GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 12th FEBRUARY 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 12th February 2009 at which the following members were present:
Dr. A Seymour (Chair) Dr. P Fielding (Deputy Chair), Dr Steinhardt (Treasurer)
Drs. Bayley, Booker, Bye, Coker, Fellows, Good, Hayes, Kanga, Morgan, Morton, Patterson, Rigby, Salter, Simpson, and Siva.

Also present:
Representing the PCT:
Debra Elliott, Programme Director, Primary Care & Community Care Services
Jackie Huck, Deputy Director
Mr Eddie O'Neill, Assistant Medical Director

Representing the 2Gether Mental Health Trust
Mr Paul Thompson, Operations Director

From the LMC Office:
Mr Mike Forster, LMC Lay Secretary

13/2009 APOLOGIES FOR ABSENCE – Drs Alvis, Gale, Morgan, Ulahannan, Walsh, Yerburgh and Sue O'Sullivan

14/2009 CHAIRMAN

Tea Rota: Drs. Morton & Simpson

The Chairman welcomed Mr Eddie O' Neill and Mr Paul Thompson. He also welcomed Dr Simpson's guest, Dr Ruth Thompson, as a spectator

15/2009 MINUTES OF THE LAST MEETING

The minutes of the last meeting were agreed subject to:

- A small amendment on page 4. Mrs. Huck had, as minuted, stated that the monies for flood relief had been given to the PCT only in the financial year 07/08, but what she had also stated, and which needed to be minuted, was that the PCT would honour its commitments to the practices affected.
- Closed Session. Dr Steinhardt pointed out that he had not actually asked to go onto the Negotiating Committee as implied by the Minutes of the Closed Session but had said that the chairman of the PMS subcommittee (whoever that might be) should be the PMS representative on the negotiating committee.

16/2009 REGISTER OF INTERESTS

There were no new conflicts of interest to report.

17/2009 ACUTE TRUST ISSUES

In the absence of Dr Ulahannan, and of any input or questions, this item was shelved until March.

18/2009 IAPT MENTAL HEALTH (Improving Access to Psychological Therapies)
EDDIE O'NEIL

Mr O'Neill briefed the meeting. The review of mental health provision had arisen out of a number of factors. The PCAT responsibilities straddled secondary and primary care but were paid for out of primary care budgets. There had been significant changes introduced in 2007 (a 12.8% reduction in funding and a demand for greater performance) and it had always been planned that there should be a review at the one-year point, which this review was now providing. There were still differential services across the 3 former PCT areas which needed to be harmonised. The government was feeding in new money (about £800K in year 09/10 for Gloucestershire, which would be matched by the 2Gether trust) to fund the recruitment of an extra 40 psychologists in the county to improve access to Psychological Therapies; the government's intention was to provide an extra 6000 treatment episodes a year by 2011. He mentioned also that the Department of Health, through the PCT, was only issuing one-year contracts to the Mental Health Trust to fund the service. The review had started by commissioning a mental

18/2009 cont.

health needs assessment, which, for reasons of capacity rather than capability, had been given to external consultants to develop at a cost of about £20K. Mental health data for the study had been obtained from GP practices amongst other sources. Resourcing would be based on the identified needs. As to what that resourcing should be, he hoped that the LMC would agree that GPs should get involved in a county-wide mental health commissioning group.

After the presentation the committee:

- Questioned the statement by Mr O'Neill that GP practices had been consulted – none of those present had been. He said he would look into this.
- Were concerned that secondary care, and thus perhaps the study, were unaware of how much mental health care was carried out by GP practices. An absence of mental health referrals to secondary care did not necessarily mean that the overall mental health of the population was improving.
- Believed that information systems provided inadequate data on mental health issues.
- Were concerned that current provision was in inverse proportion to need, and that PBC involvement alone might not solve the problem.

Mr Paul Thompson then briefed the meeting on the operational side. He said they would welcome more focused contracts rather than block contracts. PCAT had been set up to meet local needs but had not worked well in all areas, perhaps because at the time the PCT was trying to recover from a severe financial deficit but also trying to improve access to psychiatric treatment. Overall though, PCAT had delivered triple the expected (and budgeted) activity. The new measures to improve access would be implemented in a phased approach between Apr and Oct 09, during which the 2Gether Trust would have 'preferred provider' status. They would be looking at historical PCAT figures to avoid repeating mistakes. They were proposing a 'telehub' system (whereby outside agencies had a single phone number by which to access all 2Gether services). They wanted to introduce payment by results in mental health, which was not currently supported by their IT systems. He regretted the poor quality of communications with GPs over what was being done with their patients. He would welcome involvement from GPs to shape the commissioning framework for mental health services if this would lead to not repeating past errors.

