

# **GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE**

## **MINUTES OF THE MEETING ON THURSDAY 9<sup>TH</sup> APRIL 2009**

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 9<sup>th</sup> April 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, Kanga, Patterson, Rigby, Simpson, Siva, Yerburch and Ulahannan.

### **Also present:**

Representing the PCT:

Debra Elliott, Director

Jackie Huck, Deputy Director

From the LMC Office:

Mr Mike Forster, LMC Lay Secretary

Sue O'Sullivan, Admin

### **39/2009 APOLOGIES FOR ABSENCE**

Dr. M Hayes, Dr. T Morgan, Dr. S Tan, Dr A Walsh

### **40/2009 CHAIRMAN**

Dr. Seymour welcomed the PCT representatives and as observer Dr. Tom Agombar, Dr. Morgan's Registrar.

Tea Rota: Drs. Coker & Patterson

### **41/2009 MINUTES OF THE LAST MEETING**

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

### **42/2009 REGISTER OF INTERESTS**

Dr. Bayley reported that the Gloucester Darzi Centre contract had been signed by G-Consortium; opening date 5<sup>th</sup> May 2009. The Board was due to meet on 23<sup>rd</sup> April to make appointments and officially set up the company. There were no other new declarations of interest to report.

### **43/2009 ACUTE TRUST ISSUES**

#### **• Path Lab Results**

A discussion at the March meeting considered the facility GRH Trust had in place to allow GPs to access results stored on the system but generated within secondary care. Dr. Walsh who unfortunately was not present, had agreed to investigate further. Dr. Ulahannan reported a conversation with Adrian Banford about the Anglia system but realised this was not what GPs were requesting. GPs wanted to log in as a registered user; it would mean creating a user log. There was in existence a single login which had two streams; GPs didn't want to see every single result, just the ability to log in to view the result they required to see. Dr. Rigby reported that the IT team were currently looking at a project to deliver such a system.

#### **• MRSA**

A communication from Microbiology Consultants to GRH Consultants regarding the Trust's compliance with the DH strategy on screening for MRSA carriage from 1<sup>st</sup> April 2009 was considered. The strategy included the requirement to screen day case patients, but not elective admissions. The Trust would be performance monitored on its implementation of this DH policy by both Monitor NHS Gloucestershire and the SHA. It was recognised that any screening programme would have a potential impact on service delivery (with possible delay or cancelled surgery).

The Chair felt that the Trust had done well, excluding GPs from onerous testing. Dr. Ulahannan had discovered in conversation with Jim Stone that there were different policies for different patients. A problem still existed with the surgical division, on which Paul Garrett had been tasked to seek proper clarification. The Chair asked why, if they could do this, then why not for all categories of patients?

#### 43/2009 cont.

Debra Elliott said that Microbiologists felt it would still impact on GPs; the PCT was trying to secure funds to comply with the strategy. Overall though, it was relatively encouraging that the Trust was taking things forward. The PCT would keep a watching brief.

- **Sick Notes**

Patients seen in A&E were not being issued with a sick note if they required time off work; A&E national guidance stated that sick notes were not written, although some patients were followed up in A&E. Dr. Ulahannan and Debra Elliott agreed to pick this up.

**Action: Dr. Ulahannan/Debra Elliott**

#### 44/2009 **MATTERS ARISING**

- **Prescribing Incentive Scheme (Draft)**

The PCT did not promote a specific PIS for 2008/9, but as a result of general feedback coming through PBC groups during 2008 it was learned that the schemes had been found to be useful. Mark Gregory and Laura Bucknell had raised an option for consideration at the PBC Clinical Leads meeting of an 'invest-to-save' -based Prescribing Incentive Scheme for 2009/10. No consensus of opinion emerged from the various PBC Groups involved on the key discussion points. Mark and Laura's overall conclusion was that they felt unable to produce a Gloucestershire PCT-wide PIS 2009/10 proposal that adequately satisfied the range of opinions that had been raised; however it was felt that some form of PIS would be useful and they proposed two schemes for a generic PIS 2009/10.

Scheme 1: would be open to all practices and would reward practices with 25p per patient for producing a savings plan, and achieving savings of more than 25p per patient. If they could also end the year with their PBC group at least 0.25% under-spent on its high cost drug adjusted prescribing budget then the previous award would be doubled to 50p per patient.

