

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 10th DECEMBER 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 10th December 2009 at which the following members were present:

Dr. A Seymour (Chair) Dr. P Fielding (Deputy Chair), Dr Steinhardt (Treasurer):
Drs. Alvis, Bayley, Booker, Bye, Coker, Fellows, Gale, Good, Hayes, Hodges, Morton, Rigby, Patterson, Salter, Simpson, Siva, Yerburgh and Ulahannan

Also present:

Representing the PCT:

Debra Elliott, Programme Director, Primary & Community Care

Jackie Huck, Deputy Director

Dr. Helen Miller, PEC Chair

From the LMC Office:

Mr Mike Forster, LMC Lay Secretary

Sue O'Sullivan, Admin

134/2009 APOLOGIES FOR ABSENCE

Dr. T Morgan, Dr. C Morton, Dr. J Salter, Mrs J Knight

135/2009 CHAIRMAN

The Chairman welcomed everyone to the final meeting of the year. Dr. Jonathan Steel had been unable to make the meeting and might attend at a later date to update and take questions on Revalidation. Dr. Seymour also welcomed Eddie O'Neil (Joint Commissioner for Mental Health (Adults) and Stephen Davis, Community Services Manager to update members and take questions on the progress of mental health changes concerning IAPT and PCAT; Simon Thompson had been unable to attend.

Tea Rota: Drs. Coker and Preston

136/2009 MINUTES OF THE LAST MEETING

The Minutes of the last meeting were accepted and signed as a true record.

137/2009 REGISTER OF INTERESTS

Dr. Fielding reported that he had been appointed Appraisal Lead for Gloucestershire; members offered their congratulations. Otherwise, there were no other declarations of interest to report.

138/2009 ACUTE TRUST ISSUES

Dr. Ulahannan reported on ASCEND, a national study being coordinated by the Clinical Trial Service Unit of Oxford University investigating the efficacy of aspirin and fish oil (omega 3) in the primary prevention of cardiovascular disease in people with diabetes. It was a national randomised controlled trial; a letter would be coming out with Dr. Ulahannan as a signatory. The letter was asking for suitable patients aged over 40, with no previous known events, to invite to take part in the trial.

If GPs were interested in the trial, Dr. Ulahannan asked that they electronically searched their practice diabetes register for potentially eligible patients.

DNA (Did not attend) Policy:

Dr. Booker asked for clarification of the DNA Policy. If patients did not take up their outpatient appointment was it correct that they were discharged and another appointment had to be made? He wondered whether the system at GRH was robust enough to guarantee that the patient had received their appointment letter. Jackie Huck thought that there had to be 2 or 3 DNAs before a patient was

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discharged; Dr. Ulahannan believed it to be discretionary. Jackie Huck agreed to establish what the current contract position was; the LMC felt uncomfortable with patients being discharged after just one failure to attend. They suggested the letter could include a sentence asking if the patient wanted another appointment. Concerns were raised about cost implications but Dr. Hodges felt that maybe due to delayed letter problems 'one strike and out' was disproportionate.

Action: Jackie Huck to establish current contract position

Orthopaedics – GHT:

Jackie Huck reported that a letter would be going out shortly informing that the Hospital Trust had closed their list for Orthopaedic ankle, foot and spine surgical procedures for a limited period:

Alternative choices were to refer to Worcester/Winfield etc. or send the referral through to the PCT who would arrange for an appropriate referral to be made. The PCT would let practices know if the closed list continued beyond 6 weeks. The PCT assured the LMC that practices would not be penalized in terms of C&B, but that where necessary historical data/activity would be used to calculate the practice entitlements.

Availability of GPs:

Dr. Miller, in conversation with some Acute Trust secondary care colleagues, had learned of difficulties experienced when consultants tried to contact some GPs, particularly in the afternoon; the problem only applied to a few practices. Occasionally a consultant felt it 'good practice' and the best outcome for the patient, to inform a GP that someone had been given a nasty diagnosis. Dr. Fielding said that Project Utopia had identified communication system problems as well.