The committee raised the following points:

- There was a severe shortage of space in most GP practice premises. No matter how willing they were to host mental health clinics, it might be difficult to do so. Mr O'Neill understood this, and said he would be identifying alternative sites wherever necessary.
- The Telehub system might be very useful, but should not prevent a GP from referring those with severe mental health problems directly to consultants. Mr O'Neill confirmed that this procedure would continue in parallel to the Telehub system.
- What would happen to existing PCAT staff? They would be 'rebadged' but would not be among the extra 40 psychologists.
- On what success criteria, and using what procedure was the new system to be evaluated, and would GPs have a hand in it? Mr O'Neill stated that review of this was part of the strategic commissioning role which GPs can be represented on.
- Actually the existing system, and communications with GPs, were good. However there were not enough psychologists – minor cases of anxiety had to be treated by GPs – and more psychiatrists were also needed to administer cognitive behavioural therapy for serious conditions that would otherwise have to be treated with drugs.
- One-year contracts made no sense. Was there a hidden agenda to commission the service from private contractors? Mr O'Neill doubted there was any such agenda, not least because a private provider would have to take on the NHS pension obligations of those involved.
- Do we need additional training to identify the onset of dementia?
- There was a shortage of social services input – more carers were needed in the community.

18/2009 cont.

- In nursing and care homes there was still a temptation to use a 'chemical cosh'.
- The recent QoF changes included a new Depression3 section which would give GPs more work. Perhaps mental health teams could carry out some of the follow-up work.
- How was staff morale bearing up under this threat of change? Mr O'Neill believed that the figures spoke for themselves: the DH target for turnover was no more than 4.5%, which 2gether had met easily. The new money would be used to create further career opportunities.
- Why was a pan-PBC commissioning group particularly needed for mental health? Jackie Huck suggested that as other counties had such groups there might be merit in having one – developing a greater commonality in commissioning would be one obvious benefit supporting Payment by Results. The general feeling was that it was too early for the LMC to approve this concept, but that the PCT should consult the next PBC clinical leads group about it, and let the LMC know their views. **Action: PCT**
- This led on to the continuing potential for stress in the 3-cornered relationship between the PBC clusters, the PCT and the LMC. Different issues required different solutions, so no 'one size fits all' approach would work. The POC for mental health matters in the PCT was the clinical psychologist Alison Sedgwick-Taylor.

19/2009 MATTERS ARISING

- **Echocardiogram Access**. Jackie Huck said that the matter was still being discussed between the PCT and the Acute Trust. It would be possible to commission the service in other ways, but it would have to be specifically commissioned.
- **Follow-up appointments**. Jackie Huck informed the meeting that there was no evidence of new referrals being raised as a result of delayed follow-up appointments. The 2 cases raised had been from respiratory services; a review of these services would be going to the PEC in Feb 09. Any necessary changes will be requested from PBC groups.
- **Do Not Attempt Resuscitation (DNAR)**. Jackie Huck stated that:

1) So far as GPs were concerned, when a valid DNAR order was in place on discharge to a community team that documentation would be held within a patient's home, and would remain valid. The GP might wish to review whether this was appropriate to their individual patient and document that review. On occasions when a patient's condition had deteriorated the community team might discuss with the patient's GP the appropriateness of initiating a DNAR order. It might not always be possible for that GP to visit to record that discussion in the patient record. On such occasions the nurse might complete a "yellow sticker" and sign as first witness, noting the discussion with the doctor and the decision. The nurse might wish to have that conversation witnessed by a second nurse if one were available.
2) Many nursing homes had adopted the PCT policy, but were not obliged to do so.