Scheme 2: would be open to practices whose

- a) practice total prescribing costs per ASTROPU were at or below the PCT average for 2008/09  
AND
- b) practice percentage of simva/prava items vs statins/ezetimibe items were at least 75% in Q4 2008/09.

They would be rewarded with 25p per patient if they could achieve a high cost drug adjusted annual practice prescribing cost growth rate below the South West SHA average in-year. As with Scheme 1, if their PBC group could also end the year at least 0.25% under-spent on its high cost drug adjusted prescribing budget then the previous award would be doubled to 50p per patient.

Twenty practices in the county fulfilled Scheme 2 entry criteria and had prescribing growth below the SHA average in 2008/09.

A further PIS draft (v2) was tabled at the meeting for endorsement by the Committee. Members asked whether practices were required to opt for Scheme 1 or 2, or could both schemes be run. Jackie Huck would get clarification.

**Action: J Huck**

Practices would be told who had been identified for Scheme 2. Members also asked that practices that did not qualify for Scheme 2 needed to be informed so they could work towards Scheme 1.

Other papers in the pack included a Scriptswitch summary report which had potential for prescribing savings. Dr. Yerburch, Medicines Management LMC Representative had no experience of Scriptswitch. Dr. Fielding reported that some PBC Groups had been involved in the scheme; Rosebank Surgery was one of the piloted practices and had made some savings. Members were reassured that savings would be spent at practice level and there was potential reward for working collectively. An incentive scheme based around 70/30 was fine at Cluster level but at practice level it should be a scheme that rewarded practice efficiency. Dr. Rigby was concerned whether running Scriptswitch would slow a practice system down. The Committee welcomed it in principle.

#### 44/2009 cont.

- **Joint meeting PCT/LMC/LPC**

Both the PCT and the LPC strongly supported a joint meeting. The hope was to hold it on the 28<sup>th</sup> May prior to which the LMC/LPC were hoping to organise a meeting with dispensing practices to discuss pharmaceutical needs assessments.

Pharmaceutical needs assessments should benefit Dispensing Practices as well. The meeting would be held at the Thistle Hotel, sponsored by local Pharmaceutical representatives, on 6 May starting at 12:30 and lasting all afternoon. The LMC would not be paying for GPs time to attend the meeting. The Secretary would take this forward. **Action: LMC Secretary**

- **PCT Medical Directors**

The PCT was advertising for two part-time Medical Directors: one for Commissioning and one for Provider services. These posts had previously been advertised without success.

Dr. Gale requested a copy of the advert to inform Sessional GPs. It was remarked that there was no closing date for applications. Jan Stubbings wanted people from Gloucestershire to apply for the posts, which the LMC wholeheartedly supported. Dr. Rigby wondered if a GP's NHS Pension would be affected if appointed; PCT representatives did not think so. The advert cited being a PEC member as an essential quality, which might limit applications. Jackie Huck would check on this. It was noted that remuneration was not mentioned.

**Action: J Huck**

- **Summary Care Records**

This was considered at the March meeting. Summary Care Records would be introduced in December 2010. It had been agreed that Dr. Fellows & Rigby would investigate the issue of opt out re C&B and report back.

Dr. Rigby had sent an email to the PCT C&B team but had had no reply. It was agreed to bring this back.

**Action: Dr. Rigby/bring back to May meeting**

- **CRB checks**

CRB checks were aimed to help organisations in the public, private and voluntary sectors to identify candidates who might be unsuitable to work with children or other vulnerable members of society.

Dr. Gale was concerned that as a Freelance GP he could not apply for a CRB check. Every organisation he worked for had to implement a check, at £35 a time. Could the PCT hold a CRB check for Freelance GPs and share the information with employers?

He wondered if the Trust had a vision of how many people on the Performers List had a CRB check. There were 60 people on the List whose CRBs were out of date i.e. 10% of the list. Dr. Gale also raised the Ambulance Trust issue as employers but as the PCT commissioned the service CRBs were covered. A Registrar at Dr. Patterson's surgery had had to wait 6 weeks for a CRB check. This was probably because he was going to work outside the county as other employers would have to initiate a CRB. In-county Registrars were given a period of grace. Debra Elliott agreed to contact Dr. Bill Foster and draft a paper to inform Registrars.

**Action: Debra Elliott**

#### 45/2009 **FOR DISCUSSION/INFORMATION**

- **Revalidation**

- Guidance paper

Wessex LMC had produced a very useful guidance paper which they had kindly agreed Gloucestershire LMC could use.