140/2009 MENTAL HEALTH NURSE ROLE IN GP PRACTICES

Eddie O'Neil & Stephen Davis reported that the 2Gether Trust was about to embark on implementation of significant changes in the treatment and intervention for mental health patients in Gloucestershire.

IAPT targeted people aged 18 plus suffering from:

- Depression
- Anxiety – such as: Panic disorder, Phobias, Health Anxieties, Obsessive Compulsive disorder etc; patients suffering from depression/anxiety may be directed to IAPT.

From 4th January 2010 there would be a newly configured PCAT (PMHS) Primary Mental Health Service giving direct access for mild to moderate depression/anxiety and severe stable mental illness. The new service would offer assessment and onward referral to secondary care services if required. There would be support and consultation for primary care colleagues plus training sessions for primary care staff.

At practice level it would be very much a nurse-led service, and therefore each practice should have a Mental Health Nurse. Depending on skills and geographical constraints it might not be the same one as at present. There would also be access to a consultant service. Members were assured that 2Gether would be going out to practices to inform the changes. Previously GPs could arrange an appointment in practice for a patient to see the nurse and it now appeared that the pathway was more complex, requiring a letter. Stephen Davis said a phone call with plenty of information would be adequate, but Dr. Hayes reported that her patients were being told they needed a letter. In response Mr Davis said the process was ongoing, the ultimate aim was for the primary care MH nurse to work with the practice.

Debra Elliott confirmed that referrals through C&B to IAPT and PHMS would not count towards the C&B target.

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Dr. Gale questioned whether patients with a Gloucestershire postcode but registered with a Welsh practice would have access to mental health services. He also asked about OOHs (red eye shift) during which he had to wait for a return call in order to refer patients whom he thought required mental health crisis management input. Eddie O'Neil was not aware of any changes from the previous system and he promised to look into it. There were concerns that mixed messages were coming out to MH nurses concerning in-practice time, some being led to believe that they would only be in practice once a month. Eddie O'Neil was able to confirm that contractually it was once a week and nurse absence would be covered.

Doctors also raised the perennial problems of limited physical space in surgeries and the costs involved. Mr O'Neil said the service had made no assumptions on space in surgeries, there was no easy answer; libraries or community centres might have to be made use of, freeing up surgery space. Despite difficulties, the aim was to deal with mental health patients at primary care level rather than sending them to a Mental Health Specialist service.

Dr. Good had concerns about the general restructuring and remembering which part he should refer patients to. Mr Davis said the website would have guidelines for GPs. The restructured system followed national guidelines; a single access point was found not to work but Mr O'Neil appreciated that navigating patients through the system was complex but should in time show improvement. Dr. Bayley asked who GPs should go to if there were any problems; Eddie O'Neil replied that any concerns should be forwarded to him.

Action: Eddie O'Neil/Stephen Davis to progress communication issues

It was agreed to keep Mental Health Nurse issues as a rolling agenda item and to invite Mr O'Neil back to update members in a couple of months' time.

The Chair thanked both Eddie O'Neil and Stephen Davis for their time and useful update on progress.

Action: Mental Health Nurse issues keep as rolling Agenda item

141/2009 MATTERS ARISING

• **Antenatal Children's Centres – Relocation of Midwives**

Jackie Huck would come back to this at January's meeting.

• **Health Visitor Report**

Following the November meeting Jackie Huck agreed to establish the current situation by speaking to Trish Jay. There were no formal plans to move Health Visitors out of practices although some practices with a lack of space accepted the alternative of moving HVs to Children's Centres.

The Health Visitor original report had been rejected by the PCT as inappropriate and had been followed by lengthy discussion/work with the PEC and PBC Clusters earlier; that work would supersede the original report. There was still much to do, which was ongoing.

Dr. Fielding enquired if the final report would come to the LMC eventually; PCT representatives agreed to copy in the LMC. Dr. Simpson had been at the PEC meeting and felt the criteria had been very much resource allocation based. Dr. Miller admitted that the PCT were not always clear in saying what they wanted from GPs.

