GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 10th SEPTEMBER 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 10th September 2009 at which the following members were present:
Dr. A Seymour (Chair) Dr. P Fielding (Deputy Chair), Dr Steinhardt (Treasurer):
Drs. Alvis, Bye, Coker, Good, Hayes, Hodges, Morton, Preston, Salter, Simpson, Siva, Yerburgh and Ulahannan.

Also present:
Representing the PCT:
Debra Elliott, Director
Jackie Huck, Deputy Director
Dr. Helen Miller, PEC Chair

Representing Practice Managers:
Jan Knight

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

91/2009 APOLOGIES FOR ABSENCE

Drs J Bayley, R Gale, T Morgan, A Rigby and S Tan. Eddie O'Neill and Simon Thompson

92/2009 CHAIRMAN

Dr. Seymour welcomed: Dr. Robert Hodges, Gloucester GP, and Dr. Emma Preston, Registrar GP; Mrs Jan Knight (as a PM representative); Steven Davies and Jan Bagnall to present Improving Access to Psychological Therapies (IAPT); and Dr. Charles Buckley to talk about the National Primary Care Cancer Audit. Dr. Martin Freeman would be joining the meeting later to talk about a Dementia project.
Eddie O'Neill and Simon Thompson of the Primary Care Adult Treatment Team (PCATT) unfortunately had cancelled their attendance as Eddie O'Neill had been ill for the past week and was insufficiently recovered to attend.
Tea Rota: Drs. Yerburgh & Good

93/2009 MINUTES OF THE LAST MEETING

The Minutes of the last meeting were accepted and would be signed as a true record once amended to reflect one small change requested by Dr. Miller to page 2:
'The practice had been 100% successful over the last 5-years but had lost out in the last year because of QoF'.

94/2009 CO-OPTION OF MEMBERS: Drs Hodges and Preston & Mrs Knight

The Committee unanimously supported and formally co-opted:
Dr. Robert (Bob) Hodges, Gloucester on the basis that he would be representing GP constituents in the usual way although he himself was a salaried GP. However, clearly the Committee would welcome his experience and input when it came to discussing matters that affected salaried GPs.
Dr. Emma Preston as GP Registrar representative to the LMC.
Mrs Jan Knight as a Practice Manager representative to the LMC

95/2009 REGISTER OF INTERESTS

The newly co-opted members provided their declarations of interest; there were no further declarations of interest.

96/2009 ACUTE TRUST ISSUES

- **Radiology letter to patients – Image consent**

The Secretary had contacted Dr. McGann who had informed him that he had passed this onto another Committee but did not expect to hear anything for a while: Dr. Ulahannan had nothing more to add.

- **Sun awareness mole checks**

A letter from Irwin Wilson, Associate Director Contracts & Marketing GRH, having investigated the background explained that the Sun Awareness events had been held for the past three years and were a key part of the work of GHFT as a health promoting hospital. The events were part of their strategy to improve the health of their staff and to be a good employer. They were popular and well received and they had also received national recognition.

If a problem was found that needed to be followed-up, then a referral was made to the GP. It was felt inappropriate to bypass GPs. The dermatology team had reviewed the protocols in relation to urgent referrals of patients from the sessions under the two-week wait; this was a rare event. However, it was recognized that if a patient did require this type of referral it was inappropriate to send a second-class letter.

Members considered the letter and requested they wished for urgent referrals to be made directly (not to go to GP). Jackie Huck agreed to relay this decision.

Action: Jackie to relay decision to GRH

- **MRSA pre-operative screening**

Dr. Ulahannan had spoken with Dr. Challenor about admission details sent out to Cardiology patients which closed by saying *"If you have not had an MRSA skin wash swab taken in the clinic, please will you attend your GP to have this carried out before your procedure: this is required by the DoH".* The LMC stance was that the carrying out of such swabs was part of the secondary care pathway and was not yet commissioned from GPs by the PCT. Debra Elliott said if it was wanted in primary care the PCT would commission it; to date they had not had a response from Dr. Phillipa Moore. Debra would take back. Members requested it be on the October agenda.

