

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 8th JANUARY 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 8th January 2009 at which the following members were present:

Dr. A Seymour (Chair) Dr. P Fielding (Deputy Chair), Dr. S Steinhardt (Treasurer)

Drs. Alvis, Bayley, Booker, Bye, Fellows, Gale, Good, Hayes, Kanga, Morgan, Morton, Patterson, Rigby, Simpson, Siva and Ulahannan.

Also present:

Representing the PCT:

Debra Elliott, Programme Director, Primary Care & Community Care Services

Jackie Huck, Deputy Director

Dr Walsh, PEC Chair

From the LMC Office:

Mr Mike Forster, LMC Lay Secretary

Sue O'Sullivan, Administration

1/2009 APOLOGIES FOR ABSENCE

Drs. Coker, Salter and Yerburgh.

2/2009 CHAIRMAN

Dr. Seymour welcomed everyone to the first meeting of 2009 and wished all a Happy New Year.

Tea Rota: Drs. Fellows & Booker

3/2009 MINUTES OF THE LAST MEETING

Dr. Booker asked that his apologies be recorded for the December meeting; subject to that small amendment, the December Minutes were agreed and signed as a true record.

4/2009 REGISTER OF INTERESTS

There were no new conflicts of interest to report.

5/2009 ACUTE TRUST ISSUES

Bromocriptine

At the December meeting Dr. Ulahannan had drawn attention to a report from the European Medicines Agency, which had recommended updating the product information for bromocriptine with new warnings and contraindications in relation to the risk of pulmonary fibrosis. Dr. Walsh had been concerned about clinical safety. Dr. Ulahannan reported that he had taken GP concerns regarding open access to echocardiography back to Dr. Mark Petersen, Consultant Cardiologist, who confirmed that there was no open access contract in place. Members felt that there would be an increase in referrals and thereby a cost implication. There were around 100-200 patients receiving bromocriptine therapy at Gloucestershire Royal and probably the same at Cheltenham. Dr. Rigby enquired whether the PCT could perhaps make this a commissioned service. Jackie Huck agreed to take it back to the PCT to consider whether there was potential to change to an open access contract.

Action: Jackie Huck

Follow-up appointments

Dr. Seymour reported a practice's concerns regarding follow-up appointments with the Acute Trust; there had been long delays in dealing with the request and in some cases a complete lack of communication.

Patients not getting their 4/6-month follow-up appointments with Consultants seemed to be an increasing problem and were going back to their GPs. Dr. Ulahannan said that if patients were not seen for 12 months then the procedure had to be started again. There was in existence a pending pool of 6/8-week appointments but urgent cases could delay those pending appointments and they were moved further down the list. It cost £75 for a follow-up appointment and in the region of £150 plus for a new referral. Jackie Huck was asked if the PCT could investigate; she agreed to take this back.

Action: Jackie Huck

6/2009 **MATTERS ARISING**

• **Health Visitors**

The LMC position on Health Visitors remained that HVs should be a vital part of a practice team and would continue to urge the PCT to deal with the changed plans for them appropriately. Within the PCT Ann Nash was still discussing the future role of Health Visitors; what interesting model she would come up with would be keenly awaited. Health Visitors were feeling the silent victims in the whole process and were looking for a better way of working in the community. Dr. Morton wondered whether Clusters could take over the employment responsibility for HVs but it was felt that could be problematic.

Dr. Alvis enquired if there were any moves to improve the training for HVs; Dr. Fielding responded that the PCT were looking at a sustainable approach to improve training.

Safeguarding Children

Dr. Bayley drew attention to a letter which had gone out to GPs encouraging them to become more engaged in safeguarding children and to accept the default coordination responsibility. Whilst it was an admirable principle, the practicalities of how it would work were questionable, especially as Health Visitors and Social Services would more normally be involved in the everyday aspects of this work. There was ongoing dialogue with Jill Crook.

7/2009 **FOR DISCUSSION**

• **Cervical Cytology – 3 year update training**

The Chair reported a suggestion from the SW Region Quality Assurance Reference Centre (QARC) that GPs should have a half days' training every 3-years to keep them updated on the techniques of smear taking. The Committee unanimously agreed it would be more sensible to have one member of the practice receive this training and then pass on the knowledge gained in-house. The LMC would negotiate for this. **Action: Office**

• **Do Not Attempt Resuscitation (DNAR)**

A Gloucester practice was concerned about the DNAR policy in Nursing Homes with regard to patients under the care of GPs and in particular a set of forms from the St. John's Care Trust. It appeared that some Nursing Homes were attempting to implement the DNAR policy already in place in Community Hospitals. A local policy worked up by Dr. Ian Donald was currently on hold. Dr. Rigby said that in his local Community hospital the DNARs were reviewed weekly along with a general review of the patient. There were Mental Health Capacity Act implications regarding decisions of patients. Dr. Gale reported that many Nursing Homes in his experience were unable to produce a significant health history, never mind any DNARs! Dr. Rigby's view was that resuscitation was a treatment and therefore the doctor had the final say.