• **Diabetic Retinopathy**

- *Capacity*. Analysis was taking place across the county. Practices had been categorised as:

- Having no space.
- Having difficulty but working with the service.
- Having screening undertaken at other sites
- Having no identified problems (this covered 75% of practices)

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- *Coding.* Practices had been colour coded into Red/Green zones. Jackie promised to share a breakdown of practices with Mike Forster. Dr. Simpson was not sure practices were specifically asked and would not be aware they were being placed in the green zone.

- *Discussion.* Dr. Yerburgh asked about the Mobile Unit mentioned at the last meeting and asked that Jackie speak to Jan Marriott, as technology had moved on such that more complex procedures could now be performed in a mobile unit.

Action Jackie Huck:

- To share details with the LMC

- To speak with Jan Marriott re Mobile Retinopathy unit

• Christmas Eve and New Year's Eve opening

Christmas Eve: The PCT had looked at the regulations and contract and established that surgery opening was at the discretion of the practice. The PCT had to be sure that robust clinical arrangements were in place to cover the practice once the phones had been switched over. In 2008, Christmas Eve saw an increase of 17% to 20% during OOHs. Six practices had advised the PCT that they would close their doors at lunchtime; the PCT planned to contact them again to ask them to reconsider but if they would not the PCT wanted evidence that a robust system would be in place. Patients needed to be informed how to access essential services and a return call within one hour was vital. Members asked if the on-call system could cover but some of them were felt to be out-of-date.

All other practices (79) would stay open until 4 p.m.; availability of doctors was the issue. Dr. Fellows' practice had historically closed at lunchtime on Christmas Eve but there had always been a GP to cover. The Chair felt that as long as the 6 practices had good and robust systems in place, the LMC accepted their decision to close at lunchtime, a view that Dr. Miller supported.

News Years Eve: A normal working day. Only 2 practices would not stay open as normal: one until 12.30 p.m. and the other 4 p.m. Again robust systems which the PCT would test needed to be in place.

142/2009 FOR DISCUSSION/INFORMATION

• Sharing information about domestic violence with GPs

Dr. Penny West had invited members to examine and comment on a planned confidential information-sharing document concerning domestic abuse victims deemed at high risk of serious harm.

Members agreed that the whole report should be made available to GPs and in principle transmitted via email when the web-based email system was in place and secure but the preferred method of transmission should be agreed in consultation with Practice Managers. Confidential issues were of concern; for instance the information should be filed separately from the patient's medical file. Dr. Bayley felt that for personal safety, practices should receive the form.

• FACE Background Information Form & FACE Overview Assessment

Dr. Bayley reported that a District Nurse had been asked to complete a FACE Background Information Form and Overview Assessment for use in the Single Assessment process. Form 1 was to be completed for any medical contact with a patient; the Form 2 had to be filled in if there were social services implications to the case. Dr. Coker reported that none of her District Nurses had done any swine flu vaccinations because of the need to complete the form.

Members wondered how on earth the form had got into GP practices; the PCT needed to go back and establish where it had come from, it was totally inappropriate. Members noted that in Dorset such forms were shared electronically with Social Services but in Gloucestershire there was no way of sharing this information and Social Services would still have to do their own assessment. It was agreed to have this as a Matter Arising on the January Agenda; the PCT were invited as a matter of urgency to have the introduction of these forms halted until

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proper reflection allowed a sensible use of them.

- Action: 1) Matters Arising January meeting
2) PCT to establish where form was generated**

• **Vascular Screening LES**

A PCT Clinical Model was tabled. Any comments were to be made through the Negotiators Committee giving time to consider/discuss; it was a difficult document to go through in one meeting. The LES would start in Gloucester City run by GHAC and then picked up by City practices. Members were concerned how the PCT proposed to manage those practices that did not have EMIS (about half of practices). Dr. Bayley had learned that EMIS could not be used but Adastra could be.

Training issue: most of the work would be done by GPs and not Nurses apart from Nurse Practitioners who would need training. Dr. Fellows thought discussion with Practice Manager Groups would be productive.

• **Pre-operative Prescriptions**

Dr Good's partner had been instructed to stop a patient taking aspirin before a procedure and prescribe Fragmin until the day before the operation. The committee felt that this was improper – the consultant in charge of the operation should be responsible for pre-operative prescriptions. Jackie Huck agreed to take this back to PCT.