Action: 1) Debra Elliott to take back to PCT
2) October agenda item

- **Project UTOPIA**

Dr. Ulahannan reported that Project UTOPIA was up and running and seen as working quite well; since its inception there was at one point 100 empty beds: this allowed for an empty ward to be cleaned/decontaminated in rotation. It was noted that not all consultant posts had been filled and for the system to be sustainable they had to be appointed.

- **Email Communication**

The project had not moved on. It was agreed to make it a rolling agenda item.

Action: Rolling agenda item

97/2009 Improving Access to Psychological Therapies (IAPT) Provision - Steven Davies and Jan Bagnall

A presentation by Stephen Davies Community Services Manager and Jan Bagnall Senior Therapist/Professional Manager to inform members about Improving Access to Psychological Therapies (IAPT) to support Primary Care Trusts in implementing the National Institute of Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders was discussed.

97/2009 (cont)

- IAPT was to be launched and be open for referrals from the 28th Sept 09 for people 18+; the telephone number was **0800 073 2200.** Steven Thompson reported that it had actually opened on 3rd September but was not up-to-speed; he urged people not to start using the service until the 28th September.
- It would provide psychological treatment, including CBT, for people with anxiety and depression and would see over 6,000 people for treatment each year in Gloucestershire
- IAPT was a robust new system and service, with over 40 new clinical staff with further expansion planned in April 2010
- IAPT would provide psychological information and treatment using the Stepped Care Model, (least intervention first) increasing capacity:-
  •**step 1 in Primary Care;** patients and practitioners would have access to self help material via the website, leaflets and Books on Prescription, as well as telephone advice from 0800 073 2200
  •**step 2 in IAPT via 0800 073 2200;** supported self help using CBT treatments via the telephone, computer and in groups
  •**step 3 in IAPT via 0800 073 2200;** formula driven CBT delivered individually or in groups

  a) If patients were not making progress in Step 2 they would be moved to Step 3; if their problems could not be resolved then on to Step 4 (although this was not currently in place)
  b) All patients would complete questionnaires at regular intervals to ensure appropriateness of treatment to establish progress, requiring 25/30mins of conversation to complete.
  c) GPs would be informed about any of their patients who had attended the service, including those who had self-referred.
  d) Access to the service would be within 3 working days and the patient offered treatment within 5 to 14 days. The telephone hub would be sited in Eastgate.

Steven Thompson stated that PCATT services would change alongside IAPT, interface work was taking place and some people would be referred from PCATT to IAPT; it was vital though that no one fell between the two services. PCATT would not be the gatekeeper for all issues.

Dr. Salter was anxious about the plan to place IAPT workers in the primary care setting (Step 1), as there was so little premises space. There would be a funding issue; could the LMC be involved in discussions with Eddie O'Neill? Jackie Huck felt that this should be encouraged. Dr. Hodges wondered if custody suites could be considered as an area of business; Steven Thompson admitted they hadn't thought about the Criminal Justice System and promised to provide information to them.

Dr. Alvis was concerned that anger/anxiety often overlapped with drug/alcohol issues; would these people be able to access the service? Jan Bagnall thought they would if they were seen to be in a moderate state. Traditional psychotherapy would still exist in Step 4, and it was hoped that those referred to Step 4 would be able to step down to Step 3. There would be no hesitation in sending a patient direct to Step 3 if it were judged necessary. Dr. Salter felt it was good news that PCATT would take back people judged as unstable.

Prescribing issues. The service would contact the GP or ask the patient to see their GP if medication was required; IAPT therapists could not prescribe. Dr. Salter felt that there was a need for an expert

97/2009 (cont)

Practitioner to be involved so that prescriptions could be initiated by the service.

Members asked about:

- Making referrals through C&B: the functionality was there but had there been any discussion with the C&B team at the PCT? Funding of C&B referrals was not within IAPT's remit. The PCT promised to come back on this.

Action: PCT

- Communication to practice nurses: everyone should be made aware that IAPT was coming on-line. Steven Thompson would ensure that everyone would be informed.

