse practitioner.
- <http://www.primarycare.ox.ac.uk/3C>

COPERS

- A RCT study to test the effectiveness of a non drug pain management course for those with chronic musculoskeletal pain.
- Average-sized GP practice will receive ~£800 for participation.

Medicated Sleep & Wakefulness: A Social Scientific Study of Stakeholder interests, Policies & Practices

- Qualitative study on developments & debates of sleeping pills, with particular reference to management of sleeping disorders.
- GP to agree to a 1 hr interview by study team.
- Average-sized GP practice will receive ~£250.

If you are interested in finding out more about PCRN and participating in research, please email S.Elwell@warwick.ac.uk or t.al-salihi@warwick.ac.uk.

Dr Tara Al-Salihi is a non-principal GP and one of four GP Research Champions for PCRN WM-S.
Answers to the first two questions are provided by two studies conducted in West Midlands:

Professor Lilford's "BALLETS study - cohort study of follow up of patients with mildly abnormal LFTs in primary care".

Professor Hobbs' "Disease burden, diagnosis and management of heart failure in primary care - a 10 year study".

We expect the third question to be answered by the Cough Complication Cohort Study (3C Study) – see above.