Jackie Huck agreed to take back to the PCT:

- 1) Independent contractor issue
- 2) Nursing Home issue

Action: Jackie Huck

• **084 numbers – DH Consultation**

The Department of Health was holding a public consultation on whether it should prohibit the use of 084 numbers to access services provided by the NHS.

The Department of Health was keen to hear from:

- People who have had experience of using 084 numbers to call services provided by the NHS;
- People who have used a local number to call services provided by the NHS;
- GPs, practice managers, pharmacists, hospitals and other organisations providing services for the NHS that use 084 numbers;
- NHS organisations that do not use 084 numbers;
- The telecommunications industry; and
- Other interested parties.

The Chair asked whether GPs wanted the LMC to complete the survey on an LMC basis or would GPs prefer to complete it independently. Dr. Fielding wondered how much money was being spent on this questionnaire and exactly how they would ban 084 numbers if they felt it necessary; he drew members' attention to the back

7/2009 cont.

page of the form where it gave an email address to return the completed form. Dr. Morgan felt it was a fundamental issue of GPs autonomy; they were running a business and if they felt 084 numbers were a necessary part of that business it was up to them.

Members agreed that GPs should complete the questionnaire themselves and the Secretary was asked to highlight this as an issue in the meeting synopsis.

• **Pharmaceutical White Paper update**

The Secretary reported that the Government had decided that there should be no change in the rules by which practices qualify to dispense, and the status quo would thus continue.

8/2009 **ACTIVE TOPICS**

• **Project UTOPIA**

Sean Elyan would attend an LMC meeting in the Spring.

• **PBC**

There had been a PBC Leads meeting of all the movers and shakers!

Alison Sedgwick-Taylor had chaired the meeting to give an overall picture of what was to be delivered as part of the plan to move psychological therapies into primary care. It would be a phased implementation of community-based psychologists; there had been a broad and searching discussion, there was much more to learn, such as: guarantees; and would practices be able to employ these people? The proposal had not gone out to tender, 2gether being the preferred provider, and it would be coming online in April 2009.

Dr. Alvis felt there was a space issue for practices, as well as reception staff, heating and lighting, all additional costs. Jackie Huck stated that national funding existed for this; the PCT had gone out to Clusters on 17th December to inform GPs and it was agreed to feedback by 9th January to inform and draw up a specification; this was the first step in that process. It was a joint commissioning budget with PBC, and consultations would be triaged into a two-tier system with some interventions being by telephone consultation.

Dr. Bye was concerned that people with high levels of distress couldn't access high-level intervention. 40 Psychologists were being sought; members questioned where these people were, since there was a huge shortage of psychologists in the country. Dr. Fellows was worried about more inequity creeping in. Dr. Hayes said that psychology was extremely time-consuming and an adjunct to mental health.

Jackie Huck reported that the PCAT system was under review; members questioned whether there had been a complete failure in the system but she stated that a review had been planned at its inception.

Dr. Tan said that he hadn't heard anything definite about it yet. He would take back and feedback to the Committee.

Members agreed to invite Eddie O'Neil and Alison Sedgwick-Taylor to the February meeting to answer GPs concerns. Absolute clarity was a priority.

Action: 1) Dr. Tan to feedback

2) Invite Eddie O'Neil/Alison Sedgwick-Taylor to February meeting

• **IM&T**

Fortuitously, there had been a meeting that morning at which Dr. Rigby had been present.

Adastra: There was a capability for information to come as an electronic message but unfortunately everyone had mislaid the manual but it would be looked at.

Extended Hours: Anyone experiencing IT problems should contact Dan Corfield.

GP Email List: This was on the list to be done in the next financial year.

Training: There was a move to provide a day's clinical system training for practices; it was likely to be more effective if the whole practice was involved. Dr. Morton asked if the PCT had any back-fill arrangements in place similar to the 'Target' days but as they didn't he asked for a letter to be sent to PCT requesting such.

