# GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

## MINUTES OF THE MEETING ON THURSDAY 14TH MAY 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 14th May 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, Morgan, Morton, Rigby, Salter, Simpson, Siva, Yerburgh and Ulahannan.

**Also present:**
Representing the PCT:
Debra Elliott, Director
Dr. Tony Walsh, PEC Chair

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

### 52/2009 APOLOGIES FOR ABSENCE

Drs Kanga and Patterson and Jackie Huck

### 53/2009 CHAIRMAN

Dr. Seymour welcomed the PCT representatives and Dr. Sen Tang, the 2Gether representative; Dr. Sean Elyan would be joining the meeting later to answer questions on Project Utopia; two aspects to consider – Single Point of Contact (SPOC) and GP engagement. The Chair's expectation for the Utopia discussion was for a spirit of moving forward.
Dr. Walsh said that June would be his last meeting as PEC Chair, Dr. Helen Miller would be taking over from him; he would like to bring her to the June meeting. Members were happy for her to attend.
Tea Rota: Drs. Gale & Morgan

### 54/2009 MINUTES OF THE LAST MEETING

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

### 55/2009 REGISTER OF INTERESTS

There were no new declarations of interest to report.

### 56/2009 ACUTE TRUST ISSUES

- **Path Lab Results**

Dr. Ulahannan had received no further answers from Adrian Bamford, Service Delivery Director, (Diagnostics and Specialties Division); the IT solution Dr. Rigby had reported at the April meeting was no further forward. Not everything on the Anglia system ended up on the Path Lab link. Anglia was due to be replaced by another, as yet unknown system. Bandwidth issues were still of concern.
Dr. Walsh had also contacted Peter Jackson, Path Lab; who said that a system was being put in place within 6 months, (hopefully 3 months), which would allow practices to access all results remotely including those taken on in-patients.
It was agreed to keep a watching brief.

- **Sick Notes**

Following discussion at the April meeting the office had asked for examples from practices; the PCT felt unable to take this forward on anecdotal evidence only. An example was handed to Debra Elliott by the Secretary.
As far as Stephen McCabe, Senior A&E Consultant was aware, the Department were issuing sick notes for a small number of patients who were followed up in A&E; Orthopaedics should issue sick notes. Members had experience of patients who had sustained fractures and were unable to return to work within 2 weeks making appointments to see GPs just for a sick note.

**56/2009 cont.**

Debra Elliott stated that in the main GRH did not have patients going back to A&E, but in Cheltenham a small number did.

- **Consultant Letters**

Dr. Hayes raised the problem of who was responsible for follow-up after a patient had undergone an investigation by a Consultant; whether it should be the person who instigated the investigation or the GP. An example was a patient undergoing a thyroid examination and the GP being asked to interpret the results of the investigation. Dr. Elyan felt that often Junior Doctors were initiating these letters. Consultant letters frequently advised a patient to contact their GP; stays in hospital were getting shorter; GPs would need to follow-up some investigation results.

## 57/2009 PROJECT UTOPIA

UTOPIA, an acronym, which unfortunately had stuck was an internal project to speed up the progress of patients who came in as emergencies or who became more unwell while already in hospital. Dr. Sean Elyan outlined the project as it currently stood:

- Remodelling what currently was being provided
- Patients stuck in the system
- CT scan issues/timing
- The project was not about moving people out of hospital who were still unwell.

There had been a series of evening roadshows with GPs, one of which had been based on emergency care. At a meeting in Stroud there had been a strong feeling that streamlining patient progress through the system would have a positive outcome. The proposal was to have up to two Band 6 Nurses manning a direct line. They would know the internal system (not being transient staff) and would be able to deliver better pathways for patient care. Linkage to expert staff would improve, enabling useful dialogue between teams.

Dr. Elyan apologised for the failure to engage with GPs; the project did have a GP on the team and communication re meetings had fallen short.
It would be a gradual implementation as not every part of the system would be in place by late July.

