

# **GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE**

## **MINUTES OF THE MEETING ON THURSDAY 18<sup>TH</sup> JUNE 2009**

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 18<sup>th</sup> June 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, Kanga, Morton, Rigby, Salter, Simpson, Siva, and Ulahannan.

### **Also present:**

Representing the PCT:

Debra Elliott, Director

Jackie Huck,

Dr. Tony Walsh, PEC Chair

From the LMC Office:

Mr Mike Forster, LMC Lay Secretary

Sue O'Sullivan, Admin

### **64/2009 APOLOGIES FOR ABSENCE**

Dr. T Morgan and Dr. T Yerburgh. Dr. Helen Miller, the newly appointed PEC Chair (Dr. Walsh's replacement from 1<sup>st</sup> July 09) was unable to attend the June meeting as planned.

### **65/2009 CHAIRMAN**

Dr. Seymour welcomed the PCT representatives; it would be Dr. Walsh's last meeting as his term as PEC Chair would end on 30<sup>th</sup> June. The Committee thanked him for his valuable input over the past couple of years and wished him well for the future.

### **66/2009 MINUTES OF THE LAST MEETING**

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

### **67/2009 REGISTER OF INTERESTS**

There were no new declarations of interest to report.

### **68/2009 ACUTE TRUST ISSUES**

#### **• Consultant Letters**

Dr. Ulahannan confirmed that practice concerns/complaints were being logged into the PALS office and consultant's responses were routinely copied into PALS to 'close the loop'.

#### **• Letters to patients from Radiology Department:**

Correspondence from a Cheltenham GP expressed concern regarding a letter a patient had received from Cheltenham Radiology Department, advising that patients had to give their consent for their images to be stored on a national database and that if consent were not given, the radiological procedure would not go ahead.

Mike Forster had contacted Dr. McGann who had said that it was a limitation of equipment which could only handle one image at a time. To work at all the image had to be stored somewhere, and the way the equipment was set up was that it was stored centrally in Guildford. The way the letter was written, though, raised inferences of public visibility. Actually the data was secure and accessible only by passwords held by those having clinical care of the patient. The Secretary agreed to write to Dr. McGann urging him to look at the wording of the letter which may have been promulgated centrally, but was capable of generating misunderstandings.

**Action: Secretary to write to Dr McGann**

- **Cancer referrals by Sun Awareness Mole Check**

The meeting considered an incident 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). The Secretary would contact the GP who had first raised the concern to check on any response received. Jackie Huck was asked if it were a tariff issue; there were no different tariffs but there might be more on each subsequent contact. Jackie Huck agreed to take this to the Contract Board, as it could be a governance critical issue. There was a need for guidance; it was difficult for Primary Care to react immediately to such requests.

**Action: Jackie Huck to take to Contract Board**

**69/2009 MATTERS ARISING**

- **GHAC LMC levy - representation**

Following discussion at the May meeting Jo Bayley had suggested that the LMC levy for the GHAC should for this year be assessed on the basis of the number of patients projected to be registered at the end of the year. The Chair was happy with the suggestion and opened it to the floor; Committee members agreed to the suggestion.

Dr. Bayley reported that there were still IT problems and they were currently writing hand-written reports. As reported previously they were very keen to get feedback from GPs whose patients had used GHAC.

**70/2009 LMC ANNUAL CONFERENCE**

The Secretary had written a very good précis of the 2-day Conference; members asked for it to be placed on the LMC Website.

Dr. Bayley reported back on Dr Laurence Buckman's keynote speech. The main thrust was that the profession faced a number of challenges, both external and internal. Externally the government was determined to claw back as much as possible of the increase in remuneration given in 2004, and to demand ever-greater services for the remuneration they did give.

Internally the movement to revalidation and accreditation, both theoretically welcomed in that they would reassure patients that GPs were up to the job, would have to be introduced carefully to ensure that the burden was proportionate and manageable.

Gloucestershire's Motions:

- Media Attacks: won by a large majority.
- Optional Extended Hours: unanimously supported as a Reference, not a full Motion. The Committee were disappointed and felt that it should have been a full Motion.

Other Motions:

- There was a great deal of dissatisfaction expressed about the Patient survey.
- Salaried GPs terms being too generous; was opposed. There was support for appointing partners to strengthen the profession.

Dr. Fellows reported that Gloucestershire's delegates spoke well although it had not been a very exciting Conference; there was not a great deal of money coming GP's way in the near future; privatisation was still a worry. All delegates had expressed a lot of support for Registrars.

