

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 12TH MARCH 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 12th March 2009 at which the following members were present:

Dr. A Seymour (Chair) Dr. P Fielding (Deputy Chair), Dr Steinhardt (Treasurer):
Drs. Alvis, Booker, Fellows, Gale, Good, Hayes, Morgan, Rigby, Salter, Simpson, Siva, Yerburch and Ulahannan.

Also present:

Representing the PCT:
Jackie Huck, Deputy Director
Dr. A Walsh, PEC Chair

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

26/2009 APOLOGIES FOR ABSENCE

Apologies had been received from Dr. J Bailey, Dr. R Coker, Dr. D Kanga, and Dr. L Patterson from the LMC, Debra Elliott from the PCT, and Sue O'Sullivan from the LMC Office.

Dr I Bye or Dr C Morton were not present.

27/2009 CHAIRMAN

Tea Rota: Drs. Alvis & Siva

The Chairman commented that the reason Dr Patterson was absent was that she was to be married on Saturday. The Committee unanimously joined the Chairman in wishing her well. Our regular minutes secretary, Sue O'Sullivan, was on the mend.

28/2009 MINUTES OF THE LAST MEETING

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

29/2009 REGISTER OF INTERESTS

There were no new conflicts of interest to report.

30/2009 ACUTE TRUST ISSUES

• Forest Diabetes Service

Dr Ulahannan informed the meeting that a new Forest Diabetes Service would be in place at the Dilke Hospital from April, and that there would be a dinner at the Blue Bell Hotel on 25 Mar at which all primary care members were invited to find out the details. It was intended to be a 'one-stop shop' providing dietary advice, podiatry, eye screening etc. It would build on existing work at the Dilke Hospital. If successful it might be regarded as a pilot for the county. The meeting raised the following comments:

- Good communications with practices would be essential in order to facilitate the transfer of QoF data.
- Eye screening went on very successfully in many practices at the moment; the Dilke was not very accessible. Dr Ulahannan assured the meeting that the aim was to pick up poor responders not to replace the services provided by GPs.
- All agreed that the eye screening service was absolutely excellent, but it put a huge burden on premises, to the extent that in some practices doctors had to be encouraged to take their holiday during those weeks

when the eye screening team needed a room. A van or trailer-mounted facility had been suggested by GPs before, and Jackie Huck said that the PCT was examining the possibilities. Unfortunately the testing team were not keen on it. It was agreed that the Office would write directly to the Diabetic Screening Service to urge a quick solution to this widespread problem.

Action: Secretary

- **Electronic Path Lab Results**

A practice in Cirencester had written asking for LMC support in getting direct electronic access to Acute Trust Path Lab results. The path lab result system (Anglia) available to practices through GRH Trust had a facility to allow GPs to access results stored on the system but generated within secondary care. If practices were able to access the results it would save time in contacting the lab and in turn save the hospital time spent in answering GP queries. The system was already provided in Wales and was highly regarded there. Dr Rigby warned that there was always huge pressure on the IT agenda, and this would probably not be seen as a high priority, especially as there would be a significant training bill involved. However, he understood that if a practice had a midwife working within the surgery building this would enable the practice to request this service as of right. Dr Walsh mentioned that the PEC had a quality initiative that might provide the necessary funding. He would look into it. **Action: Dr Walsh** Concerns about confidentiality were raised, but laid to rest.

31/2009 MATTERS ARISING

- **LMC Away Day**

At the February meeting the Committee had been asked to consider the need for an Away Day and what benefits and useful purpose would be achieved, bearing in mind the cost involved. The Chair would be prepared to cancel a monthly meeting to save on costs and hold an Away Day in place of the regular meeting, if members felt it was a good use of time. The general feeling was that an Away Day would be suitable if there was a pressing need for one, but none was seen at present. It was therefore decided to put the matter on hold until circumstances should change.

