GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 9th JULY 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 9th July 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, Good, Hayes, Kanga, Morgan, Morton, Patterson, Rigby, Salter, Simpson, Siva, Yerburgh and Ulahannan.

Also present:
Representing the PCT:
Jan Marriott, Director of Clinical Change
Dr. Helen Miller, PEC Chair

From the LMC Office:
Mr Mike Forster, LMC Lay Secretary
Sue O'Sullivan, Admin

78/2009 APOLOGIES FOR ABSENCE

Jackie Huck, Debra Elliott and Dr. Richard Gale and Dr Peter Fellows

79/2009 CHAIRMAN

Tea Rota: Drs Hayes & Kanga
Welcome: Jan Marriott, Director of Clinical Change, Glos PCT, standing in for both Debra Elliott and Jackie Huck.
Dr Helen Miller, PEC Chair to her first LMC meeting in her new role; Dr. Miller had been an LMC member some years ago.
Dr. Chitra Arumugam, Consultant in Communicable Diseases, Health Protection Agency to talk to and take questions on Pandemic Flu.
Dr. Seymour announced that it was to be Dr. Kanga's last LMC meeting as he had completed his training and would be moving to the South coast to take up a position. Dr. Kanga said his time on the Committee had been an enjoyable and interesting learning phase in his GP education.

80/2009 MINUTES OF THE LAST MEETING

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

81/2009 REGISTER OF INTERESTS

There were no new declarations of interest to report.

82/2009 ACUTE TRUST ISSUES

- **Radiology letter to patients**

Mike Forster had written to Dr. McGann following concerns about the consent issue raised at the June meeting, to date no response had been received. Mike would contact Dr. McGann and feedback to the September meeting.

Action: (1) Mike Forster to get in touch with Dr. McGann for a response
(2) Item for the September meeting

- **Sun awareness mole checks**

At the June meeting an incident was considered arising from the Sun Awareness Mole Check clinic organised by GRH. The serious issue was that GRH had referred the patient to her GP for a 2-week rule referral (and it took 12 days for the referral to reach the GP). Jackie Huck had agreed to take this to the Contract Board; unfortunately Jackie was not present at the July meeting but Jan Marriott was able to report that Jackie would be taking this forward and would report back to the Committee at the September meeting. **Action: September agenda item**

- **Admission Wards – name change**

Dr. Ulahannan reported that wards currently known as the Medical Admissions Unit (MAU) and Acute Assessment Unit (AAU) would shortly be rebadged as Acute Care Units (ACU) (A) (B) and (C). ACU (a) and ACU (B) would be in Gloucester Royal; ACU (C) would be at Cheltenham.

It was agreed to make this a Newsletter item when it was clear at what point the change would take place. **Action: Pending Newsletter item**

83/2009 MATTERS ARISING

- **Breast Screening Steering Group**

Screening Learning Disability Patients:

Concerns about information sharing and Data Protection issues had been raised at the June meeting. Debra Elliott had agreed to have a discussion with Dr. Patterson (LMC Rep on the Steering Group) concerning information sharing; and also to speak to the Chairman of the Breast Screening Group to clarify the mental capacity of moderate LD patients and whether they had the capacity to make decisions or whether a judgment should be made as a best interest decision.

Dr Patterson reported that the Steering Group had put together a very good pack for women with LDs which it was hoped they would be able to go through with their carers. The Steering group wished to be able to identify those patients who had learning difficulties to enable them to send out the packs. Dr Paterson understood that the PCT had a list of those practices who had signed up to the LD LES; the problem was how to engage with those few practices (2 or 3) who had not signed up – could the Steering Committee write out to those practices who had not signed up to the LES?

Dr. Good still felt it was a Data Protection issue, the counterbalance a best interest issue. Dr. Bayley thought it a Mental Capacity Act issue; stressing ethical problems were more about people with mild LD.

Dr. Alvis felt a solution would be for the Steering Committee to contact those practices who had not signed up to establish how many LD women patients they had on their list and send them the appropriate number of packs for the practice to distribute. Dr. Yerburgh asked that the subject be placed on the Listserver; there must be other LMCs who have experienced the same difficulties.