Action: Office

Dr. Rigby reported that the PCT would be happy to have LMC backing. Having a better network in place would, in the long run, save money.

Dr. Fielding said that the Springbank Surgery had been waiting 2½ months for a basic connection to electronic communications to be actioned.

8/2009 cont.

- **Choose & Book**

Dr. Rigby reported that there would be a meeting the following Thursday; this would be a long affair mainly looking at the directory of service, trying to set up a user-friendly directory. Functionality was a big issue of C&B. Orthopaedic Surgeons seemed to disappear off the list so that under C&B no bookings were available, which resulted in a loss of money for practices. Debra Elliott reported that from Monday practices could send in referrals direct to the PCT but payment couldn't be backdated. Dr. Simpson was unhappy about this; he could submit all failed referrals from his records and felt that a reassurance had been agreed previously to honour payment. Dr. Good had, as advised, logged every failed C&B booking but now it appeared that the failed bookings could not be backdated; this was no fault of GPs as they had tried to use the system, reporting errors. Now it appeared there were financial implications of a poor system.

Debra Elliott suggested that the Negotiators needed to discuss further and she was prepared to look at this again. The Chair asked that Drs Simpson & Good let the office have figures of their losses.

**Action: 1) Take back to Negotiators
3) Drs. Simpson & Good to let office have figures**

2007 Flood issue

Dr Bayley's practice had suffered loss of use of surgery buildings during the floods of 2007 and had moved into Portakabins. Jan Stubbings had given a promise that no practice would not lose out as a result of the floods. Dr Bayley's practice had lost a comparatively small sum but wanted it recouped. Jackie Huck stated that the money for flooding came in last years' budget and was non-recurring and the PCT no longer had access to it.

- **Extended Hours**

The OOHs service had been working incredibly hard over the Christmas break and large numbers of doctors were called in; a 30% increase in traffic. This had resulted in a group of very tired doctors, most of whom were GPs working normal hours during the day. Jackie Huck stated the PCT recognised all the hard work done by doctors over the period.

- **QoF**

17 QoF visits had been completed; there was a slight delay in reports going back; there were 13 more to go which would be followed by end of year verification. Lay inspectors had been impressed by the work being done and the high standards being achieved. High scores were envisaged.

- **New DESs**

Learning Disability:

It appeared that 2Gether had not got a Learning Disability Register and were therefore unable to share it with practices! There was a lot of work to be done, coding etc. Debra Elliott promised to go back and chase.

Action: Debra Elliott

Members were very concerned about the timescale of Learning Disability review/reporting. The PCT were willing to allow another 3 months slippage for this year, then the whole of next year and part of the following year, particularly so that practices were not tempted to pull people in twice in a 6-month period for a review. Dr. Good asked whether the PCT would accept a GPs Register for LD patients out of county who were in homes but would not appear on the Social Services list, some of them would be hidden from the system. It was agreed to make this a Newsletter item; Debra Elliott promised to email the office the following day with the PCT stance.

Action: Debra Elliott

Dr. Morgan was not happy with the financial support from the PCT and proposed that all practices get the full payment for the first year and cited the timescale issue; Debra Elliott's view was that the PCT were being flexible, the time had been extended.

Members agreed that this would be further considered in the Closed Session

9/2009 REPORTS

- **Negotiators' Meeting 15 Dec 08**

As tabled. The main subjects considered were:

9/2009 cont.

PCT Investment Framework/Review: The PCT was committed to protecting core payments for practices. Practices should receive a guaranteed core level of funding, but in addition be able to earn more as a result of meeting quality markers.

Dr. Bye felt that things could only get better! The paper to consider the monitoring of Primary Care had been tabled on the day; the PCT was unclear what it was spending in primary care and was looking at PMS. The Negotiators felt that there was a great deal more work to be done in this area. It was a 29-page document which needed to be made less onerous and the Negotiators would be looking at in detail. Debra Elliott responded that the PCT lacked core information though it was much improved. They had come up with the Framework solely because of a lack of information.