Questions were opened to members:

Dr. Seymour highlighted 3 aspects of the project:

- Dissemination
- SPOC
- Internal process

Dr. Walsh was concerned that if he needed to speak to a consultant about an admission there should be a facility in place to do so; contact clinician to clinician was pivotal, not the bleep holder!
New doctors were being employed into the system, providing consultant presence to see patients on admission from 8 a.m. until midnight. Dr. Elyan admitted there was a recruitment challenge; it was important to unlock the system to enable a GP to speak to a consultant pertinent to his/her patient's acute problem.
Dr. Hayes was concerned about Orthopaedic consultants' availability e.g. the Registrar rota issue. Dr. Elyan said they were hoping to release more time for Registrars but GPs might consider having a conversation with an A&E consultant. It was vital to have a feedback forum set up. It was agreed that Dr. Walsh and Debra Elliott would discuss how to put this in place.

**Action: Dr. Walsh & Debra Elliott to consider setting up a feedback forum**

Dr. Morton had concerns that the Band 6 nurses had sufficient skills; whether the whole scheme was a perverse incentive to increase revenue for the Acute Trust.
It was about quality, unnecessary delays, extended length of stays; there had been lots of complaints about an internal clunky system; there was no added value for

patients staying an extra 12 or so hours. Some financial gains could be made based on predicated shorter stays arising from a streamlined system.
Dr. Fellows felt it important that Consultants and GPs understood each other's skills. He had been very impressed when Dr. Tan made a policy of meeting GPs when he started as a Consultant; it had been very much appreciated.
Dr. Elyan said currently Cardiologists were doing work other than cardiology; the newly employed consultants would release expert consultants to concentrate on their own areas. One of the drivers of the project was training in general medicine/surgery before embarking on specialist training.

Communication:
The LMC were willing to play a role disseminating information to practices; Dr. Elyan had tabled the idea of holding some evening meetings which members felt was probably not a good idea; the LMC was the best conduit for information. The office would send a communication out a couple of weeks before the system went live and follow-up with something a couple of days before the launch.

Questions from around the table:
Q: Would there be a separate contact number for advice?
A: There would be just a single number- 08454 22 00 22
Q: Since A&E would be used as the single point of access for unscheduled patients to be seen by MAU, would the standard A&E tariff apply in addition to charges from the MAU?
A: Probably not, but clarity was required.
Q: Band 6 Nurse Hours?
A: Band 6 Nurses would be employed from 9 am until 8 p.m. Monday to Friday and 9 a.m. to 5 p.m. Saturday and Sunday
Q: Would there be an internal system to capture calls?
A: Dr. Elyan agreed to pick up this problem.
Q: Dr. Tan had concerns about his patients. Would they have to use the same number?
A: Medically unfit patients would go through the same number but patients known to a consultant in Dr. Tan's area of medicine (Psychiatry) could still be contacted direct.

Utopia did not include paediatrics or oncology.

It was agreed that the LMC would need a representative on a group not yet identified.

The Chair thanked Dr. Elyan for attending the meeting and his useful input.

## 58/2009 MATTERS ARISING

- **Prescribing Incentive Scheme**

In the absence of Jackie Huck, Debra Elliott reported that Practices could not utilise both Schemes 1 and 2, it was either one or the other. To qualify for Scheme 2 practices would have to have achieved A & B. It was worth applying, but if nothing further was heard then they had not qualified for Scheme 2. Dr. Simpson was concerned that low spending practices i.e. 20% below budget would be penalised and wanted a scheme they could take part in. Dissemination of the proposals had been a problem and should have come to the LMC before going out.

- **PCT Medical Directors**

The requirement to be/have been a PEC member had been questioned at the April meeting; Debra Elliott reported that it was not a prerequisite to have been a PEC member but Board experience was desirable. Should the applicant not have this knowledge then they would need to demonstrate experience at a senior level working with other agencies. The PCT needed to issue a communication. The PCT

had received 3 applications, all from local GPs for the Commissioning arm but none for the Provider arm.