- **Improving GP Services**

The Secretary had produced a summary of this 57-page document which had been written for PCTs rather than GPs, instructing PCTs how they should be improving the quality in all practices. It was part of 'World Class Commissioning' of which much was made in the paper. One of the key items was much closer liaison and visits by the PCT to practices. Jackie Huck emphasised that these visits should not be seen as threatening but as mutually beneficial; part of what the PCT wanted to do was to gain a thorough knowledge of the problems as seen by practices. The PCT recognised that some practices might be wary of such visits, especially those that had not so far had close links with the PCT, and they agreed to field their more experienced and tactful teams when appropriate.

Action: PCT

Progressive benchmarking figures as required by the instructions to the PCT were expected to be published on Fri 13 Mar in time to be shared with the Negotiators for their meeting the following week. The meeting commented on the difficulties for practices having to respond to the requirements arising from external agencies and the possible struggle to achieve a certain benchmark. :

- For instance the Disability Discrimination Act had a huge impact. The example quoted was of 2 sliding doors recently installed at Lydney at a cost of £20K each. Admittedly practices only had to carry out modifications to premises that were 'reasonable' but how far were the PCT going to push practices in this area, particularly in branch surgeries that were often sited in far from ideal conditions? Jackie

- Huck stated that the PCT would always try to be supportive of practices. The meeting asked the PCT to contact the LMC before taking any action in such cases.

Action: PCT

Dr Fielding pointed out that these extra visits, however welcome in principle, had to be scheduled to fit in with QoF visits etc so as to reduce disruption to practices. The analogy was that of many different organisations digging up the same piece of road at different times without coordinating their efforts first.

Action: PCT

- **Child Protection**

The Chair reported that the LMC had 2 concerns:

- GPs were being asked to take on the responsibility by default. This could give rise to difficulties for the GP in situations where medico-legal issues arise and a GP had not been adequately kept in the loop of information yet could become accountable as a consequence of the proposed default mechanism. He had been trying to get a meeting with the PCT to arrange a suitable policy, and understood that Debra Elliott was now the person to speak to. It was unfortunate that she was unable to attend this meeting.
- There was need for better communication and Dr. Seymour hoped to identify an LMC member willing to undertake representation. In the past the Committee had had representation on the ACPC (Area Child Protection Committee). Dr Fielding said that his wife, Dr Penny West, who was the named doctor for child protection issues for the PCT, would be meeting Imelda Bennett at the PCT to define roles and responsibilities and a child protection policy for practices. He would arrange for the policy to be sent to the LMC office. However the committee felt that a more direct link was also necessary. The Chair asked for volunteers, and Dr Morgan suggested that Dr Coker might have volunteered had she been present. He agreed to ask her.

Action: Dr Tom Morgan

Dr Fellows noted that the Lamming Report, coincidentally issued that day, spoke of a coordinated social care record, which seemed to him dangerous on grounds of commercial and patient confidentiality. It also seemed that social workers were spending too much time entering reports into computers rather than looking after children.

32/2009 FOR DISCUSSION

- **LMC Conference 2009**

The Conference would be held over 2 days, 11th and 12th June. LMC representatives would be, as last year: Drs. Alvis, Bayley and Yerburch.

The Secretary would attend as an Observer on both days; the Chairman on the second day only. Dr. Fellows would attend as a GPC representative.

- o **Funding**

The committee noted that the GP Defence Fund would be paying for representatives and the GPC member to attend the dinner and agreed that:

- The LMC should pay for the Secretary's travel and subsistence costs as well as the Conference Dinner.
- The LMC should also pay for the Chairman's locum cover and travel to attend the conference on the second day.

- o **Motions to Annual Conference**

An amended draft list of Motions was tabled for members to consider and agree which Motions should be submitted to Conference. Some minor changes were made but it was agreed that there was enough support within the LMC for each of them for all to be submitted to the GPC agenda committee. The final list is attached at Annex A.

- **Licence to Practise – Guidance for Doctors**

The Secretary had prepared a summary of a paper produced by the GMC which outlined its plans for Revalidation. Revalidation would consist of two parts – Relicensing (as a doctor) and Recertification (as a GP or Specialist). As Licences to Practise currently did not exist, the first step would be this Autumn, to give a Licence to Practise to every doctor who wished to continue practising. Nothing need be done at this point as these licences would be issued automatically. But it was very important that after that GPs collected enough 'credits' to prove their commitment to professional development as an essential part of the revalidation process. It was not clear how much training would be required to gain one 'credit' – it would probably depend on the type of training involved.