The next Breast Screening meeting was in 6/8 weeks by which time it was hoped to have more information to bring to the September meeting.

Action: Item September meeting

- **PE7/PE8**

The data was out in the public domain and guidance was awaited from the GPC who were discussing with NHS Employers. The PCT had received appeals which were being looked at on the basis of advice about relevance/percentages and extenuating circumstances. Jan Marriott agreed to get information to the LMC during August to satisfy the Committee on the criteria being employed to handle the appeals. Dr. Bye would like feedback directly from practices on the questionnaire. Dr. Miller, in her role as a GP, said her practice had lost out on QOF against achievements during the past 5 years. Dr. Fielding had done some research in his practice; statistically the figures were not sound. Dr. Rigby asked if practices should advertise to patients that they could ring in to make an appointment six weeks in advance or be seen the same day through nurse triage. Dr. Miller's practice had done that via their website and a newsletter and still only got 50% on Access! It was a sad reality that probably those patients who felt they had an axe to grind were most likely to complete the questionnaire.

The Committee were not sure if the now-quarterly survey results would be treated as cumulative, averaged or looked at as a series. Jan Marriot agreed to take this back.

Action: Jan Marriot to establish if figures were cumulative

The figures were available on the DoH website through a very convoluted link; Mike Forster would investigate to see if there was a quick, simple link.

Action: Mike Forster to investigate website link

84/2009 FOR DISCUSSION/INFORMATION

- **Child Protection Issues**:
  - **Report of Meeting 1 Jul 09**

The meeting had been held with representatives from the PCT and the LMC. The purpose of the meeting was to re-establish those links which had been lost with the split into 3 PCTs some years before. After discussion it was agreed that Dr. Coker would represent the LMC on the Health Sub-Committee of the Gloucestershire Safeguarding Children Board.

- **The Commissioning Standard Paper**

A new draft of the paper was being prepared as a result of the meeting.

- The language had softened from 'must' to 'should'.
- Employer (CRB) checks were for employed staff in contact with children, not for work experience school children and students.
- Training would be at 3 levels: all staff would be told on induction about the safeguarding of children, and who to turn to in the practice if there was an issue with it. All staff having contact with children, young people or their parents should be trained to Level 1. Those with regular and close contact with children etc should be trained to Level 2. There was also further multi-agency training available for those with special interest. The Levels of training would also be explained.

- **Referrals to Children's and Families Helpdesk:**
  - **Safeguarding concern protocol**. Imelda Bennett produced a poster to assist GPs who had child protection issues; the first point being able to discuss a case with a child protection clinician before taking the route. Members were not happy with the poster which they felt was confusing and needed further work. There were two separate contact numbers for in hours/out of hours. Could there be just one number? How would GPs be made aware of the Social Services outcome? Dr. Miller said that this was just initial PCT guidance. It was agreed that the pathway/algorithm needed more work to make it clearer.
  - **Referral Form**. As regards the referral proforma, there was a general feeling that it needed further work.

It was agreed to invite Dr. Imelda Bennett to the LMC in the Autumn.

Action: Invite Dr. Bennett to an Autumn meeting

- **Lead Health Professional**

A solution to the Lead Health Professional issue had not been reached at the meeting with Child Protection representatives and was brought to the Committee for consideration.

The PCT had suggested that GPs should take the lead health professional role in any given child protection case by default. There might well be insufficient numbers of health visitors (HVs) and school nurses (SNs) to do an adequate job of keeping an eye on the safety of all children. GPs were reluctant to assume a default responsibility for a situation in which they might be unsighted. Dr Bennett admitted that in many, if not most, cases the HV or SN might know much more about the case than the GP, but would not necessarily be receiving copies of hospital letters and discharge summaries or accessing the notes of a child who had been seen by their GP. She suggested that GP practices should copy these to Health Visitors and School Nurses. The counter argument was that this would involve a lot of work for GP staff, and was this a proportionate solution to the risk involved?