The Committee raised the following points:

- Relatives do not have a right to be consulted over resuscitation unless they have been given that right through a court order e.g. a Lasting Power of Attorney. The PCT said they would review the guidance given to ensure this was reflected. **Action: PCT**
- Perhaps this should all be part of a new Nursing Home LES since the work needed to be done but as it was not core work, would have to be commissioned.
- Do Care Homes have a county-wide representational body?
- It should always be borne in mind that relatives might stand to gain financially from their elderly relative's death.
- Finally, there is great difference between 'Do not Resuscitate' and 'Do not Attempt Resuscitation'.

- **Cervical Cytology Smear Training**

The Chairman noted that other LMCs, notably in Wessex, had agreed a system to cascade such training. No one doubted the need to keep clinically up to date, but

19/2009 cont.

the method had to be proportionate. Two of our LMC members had attended the training and had been alarmed that the clinical content took about 10 minutes and the rest of the half day was spent in minor bureaucratic matters which could easily be disseminated otherwise than by taking doctors away from patients. The committee agreed that a small working party of the Chairman and Dr Coker (the LMC's cervical cytology representative) would meet the PCT, represented by Debra Elliott and Sola Aruna, to identify a workable and sensible local solution.

Action: Office

20/2009 FOR DISCUSSION

- **Working with Pharmacists**

The General Practitioners Committee (GPC), Pharmaceutical Services Negotiating Committee (PSNC) and NHS Employers had issued a letter encouraging GPs and community pharmacists to get together locally to arrange for repeat dispensing and medicines use reviews (MURs) to be put in place. The Secretary had circulated this letter and summaries of the documents describing the 2 proposed systems. The committee was content for the Executive to continue to meet the Local Pharmaceutical Committee but expressed concern over 2 aspects:

- Pharmacists were not allowed to do medicine use reviews in patients' homes. Since the majority of medicines waste occurred among the elderly, housebound patients who did not go to the pharmacy, the overall benefit to the NHS of the MUR was reduced.
- The PCT should agree funding to allow pharmacists to visit Nursing Homes to carry out MURs. It was noticeable that there had never been a joint meeting between the PCT, LMC and LPC – this might be a good first step towards improved coordination between the professions.

- **Prescribing of Specialist Drugs**

A letter from Dr. Good outlined correspondence with reference to prescribing Stiripentol for a patient with severe epilepsy. The cost of the drug came to approximately £10k per annum. A letter from Laura Bucknell, Locality Medicines Management Pharmacist (PCT), informed that the drug was normally used as an adjunctive therapy in patients with severe myoclonic epilepsy of infancy whose seizures were not adequately controlled with clobazam and valproate. This drug was not listed on the Traffic Light system due to the small number of patients for which it was used. If the practice were to take over clinical responsibility for prescribing there would be no additional funding within their drug budget to cover it. Ms Bucknell recommended the practice should seek a shared care document explaining which part of the patient's care they would be responsible for.

The committee felt that:

- Because the prescriber has to take responsibility for the consequences of a prescription it might be unwise to prescribe an unusual drug unless all the side effects etc were known to the practitioner.
- Dr Fellows' strong view was that the budget responsibility was far less important than prescribing the clinically appropriate drug for the patient.
- Anyway, repeat prescriptions could be posted for local collection.
- Top-slicing the drugs budget was a mechanism, once used in 2 of the 3 former PCT areas, which could have cushioned the financial blow for this practice.

The PCT informed the meeting that Laura Bucknell would be raising this issue with the Drugs and Therapeutics Committee, which Dr Yerburgh would be attending. In this particular case it was felt that Dr Good and Jackie Huck should discuss specifics outside the committee.

- **LMC Conference Motions 2009**

The Chairman informed the committee that the first draft of the motions was to be reviewed at this meeting, and any further suggestions would need to be made fairly quickly afterwards as a final list of motions would need to be agreed at the March meeting. The wording would then be polished by the Executive Committee, leading to a final agreement both as to wording and which motions would be submitted, at the April meeting of the LMC. The Secretary would then submit them electronically to the BMA over the Easter weekend. *[The amended list of draft motions agreed at the meeting is at Annex A.]* Dr Morton suggested another motion but agreed to send it in writing to the Office **Action: Dr Morton**

20/2009 cont.

- **Patient Participation Groups**

The Secretary had prepared a summary of guidance produced by the BMA covering key areas of Patient Participation Groups (PPG) set up by GP practices: why to have a group, how to set one up and how to maintain it.