- **Revalidation Timescale**

A letter from Dr Hamish Meldrum reported some PCT medical directors had written to GPs informing them that revalidation with a revised system of appraisal would be introduced early in 2010 and that GPs should be preparing for this now, in accordance with the proposals on revalidation recently issued by the Royal College of General Practitioners (RCGP). He warned that LMCs and GPs should be aware that no decision had yet been made on a date for the introduction of revalidation and that the earliest this could commence would be in 2011. Moreover, the RCGP's proposals were just that – proposals – and a decision would not be made on the final form of revalidation, including a revised system of appraisal, until after a full assessment of pilot schemes, which were not due to be completed until the second half of 2010.
At April's LMC meeting, Dr. Fielding had urged GPs to prepare for revalidation but now it appeared that there would be a respite for a year or so. The advice for a reflective log was still relevant i.e. audit and review. Gloucestershire NHS were still resolving contracts for Appraisers; and were keen to maintain their gold standard.
We would await the outcome from the Royal College.

- **Contract Review**

The PCT had a contractual obligation to ensure that contracts were correctly fulfilled; the plan was to work constructively and in co-operation with practices, avoiding duplication of effort especially QoF wherever possible. Mike Forster had attended a meeting in Cheltenham at which the PCT's suggestions had generally been well received. The one anxiety raised was that after all the time spent on completing the form would the information be used?
Debra Elliott said the third part of the questionnaire was important; it would highlight where practices were not so strong, and thus help to ensure that when practices had to be accredited by the Care Quality Commission they would be able to do so. The information would inform the PCT which areas they needed to work on with practices and was developmental. The aim was to protect practices from visits from the Care Quality Commission

- **Summary Care Records**

The issue of opt-out re C&B was brought back from the April meeting. Dr. Rigby reported that he had been unable to find anyone who knew the answer; the PCT were trying to get some information. It was agreed to wait for feedback and in the meantime take the subject off the agenda.

- **Buying Group update**

Because of Swine Flu being at the forefront of people's minds it was not planned to hold meetings to present the idea of a Buying Group to practices in the short-term but the LMC was intending to go ahead and would publish electronically in due course; meetings may be held to address particular queries. The Secretary reported that he had not yet received the paperwork from Nottingham. Realistically it would not be up and running until July 2009.

**59/2009 FOR DISCUSSION/INFORMATION**

- **Gloucester Health Access Centre (GHAC)**

The centre had opened on 5th May, temporarily based in the Hadwen (St. Michael's Square) branch surgery; other sites within the City Centre were being explored for a permanent base. Patients did not have to be registered with the Access Centre to use its services. It was open to all residents and visitors in Gloucester and further afield, whichever practice they were registered with. However local patients could register if they wished.
Dr. Bayley reported:

The Centre was open 8 a.m. until 8 p.m. every day. GPs would receive information if their patients attended the centre. There had been initial problems with the link for data transfer. Patients could drop in to the Centre but there would also be an appointment system.
GPs working at the Centre should not alter any prescribed medication unless a risk situation was identified
Feedback from GPs would be very useful to ascertain any weak areas. There would be no subtraction of patients from existing practices; there existed a cap on activity levels.
Dr. Bye believed it was set up to triage people who were at work and unable to make an appointment during the working day. He felt there needed to be transparency whether the Centre was in fact cheaper.
To an enquiry on the uptake to date, Dr. Bayley said that there had been no publicity as there were IT problems; leaflets had been printed but not distributed but they had made page 16 of the Citizen. At the moment there was plenty of spare capacity.
Dr. Fellows said in Avon there were serious problems. A PFI contractor had won the contract and poaching of staff by Darzi Centres was evident; people should be aware that there was no right to join the NHS pension scheme for staff that chose to move to a Darzi Centre. It would depend on their contract.
Concerns about chronic disease management were expressed: they would be able to do blood tests which would be followed-up by them and results sent to the patient's registered GP. Diabetic checks/management would probably form a large part of their work. There would be a safety net if anything were picked up that was a serious health issue; patients would be advised to make an appointment with their registered GP.
Phlebotomy could eventually be phased in by the Centre as they engaged staff.
The Centre boundary for registered patients was essentially Gloucester city and home visits would only be made to patients who had registered with the Centre.