The committee felt that it was important enough to be a newsletter item:

Action: Secretary

Dr Simpson was also concerned that if a GP was willing to have an appraisal but the PCT had no facilities at the time to deliver it then the GP should not be penalised; there had been verbal promises to that effect from the PCT in the past but the committee hoped that the PCT would be able to put it in writing.

Action: PCT

Dr Salter suggested attendance at LMC meetings should be accredited, in that members were providing a wider service to the primary medical care community and were broadening their personal knowledge base.

Action: Secretary

- **Personal Health Budgets**

The DoH had launched a pilot programme in various PCO locations to test out personal health budgets. There were three options being assessed: a 'notional budget' under which patients would be made aware of the financial implications and budget constraints affecting their treatment; a 'real budget held by a third party' and a system of 'healthcare direct payments'. The first 2 options were possible under existing law. The third would require a new Health Act. The PCT stated that they had not applied for pilot status, so it was not discussed further.

33/2009 ACTIVE TOPICS

- **Project UTOPIA**

The PCT confirmed that they had not been asked to provide any funding for this project. To introduce it effectively would require information and training and a proper lead-up to its introduction. The committee felt that with a projected in-service date of Aug 09 it was a high risk project. They asked the Secretary to write formally from the LMC to put these points.

Action: Secretary

- **PBC**

Dr. Fielding was concerned that, although various activities were going on, there was not the hoped-for momentum. He appreciated that the PCT intended to set up improved management support, and eagerly awaited their proposals, particularly as to the impact on PBC clusters' relationships with each other and with the PCT. Comments from the committee included:

- Dr Yerburgh reported that he had been asked by the medicines management committee to sound out the LMC for a view on a possible prescribing incentive scheme for the coming year. The committee gave some support to the idea preferring a scheme which allowed a scale of rewards to reflect performance against targets, rather than the previous all-or-nothing approach. The committee asked for a relaxation on the strict criteria that currently exist on how to spend the reward (e.g. that it should be used to further existing PBC projects). It would certainly be useful to have joint PBC/LMC involvement in the planning of such a scheme.

- The PCT confirmed that prescribing targets remained a big issue for them, but congratulated the county's GPs on their sterling performance in keeping prescribing costs down to planned levels after the earlier surge this year.

The committee agreed to address Prescribing under 'Matters Arising' at the April 09 meeting.

Action: Office

- **IM&T**

Both LMC IM&T representatives, Drs Rigby and Siva, had attended a Steering Group meeting on 19th February 2009. They reported that most of the meeting was devoted to looking at ambitious IM&T plans from the PCT, across primary care, care services and supporting commissioning.

GP Coin (Community of Interest Network)

The cost of GP COIN was estimated at over £5M over the next 5 years. It was expensive, but would bring great benefits in its wake because all practices would eventually be on the same internet domain (glos.nhs.uk). This would greatly reduce the complexity and thus the cost of managing the network. The next version of N3 (the NHS network) was being rolled out and might improve matters, but lines were still contended (shared) and hence performance would be variable. C&B, summary care records, electronic prescriptions, and community integration would run at a usable speed over better networks when GP COIN came into service.

Other advantages for GP practices might be 'internet' telephony, where the practice phone system would tap into the network and make calls into the rest of the NHS in Gloucestershire 'for free'. It might also provide on-line central storage of business files for practices. Both of these would involve a cost to practices, but might replace some of the expenses (like telephony) that practices incur now. Services taken up by practices would help to defray the initial set up costs.

GP email

The current email server was to be replaced by a more modern and robust system to allow transmission of clinical information to other users on the glos.nhs.uk mail domain, and remote access via the internet or N3 from anywhere. It had been feared that all existing email addresses would need to be manually changed to something like john.smith@glos.nhs.uk However Dr Rigby assured the committee that the transfer would be seamless, messages sent to old addresses would be automatically rerouted to the new one. Meanwhile the current embargo on sending clinical information over email remained. There was some concern that it would be hard to know where in the overall healthcare organisation each individual fitted and how to tell the various 'John Smiths' apart, but the answer lay in everyone using detailed signature blocks on their messages.