The BMA view was that Patient Participation Groups made an important contribution to the well-being of their communities. Their activities included health promotion, information provision, service delivery, fundraising and strategic input to the practice and brought patients and practice staff closer together, providing a valuable means of passing information back and forth.

A few of the members' practices had existing PPGs. One was a re-titled 'Friends of the Practice.' The question was raised as to why practices were adversely commented on by the PCT if they did not yet have one. There was a difference between encouraging practices to opt in and imposing a penalty for an assumed opt-out.

- **LMC Away Day 2009/2010**

It was a while since there had been an Away-Day. The cost would be considerable so it was important for it to achieve a useful purpose. It could either be internal, although, as the Chairman pointed out, the LMC had been 'navel-gazing' twice already. Avon held an AGM before its usual evening meetings, which was usually attended by about 60 GPs. The committee agreed that they would think about it and would decide what they wanted, and having so decided in outline would task the Executive Committee in the first place to consider the details, including the cost, and make recommendations. **Action: All to consider**

- **'Improving GP Services' – a DoH document**

The purpose of the guide was to form part of a series of supportive guides to help Primary Care Trusts (PCTs) become world-class commissioners of primary care services. They had been co-produced by NHS East of England, NHS Primary Care Contracting (NHS PCC), and the Department of Health.

This first guide focused on improving the quality of commissioning GP services, by list-based primary medical care, including both GP practices and health centres. The guide provided practical advice on how PCTs could: assess their current performance; identify their vision for the future; and commission services that met the needs of their local communities. The guide had been developed for senior managers responsible for commissioning primary medical care. The Chairman had read it and informed the meeting of the main points:

- Much closer management of practices by the PCT.
- Benchmarking, targets and standards.
- Quality score cards.
- Funding to follow the patient.
- Expanding practice allowance.

Dr Bye quoted Karl Marx – something to the effect of people knowing the cost of everything and the value of nothing. Dr Good commented that for all the disadvantages under which practices now labour, the quality of life and level of income that practices currently enjoy is much better than it used to be, and the current government had to take the credit for that at least. The PCT reassured the committee that they had considerable room for local interpretation of any directive that came out of the Department of Health, so long as the intention was observed and the goal achieved within overall financial targets.

21/2009 ACTIVE TOPICS

- **Project UTOPIA**

No further news. The Secretary was asked to make contact with Sean Elyan and find out what was going on. **Action: Secretary**

- **PBC**

Jackie Huck acknowledged that more infrastructure support needed to be allocated to PBC, but pointed out that this would have to be to support confederations of local clusters on local issues (e.g. community hospitals in Cheltenham) rather than to support individual clusters or practices. The PCT was now looking at how much support they could provide. They were not trying to force inappropriate clustering, but a balance had to be struck between need and capability.

21/2009 cont.

The committee wondered how much money PBC had actually saved in the county? The PCT could not provide that information, but emphasised that the issue was not really about costs and budgets, but rather to focus on the wise use of available funds.

In answer to a further question she stated that the PCT had been tasked to finish the year with a £5.8M underspend, which they were currently on target to achieve. Last year they had been required to come in within £100k of their target saving, which on a budget of some £800M was like landing a helicopter on a postage stamp. The current system of aiming for a surplus, while preserving a contingency, was working well - this year it had enabled the PCT to absorb rises in secondary care referrals without having to cut back on other projects.

- **IM&T**

The Committee agreed with Dr Rigby that the improvement to connectivity likely to flow from the GPCOIN project meant that the PCT should be strongly encouraged to go ahead with it, despite its considerable cost.

Similarly the new e-mail system needed top-down pressure to make it happen.

The committee considered the possibility of GPs being able to interrogate Acute Trust systems to obtain downloads of test results etc (thereby saving much receptionist time on telephones). Dr Rigby was invited to examine this further with the relevant experts.

The committee also felt that in the light of recent snow-falls, floods etc and the possibility of pandemic flu, it would be sensible for GPs to be able to access their surgery systems remotely, and wondered how that might best be accomplished? Dr Siva, representing Dr Rigby, would attend the next IM&T committee to put this forward. **Action: Dr Siva**

- **Choose & Book**

There had been a meeting, the notes on which were tabled. In discussion, the PCT stated that the main obstacle to meeting C&B targets seemed to be obstructive attitudes to change in the Gloucestershire Hospitals Trust. The PCT were dealing with that. Other problems included a lack of bandwidth (which should be cured by the roll-out of GP-COIN).