Christmas Opening: The PCT had asked practices for their opening times over the Christmas period. 12 practices had said they planned to close their doors at 12 noon on Christmas Eve; others would remain open until 6.30 p.m. Contractually Christmas Eve was a normal working day and should be treated as such. The PCT had decided that to achieve equity across the county, they would negotiate this year with the OOHs service to cover from sometime in the afternoon of Christmas Eve, which the PCT would fund. Dr. Alvis said that the majority of practices who had closed their doors at 12-noon were in fact in his constituency; he agreed to talk them round to accepting this offer. He would report back at the next meeting. Dr. Bayley's experience was that during the extended hours period Christmas Eve and New Years' Eve, there had been no patients and suggested not involving extended hours, as there was no demand at all for a GP. Dr. Morton favoured a more flexible approach, taking into consideration when the holiday fell; Dr. Gale reported that OOHs had experienced busy normal routine general practice and Dr. Walsh urged a commonsense approach, drawing attention to a crisis over the weekend. Debra Elliott promised to investigate, though acknowledging the LMC ideal for equity across the county.

**Actions: 1) Debra Elliott
2) Dr. Alvis**

• **Substance Misuse Treatment Shared Care Monitoring Group (SMSCMG) –
12 Dec 08**

As tabled. Dr. Good reported the Primary Care Self Audit which the PCT had to undertake for the National Treatment Agency for Substance Misuse, had formed the large part of the meeting. The questions in the Audit seemed to suggest that Primary Care treatment was the first choice model for substance misuse. This was against a background in Gloucestershire where the majority of treatment for substance misuse took place in Secondary care.

An interesting discussion had taken place about the balance of Primary versus Secondary Care Services for Substance Misuse. The Shared Care Monitoring Group was looking at ways to address this issue.

In the light of the new Alcohol DES, GDAS was offering training for Practice Nurses and Healthcare Assistants for brief interventions in Alcohol Misuse Management. It was agreed to make this a Newsletter item.

Action: Newsletter

• **GPC Meeting M5**

Dr. Fellows reported that QoF was under attack, being seen as not delivering value for money. He felt this to be rubbish as it had made a huge impact on quality of care, but the Government did not like it. It had been brought in to provide a demonstration of quality of care but had led to increased costs. The Government were intending to involve NICE in QoF or even to take it over; the GPC were very unhappy with NICE and did not regard it as a suitable body to monitor QoF.

There was to be no GPC meeting in January 09, about which Dr. Fellows was not that happy, the result was a very truncated GPC News.

Dynamising Factor: Would not drop below 1

Prescription Charges: Exemption for patients battling cancer. Prescription charges were not equitable across the United Kingdom, no charges in Scotland and Wales.

Revalidation: Dr. Fellows urged that GPs started to get their portfolios together.

Square Rooting: There was a big debate in October and it had been re-debated but again ratified but with a much smaller number of GPC members voting for it.

Cremation Forms: Local Undertakers had asked for help; the new forms were coming into force this month and Undertakers would have to show the forms to

9/2009 cont.

relatives before release of the body if they so request at the time of applying for a cremation. This could mean a logjam at chapels of rest. Clarification of the completion of Part 2 and the question of a GP Partner signing was required.

Revalidation. Dr. Fielding pleaded that GPs read the revalidation document and asked the PCT to recognise that this was a major piece of work and so needed dedicated personnel to be assigned to revalidation; it was a GPs lifeline, their career! The closing date for the Revalidation paper was far too soon.

In the past there had not been a great deal of input from the PCT.

Dr. Good asked about revalidation failure and the need for training; what would a GPs pay status be? The Royal College had become involved; it had become a political issue as to who owned it. To retrain a GP would cost in the region of £12k.

- If the PCT suspended a GP, the PCT would pay the GP.
- If the GMC suspended a GP there would be no pay.

70% of doctors referred to the GMC never practiced again, not because of clinical issues but because of the trauma experienced going through the procedure.

10/2009 ANY OTHER BUSINESS

Patient Survey

47 questions with political undertones. It was agreed to put on the LMC website.

Action: Place on website

11/2009 FORTHCOMING MEETINGS/EVENTS

- 19 Jan 09 – Negotiators Meeting
- 22 Jan 09 – Executive Meeting

12/2009 CLOSED SESSION

• PCT Payment Errors

Dr. Seymour reported that the LMC had been made aware of practice cost rent overpayment errors made over a number of years and asked whether the LMC should inform the PCT or leave it for the PCT to discover eventually. Dr. Patterson's practice had experienced an underpayment issue which had continued for years but was eventually sorted out, but there was no communication at all and the correction just appeared in their account. Of interest Dr. Fellows said that VAT was not included in rent reimbursement, a matter he felt should form a Motion to Conference. Dr. Rigby said that as a matter of course his practice appealed successfully every time re notional rents; the accounts service from the FHS was historically poor. Dr. Bye felt that the PCT had lost a lot of data since the merger and move. It was seen as an issue for Sarah Truelove (PCT Director of Finance).