**71/2009 FOR DISCUSSION/INFORMATION**

- **Standards for safeguarding children**

Jo Bayley had written to Dr. Imelda Bennett, the named Doctor for Safeguarding Children at Rikenel, with her concerns about communication with GPs regarding Child Protection issues having recently learned that GPs were only sent reports from Child Protection Planning meetings if the GP had proffered formal apologies to the meeting's organisers.

Other issues of concern were:

- Signing an amendment to GMS/PMS contracts;
- CRB checks – did this involve every person in the practice e.g. 6<sup>th</sup> formers on work experience

Debra Elliott agreed to have these points investigated immediately.

**Action: Debra Elliott to check on CRB check extent: Signing a contract: GPs receiving reports of Child Protection Planning meetings**

A meeting was planned with Shona Arora, Imelda Bennett and colleagues on the 1<sup>st</sup> July at which it was hoped more discussion would dispel some fears. Dr. Bayley asked if Imelda Bennett should come to the LMC to discuss the issues; it was agreed to wait and see how the meeting on the 1<sup>st</sup> July went before inviting her to attend a full committee meeting.

Dr. Seymour's view was that training could be quite prescriptive but not mandatory on GPs. The Lead GP would not necessarily hold all the health information; health visiting was an important part of the whole picture.

Dr. Gale returned to CRB checks on the Performers List raised at the April meeting where it was learned that there were 60 people on the List whose CRBs were out of date i.e. 10% of the list. Debra Elliott was able to report that everyone on the list had been contacted by the PCT and they were currently working through the list.

• **GPC Paper: Factors Influencing GP Referral Rates**

The Secretary had produced a summary of the document; both the original and the summary being considered. Referrals were a complex issue but there was nothing new; demographics were against GPs in the present climate.

GP referrals to secondary care had shot up by 15% in the first quarter of 08-09 and had since risen further. The cost of this to the NHS was considerable and the need to know why it happened was a priority. Equally, the paper had emphasised that there were many potential factors, not all working immediately or in the same direction, virtually none of which had been studied. The paper was therefore based on hypothesis, but was logical.

Dr. Alvis was surprised by the Government reaction to increased referrals; they had been instrumental in raising patient expectation. Dr. Walsh also felt that the increase in health professional consultants also increased referrals. It was agreed to put the summary on the LMC website – those wanting the original could follow the link.

**Action: Summary of GP Referral Paper on LMC Website**

• **Five New DES payments**

The aspiration payment for LD (Learning Difficulties) should be made by the end of June. The final figures for the achievement payment for last year were not yet available. Consequently a payment would be made by the end of June to help practices' cash flow, with the remainder being paid in July 2009. Debra Elliott reported that PRIMIS had let the PCT down; data gathering had been slow. When asked whether coding was fully resolved Debra felt that it was. She would ensure that payments were fully identified, both aspiration and achievement. Dr. Simpson was unhappy about an email received by his practice that day asking for DES figures by the next day. Debra Elliott took full responsibility, and said it was not good enough and would be performance managed.

In the same vein, Dr. Bayley cited a request by the PCT for a report within 24 hours of the number of practice fire alarm drills over the last 2-years; why did the PCT need the information, and why so urgently, what were they going to do with it?

Dr. Fellows felt that late payments were a deliberate ploy by the government to reduce GP payments.

The tracking and understanding of all practice payments was a complex issue and not easy for the LMC members. The suggestion was made to co-opt a Practice Manager to the full LMC meetings. This was fully supported by members. It was felt that Practice Manager Forums should decide who should sit on the Committee. In the meantime Debra Elliott would send Mike Forster a list of the practice managers' groups chairs.

**Action: Debra Elliott to forward PM contact list**

- **Annual Report 2008/09**

- **Chairman's Report**
- **Secretary's Report**

Supported by the Committee as tabled.

- **Mental Health**

- **DEPOT injections in primary care**

A communication to GPs from the 2Gether Recovery Team based at Coleford House indicated that staff from Coleford House would be contacting them to arrange for the transfer of patients to practices who were stable, ready for discharge and no longer required their specialist service but required Intra Muscular Injections. The Recovery Team would support practice staff to enable this to be undertaken. If the patient were to relapse there was a fast-track procedure back into specialist services if required.

Dr. Salter said there was no QoF element now; it had been dropped after a year. Nursing staff were keen to discharge patients into primary care but consultants were not so happy. 2Gether would like a GP on board to improve contact with general practice.

Concern was expressed about patients who didn't attend appointments and subsequently relapsed. It was felt that patients with serious mental health issues were more appropriately treated in secondary care, as they were better able to assess conditions as well as giving treatment and continuity of care. Mike Forster was asked to write to Eddie O'Neil and copy Dr. Tan into the correspondence. Dr. Simpson asked why the Negotiators were not picking this up as a potential LES. The PCT agreed to take this back to the responsible Commissioners.