- **LMC representation of GPs employed by GHAC**

Members considered LMC representation of GPs employed by the Centre. Sixteen GPs had formed the consortium and most of these were already represented by the LMC in their regular practice. One GP would be employed full-time by GHAC. There could be a PBC issue, Revalidation issue and did the LMC Constitution allow the LMC to represent APMS. The LMC already represented GPs on the Performance List and a GP has to be on that list to work at the Centre.
The consortium (and once incorporated, the company) should pay the levy, rather than the GPs. The question was whether it should be based on the list size? Dr. Bye disagreed as he felt the care was episodic; the registered list was not a good basis on which to pay. Dr. Bayley suggested that the levy could be paid on projections year by year. It was agreed to take away and Dr. Bayley and Mike Forster would look at a model. **Action: Dr Bayley and Secretary**

- **Handling of GP complaints by GHT**

Dr. Bayley reported handling of complaints by GHT which arose at a GHT meeting. GPs could not make complaints through the formal system as patients could. GPs who wrote to a surgeon/consultant would nine times out of ten never hear anything further. A less formal system of 'concerns' was suggested so every complaint did not escalate. When writing, GPs should copy in to PALS; it would be logged and if no response was forthcoming from the consultant within 6 weeks, PALS would get involved. The PCT/GHT would share the logging in and out of information going to PALS and give an overview.
Dr. Bye felt it could not be a one-way process, but logging by PALS should mean that 'concerns' did not disappear into the ether. Dr. Simpson asked about the Significant Event Form which went to Alan Potter at the PCT; the suggested system would not interfere with the S.E. Form. Dr. Walsh still had concerns that the Significant Event system was not happening and needed work.

Dr. Seymour asked that a PCT/LMC meeting be set up to fine-tune the system. It was agreed to set up a small group to take this forward

**Action: Set up Significant Event working group**

## 60/2009 LISTSERVER

- **King's Fund inquiry into the quality of general practice**

The King's Fund inquiry ambition, in an age of increasing transparency, was to attempt to define what good-quality care looked like, setting out the role of general practice in achieving that good quality and producing measurements that would be useful for GPs themselves, for others who work in general practice and for commissioners who buy their services.
There was currently a lack of information about the overall quality of care in general practice. The King's Fund were aware that while there were many excellent practices there were others in which standards were not as good as they could be.
Dr. Salter suggested keeping a close eye on the inquiry.

- **Channel Islands residents' entitlement to NHS treatment**

From 1st April 2009 residents in the Channel Islands and from 1st April 2010, Isle of Man residents would not be entitled to NHS treatment and UK visitors to these islands would have to ensure that they had adequate health insurance before travelling.

## 61/2009 ACTIVE TOPICS

- **Pandemic Flu**
  - **Current Update**

Dr. Fielding had met with Gloucestershire's Director of Public Health, Dr Shona Arora, for a local update on the Swine flu virus. It was not yet a full Pandemic but World Health Organisation Phase 5 had been reached. Around the UK there was lots of activity; in Gloucestershire Shona Arora had set up a number of meetings with all local agencies. Serialised information had been released by the PCT which Dr. Fielding urged GPs to file on their practice system. 30 countries currently had swine flu cases; the USA had reported its third death. Britain had 65 confirmed cases and 336 under investigation but none in Gloucestershire, where all suspected cases had proved negative.
Swine flu was following the pattern of the 1957 Asian flu pandemic and was more infectious than first thought; there was a 33% chance of contracting it. The flu season had started in the southern hemisphere and there was the possibility that this virus could transmute into a more dangerous virus, if for instance it piggybacked onto the Bird Flu virus.
Dr. Fielding thought vaccine supplies could be a problem and some interesting patterns were developing.