The committee mentioned, yet again, that if a patient wanted to wait over the normal delay period in order to be seen and treated at their local hospital then the system should allow this, and currently did not.

- **QoF**

Dr Fielding reported that the visits were nearing completion and, although the weather had put the non-visits a little behind, these were catching up also. There were very few practices now affected by the Depression2 mix-up, and he did not think that it would be a problem to get them on side. He suggested a small meeting of the relevant people. He warned that next year's new QoF targets which had just been published would mean that it would be harder to get the same level of points next year, with more administrative hassle.

22/2009 REPORTS

- **Gloucestershire PCT Antibiotic Management Committee Meeting 13.0.09**

Dr. Alvis had attended this meeting where it was confirmed that the GP antibiotic guidelines had been distributed. These would be updated annually. The meeting looked at the community hospital guidelines which needed updating; they were an extended version of the GP guidelines. Unfortunately no community hospital representation was present which made it difficult to discuss these and prescription charts.

- **Glos PCT Controlled Drugs Local Information Network 15.01.09**

Dr. Alvis had attended this meeting for the first time on behalf of the LMC. It was chaired by Teresa Middleton, as the accountable officer for the PCT, and had representation from all county users of controlled drugs.

During the first section Dr. Alvis raised a concern that he had held for a while. This related to Controlled Drugs returned to practices and was mainly linked to dispensing practices. At present there was no obligation to record and witness the destruction of these drugs. It was recommended as good practice to have a member of staff witness destruction. He felt that it would be safer for all concerned to have an outside party witness their destruction in the same way that out of date

22/2009 cont.

drugs were destroyed. In the past the police had been unhappy to do this but Teresa Middleton confirmed that the approved pharmacists were happy to do this.
As a consequence, the meeting proposed to reword the local guidelines and hoped that the LMC approve.
The committee agreed and tasked the Secretary to confirm to Dr Alvis.

Action: Secretary and Dr Alvis

- **Negotiators Minutes 19 Jan 09**

Among topics considered were:
PCT Draft Framework/Review. Fiona Davenport (PCT) had been looking at how much information could be gathered from existing sources. Both sides recognized that the work would probably not be completed by April 2009; changes to take effect in April of one year usually needed to be identified by the previous September. However the PCT was asked to consider an uplift to the staff part of the PMS funding which might be agreed in time for Apr 09.
Learning Disability DES. It was agreed, after a short discussion, that the clinical examination of each LD patient in the first year could take place up until 30 June 2009 (i.e. a 3 month slip as the DES was so late in arriving) but that the second examination would take place on or before 31 March 2010 and at least one and preferably 2 quarters after the first examination.
Choose & Book. The full LMC at an earlier meeting had been told by Stuart Sedgwick-Taylor, when in the PCT, that if a practice was unable, through a fault in the system, to make a booking through C&B then, if they kept a log of the appointments that had to be made manually because of it, they would not lose their reward for using C&B for those referrals. Debra Elliott agreed that this promise had been made and asked the LMC to publish a note in the Newsletter asking practices to submit their logs to support payment. **Action: Secretary – Newsletter Item**

- **Executive Minutes 22 Jan 09**

Noted as tabled.

- **Verbal report on Health Visitor liaison meeting 2 Feb 09.**

Dr. Fielding reported that Ann Nash, a former director of health visiting in Swindon, had been carrying out a root and branch investigation and had uncovered significant issues. She had been very open and honest about this with the committee, and they looked forward to hearing how she intended putting everything to rights by April. However if that timetable proved too ambitious her contract was extendable and he was sure she would be delivering significant improvements in due course. In the meantime recruitment of health visitors had restarted and the budgeting aspects were being re-examined. No further meetings were planned yet, but they would be held when needed.

23/2009 ANY OTHER BUSINESS

- **LMC Communications**

The Secretary thanked everyone, and through members very nearly all practices, for responding so quickly and so positively about the Newsletter and Minutes which had been circulated. It was heartening to hear that the Office's efforts were useful and appreciated. It would now be a question of finding out why the hit-counter did not seem to reflect the number of hits actually being made on the website.