Action: Steven Thompson to communicate with all those concerned

Complex CPA cases at the severe end would be referred to the Recovery Service; GPs could access PCATT for advice. Dr. Bye was concerned about patients with severe anxiety involved with PCATT but only seen once a week. Dr. Salter, the Mental Health representative for the LMC was attending a meeting and would bring up all the issues raised.

It was agreed to put IAPT on next month's agenda, to include Premises Funding, PCATT, Choose and Book and keep it as a rolling agenda item:

Action: Rolling agenda item

- **Support for Anger Management**

Dr. Patterson, in a letter to the office, had raised concerns about support for anger management, unfortunately she was not present but Jan Bagnall commented that the service was not commissioned to work with anger management, although they could still accept referrals which they would need to signpost on. It was agreed to bring this back next month.

Action: Agenda item October

Dr. Seymour thanked Steven and Jan for their helpful presentation.

98/2009 NATIONAL PRIMARY CARE CANCER AUDIT – Dr Charles Buckley

Dr. Buckley was the acting Primary Care Cancer Lead for the Gloucestershire part of the Three Counties Cancer Network and had been asked to lead on the rollout of their contribution to the National Primary Care Cancer Audit - coordinated by the National Cancer action Team and an important contributor to the Cancer Reform Strategy.

Funding was provided to the Cancer Networks for completing the audit and they had been fortunate enough after a successful bid to have been allocated £94,300 to fund this work, but the money must be spent and the work completed within the current financial year.

Sadly, in Dr. Buckley's opinion, the organisation and rollout of the audit has been left to individual Networks and PCTs which had meant each local area had to invent its own local arrangements and try and develop the necessary paperwork, payment procedures and infrastructure rather than following a NES route.

They had set up a local steering group, reviewed the prescribed national audit tool developed by Dr Greg Rubin and his team from Durham, and were making preparations to develop supportive materials, paperwork, data collection arrangements etc.

Dr. Buckley's main priority was to seek clarification from the LMC on how they could practically get on with sorting out how to enlist practices and then pay them for this work.

The steering group had already discussed with Jackie Huck and Karen Butler, Glos PCT, with lead roles for cancer, possible approaches; there

98/2009 (cont)

was a draft LES agreement that had been used elsewhere. There was a simpler and less bureaucratic route in that local practices had been paid for bespoke pieces of audit work - the recently completed Hospital Discharge Audit for example - without formal contracts being in place.

Dr. Buckley asked for an urgent response from the LMC to the question *'Would the LMC sanction a local agreement rather than formal LES contract whereby practices were paid about 200 pounds to take part in the audit and 20/30 pounds per patient review or would the LMC require us to draw up a formal LES contract?'* The meeting agreed to accept the Local Agreement.

Dr. Buckley reported that the audit would cross over two other areas: QoF and Revalidation. The Network would involve Herefordshire, South Worcestershire and Gloucestershire and he would write out to everyone once all 3 counties were onboard. Members endorsed the audit which they stressed was entirely voluntary. It was agreed that it was best that Dr. Buckley disseminate to GPs. There was a link to all the information:
http://www.dur.ac.uk/school.health/erdu/cancer_/audit

99/2009 MATTERS ARISING

- **Breast Screening Steering Group**

As Dr. Patterson was not present it was agreed to bring back next month.

Action: Agenda item October

100/2009 FOR DISCUSSION/INFORMATION

- **Dementia**

At this point Dr. Martin Freeman joined the meeting. He opened by giving an account to members about planned changes in the provision of services to patients in the county with dementia. Dr. Freeman had been appointed by the PCT as GP Clinical Lead for Dementia.
The National Dementia Strategy was published in February 2009. It set out an ambitious agenda to transform dementia services across the UK over the next three to five years around three key themes:

- Raising awareness and understanding
- Early diagnosis and support
- Living well with dementia

This agenda was seen as a high priority for the SW Regional HA and for NHS Gloucestershire. In line with the national strategy, NHS and social care organisations in Gloucestershire were developing a comprehensive work programme for the next three years. This would involve the voluntary sector and the independent sector as well as people with dementia and their carers.