  - **Practice buddying – co-ordinated by LMC on behalf of PCT**

Mike Forster reported that distance between practices could be a problem when it came to mutual support. If a practice had to close, getting information to their patients could pose difficulties. The PCT were well up to speed in urging practices to make buddying arrangements. Dr. Fielding felt the more practices did in preparation the better prepared they would be when it came to a pandemic.
The virus spreads most easily to those in close contact (currently defined, as being within one metre of the infective person for more than one hour.) The best defence therefore was isolation of those who were infectious, and general avoidance of people contact.
The PCT had procured a large quantity of masks centrally and were getting them out to practices within the next 2 weeks. When asked about the costs involved Debra Elliott said the PCT were not getting involved in costs at this time as it was more important to get stocks out to practices. When asked whether the antivirals were in the flu packs, Debra said it just contained masks, swabs etc. It was suggested that a 48-hour supply of Tamiflu should be put in the Swab pack.

Tamiflu held at practices would be for staff or someone who had been in contact with a positive patient. Some members were concerned that Tamiflu held at practices could be subject to criminal attack! One dose pack had a street value of £150 and was fetching £100 on Ebay. Debra felt that Tamiflu should be treated as any controlled drug held at a practice.
It was agreed Dr. Seymour would act as deputy for Dr. Fielding on the Pandemic Flu Committee if Dr Fielding were unavailable.

**Lessons learned for future planning**

It was learned that less than 50% of PCTs in the country had kept GPs on the Performers List up-to-date. Debra Elliott would take this back to the PCT.

**Action: Debra Elliott to take Performers List GPs issue back to PCT**

Dr. Fielding listed the following issues:

- Provision of swabbing teams early on in an outbreak
- Fitting of FFP3 masks
- Provision of protective equipment
- Communication
- Mental Health – identifying buddies for all their patients. Tamiflu access to CHMDs.

- **Project UTOPIA**

This had already been covered earlier in the meeting.

- **PBC**

A meeting of Clinical leads the day before had seen the introduction of Tribal the consulting group who had been appointed to assist Gloucestershire PCT in developing a rejuvenated system.
There was a move to put more items from secondary care into PBC e.g. Physio, Radiology etc.
The monthly budget was now being shown in terms of pounds per thousand patients, but the meeting was not sure how useful this was. Feedback was needed to clinical leads on how best to present financial information.
Dr. Morton felt that there were some wins, but measurements of change and improvement were essential if they were to be recognised.

- **IM&T**

**Steering Group Meeting**

There had been a meeting of the IM&T Steering Group that morning. Email migration would require a move from XP to Office 2003; training would be available through the PCT; any practices interested should contact Debbie.rice@glos.nhs.uk
It was agreed to make this a Newsletter item.

**Action: Newsletter**

**Notes of E-mail Migration Board 5 May 09**

The plan was to pilot in 3 practices, Tewkesbury, Gloucester and Cheltenham and the experience drawn from the pilot would inform the migration process including training needs in the rest of the county. GHT were willing to incorporate the issuing of clinic letters onto the project, rather than initiating another pilot. The board would be examining the format of the letters to ensure that it was suitable for clinical systems to read and for practices to use without needing to print or further process the letter.

- **Choose & Book**

Dr. Rigby reported that at the last meeting the PCT had achieved 98% utilisation. Sixty five percent of those GPs actively engaged in C&B had achieved 90%. The PCT were consistently above 92% but they needed to have a discussion around patient choice.
A system called SNOMED to add on to C&B was due to launch in July. There was no learning curve with the system, as a GP could just enter a disease and it would display the appropriate clinic. There were teething problems though with consistency in the system which had to be resolved.

The PCT could now inform practices on a monthly basis where they were with C&B at: https://www.glos.nhs.uk

- **QoF**

Trends had been spotted especially in Depression 2, and other sub-domains for future work and review, but results had generally been very positive with one third of practices achieving maximum clinical points.

## 62/2009 REPORTS

- **Foundation Trust Contract Quality Group meeting 5th March 09**

As tabled. The LMC were copied into their meetings through Dr. Haseler's earlier involvement.