**Action: 1) Mike Forster to write to Eddie O'Neil (copy in Dr. Tan)  
2) PCT to talk to responsible Commissioners.**

Jackie Huck was asked if the PCT were happy with the delay in the delivery of the new psychological therapies service in County? The PCT replied that they were not tied into the contract forever. Dr. Salter felt if the service worked it would be a brilliant service but it had slipped a bit. PCAT was undergoing redesign and it was agreed to invite Eddie O'Neil to the LMC November meeting.

**Action: Invite Eddie O'Neil to November LMC**

It was agreed before making this a Newsletter item, to run it by John Salter before going to press.

## **72/2009 LISTSERVER**

There was nothing of particular interest to report at the moment other than those issues already covered elsewhere in the agenda.

## **73/2009 ACTIVE TOPICS**

- **Pandemic Flu**

A Q&A document issued by the BMA would be placed on the LMC website. Of note was the 'buddying' agreement with other practices. Practices were free to choose not to enter into buddying arrangements with other local practices; but it was strongly recommended that they did so. Failure to buddy-up was likely to be viewed as a failure to comply with the terms of the 'costing methodology for GMS practice payments during an influenza pandemic' agreement between the BMA and NHS Employers e.g.

"to be eligible for the income protection offered to practices under this agreement they must be:

- a) actively participating in the national and PCO response to the pandemic or have made their resources available to the PCO
- b) actively supporting their staff in line with any recommendations for good practice within general practice which may be agreed at a national level."

Mike Forster was asked to highlight this in a Newsletter item.

The list held by the LMC should be formalised; activities should be recorded.

**Action: 1) Buddying arrangements Newsletter item  
2) Formalise the buddying arrangement list held at the LMC office.**

There had been a recent pandemic meeting on Monday. Swine flu figures:

- 30,000 cases worldwide
- 1,226 in the UK
- 19 over the South West
- 1 in Gloucestershire

One third of Gloucestershire's Antivirals were held at an in-county safe location (Narnia 2).

Forty-one centres were planned but how long it would take to set them up had not been fully exercised. A dry run to set up one centre was planned in the near future to test command and control elements of the Flu Plan.

Taking of swabs would cease once numbers of cases had reached a certain level; in Scotland and Birmingham they had already ceased.

In some areas large numbers of swabs had been occurring. One OOHs GP in Birmingham had been recorded as taking 57 swabs in one day. Dr. Simpson wondered why patients couldn't take their own swabs!

National guidance suggested that pregnant women and children <1 year old would need assessment by a GP. Over-65s currently appeared to be less affected, possibly due to partial immunity.

Dr. Fielding felt it important that the LMC had stronger representation on the Pandemic Committee and asked for an additional member. Members decided to opt for a core group of 3 and go for availability:

Core Group:

- o Dr. Gale
- o Dr. Seymour
- o Mike Forster

It was essential that the LMC were copied into the Pandemic minutes.

With reference to the protection of practice income during a pandemic, Debra Elliott confirmed that PMS practices would not be treated any differently from GMS. Dr. Rigby urged practices to get to know the IT system, telephone numbers etc. of their buddying practice to ensure they were prepared before any pandemic hit Gloucestershire.

Antibiotics could be an issue for any secondary infections; OOHs doctors needed to be formally involved and Dr Robin Hollands was already being briefed.

There could be a shortfall in ordinary flu vaccine for the year as the availability of eggs to grow the necessary culture, were in great demand. Novartis and Baxter had chosen cell-based culture methods for their swine flu vaccine, which they said was faster than traditional production methods that used chicken eggs.

The PCT noted the points raised and would report back

**Action: Secretary to write to Dr. R Hollands  
2) PCT to report back**

• **Project UTOPIA**

As tabled. The office planned to have an item in the June Newsletter announcing the partial launch of the project.

The committee hoped that the call centre would be able to book an ambulance if necessary. It was confirmed that GPs would not expect a confirmatory return call. Mike Forster would feed this back.

**Action: Mike Forster to feed back ambulance booking issue**

Justine Rawlings, the Lead of the Unscheduled Care Group, had requested a representative join the group from the LMC. Dr. Chris Morton agreed to do this. Dr. Rigby felt unscheduled care was a commissioning issue, quoting £3k as an in-patient tariff and wondered if community hospitals could be involved. Debra Elliott however said that community hospitals were more costly.

• **PBC**

A meeting with Jackie Huck did not identify any huge issues/changes with this year's Accountability Framework. It was down to Commissioning Groups to sign

up. The communication channel between the LMC and clusters could be better, especially when issues affecting the whole county were involved.