Summary Care Record

The summary care record would be introduced by December 2010. There was a concern raised that if a practice entered a code against a patient indicating that his record was not to be uploaded to the spine then this also prevented GPs referring the patient to secondary care using the automated Choose and Book system with consequent unfair loss of income. Drs Fellows and Rigby would investigate this and report back.

Action: Drs Fellows and Rigby

Access to pathology results and x-ray results by GPs

The request made by LMC members was passed to the committee. If and when the GP COIN was implemented this would make it easy for GPs to access due to the increased bandwidth of the connection. [See also 'Electronic Path Lab Results' under Acute Trust Issues above.] Dr Gale also mentioned that doctors in Welsh practices who referred patients to English hospitals were unable to get access to lab results electronically.

Access to GP computers from home

The LMC wondered whether it would be possible for GPs to access their surgery computers from home. The PCT, for example, encouraged many of their staff to work from home once a week, thus saving on desk space, car parking and travel costs. Dr Rigby told the committee that the official (and expensive) way of introducing remote access to the NHS net was by a secure token system. There were less expensive, but less secure, ways of achieving the same aim. Dan Corfield was studying the relative costs and risks to see if there was an affordable technical solution that was sufficiently secure to be implemented in the county. The advantage in easing pressure on premises was obvious, but there would also be issues of cost, training, enforcement and accountability to consider.

- **Choose & Book**

Dr. Rigby reported that there was a new LES planned for 2009/10, which would probably reward actual referrals rather more and the intention to get involved with C&B rather less than at present. The committee wondered how much would have been spent on C&B by the end of this year and whether the uptake had increased?

The other point, which should be put in the Newsletter, was that a 2-week referral should never be rejected by the system, even if it was on an out-of-date form. There was no reason why those running the system could not contact the GP for clarification, but they should never reject it.

Action: Secretary

- **QoF**

The Chair reminded the committee that aspiration payments would be 70% this year, but that final achievement payments for the current year would not be paid until Jun 09. It was agreed to attach a list of the new indicators for 2009/10 to the March Newsletter; the information was not new, but some might have missed it when it was first announced. New codes would be issued when known.

Action: Secretary

Other points arising:

- Dr Fellows was concerned that the eGFR used to grade CKD was clinically meaningless unless combined with data on ethnicity, height and weight.
- Dr Fielding said that only a handful of practices were not up to speed on Depression2. These few would be asked to do a simple search to confirm their prevalences. Codes would then have to be entered in the medical records to close off those cases that were no longer being treated. Dr Alvis was concerned that in cases of long-term depression it would be misleading and might be ethically wrong to state via such a code that the condition had been cured. Dr Fielding agreed that it was a work-around rather than a perfect solution, but in the absence of a nationally-developed software 'patch' it was necessary to bring this matter to a satisfactory local conclusion by whatever means the system allowed. The PCT had promised not to claw back considerably over-paid funding in this area and it was up to the collective body of GPs to help them draw a line under the situation and then go forward from a clean start.
- A useful QMAS bulletin from Connecting for Health would be attached to the Newsletter.
Action: Secretary
Dr Siva pointed out that currently it was impossible to update the PE7 and PE8 figures as they were 'greyed out' on the system, but these would be updated by the PCT in May.
- Dr Siva also advised that in the areas of Records 23 (Ex Smoker) and Palliative Care Register (PC03) there was a need for an emergency clinical audit to be downloaded from http://www.inps4.co.uk/my_vision/ngms/ and actioned before the

end of the financial year. Also the version and date of downloading had to be reported at

http://www.surveymonkey.com/s.aspx?sm=Dpi4OK1OZE4Nly_2fp7yFeOw_3d_3d . The PCT would then be able to use the query to adjust the year-end payments for 2008/09 where required as part of the year-end review. The meeting asked the Secretary to put this in the Newsletter **Action: Secretary**