30% of predicted dementia patients were on a GP's register. It was a large piece of work, from diagnosis to end of life palliative care. It would increase awareness of dementia, improve early diagnosis and intervention and radically improve the quality of care that people with the condition received. Proposals included the introduction of a dementia specialist into every general hospital and care home and for mental health teams to assess people with dementia.
A care plan would be drawn up within a month of being diagnosed, involving many different agencies; monitoring, support, housing etc. The workforce would come from the 2gether Trust. The Dementia Strategy talked about a named Community Dementia Nurse possibly linked to a number of practices to help co-ordinate and signpost through the various agencies. Continuity was the keyword to enable patients and their carers to be aware of what was available for them. Memory cafes and singing for the brain were possibilities. Dr. Freeman felt it was a rare opportunity to make a difference.

100/2009 (cont)

There was to be a free GP Summit Day planned on 24th November at the Cheltenham Racecourse.

Dr. Salter was worried that the last time there was a review it led to the closure of Weavers Croft in Stroud, he hoped that this review would lead to something more positive! Debra Elliott asked if there was a need to lobby up the line for funding; Dr. Freeman agreed, it was receiving such a high profile it could lead to progress.

It was agreed that Dr. Freeman would liaise with Mike Forster on any updates.

Action: 1) Debra Elliott to lobby for further funding
2) Dr. Freeman to liaise with Mike Forster on updates.

- **Referral Management Incentive Scheme**

The PCT's intention was to introduce "in year" local incentive schemes intended to reduce inappropriate referrals. The schemes would be quality based. The Local Incentive Scheme (LIS) described an incentive scheme offered in relation to elective referrals. The scope of the scheme would relate to non-urgent elective referrals, excluding cancer 2-week wait and rapid access chest pain. The Referral Management Scheme was a voluntary scheme

Jackie Huck reported that there had been general discussions with PBCs and more detailed talks with the Gloucester Cluster. Jackie had brought it to the meeting for information and comment. As discussed at previous LMC meetings the PCT had experienced a step change in levels of referrals: the trend followed the usual seasonal trends but at a much higher level than previously. Nationally, Gloucestershire was benchmarked as a high referrer but had a far healthier population status than many areas, some of which could be described as deprived. Jackie would be happy to present to practices and work with GPs on any suggestions they may have. Dr. Seymour said as a member of the Gloucester Cluster Executive, having run through the Referral Management Scheme (RMS) he felt a lot happier about the suggestions.

Dr. Morton felt there could be a C&B issue: financially there could be a trade-off. GPs may need to look at referrals before pressing the button e.g. locum referrals, especially to Dermatology. Dr. Alvis reported that Berkeley PBC was already vetting a lot of their referrals particularly those made by locums/new members of staff. Some members suggested that financially rewarding a reduction in referrals was unethical. By the very nature of developments in medicine/treatments referrals would keep rising. Dr. Miller as Chair of the PEC said that highly pressured practices with other issues appeared to refer on. Dr. Coker had responsibility at her practice for looking at locum referrals many of which were found inappropriate; she was also concerned at the time/money she had devoted to this. Dr. Steinhardt highlighted consultants referring patients back to GPs to see another consultant, surely that was also something to be looked at.

The Chair reminded the Committee that the LMC had not been asked to endorse the proposal: it was up to individual practices and Clusters whether or not they wished to participate. A view held by the BMA:

"*Some PCTs had offered financial incentives or rewards to practices to maintain or reduce referral rates at levels reached in previous years, or to maintain or reduce referral costs within their indicative practice commissioning budget. It was not acceptable for GPs to receive incentives to refer in such a manner".* Jan Knight stated that this view had been reflected at a Practice Managers meeting. Jackie Huck would continue discussions with practices and Clusters; Dr. Miller asked whether the PCT should channel more resources into high-referring practices; Dr. Bye thought that if the PCT started from the viewpoint that high was poor and

100/2009 (cont)

low was good, they had already lost the argument. The Chair explained that the PCT had not brought the paper to the meeting for comment, but for information only; it had provoked strong differences of opinion. Dr. Salter hoped that the PCT would reflect on what they had heard and come back to the LMC with suggestions. Debra Elliott asked for ideas from GPs to try to make this work.