• Negotiations

○ PMS Representation

Since PMS practices' contracts with the PCT were individually negotiated there was debate as to whether the LMC negotiators could negotiate with the PCT on behalf of PMS practices. Secondly, if they could, should there be additional PMS representation among the negotiators? Dr. Steinhardt felt that the current Chair of the PMS Sub committee should be a member of the negotiating team. Dr. Fielding supported Dr. Steinhardt in his request although the balance of the Negotiating team would be upset; currently there were 2 GMS and 2 PMS representatives. One idea put forward was to co-opt Dr. Steinhardt to the team as a non-voter, which he disliked; if he had a vote he would be able to report back more authoritatively to PMS practices. Dr. Seymour sat ex officio on the Negotiating team and as such he would be happy to be a non-voting member and for Dr. Steinhardt to sit on the Committee and vote. Prior to LMC negotiators talking to the PCT they should have a mandate from PMS practices to negotiate on their behalf. On the other hand PMS GPs may wish to take the lead on negotiations. Dr. Good felt that as every PMS practice negotiated their own contract they may wish to negotiate with the PCT, although it was felt it was important for PMS practices to stick together, the PCT would not tolerate any imbalance. Having the LMC involved would allow PMS to thrive as well as GMS.

Dr. Simpson made it clear that he wanted assurances that the pot remained the same and his fears of the appearance of black holes assuaged.

12/2009 cont.

Dr. Morton felt that GPs went into PMS with their eyes open and were made aware of the pitfalls of going down that route. He was not entirely sympathetic. Dr. Fellows said that Avon would be hugely affected, as most practices were PMS, he advised the Negotiating team to have a word with Dr. Simon Bradley.

Dr. Good offered to stand down from the Negotiating team but members felt that he should remain available to sit on the committee should it be necessary to provide a 3:3 GMS:PMS split. It was agreed that the PMS Chair should join the Negotiators on a 3 (PMS) to 2 (GMS) basis, for the time being. If it came to voting, participation would be re-examined.

Dr. Rigby urged that GPs stick together; there had been no qualms about representation when it came to Dispensing GPs.

The PCT had published anonymised figures showing income per practice; Dr. Bye had gone out to practices to ask if this data could be shared and there had been no objections, and several statements of support. The PCT had been informed.

The Chair suggested that the meeting should be held at Sangar House, as the LMC office would be tight for space. Mike Forster to investigate the possibility.

Action: Mike Forster to contact Sangar House

Dr. Bye felt that fair collective bargaining was the way to go and to set aside the feeling that we were going to prejudice GMS. The Government were trying to drive a wedge between GMS and PMS and GPs could find that GMS had to renegotiate their contracts every 5-years, something which Dr. Bye felt was inevitable.

Dr. Fielding said that negotiations should be taken very slowly and carefully, the timescale of meetings he thought needed moving from a monthly basis, Dr. Bye agreed that there was a need to meet more frequently; the PCT hadn't put any timescale in place but there was pressure from the Centre. It was agreed that the Negotiators should go for a mandate from PMS practices before doing anything. Dr. Good felt there was room to move on broad principles but on small issues it would prove extremely difficult and complex. **Action: Office organise Mandate**

Under the current PCT proposals, the amount per patient received by some PMS practices varied considerably but could fall by up to 30%. This was unacceptable; the LMC wanted to bring GMS up to the PMS level not negotiate down. Under the PCT plans for GMS practices, most would receive an increase. Dr. Steinhardt stated that the PCT would have to examine all payments to practices.

Dr. Simpson asked how the LMC would inform practices about this process; it was agreed to do this by Newsletter.

The subject of square rooting was raised; some members had no idea whether they were big/small losers.

The general feeling was that it had been the first meeting on this huge issue and the priority was to get a mandate before proceeding further. Dr. Simpson urged that PMS should not dominate discussions/negotiations. The merits of GMS versus PMS would never be resolved and the LMC needed to decide how to negotiate. Dr. Bye warned not to play such a hard ball game that the PCT had no room to manoeuvre; and to be aware that APMS could be brought in! He felt that referral management would be a good negotiating avenue to link the two issues as a lever. It was agreed to approach the PCT to ask if the 29-page document produced by the PCT could be disseminated to everyone.

Action: Approach PCT re dissemination of document

Dr. Seymour closed the discussion and hoped that the Negotiators were happy with comments received so far.

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