- **LMC/PCT Negotiators Meeting 20th April 09**

As tabled.
Practice Premises: The LMC made reference to the National Guidance standards set for practice premises which were not being met in Gloucestershire. The PCT assured the negotiators that there was money in line for premises upgrades and that Health was one of few areas that developers were still keen to invest in as the budgets were held at PCT level, not by the Treasury.
New style Prescription Charts: The PCT agreed to circulate a new style prescription chart. The concern was that it might surreptitiously be creating new, unfunded work.
Remote Access to Surgery Systems: there were two possible solutions; the use of such programmes as 'LogMeIn' which allow access to one of the practice computers but give no direct connection to the server, or the provision of a Virtual Private Network. Both solutions would be piloted in parallel at a practice. The main issue was whether either would be able to work over the very limited bandwidth available at surgeries.
PMS practices cost per patient. The LMC requested that the figures were rechecked against practice baselines and payments to ensure accuracy.
Dr. Good informed the meeting that he would be resigning from the LMC Negotiators; if the agenda changed he might reconsider representation.

- **Executive Committee Meeting 23rd April 09**

As tabled.
QoF Data Security: There was concern that when reporting for QoF and Enhanced Services the use of NHS Numbers actually provided very little anonymity. People could find out personal information from the number. It was agreed to make this a Newsletter item.

**Action: QoF data security Newsletter item**

- **Report from Cervical Smear Steering Group Meeting 8/5/09**

Sample taker training: Discussed again difficulties with GPs and practice team all attending sample taker training and the time involved. An NHS online training package was being looked into, but it was not yet clear who would have to pay for it.
Spending a half-day training would severely impinge on practice time; members requested further details on the online training scheme when available.

Vault Smears: Women who have had hysterectomy for cervical pathology require vault smears at 6 months and 18 months post-hysterectomy. This was a small number of patients and the consultant gynaecologist would inform the GP if needed. However, it was the responsibility of the GP to recall these women, as they were not included in Exeter recall system.

Smears in women under 25**:** *As a rule, primary care should not be taking smears in women under 25!* A few women under 25 would have diagnosis of CIN1/2/3 and required follow up cytology. Again, these women were not included in Exeter recall system. It was agreed that colposcopy would be responsible for recalling these women. Smears would be taken in primary care; lab would process if a letter from

gynaecologist was included with request form. The lab was, however unable to report smears on women under 20 in any circumstances.

Send back policy: From Nov 2009 it would be national policy to destroy any samples with major error in patient identification. There would be a 6 month 'grace period' where the lab would send the sample back to be amended. Also from Nov if cervix visualised/360 sweep box had not been ticked the smear would be reported as inadequate.

- **Meeting with Dispensing Doctors 6th May 09**

Dr Silver (a GP from Henley on Thames who had been much involved in opposing the suggestion for changing the rules about dispensing practices in the recent Pharmaceutical White Paper) spoke to that meeting.

- The Pharmaceutical White Paper wanted chemists to increasingly earn their money through clinical work rather than dispensing drugs.
- It was most important that the LMC and LPC together talked to the PCT to ensure that when drafting the Pharmaceutical Needs Assessment their natural tendency to concentrate on particular needy sections of the population in urban pockets should be tempered by the needs of the whole community, and in particular the dispensing patients for rural practices. *(This LMC had already been meeting with the LPC and had such a triangular meeting arranged for 23 Jul 09).*

- **GPC News Issue 8**

Noted as tabled.
Dr. Fellows reported an allowance for practice expenses had been factored in. MPIG was to cease at some time. A sliding scale negotiated to protect practices had led to quite a range of increases; as much as 11% for those with small MPIGs. On the other hand large MPIGs would not attract much – 0.7%.
The GPC would expect PMS practices to get the basic 0.7% plus the standard 1.74% uplift for each of QoF and Enhanced Services

## 63/2009 FORTHCOMING MEETINGS/EVENTS

- LMC/PCT Negotiators 18.05.09
- Executive meeting 28.05.09
- LMC Conference 11/12.06.09
- BMA South West Regional Meeting 17.06. 09
- **LMC June meeting 18.06.09**

**There being no further business the meeting closed at 4.45 p.m.**