- **Cascading of information to GPs by the PCT**

The committee formally thanked the PCT for circulating operational updates to practices from the Operations Control Room; they had been much appreciated. There was a concern that this had not happened without being prompted. Would it be possible for the distribution list to be modified so that practices were kept informed from the beginning of a crisis? This would be important in any future emergency of whatever type **Action: PCT**

24/2009 FORTHCOMING MEETINGS/EVENTS

- Pre-Negotiators Meeting 13th February
- LMC/PCT Negotiators 16th February – Sanger House
- Executive Meeting 26th February
- Meeting with Jan Stubbings, Sanger House now postponed to 10th March
- LMC Meeting 12th March

There being no further business the meeting closed at 17:04

ANNEX A TO
GLOS LMC MINUTES
DATED FEB 09

DRAFT LIST OF MOTIONS

No.	Issue/Originator	Motion
1.	The inexorable move of non-core work into core. Proposer: Office	That Conference regrets the lack of clarity in the current contract between what is and is not core business, and the consequent trend for non-core work to become assimilated into core.
2.	Extended Opening Hours. Proposer: Office	That Conference stresses that provision of any Extended Service is optional to practices, but wishes to be sure that the GPC will not allow extended hours of opening to be extended to become 'core' without a suitable increase in the Global Sum.
3.	Premises improvement and renovation. Proposer: Office	That Conference is concerned about the state of many practice premises and is worried that with widespread retrenchment in Government finances, the situation will not improve.
4.	Overseas Visitors: Proposer: Office	That Conference has been waiting for over 5 years for a definitive and clear statement from the Department of Health on the entitlement of foreign nationals and UK citizens living overseas to free medical treatment at primary and secondary care levels, and wonders how much longer the wait must continue?
5.	Contract Tendering: Proposer: Jo Bailey	That Conference believes the requirement for tendering for contracts by the PCO to be frequently unnecessary and often destabilising for the NHS.
6.	Too many specialists demanding too much time from GPs in update training etc: Proposer: Jo Bailey	That Conference rejects the siren voice of the specialist urging GPs to spend disproportionately great amounts of time on those patients with ailments of interest to his speciality; GPs' time should be available to patients on the basis of patients' needs and they should spend little time reacting to the frantic bureaucratic requirements emanating from quill-drivers in Whitehall.
7.	NIC and QoF: Proposer: Michelle Hayes	This conference believes that the Quality and Outcomes Framework should not be evaluated by NICE, as this organisation is mainly secondary care led with little understanding of the work of primary care. Intrinsic to its existence, QOF only rewards quality practice. As QOF makes up a significant part of GP income, any additional change or evaluation of this should be led by GP negotiation with NHS Employers, with the principle of quality practice and patient care underlying this negotiation, and not a cynical ploy by politicians to reduce GP income.
8.	Police requests for information: Proposer: Michelle Hayes	This conference proposes a national system, (perhaps via defence union legal advisers), for dealing with both working hours and out of hours police requests for GP patient records.
9	Stop stabbing our backs! Proposer: Michelle Hayes	This conference calls upon the current government to call off their cynical media assault on GPs, who for the main part are providing excellent patient care under difficult circumstances and to acknowledge that we are the bedrock upon which the NHS is built.

10.	Increasing complexity of maladies: Proposer: Chris Morton	This Conference believes that the increasing complexity of management of chronic and frequently multiple clinical problems in primary care requires the average GP consultation to be set at 15 minutes with a workforce allocated and funded accordingly
11.	Health Visitors: Proposer: Chris Morton	This Conference considers that Health Visitors' and District Nurses' contracts of employment should be transferred from PCTs to GP practices to facilitate joined-up care, replacing the existing clinically dissociated 'lost tribe' situation.
12.	Contract Length: Proposer: Steve Steinhardt	That Conference believes that the introduction of short-term (annual) contracts for NHS clinical providers is detrimental to the continuity of high quality patient care
13.	Generalist v Specialist: Proposer: Chris Morton	That Conference believes that Generalists are now being forced by an excessively bureaucratic approach into spending a disproportionate amount of time maintaining certification in all the sub-areas which make up our daily practice. These processes are invariably set by specialists/enthusiasts who do not see their bit in the context of overall generalist activity. These processes should be pruned, co-ordinated and controlled by a central generalist group.