'Revalidation for GPs would be a process by which GPs would renew their GMC licence to practise and be placed on the GMC's General Practice Register. Revalidation would be a continuing process in a 5 yearly cycle.

The debate had moved on from whether revalidation should happen to how it would be implemented and more importantly how GPs could embrace the process with maximum benefit and minimum effort.

The first revalidations would take place in 2010/11 and it was therefore important that all GPs started the process in April 2009. For the year 2009/10

## 45/2009 cont.

the only requirement would be for each GP to complete their annual appraisal. There would be no requirement for evidence to be submitted prior to April 2009.

It was important to remember that the process of revalidation had started, a process which would evolve over the next few months and years.

Dr Fielding drew attention to page 8 as a precise preparation guideline, urging GPs to maintain a log of educational reflection.

To members of the Royal College revalidation was free; others would have to pay approximately £400.

- Credits

There was no simple correlation between time taken in learning experiences and the credits allotted. Mere attendance at an event was not enough; there had to be reflection and action and these had to be recorded. In short, everything possible should be reflected on, reacted to and well-documented. Even attendance at an LMC meeting might be worth credits if much reflection and action was the result. At least revalidation did not require an exam. The committee wondered whether practices might commission their own patient survey, especially if the national survey results were surprisingly adverse. It was important that appraisers work was validated. Failure to gain revalidation would cause a GP to be unable to practice until a fresh licence to practice had been earned. Practices would need to document in advance what would happen in these circumstances (pay, responsibility for locums, share of practice profits etc)

Dr. Simpson said lots of practices in Gloucestershire were already doing 360° Appraisals and felt they would not have a problem with it. Gloucestershire was doing well as a county.

Appraisal Indemnity: the PCT already had this in place.

It was pointed out that Sessional GPs might not be in a position to have 360° appraisals, and a possible fall-back position for them might be an exam/knowledge test. The Appraisal year carried over from 2009 to 2010 and was out for consultation on the RCGP website for 5 months.

It was agreed to put the Wessex document on the LMC website.

**Action: Office**

- SouthWest Region Appraisal Development Workshops

No one present at the meeting had attended. It was work in progress.

- **DDRB**

The Doctors and Dentists Review Body (DDRB) report had been published. This year's arrangements for translating any uplift recommended by the DDRB into practice resources were more complicated than in previous years. Practices would not necessarily receive the DDRB's headline increase. Instead the amount received by each practice would depend on each surgery's circumstances.

The Review Body had recommended that the overall gross uplift in GMS contract payments be increased by 2.29% for 2009/10. This was intended to achieve an average uplift to net income of 1.5% across the profession. However, it was important to remember that because of the ratio formula that would be applied, the actual amount of net uplift would vary between practices.

The Chair tabled a paper from the DH which gave clear guidance on how the uplift was being applied.

- **World Class commissioning**

- **PEC paper:**

The paper had been prepared to brief the PEC on the programme of work that the PCT was about to undertake on behalf of the DH and based on the national guidance *Primary Care & Community Services: Improving GP services*.

Gloucestershire PCT had 12 indicators to work on and some data collection would be required:

Some of the areas to be worked on were:

- Developing the vision
- C&B numbers
- Infection Control Visits
- Premises Inspection

## 45/2009 cont.

- Quality
- Extended Hours

Dr. Bye was bemused by the title 'World Class Commissioning' and wondered against whom in the world we were comparing ourselves? Debra Elliott urged sensible implementation.

Dr. Rigby asked about practice level data: Debra would share with practices individually before going public. The PCT had to be very careful over releasing data.

- **Contract review template:**

The PCT had a contractual responsibility to review all contracts held with Primary Care Independent Contractors annually. The template for 2009/10 had been tabled and covered all areas of general practice. The first two-thirds covered what GPs were already doing, essentially QoF-related. If a practice were not getting a QoF visit they would not need to produce evidence; those having a QoF visit would.

The process was designed to be evolutionary and developmental, not critical. Practice Managers should not be afraid to tick 'No', for instance against the Premises question. The important thing was to tell the PCT where things could be improved, which could then be discussed during the visit. There would probably be many questions. The PCT were to hold 3 events for Practice Managers to talk them through the document and procedure. The LMC/PCT Negotiators would be discussing this further at their meeting on 20<sup>th</sup> April.