- There was widespread concern in the committee over Records23. In the case of smokers who successfully stopped many years ago it would be senseless to ask them 3 years running whether they were still not smoking, but that is what the regulations were asking for. It was unclear how much of this was 'cock-up' and how much 'conspiracy'. The strong feeling was that, even though it was national policy, it was clinically unnecessary and would be very costly to achieve. It would also be bound to create confusion when attempting to work with the unworkable. The meeting asked the PCT to consider quickly whether they could drop the threshold for this year (which under the regulations they had power to do) and give the LMC Office a quick decision which could be disseminated electronically. **Action: PCT**

34/2009 REPORTS

- **Executive Committee Meeting 26.02.09**

Noted as tabled.

- **GPC Newsletter Issue 6 dated 20 Feb 09**

Dr. Fellows presented the GPC Newsletter, mentioning in addition that:

- There was considerable doubt as to what constituted a 'credit' towards revalidation. Some even thought that the individual could define it.
- There was an ever-increasing incidence of audits and surveys.
- Under the proposals from the RCGP doctors would be forbidden from registering with their own practice; Dr Fellows felt that this would be unrealistic, especially in rural areas.
- Many in the GPC now felt that abandoning the square rooting formula might not be a good thing, but it had gone too far now to stop.
- Some were wondering whether it might be better to renegotiate the contract again, but the risk was of ending up worse off.
- Salaried service should be given a higher profile.
- No one knew why the DH had selected Cervarix rather than Gardasil, although the latter was known to be a more effective vaccine against cervical cancer and genital warts. It was interesting that in the USA the age limit for vaccination was 22.
- Arrangements for pandemic flu were still muddled, with buddying of practices being mentioned again.
- It seemed wrong that a third of GPs' incomes should come from QoF, which sometimes consisted of ticking boxes for which there was no evidence of clinical benefit.
- The Doctors and Dentists Review Body (DDRB) recommendations would be very hard to predict. A 3.5% recommendation could be justified on the basis of falling behind over the last 3 or 4 years, but with the reduction in inflation it was also possible that very little rise would be recommended.
- GPs retiring briefly in order to start claiming their NHS pension and then continuing to work, should be aware that practice profits should be divided according to the agreed ratios before any superannuation contributions are taken and then each partner would pay any superannuation contributions (employer's or employee's) personally.

If the GP had 'retired' then he would no longer be making superannuation contributions so he could keep the money as income (taxed, of course). Payments from profits into a superannuation fund benefit the individual partners individually and have nothing to do with the partnership.

- With Revalidation looming, partnerships should consider very carefully and put into their partnership agreements what is to occur should a partner fail revalidation. For instance, would the partnership continue to pay him/her a share of the profits while retraining?

35/2009 TREASURER'S REPORT

Dr. Steinhardt presented the financial reports for the year ended 31st December 2008.

- **Gloucestershire Medical Benevolent Trust Financial Statement**

A proposal to accept the report was unanimously supported by the Committee:

Proposed by: Dr. Salter
Secoded by: Dr. Good

- **Gloucestershire Local Medical Committee Receipt & Payments Account**

A proposal to accept the report was unanimously supported by the Committee:

Proposed by: Dr. Rigby
Secoded by: Dr. Salter

- **Forecast 2009**

The Treasurer outlined the plans for 2009. It would be a tight budget designed not to increase the levy in the present difficult economic climate. He warned that the costs of members attending meetings had come in at 17% over budget in 2008 for a variety of reasons and would be expected to continue at that level. The office budget had been reduced by approximately 10% through internal efficiencies, but this did not outweigh the above increase. The existing surplus would just allow the budget to be set without increasing the levy, but he warned that unplanned expenditure during the year would need to be considered carefully before being embarked on to ensure it would be affordable. A vote not to increase the levy was unanimously supported by the Committee:

Proposed by: Dr. Fellows
Secoded by: Dr. Salter

- **Claims**

The Treasurer requested all members to ease the pressure on the budget and office staff by putting in their claims regularly and promptly by the 20th of each month. **Action: All**