Dr. Salter thought that there needed to be many more HVs attached to practices; the PCT needed to employ more HVs. The Committee was still awaiting the outcome of Ann Nash's Health Visitors report which was currently being collated for presentation to this Committee. Dr. Simpson was concerned that no one knew who the over-5's school nurses were: a role which was expanding. Dr. Morgan felt it

was a lack of action, not information, that caused the problems in child protection cases, citing Baby 'P' and Victoria Climbie.
Until all the problems had been sorted GPs would not co-operate.

- **Interventions Not Normally Funded (INNF)**

A draft proforma was tabled for LMC consideration when applying to the INNF Panel for consideration of an individual case exception to NHS Gloucestershire's commissioning policies. The letter announcing the change of policy had already gone out (1st July) and as an afterthought came to the LMC, which was why the proforma had been stopped to allow consideration by the LMC.
Question 10 was perceived as a problem; it was not a GP's job to trawl medical journals in order to provide evidence-based information; this needed to be made clear. Dr. Simpson felt the form should be online, completed online, details of medications and medical history could go across automatically, linking into the clinical system. It was felt there needed to be two forms, one for GPs and one for Consultants. Jan Marriott would feedback to the PCT the requirement for two forms and the need for electronic completion of as much of the form as possible; manual filling in of forms was undesirable.

Action: Jan Marriot to take back to PCT

- **'High Quality Care for all: our journey so far'**

The report was tabled: It recognised that change should be for the benefit of patients and clinically driven.

In primary care 50 of the planned 152 GP-led health centres were now open, 65 of the planned 100 new practices in disadvantaged areas were open, and more than 75% of practices now provided extended opening hours in the evenings or at weekends (against an original 50% target). According to Lord Darzi 'Quality' should be measured by patient experience, effectiveness of treatment and safety. All acute trusts were now recording the quality of care they provided and it was just a question of time before GPs might have to do the same. The summary would be put on the website. **Action: Summary to be put on the LMC website**

85/2009 LISTSERVER

There had been a lot of talk about the Global Sum increase of 12.5% for those practices that had got out of the MPIG zone. However, it was not all good news as an increase in the Global Sum would also result in an increase in the amount (6%) deducted for opting out of Out of Hours responsibilities.

86/2009 ACTIVE TOPICS

- **Project UTOPIA**

Confusion appeared to reign about the actual launch date, the Utopia team saying 1st September and Jan Stubbings pushing for the 3rd August. Dr. Sean Elyan would attend the October LMC meeting. *[Postscript: The Acute Trust has since informed us that the Single Point of Access at both Gloucester Royal and Cheltenham General, and the Unscheduled Care Referral Centre, will be opening on 3 August.]*

- **PBC**
  - Practice Budgets – Fair Shares Adjustment

Clinical Leads had seen the figures 6 weeks ago. The rate of change 5% in the first year represented a balance between what the DH wanted (all at once) and what practices wanted (no more than 1% a year). There were winners and losers. Clusters needed to look at the figures.

- **Choose & Book**

Around the table it appeared that everyone had tried the new SNOMED system; Dr. Salter had used it but did not find it at all useful. The general consensus was that it appeared a waste of money.
The next C&B meeting would not be until September!

- **IM&T**

Dr. Rigby reported an IM&T Steering Group meeting on 2 Jul. (Report attached for ease of reference). Sylvia Tute (deputy information officer) would like the LMC view on the **Informatics Plan for Gloucestershire**. Dr. Rigby had forwarded the 34-page document to the office. It was intended to be an 'iterative' document, with a final version before March next year. Dr. Rigby welcomed the committee's view on how best to formulate a response.

- **QoF**

All very quiet at the moment; they had not had the annual planning meeting as yet. Dr. Simpson was still unhappy that the LMC Negotiators had not taken his concerns at the number of practices losing money any further and had taken it upon himself to meet and have dialogue with the PCT. He had been told that the loss at his practice would be somewhat negated by his other rises in income.
In defence, Dr. Bye said the Negotiators at each meeting had raised this problem; Mike Forster had sent out an email to each practice asking if they had problems with the square rooting to get in touch. None had!