Dr. Good described some work that had been done while he was involved with the Forest Coop OOH service. The GPs had looked at the different levels of telephone advice and home visiting done by the various GPs. Initially there was a wide variation; over time the variation between GP narrowed considerably. He felt that if a similar process was applied to GP referrals in an educational environment, a similar reduction in high referring could be achieved.

- **Child Death Review Process – Roles and responsibilities for GPs**

Tabled for information.

The death of a child was a tragedy in any circumstance and local authorities and health professionals had a duty to investigate all child deaths regularly and systematically.

- **Roles & Responsibilities** (draft Amendment 4)

As tabled. Members were asked to destroy all previous versions and to check that the list was correct for their particular area. A few amendments were drawn to the Secretaries attention which he would correct.

Action: Secretary

- **LMC Attendance at LMC Secretaries' Conference 3/4 Dec 09**

The Chair sought the approval of the Committee that he should attend together with the Secretary the Secretaries' Conference and be reimbursed for a locum by the LMC, as the GPC would not fund a second attendee. Members fully supported Dr. Seymour's attendance and funding.

101/2009 LISTSERVER

As tabled for information only:

102/2009 ACTIVE TOPICS

- **Pandemic Flu**
  - *DH 'Planning and Responding to Primary Care Capacity Challenges'*

The Secretary had prepared a document extracting points arising from the DoH paper on Capacity Challenges for Pandemic Flu which was tabled. *(see Appendix 1)*

New guidance had been published for PCTs on how to deliver primary care services whilst potentially short staffed, and how to cope with increased patient demand during the pandemic and the anticipated seasonal flu.

The current swine flu pandemic was likely to present Primary Care Trusts (PCTs) and primary care services with increasingly significant capacity challenges, not only in terms of demand pressures from patients who present with influenza-like illness or secondary complications arising from swine flu, but also potentially in terms of supply pressures due to illness amongst primary care staff themselves.

This first practical guide to support PCTs in relation to primary care during a pandemic situation covered those services provided by GP practices, GP led health centres and Out of Hours Providers (OOH). Further practical guides would be produced for other independent contractors and to support any vaccination programmes that related to this pandemic.

guide for pharmacy services and access to medicines was already in development.

Members agreed that the Secretary's precis of the paper was excellent and should be taken to Negotiators.

102/2009 (cont)

Locums were to be awarded honorary contracts to allow death in service payments to be made if the need arose.

Dr.Alvis again raised a perceived problem in his area: if snow bound and no Pharmacist available to hand out drugs, would Dr. Alvis from a dispensing practice be abe to offer practical help? Debra Elliott agreed to take this back. **Action: Debra Elliott to find out if dispensing practices could assist in such circumstances**

Dr. Fielding pointed out that the LES was time-limited: when it was agreed nationally we would be at a point when there was a major flu outbreak. Locally he saw a gap appearing through local clinical involvement and other agencies; people were not turning up to Pandemic meetings.

At present there was a low activity rate, the death rate on investigation had been downgraded by 70%: the first peak had been in July, a second peak was expected at the end of October. There was still a great deal of work to be done:

- Convincing patients to have the vaccination.
- Clarification of death certification.
- Vaccine might not have been properly researched.

Dr. Simpson saw a growing degree of cynicism in the population.

Dr. Miller had been very impressed by the hard work put in by staff at Sanger House.

- **Project UTOPIA**

Dr. Ulahannan had reported earlier in the meeting that all seemed to going well. There had been no complaints/concerns from GPs received at the LMC office; the Chair asked for views from members:

- Advice line not working – needed tweaking
- Outpatient DVT Scans not working well – only available 9 a.m. to 11 a.m. – a contract issue
- Problems with the Gynae Review Clinic
- Re-admission rates needed looking at
- Dr. Fielding had heard that A&E consultants were unimpressed with the system.