The last few pages covered:

- Development
- Standards all providers were required to meet
- **'Developing General Practice, Listening to patients'**  
The GPC wanted to learn more about the way, at a local level, practices responded to patient expectations and what barriers practices encountered that prevented them making appropriate changes. Practices should be encouraged to respond to the consultation. It was hoped that the feedback would ultimately help inform GPC discussions with the UK Government.

**Action: Newsletter item**

## 46/2009 LMC LISTSERVER

This was a new item on the Agenda which the Chair felt would be of interest to members. The LMC Listserver was an electronic messaging service specific to LMCs where a message sent to the server was sent out automatically to all members, usually the chair and secretary of each LMC. This enabled LMCs to exchange views, ask questions and seek advice from other colleagues around the country.

Current topics:

- **QoF: Education 1**

Education 1 - There was a requirement for a record of all practice employed clinical staff having attended training and updating in basic life support skills in the preceding 18 months. It did not apply to GP partners since they were not employed by the practice, although they should still take such training and updating as part of their appraisals and (in due course) revalidation.

- **Car Park Liability**

There had been a lively discussion on the Listserver about the risks of being sued if someone slipped on ice in a practice car park and injured themselves. If nothing was done, the car park was closed and a warning notice put up there might still be some liability. If the ice was inadequately cleared and someone slipped, there might be even more liability, probably on the basis that the action in ostensibly clearing it might cause the victim to be less careful than he would otherwise have been. The situation as regards staff and patients might differ. A Kent LMC Guidance Document was tabled for information. It was agreed to send out a reminder to practices in November as the weather began to worsen.

**Action: Item in November to practices**

## 47/2009 ACTIVE TOPICS

- **Project UTOPIA**

An advert had been placed for 14 new A&E Consultants to support Project Utopia, none of which apparently wanted to work at GRH! There was no investment in this project from the PCT. Jackie Huck stated the PCT, as commissioners wanted the Trust to review their services improving access up through the system.

Dr. Rigby felt that the whole health care community should have been involved in the planning. Dr. Bayley was assessing other systems in her role as a PEC member.

Dr. Fielding asked if there would be a review of the success of Project Utopia; it was the biggest service redesign in Gloucestershire with an investment by GHT of some £3.4m and was planned to be implemented by 1<sup>st</sup> August 2009.

The office had invited Sean Elyan to come to the June LMC meeting but members wondered if there was any mileage in meeting Sean outside the LMC meeting within the next six weeks to take forward and pose questions. Discharge summaries would be high on agenda. The PCT also wished to be involved in the meeting.

**Action: set up meeting with Sean Elyan/PCT/LMC**

- **PBC**

Dr. Fielding reported the next meeting was planned for May, not very much was happening; Clusters were working on their internal projects.

Jackie Huck: Budgets would be out in May.

There was to be an SHA Roadshow on 29<sup>th</sup> April in Taunton and a group from the PCT were attending. Discussed would be challenges set by PBC, also PCT assessment.

A consulting group 'Tribal' had been appointed to assist the Gloucestershire PCT.

- **IM&T**

- **IM&T Steering Group Meeting Report:**

As tabled.

GP-COIN funding was still being negotiated; Virgin Media were currently interested in bidding for it.

GP Email migration: The draft business case had been approved. Initially they were going to migrate 12 sites to the new email system.

Discharge summaries: Summaries were currently not migrated into the clinical system properly. The LMC would ask Jackie Huck to take it up with the Hospital Trust.

**Action: Office**

OOH Faxes: Contacts from Adastra were still being faxed instead of being sent to the clinical system. It apparently formed part of a long list of priorities to be sorted.

Training: Training for Practice staff on using Windows, Outlook etc available through the Training Department.

Remote access to Surgery computers: Still ongoing.

Gloucester Darzi Centre: Due to open 5.05.09, clinical system EMIS PCS – for non-registered patients Adastra.

- **IM&T DES Component 4**

NHS Connecting for Health had confirmed that not all GPSoc suppliers that presently offer hosted services had met the standard in full. However, many practices had taken the necessary steps and implemented the hosted services provided by these suppliers in their practices by the 31st March deadline laid down by the IM&T DES. As it was not the fault of these practices that they had not met the standards in time the PCT had a discretionary power to make part payments to those practices if the reason they failed to reach the standard was beyond the practices' control.