- **Pandemic Flu**

Dr. Chitra Arumugam reported:
Policy:
The Pandemic Flu team were now meeting every fortnight. The pandemic was following the expected pattern so the problem would be with us for months.
There were still issues of:

- Antiviral location
- Masks
- Swabbing

Dr. Fielding felt there was urgent need for a focussed medical planning group and enquired how clinical advice should be disseminated especially as the South West Clinical Advice Centre was being wound down. Dr. Arumugam said there were direct links to the Health Protection Agency (HPA) for medical advice; GPs could access the Microbiologist if there were any issues. Locally we may have to do things differently; the committee felt a local clinical lead was required.
Of great concern to members was the paragraph in the pandemic guidance suggesting GPs should use their discretion about giving Tamiflu. The choice lay between giving the drug only to pre-defined, high-risk groups or to everyone, like 'Smarties'. Dr. Arumugam said advice had changed to just those at risk but it was difficult for GPs to identify those patients 'at risk' who may have an underlying illness that had not been identified. The risk was that if someone died who had not been given antivirals the adverse publicity would be unacceptable. The promised national 'Flu Line' had not yet opened but when it did it would not be giving clinical advice. GPs would be out of the loop; the patient would be issued with a reference number (patients may be required to give their unique NHS number) and send their flu buddy to the antiviral collection point. In answer to Dr. Morton she advised that if a patient requested Tamiflu within 48-hours of contact it would be effective; there was no point in starting treatment with antivirals after 4 days if still showing symptoms. The interim period was a problem. There should ideally be a local phased consistent approach.
Dr. Salter asked whether, if a patient had been given Tamiflu and then contacted the surgery with more flu-like symptoms, they should be given more? Dr. Arumugam said they should.
Dr. Good quoted guidance from a national source; Tamiflu should be given to the under 5s, over 65s and vulnerable groups and not routinely to those in between. Tamiflu had serious side effects. He felt GPs who had been in practice for years should use their considerable experience and clinical judgement as they did with other seasonal illnesses. Not everyone agreed with him.
Dr. Fielding urged GPs to document Tamiflu discussions with patients e.g. Tamiflu discussed/given/not given. He thought Jan Stubbings, Chief Executive Glos PCT, should make a policy decision: a fixed policy. Dr. Good felt that the only policy a

non-medical Chief Executive would ever reach would be to minimise risk by treating everyone. Sir Liam Donaldson, the Chief Medical Officer, advised GPs to use their clinical judgement:
'When considering treatment of people aged 5-64 years with no underlying illness, doctors were advised to take a precautionary approach and offer antivirals to patients with symptoms strongly suggestive of H1N1v. It was acknowledged that **doctors must use their clinical judgement** and would not usually choose to offer antivirals in circumstances where there were minor or unrelated respiratory symptoms'.
Dr. Bye asked where the local clinical leadership was; Dr. Miller agreed to respond to practice emails.
Prophylaxis: Doctors should usually offer prophylaxis (Relenza) to pregnant women who had been in contact with cases.

Dr. Miller along with other members, totally agreed with Dr. Good: PCTs had been given advice by the Chief Medical Officer and they had to follow that advice.

Dr. Seymour asked for clarification about the period a patient should be off work if suffering from swine flu. Dr. Arumugam suggested that if on Tamiflu to finish the course before returning to work. Also of concern was assessing 1-year olds; the advice was for them not to visit the surgery; did GPs need to visit? This area needed clarification, but the guidance did say that 1-year olds needed to be seen.

Antiviral collection points: currently 28 pharmacies around the county had been identified. Shona Arora would make the decision to go live on the 42 collection points and at that point GPs would not be involved in the Tamiflu issue. Tamiflu prescriptions had a black line through the payment section; Dr. Arumugam understood that patients were not required to pay and the scripts would go back to the PCT.