It was agreed to raise these concerns under Acute Trust issues - Mike to forewarn Dr. Ulahannan.

Action: Mike Forster to contact Dr. Ulahannan with issues raised

- **PBC**

Dr. Fielding reported a robust meeting at which financial issues for the following year had been considered. Jan Stubbings had been very forthright in her views sand her opinion was that GPs had not seen their incomes reduced.

Practice Clusters to be reconvened into 5 Confederations interacting with the PEC. Dr. Miller said some very good work had been done but taken as whole it had been a damp squib. Clusters had not been empowered to make decisions; people heading up PBC were moving on and the PCT were looking at appointing new Directors who hopefully would be allowed to make decisions. Dr. Miller’s vision was a clinical PEC powerhouse with working groups looking at clinical groups who were able to be proactive not reactive. Helen would ideally like another 5 people on the PEC to make it clinically driven.

- **Choose & Book**

Nothing to report.

IM&T

Nothing to report.

- **QoF**

Nothing to report.

103/2009 REPORTS

- **Report of Executive meetings**
  - 23.07.09 – As tabled

Debra Elliott was not happy with the wording under the PMS item; she felt it was an exaggeration.

'The PCT acknowledged that the gap between GMS and PMS incomes (even including the growth money) in this county was measurable in tens of pence rather than pounds, but they still wanted to be sure they knew what they were getting for their growth money'.

- 13.08.09 – As tabled

- **Report of Negotiators Meetings**
  - 20.07.09
  - 17.08.09

Take to Closed Session

- **Report of Child Protection meeting 10th August 09**

As tabled. Dr. Coker reported the need for a Lead Health Professional for every child was not correct. One was needed only for those children who needed protection. Members asked if this was Imelda's view; Dr. Coker was not sure, Debra Elliott would take this back to establish if it were Dr Imelda Bennett's view. **Action: Debra Elliott to check with Imelda**

Dr. Hayes felt that training could be much improved. Reports from around the county showed variation of effectiveness.

- **Minutes of Foundation Trust Contract Quality Group 2nd July 09**

As tabled.

- **GPC Newsletter July 2009**

As tabled.

104/2009 FORTHCOMING MEETINGS/EVENTS

- Draft Forecast for LMC meetings 2010
- 21st September LMC/PCT Negotiators 2009
- LMC Meeting 8th October 2009

105/2009 ANY OTHER BUSINESS

Nothing to report.

106/2009 CLOSED SESSION

- **Report of PMS Meeting 14th July 09**

As tabled.

Dr. Steinhardt outlined the meeting which had discussed that all PCTs were coming under pressure from SHAs to ensure that they were getting value for money from their PMS contracts. Gloucestershire PCT had started this work months ago so they were not under pressure. However the PCT had announced that it was not prepared to consider investment into GMS until the PMS issues had all been dealt with. Delays in negotiating PMS matters might adversely affect GMS practices, which the LMC needed to avoid. It was an on-going tussle with the PCT, leading to a feeling of persecution. The next stage of negotiations would be low-earning PMS practices and high-earning GMS practices. The return ticket to GMS was still a bone of contention; the PCT could not agree what it should be.

Negotiations had been obstructed by swine flu but the figures produced by the PCT were considered flawed, especially in view of Clawbacks; transparency of PCT figures was paramount.

- **Clawbacks**

The Chair reported that both he and Dr. Steinhardt's practices were involved; he asked what the LMC role should be: in the background or should the LMC get involved in negotiations. Both Drs. Siva and Morton felt the LMC should be involved in negotiating on behalf of practices.