- **Choose & Book**

- **LES – Choose & Book 2009/10 (Draft)**

Some practice achievements in C&B were greater than 100% (which was logically impossible). Nearly all practices were using C&B and more than half of them for a high proportion of the referrals. The LMC wished to know how much money had been paid in previous years under C&B, and what proportion of the budgeted amount that represented, since they feared that money was being lost to primary care because the C&B system was

#### 47/2009 cont.

unusable. Indeed the meeting expressed wholesale exasperation with the system.

Dr. Bye felt that the Negotiators should discuss this. Dr. Simpson wondered how many practices could hit the bottom line. Debra Elliott would take that argument back to the PCT. The Chair felt that it would be difficult to change people's behaviour and it would be advisable to take to Negotiators and have last year's figures available.

- **QoF Spot Check Draw**

The PCT were required to carry out QoF Spot Checks for Gloucestershire practices and in order for the process to be random, as previously agreed, all 84 practices were included in the ballot; 5% of 84 were to be selected i.e. 4. The Lay Secretary conducted the ballot during the meeting and the PCT agreed to inform the selected practices.

**Action: Office/Gloucestershire PCT**

- **(Gov. response to Consultation on developing QoF) summary**

As tabled.

- **Interim End of Year QoF Payments**

Payments for end of year QoF were planned to be made in June but 70% of those payments were now going to be paid during April, the balance to be paid in June. This news was well received by members.

#### 48/2009 REPORTS

- **LMC/PCT Negotiating Minutes 16 March 2009 – Sanger House**

As tabled.

- **SW Region LMCs meeting and GPC Roadshow**

As tabled.

- Vascular screening issue:

This was a significant area on which Public Health were leading a rolling programme over the next 3-years. Debra Elliott would be putting together a brief.

- Square Rooting

The PCT were again asked to look carefully at those practices which stood to lose significantly from the impact of the abandonment of the square rooting formula:

- Seniority payments

The government wanted to get rid of seniority payments. The GPC negotiators took the view that if this was going to happen then the money should be kept within primary care for the benefit of practices. The difficulty was that practices did not all treat seniority payments the same way; some used it as practice income and some as specific income for the GPs earning it. As time went by the pot was shrinking due to employment of more salaried GPs.

Dr. Fielding's view was that Salaried GPs should receive Seniority payments. Dr. Yerburgh was personally sad that there were no merit awards this year, the GPC had not made a submission. Dr. Fellows would refer this to the GPC.

**Action: Dr. Fellows**

- **GPC News Issue 7**

Dr Fellows pointed out that there was a new complaints procedure: practices should have a proforma in place. Practices needed to be reminded.

**Action: Newsletter item**

#### 49/2009 ANY OTHER BUSINESS

LMC Buying Groups: The Secretary was currently working this up but needed the Committee's support to take the idea forward.

Nottinghamshire LMC had a large buying group and substantial savings for practices could be made. Wessex LMC were interested in joining the group; the Secretary asked if Gloucestershire LMC should express an interest. There would be at no cost to the LMC. Mike Forster was tasked to take this forward, it could mean added value to practices. The PCT would also look at what bulk buying savings they could offer.

**Action: LMC Secretary/PCT**

## **50/2009 FORTHCOMING MEETINGS/EVENTS**

- LMC/PCT Negotiators 20.04.09
- LMC Executive meeting 23.04.09
- LMC May meeting 14.05.09

## **51/2009 CLOSED SESSION**

### **• C&B**

Dr. Simpson felt that the LMC Negotiators could have fashioned a much better incentive scheme; his view was that it was a poor way of doing business, bringing the C&B document to this meeting for a decision.

### **• LMC Rate rise**

Dr. Seymour wished to propose an increase of 1.5% (93p, rounded to £1) to the LMC rate bringing it up to £63 per hour; it was hoped that it would not be necessary to increase the levy. The £1 uplift was unanimously supported. It was agreed that the office would pay £63 per hour even in the event that the PCT didn't ratify the increase.

### **• LMC Office Staff pay rise**

The committee re-examined the pay of the office staff and agreed a 1.5% increase effective from 1 Apr 09. **Action: Shelina**

### **• Unpresented cheques**

The end of year accounts had revealed that a few Committee members had not banked their reimbursement cheques for 2008. A discussion led by the Treasurer asked if members who did not present their cheques within 6 months, would have their cheques cancelled. The Treasurer would then decide whether a new cheque should be raised. It was agreed that a state of grace would be given but in future there would be a 3-month trigger with a final warning. Paying members by BACS would be looked at, negating any need for cheques and the problem of encashment. **Action: Shelina**

**There being no further business the meeting closed at 4.45 pm**