Action: Jackie Huck to investigate

143/2009 LISTSERVER

Nothing vital to report, most of the issues having already been covered.

144/2009 ACTIVE TOPICS

• **Project UTOPIA**

- **Unscheduled Care Group meeting report**

Dr. Morton had been unable to attend the LMC meeting but had sent a report of an Unscheduled Care meeting he had attended. GWAS had appealed to larger practices to see if there was anything they could do to avoid bunching of admissions late morning; in one instance a couple of weeks ago, there had been 20 admissions arriving at about 1.30 p.m. His report outlined the following:

GPs working in the Emergency Department

There had been a brief appearance of a GP in the department; there did not appear to be a great appetite from the Acute Trust to have GPs in Casualty. At present the initiative appeared to have stalled.

Audit of Acute Admissions.

A concern about the number of false positive admissions going in under 999s; at present there was no way for GPs to screen these calls and the best suggestion was to encourage crews to call the Hub Clinical Desk if they were vague about the diagnosis, rather than taking the patient into Casualty as an immediate default position.

Single Point of Access

The vision was that there should be a single phone number for all OOHs Unscheduled Health and Social Services needs. Some mapping work had begun which showed that there was a considerable need for linking and information sharing across the services in the county.

Utopia

Dr. Dedi had a number of requests:

- That, when ringing up the hospital, practices should ring the Unscheduled Care Referral Centre (UCRC) to get specialist advice; the UCRC could link the GP to the relevant consultant, and this is preferable to the former practice of going through the switchboard and speaking directly to a named clinician.
- That GPs should help by including more information in the admission letter on the level of care or packages of care already present at home plus the drug list.
- That there be a move to develop a series of pathways for OOHs care.

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- That a Directory of Community Services be available to Doctors in Casualty; at present they had no idea what the community services were and had no way of contacting them.

Discussion. Members had experienced an increasing demand for transfer of patients from GRH to Community Hospitals. Dr. Rigby had concerns over the costs involved (paying twice) when patients spent a couple of nights at GRH and then transferred to a Community Hospital. Jackie reported that commissioners were to look at the costs involved; Kevin Brett was doing a piece of work.

A second paper from Dr. Morton 'Response to GP Feedback November 2009' was also tabled for information.

• **Pandemic Flu**

- Vaccination of children over 6 months old and under the age of 5 years. The PCT brought a draft LES to the meeting to establish whether GPs as the preferred provider would provide the service. The non-negotiable areas were £5.25 per vaccine and a relaxation of the access requirements although there could be some slippage in other areas to compensate. Debra Elliott asked members for their thoughts / ideas as they had to submit a plan to the SHA. If GPs were not willing to deliver the service the PCT's contingency plan was to provide it from Community Hospitals and Health Centres (20 premises in all) but would prefer that GPs do the work. It was agreed to feedback to the PCT the Committee's view on the LES.

Dr. Fielding reported that the Pandemic steering groups meetings had stopped; he was not sure what Shona Arora's plan was.

There should be one or two practices holding egg allergy vaccines. The PCT agreed to take back a problem Dr. Booker had raised regarding resupply of vaccines and the supply chain. The PCT would also seek clarification on whether and how practices could share supplies. Dr. Fellows reported that further supplies should be coming out shortly.

On a practical note, Dr. Fielding recommended that practices get the vaccines up to room temperature before administering as it became quite thick and if injected in that state could be painful.

It had been learned that for the under-5's a single dose would be enough. However, many practices would probably have made a second appointment, not being aware of this new requirement. It would be helpful if the PCT could go out to practices with this information.

• **PBC**

PBC clusters continued to build relations with the PCT; confederations were starting to be discussed. The DoH had published results of a survey: 54% of PBC Leads had some influence in general practice but there had only been a 58% response rate to the survey.

The second of three training events would be held in January 2010 and confirmation/information would be coming out. The next Clinical Leads meeting would be on 12th January.

Dr. Miller reported a reconfiguration of the PEC. Notice had been served on PEC members and she would be advertising for members from across the clinical community: GPs, Ophthalmic and Dentistry, etc.