106/2009 (cont)

West Glos practices had over a number of years asked for clarity of figures provided by the PCT but there had been no feedback until the PCT raised the issue of Clawbacks.
LMC Steer:
We had to prove that the PCT had been negligent; practices were not aware that they had been overpaid but in law the PCT had the right to claw back overpayments but were not under any obligation to do so.
It would be difficult to get to a negotiating position without getting legal involvement: discussion and advice. The BMA Legal Department had been very helpful particularly on superannuation issues.
Dr. Simpson asked about underpayments and hoped that the LMC would be negotiating on behalf of those affected practices.
Dr. Good wondered how much money the PCT had to spend to retrieve this money and was it financially sound; some £250k was involved in overpayments.
Approval was required for the LMC to represent the practices and someone with legal experience should be involved.

The Chair closed the discussion: further work would be required to resolve all the issues.

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

Appendix (1)

3 Sep 09

LMC Members

POINTS ARISING FROM DH PAPER ON CAPACITY CHALLENGES FOR PANDEMIC FLU

Reference: Department of Health paper 'Pandemic Flu: Planning & Responding to Primary Care Capacity Challenges.

Reference	Issue	Decision
P6 Escalation Strategy	Does Glos PCT have a Primary Care Capacity Challenge Escalation Strategy, prioritising services, minimising clinical risk and the risk of material financial loss to either the PCT or to practices?	
P6 & 7. Suspension of local services	Will income normally attributable to a LES be protected if the service under that LES is suspended?	
	Has a suspension committee as defined (including an LMC representative as a member and a senior practising local GP as an adviser, with backups) been appointed?	
P8. Suspension of non-core activities (Level 1)	Ensure that there is a distinction between PCT suspending an additional service and a practice electing to withdraw from it – the latter will result in a reduction of the global sum under SFE para 2.5.	
	Need to discuss what would happen to the money normally payable under suspended LESs to practices.	
	What is a non-essential visit to a practice?	
P9. Managed suspension of services (Level 2)	Do we yet have a template e-mail or fax for practices to use when requesting suspension of core services and the reasons why, or their reinstatement?	
	Do we have a SITREP form agreed?	
P10 & 11. Full suspension of services (Level 3)	Do we use the same template e-mail or fax to request practice closure? How is the practice to be kept informed of whether closure is agreed or how it is to be reinforced to keep it open?	
	Buddying arrangements are suggested	In place
	Does the PCT have priority plans for locum support, especially of small practices?	
	Is there a draft 'time-limited LES' to provide services from alternative providers?	
	Does the PCT agree the suggested funding formula?	
	Is the format of the agreement (p11) agreed?	
P12. Dispensing practices	Provider and public contact phone numbers at the PCT? Pre-prepared 'key messages'?	

	Pre-prepared redirection protocol etc? Timely consultation with the LMC?	
P13. Local Contracts (incl PMS)	Does the PCT agree that PMS practices should enjoy the same protection of income as that to be enjoyed by GMS practices?	
P14 - 16. OOH	Does the PCT have plans for getting practice based GPs to be re-assigned to support OOHs or A&E instead of being at their practice?	
P17/18. Locums	When is the PCT going to involve the LMC and OOH providers in the decision of the Primary Care Priorities Committee on when the PCT will assume the central control of all locum doctors?	
	Has the PCT established template contracts on a longer term fee based continuous contractual basis to give them Type 2 Practitioner status against the risk of their dying in service.	
	Has the PCT an database of active locum doctors? Has the PCT canvassed part time principals and salaried GPs to see if they would be prepared to do locum work?	
	Ditto for nursing staff.	
P19. Retired GPs	Note the current limitations on bringing in retired GPs and the likelihood of future DH guidance in this area.	
P19. Doctors in training	Has the PCT any plans for using doctors in training?	
P20. Medical indemnity	Note the warning that when doing additional work the MDO must be notified, and that non primary care work will have to be covered by NHSLA.	
P21. Access to clinical records	Do practices have business continuity plans dealing with access to IT systems by locums? Do they have induction packs? Has the PCT considered technical measures to allow remote access to clinical records? Is the PCT planning to create multiple additional log-in identities, engaging the practice and the LMC?	
P22. National Arrangements	Will PMS practices income be protected at last year's income plus the 0.7% uplift?	
P23. Communications	Is there an established communications channel keeping the LMC informed of what is going out to the local press etc?	

Mike Forster
Lay Secretary