Mass vaccination: It was anticipated that a limited amount of vaccines would be received in August - 2 doses of vaccine per patient, with a minimum gap of 3 weeks (the vaccines could not be interchanged). The list of people who would be vaccinated meant that virtually everyone would be covered; school nurses were to vaccinate school children: pregnant women by midwives. Needles and syringes would be provided.
GP involvement: Dr. Arumugam said they had only just started working this through; the anatomy was not yet clear; LMC representation and clinical lead was essential on the Vaccination Group.
A Swine Flu poster tabled at the meeting was considered for dissemination but agreed not to issue it for the time being.

87/2009 REPORTS

- **Minutes of the Foundation Trust Contract Quality Group**

Noted as tabled.

- **Substance Misuse Treatment Shared Care Monitoring Group report (SMTCMG)**

The provision of the Substance Misuse Service in Gloucestershire was discussed, which was largely done by Secondary Care. Currently there were only short waiting lists for services. There was a national drive to increase Substance Misuse Services in Primary Care. If the PCT were to implement this, they would risk destabilising the existing Secondary Care Service. It would also require some investment in Primary Care Services for GPs to undertake the training necessary to start offering services.

The National Guidance suggested that all Primary care Practitioners should be offering harm minimisation advice to their Substance Misusing patients, e.g., Hepatitis B Vaccinations.

A new Primary Care Alcohol Project had started in the Cotswolds and Stroud area. This had received 241 referrals and was now hoping to spread throughout the County. Referrals should still be sent to GDAS.

- **GPC News Issue 10 – Annual Conference**

Noted.

88/2009 ANY OTHER BUSINESS

- **Regional Negotiators meeting Taunton 1st October 09**

The Executive Committee would be attending.

89/2009 FORTHCOMING MEETINGS/EVENTS

- PMS evening meeting Oxstalls Tennis Centre 14th July.
- LMC/PCT Negotiators meeting 20th July.
- LPC/LMC/PCT meeting – pharmaceutical needs assessment 23rd July.
- LMC/PCT Negotiators meeting 17th August.
- **No LMC Meeting in August. Next meeting 10th September 09.**

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

REPORT FROM DR RIGBY ON IM&T STEERING COMMITTEE ISSUES (ABRIDGED)

Sylvia Tute (deputy information officer) would like the committee's view on the **Informatics Plan for Gloucestershire**. This is intended to be an 'iterative' document, with a final version before March next year.

A few other things:

1. **GP email**. New system to be trialled in September, with roll out before the end of the financial year to all practices. Office 2003 will need to be installed prior to this. Not very different from previous versions but on line training available (see below), and may be possible to install remotely depending on bandwidth.

2. **IT Helpdesk**. Dan Corfield would still like to hear about problems with the service. 'Customer sevice' issues (like keeping practices informed of progress and likely completion date) need addressing. Dan is happy to escalate problems taking undue time to resolve.

3. **GP COIN**. Benchmarking taking place in Lydney. Performance with current and then new link being measured to assess potential benefits of COIN. Older switches in practices will also need to be replaced. Roll out now likely to be case by case rather than big bang.

4. **Joint working**. IT links etc with GCC proving slow to achieve and agree standards etc.

5. **GP2GP**. All eligible practices are live. 11K+ transfers have taken place, and over 600 in the last 4 weeks.

6. **EPS**. 39% of prescriptions are bar coded (county has 40% target!). Realease II due in about 1 year.

7. **PAS merger**. Just as a matter of interest, both PAS systems (GRH & CGH) are being merged with a current go live date of 23rd November. There are >200 other systems dependent on PAS, that IT knows about, and these will have to be adjusted before that date.

8. **Pathology Reporting**. As Tony Walsh mentioned, all path lab results will be available to GPs when a new system is up and running later this year. The details are sketchy but it looks as if this will be a 'view' via a web based interface.

9. **PCT Intranet**. There appears to be serial tinkering going on with this, with availability to practices coming and going. Emails to practices contain links to pages which are not visible to GPs. E-learning training for Office 2003 seems to be in this category but we are assured that this is being fixed. If practices are experiencing broken or unavailable links, Roger Samples (roger.samples@glos.nhs.uk) has agreed to receive information about these and take the appropriate action to resolve it. One for the newsletter perhaps?