36/2009 ANY OTHER BUSINESS

- **Clinical Leaders Network**

A letter from NHS Southwest dated 4 Mar 09 had just been received by the LMC, via the PCT. It asked for nominations to take part in certain 'action learning sets' as part of a new national Clinical Leaders Network scheme. The closing date had been put back one week to 20 Mar, but it was still very short notice. The PCT noted the interest of the LMC in being involved, would share information and would look for volunteers. **Action: PCT**

- **Training in ear irrigation for practice nurses**

Dr Simpson mentioned an ambiguous communication from the PCT which could have been interpreted as demanding that practices send their highly

experienced nurses on unnecessary ear syringing training. The Chairman reassured Dr Simpson that the Office had already taken this up with Dr Mike Roberts at the PCT who had clarified the situation. Since practices were autonomous they had the responsibility for training their personnel to the required standard. If they felt that one of their staff needed more training then they could take a place on the training being provided by the PCT for their own employed staff. This would be a Newsletter item.

Action: Secretary

- **Criminal Records Bureau checks**

Dr Gale remarked that as a freelance GP he could not put himself forward for a CRB check, and that although there was a proposal that CRB checks should be read across from one employment to another at the moment this was not possible, and they cost £37 a time. He wondered what the PCT policy was, especially as regards the employment of locums by practices, especially as it could take weeks for a CRB report to come through.

Action: PCT

- **GP Pensions**

Dr Fellows strongly advised all GPs coming within sight of retirement to consult their financial adviser. If the GP's potential pension 'pot' might amount to more than £1.75M in Apr 09 then the surplus when he retired would be taxed at 55%. The only way out of that was to apply before the end of Mar 09 to Her Majesty's Revenue and Customs for relief. The proper way of doing that was first to get a pensions forecast from the NHS Pensions Authority, multiply that figure by 20 and then add in the likely product of any personal pension plan. With that information the application to HMRC could then be made. Unfortunately the current backlog at the NHS Pension Authority meant that a pension forecast would not be available in time. The advice to anyone in this situation was to ask for a pensions forecast and now to apply to the HMRC for relief, contingently on providing the information when it should become available. In view of the timescales the committee felt that this should be sent out as an immediate Bulletin to practices.

URGENT Action: Secretary

37/2009 FORTHCOMING MEETINGS/EVENTS

- LMC/PCT Negotiators 16th March 2009
- GPC Roadshow Taunton 26th March 2009
- LMC April meeting 9th April 2009

There being no further business the meeting closed at 16:33.

FINAL LIST OF MOTIONS (V.10) AS AT 12 MARCH 2009

No.	Motion
1.	That Conference regrets the trend for non-core work to become assimilated into core work.
2.	That Conference demands the provision of Extended Hours Services to remain optional.
3.	That Conference is concerned that first class primary care cannot be given from inadequate GP practice premises and urges the Government to increase premises funding.
4.	That Conference wants a definitive and clear statement from the Department of Health on the entitlement of UK citizens living overseas to free NHS treatment at primary and secondary care levels.
5.	That Conference believes the requirement for tendering for contracts by the PCO to be frequently unnecessary and often destabilising for the NHS.
6.	That conference believes that the Quality and Outcomes Framework should not be evaluated by NICE.
7.	That conference looks for an agreed national protocol for dealing with both working hours and out of hours police requests for GP patient records.
8.	That 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.
9.	That Conference asks the Government to recognise the increasing complexity in the management of chronic, and frequently multiple, clinical problems in primary care and to resource GP practices accordingly
10.	That Conference believes GP practices should have the option to have Health Visitors' and District Nurses' contracts of employment transferred to them from PCOs to facilitate joined-up care, replacing the existing clinically dissociated 'lost tribe' situation.
11.	That Conference considers the introduction of short-term (annual) contracts for NHS clinical providers is detrimental to the continuity of high-quality patient care.
12.	That Conference regrets that generalists are now being forced 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 field in the context of overall generalist activity. These processes should be pruned, co-ordinated and controlled by a central generalist group.