Fair Share: Dr Fielding urged that when dealing with budgets, different factors should not be looked at in isolation but with other Agencies in mind.

- **Choose & Book**

Dr. Fielding reported that C&B was running smoothly: meetings were now quarterly; weekly telephone calls to the PCT from the SHA had ceased. They were still waiting for SNOMED to come on line. There were issues over:

- SNOMED's robustness,
- EMIS/VISION user inequalities.
- Relationships with key Trusts, e.g. what clinics go on and what clinics were taken off,
- A provider/location choice issue, the virtue of C&B was for the patient to have an appointment where he/she wanted to be seen, not which the Trust provided.

Dr. Rigby felt it was an opportunity for the Winfield to get involved; particularly eye surgery.

- **IM&T**

- **GP Remote Access – Away from My Desk**

Mike Forster had been in email correspondence with Dan Corfield and learned that IM&T were quite close to finishing trials of a piece of software that GPs could use to gain secure remote access to computers in the surgery. Dan Corfield would like to do a communication piece to the GP community in partnership with the LMC, and he wondered if it were possible, for example through the newsletter or some other appropriate format.

Apart from the obvious good relationship and partnership working benefits of this approach, it would give them some continuity. It was a piece of software that the PCT could not fund, so would need to be funded by GP staff that wanted to use it. Working with the LMC would help Dan Corfield to get the message across in a more formalised way, whilst still getting across all the benefits and value for money, (of which apparently there were plenty!)

- **1. Costs**

Full price = £15 per user per month

40 users = £9.00 per user per month

100+ users = £7.50 per user per month

Dan Corfield would be happy to co-ordinate names of the first 40 to guarantee the £9 mark. It was not just restricted to doctors though - any surgery staff could take it up if they wished to.

- **2. Timescales**

Not 100% sure, but would like to start co-ordinating around early July, hand over the first 40 contact names and numbers to the company by the end of July, and then he would step out of the process entirely.

- **3. Rollout and support**

There would need to be an agreement about support and liability, etc - i.e. it was not something local IT would support and the full relationship would be between the GP and the supplier. Although they had been running the tests, it was not a PCT-funded or 'endorsed' scenario *per se* - it was purely a business relationship between the surgery and the supplier, Dan needed to be diligent about providing the surgeries with assurance about security from a governance perspective. As far as Dan was concerned, having had a quick demo by the Managing Director of the company, the security was excellent, and no further beta testing should be required.

The only real constraint, as with anything internet-related, was bandwidth, as the remote worker would be accessing the surgery via the N3 connection, though it was understood that the data flow was not large.

Likewise, all other aspects such as training, setup and upgrades would be incumbent upon the software supplier to liaise directly with each end-user – regrettably Dan Corfield could not be part of the process. All these aspects would be made clear in an item in the LMC Newsletter. There was a strong suggestion that as the PCT was now responsible for providing IT equipment, and this could be an important part of the service, especially when working from home during recovery from flu, then the PCT should be funding this facility. This would necessitate discussion with the PCT and would inevitably delay the roll-out of the project.

- **QoF**

Dr. Fielding reported that all practices had signed off their QoF.

- o **PE7/PE8**

Many practices were appealing or considering appealing their results for the PE7 and PE8 QoF indicators. There had been a suggestion that practices would be unable to appeal, but it was the GPC lawyers' view that practices were fully entitled to appeal their results for up to 3 years; QoF was part of the GMS contract and therefore the GPC believed that the contract dispute process applied.

The LMC were writing to Practice Managers reference QoF performance on PE7 and PE8 suggesting that they raise objections to the PCT; the GPC were keen for PCTs to make some payment. Debra Elliott stated she would be reasonable and take into account any extenuating circumstances.

The survey would be held quarterly; members felt that patient survey fatigue could be detrimental.

## **74/2009 REPORTS**

- **Breast Screening Steering Group Meeting 18<sup>th</sup> May 09**

It was noted in a report submitted by Dr Patterson in her absence, that a move to new premises was on target for the summer, the move should cause only minimal disruption to the screening programme.

Screening women with learning difficulties was slowly moving forward; the screening service were happy they could share information with GPs and asked if those practices not signing up to the DES would still be willing to share the information and would there be any objections to them writing to the surgeries for a list of their learning disability patients; it was acknowledged that these lists would not be complete but to aid their planning of resources some idea of numbers would be useful.

Dr. Bye was concerned that this would be a Data Protection issue; Debra Elliott would have a discussion with Dr. Patterson concerning information sharing; also 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. It was agreed to bring back to the July meeting, when hopefully Dr Patterson would be able to inform the committee more fully on the issues concerned.