• **Choose & Book**

A Masterclass had been held in Bristol; Dr. Fielding had put forward members' concerns in an email and he awaited a copy of the Minutes which he would pass on to Mike Forster.

Action: Dr. Fielding to forward Minutes of Masterclass to Mike Forster

• **IM&T**

There had been a meeting that day. It was learned that Adastra was not integrating into GP systems. There were GP systems that were not going to be developed further; Dr. Rigby urged practices to make sure that what they had was efficient. Telephone numbers beginning '03' had been discussed; they were considerably

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cheaper than 0844 numbers for patients, being the same cost to call as 01 or 02 phone numbers, but would cost practices.

Dr. Alvis still had problems with GP COIN and practice bandwidth; Dr. Rigby said he should complain and raise it with the Helpdesk and Dan Corfield also to ring Connecting for Health. Debra Elliott agreed to take this back and see what could be done.

Action: Debra Elliott

• QoF

Concerns were raised from practices that the results of their efforts were not being correctly uploaded by QMAS, involving considerable delays at the end of year. Dr Fielding assured the meeting that they would not be disadvantaged as all inconsistencies would be straightened out at the end of the year before final payments.

Depression 2 – Nikki Holmes and Dr. Fielding had met with most practices concerned; the bottom line was that there would be a plan to overcome the variation in the ways practices accounted for Depression 2 activities.

145/2009 REPORTS

• Report of Negotiators Meeting 16.11.2009

As tabled; a decision had been made to take Phlebotomy out of Enhanced Services. Further discussion was to be taken to the Closed Session.

• Report of the Executive meeting 26.11.2009

It had been a short meeting mainly to consider the November Minutes and Newsletter. No Minutes had been taken.

• GPC Newsletter 2009

As tabled.

Dr. Fellows reported:

- Since the last GPC meeting, they had submitted supplementary evidence to the DDRB; he felt there would be no big increase from the DDRB. The Department wanted to get rid of MPIG and were not minded to agree a similar formulaic plan to last year's.
- The Department was pressing PMS practices to return to GMS.
- Pandemic flu. It was hoped that there would be minimal changes to GPs contracts for next year in relation to the flu pandemic.
- Seniority figures had been published, with the final seniority baseline being higher than the original estimate; small practices might be liable for claw back.
- Pension Contributions: Locums should get their NHS Pension contributions paid promptly. It was agreed to put this in the Newsletter.
- Practice Boundaries were still an ongoing issue.
- The 'Responsible Officers' for revalidation were unlikely to be entirely independent of PCTs. If a doctor failed revalidation his or her first step might be a legal action for redress.
- He felt that the proposed abandonment of practice boundaries heralded the privatisation of daytime home visiting.

Action: Locum Pension contributions Newsletter item

• LMC Secretaries Conference

Mike Forster and Dr. Seymour had attended this year's Conference; the keynote speech by Dr. Lawrence Buckman had touched on Integrated Care Organisations, the relaxation of Practice Boundaries; the introduction of Revalidation in 2011/12.

The need for Professional Indemnity Insurance. The GPDF were no longer prepared to arrange this cover on behalf of all LMCs so from 29th December 2009 LMCs should arrange their own.

Dr. Seymour reported that behind the scenes negotiations regarding flu vaccination had stalled because one or two civil servants thought GPs earned too much and should take on this additional work for nothing. To a question that some local practices had not received many vaccines, the Chair said that in fairness Gloucestershire PCT were doing very much better than other areas.

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Another area examined was how the NHS might look under a new government.

- Ceasing of home visits
- Boundary changes – could have child protection/vulnerable patients going everywhere!
- Patient Reported Outcomes; expert patients to report back!

To balance the argument an overview of Labour's ideas was given, including giving a legal right to a health check every 5 years.

The Secretary's report was as tabled.

146/2009 FORTHCOMING MEETINGS/EVENTS

- LMC Meeting 14.01.2010

147/2009 ANY OTHER BUSINESS

A member had had a quick chat with the Cheltenham MP about the costs of producing the paper 'Let's Get Moving'. It would be interesting to see what came of it.

There being no further business the meeting closed at 4.50 p.m.