**Action: 1) Debra Elliott to speak to Dr. Patterson  
2) Debra to speak to the Breast Screening Chairman  
3) Item for the July meeting**

- **Single Point of Contact (SPOC) meeting 27<sup>th</sup> May**

The meeting had covered all the points raised by Dr. Sean Elyan at the May LMC meeting.

The hospitals wanted to bring this SPOC into service by the end of July so that any new doctors arriving in August would not have to learn the current system of bleeps before learning the new system. However the programme plan could only meet this timescale if GHT could recruit the necessary Band 6 nurses internally. The worst case for them was if they could not recruit in sufficient numbers. The temptation would then be to recruit administrative rather than clinical staff, but that would strike at the root of what they were trying to achieve. They faced some hard choices in the next few weeks.

There were still difficulties in arranging contact with specialists through the single number. The fear was that those GPs who knew the extension number of the specialist they wanted would go on ringing them direct. Janet Ropner had been very robust, insisting that the single point of contact should not have exceptions. She would be addressing this internally.

The hospitals would appreciate feedback from the GP community after about 3 months to say how the new system was going, and how it could be improved.

- **End of Life Steering Group**

No report had yet been received from Dr Healey. It was agreed to bring this back.

- **Executive Committee 4<sup>th</sup> June**

As tabled - most items had been covered in the body of the meeting.

- **Negotiating Committee 15<sup>th</sup> June**

As tabled. PMS/GMS differences would be considered in the Closed Session. Lockharts had put together a new Contract which did not require the rewriting of the whole contract when GMS terms changed.

- **South West BMA Regional Meeting 17<sup>th</sup> June verbal report**

Dr. Seymour had attended the meeting which included cross-craft representation. Structures were considered:

- The BMA suggestion that there should be more direct engagement with PCTs.
- The BMA should participate in SHA structure.

Generic discussion:

- LMCs had a role with PCTs
- What role does your local BMA Division play: Gloucestershire historically had been more of a social group and did not reflect LMC opinion. Should the LMC push Gloucestershire BMA division to be more politically active. Dr. Good thought that it would be a duplication of the LMCs role; the one difference was that the BMA had trade union status. Members were informed that Dr. Steinhardt had been elected as the new President to the Gloucestershire Division and was asked to take this as an agenda item next year when Steve assumed the role.

Reports from various Crafts:

- Darzi – in Plymouth advertising their services in local Cinemas!
- Consultants experiencing problems with their trusts; their contracts stipulated 25% free time, while many trusts were putting the squeeze on this protected time.

- **GPC News Issue 9**

Dr. Fellows reported:

- Problems with the Patient Survey. It had been too long. Many patients had not fully completed it. GPs would lose money from their QoF income if a target of 90% of positive responses were not hit. Leading questions on PE7/PE8 were not well worded. Access was certainly a concern.
- Workforce Sub Group were concerned at the possible shortage of whole time equivalent doctors due to employment of salaried doctors, part-time doctors and women doctors. There was strong support for the independent contractor status.
- It would be at least 2011 before Revalidation came on line.
- Seniority should be recognition of experience, not regulations.
- Peter had been elected to be President of the local BMA Division following Dr. Steinhardt's period in the role.

Lawrence Buckman was delighted with MPs' adverse publicity; the shoe was on the other foot!

- **PCCAG Update Report**

Accepted as tabled.

## **75/2009 ANY OTHER BUSINESS**

- **LMC Rep to 'Children presenting with a Fever' project**

Gloucestershire NHS and Gloucestershire NHS Foundation Trust had been successful in a bid to join the Rapid Improvement Programme focussed on Emergency and Urgent care for Children and Young People. Leading the project was Nicholas J Breakwell, Senior Commissioning Manager; he had contacted the LMC for advice on the best way to engage with GPs in this work. NICE had already published a paper on this and some members wondered why work was also being done locally.

It was agreed to approach Robin Hollands to write a report on the LMCs behalf as he already attended this group, with suitable reimbursement. Dr. Coker offered to stand in if Dr. Hollands was unable to take this on.

**Action: Secretary to contact Dr. Hollands**

*(Secretary's afternote: Dr. Hollands has now agreed to do this*

- **South West Performance Workshop** – Dr. Fielding would attend.

## **76/2009 FORTHCOMING MEETINGS/EVENTS**

- PMS Sub Committee Meeting 24<sup>th</sup> June
- Child Protection meeting 1<sup>st</sup> July
- **LMC Meeting 9<sup>th</sup> July 09**

**There being no further business the meeting closed at 4.40 p.m.**