GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 12th NOVEMBER 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 12th November 2009 at which the following members were present:
Dr. A Seymour (Chair) Dr. P Fielding (Deputy Chair), Dr Steinhardt (Treasurer):
Drs. Alvis, Bayley, Booker, Bye, Coker, Fellows, Gale, Good, Hayes, Hodges, Morgan, Morton, Salter, Simpson, Siva, Yerburgh and Ulahannan

Also present:
Representing the PCT:
Jackie Huck, Deputy Director

Representing Practice Managers:
Jan Knight

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

121/2009 APOLOGIES FOR ABSENCE

Dr. H Miller, Dr. L Patterson, Dr. E Preston, Dr. A Rigby and Debra Elliott

122/2009 CHAIRMAN

Tea Rota: Drs. Morton & Booker

123/2009 MINUTES OF THE LAST MEETING

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

124/2009 REGISTER OF INTERESTS

There were no new declarations of interest to report.

125/2009 ACUTE TRUST ISSUES

- **Withdrawal of Services**
  - *Pain Management Services*

At the October meeting members were informed that the PCT were endeavouring to establish an alternative interim service. It was generally agreed by the PCT that they had not handled this very well but had taken note of the Committee's comments as per Jackie Huck's letter:

> *'GHFT notified the PCT via email on 30th September that their capacity to deliver a pain management service was under pressure to the point that they needed to suspend provision of services to new referrals from 1st October. The Trust had been trying to recruit additional consultant time to meet increase in referrals without success and more recently one of their existing consultants had left the service.*
>
> *The Trust continued its attempts to recruit, both permanently and under locum arrangements, but was unable to secure appropriate clinicians; they were pursuing this with urgency. However in the interim period Dr Clarke would continue to see current new referrals, those booked or awaiting follow-ups and those booked or waiting for procedures. In addition they were using capacity as flexibly as possible and had secured additional consultant time over weekends from another Trust'.*

Dr. Seymour felt it depended how robust the contract had been; Dr. Bayley responded that the PCT recognised that they had not been rigorous in setting up the contract: Dr. Fielding thought that fledgling PBC Leads must be involved in commissioning issues.

o *Dermatology*

Dermatology-on-call had been withdrawn with effect from 1st October. Members enquired what other services were in the pipeline to be withdrawn or changed in the future.

In defence of the Dermatology department, Dr. Ulahannan said that the decision to withdraw the service came from above, unfortunately with very little notice; GRH believed that the service was under-used and cost something in the region of £30k per year to run. Dr. Bayley reported that she had tried to refer 2 patients in the last 2 weeks! Members wondered if a mapping exercise on other services GPs expected to be able to refer patients to should be undertaken by the PCT; Jackie Huck commented that provision of on-call dermatology was not actually commissioned by the PCT from the Acute Trust.

- **Project UTOPIA**

Dr. Ulahannan enquired whether the Committee had found Dr. Dedi's presence at the last meeting valuable. The Chair felt it had been a useful exercise from both sides' point of view. It was agreed that Utopia would be a rolling item on the agenda and regular feedback would be vital.

Comments from around the table:

Dr. Morton reported that feedback from GPs in his area was fairly positive. Dr. Salter was concerned that he had two phone calls in order to admit a patient having already discussed the case once with a Registrar. Dr. Ulahannan said the information should be going through Reception. He reported that in ACU big screens were being installed to track patients' progress through the system to improve bed availability information. The number of beds had been cut. Dr. Fielding reported that CGH had again recently diverted referrals to GRH but Dr. Morgan felt that the number of Cheltenham diverts had dropped dramatically.

Members were concerned that the qualified nurse who was taking the incoming calls was actually acting as a call-centre handler and not utilizing her role effectively by giving professional advice.

Dr. Bayley reported an exercise where a number of patients 'Cas cards' had been pulled and found to have been treatable in primary care. Better guidance was needed on which patients should go through Utopia and which should not. A new IT system was to be launched the following week, which, it was hoped, might bring about an improvement.

There was a meeting planned for January 2010 when more information should be available on the advice issue.

Dr. Hodges wondered if a list could be produced of people who were contactable for advice either to appear on GRH's website or to send out to GPs.

Mobile phones: this was still ongoing, there was resistance from Consultants in carrying phone in some areas, but it was recognised that there were signal black spots.

Action: Keep Utopia as a rolling item

126/2009 MATTERS ARISING

- **IAPT/PACTT**

Improved Access to Psychological Therapies (IAPT) was now up and running and appeared to be working quite well. Dr. Salter reported that 5 GPs would work in Committee to help set up IAPT. They would work monthly until April 2010 when a possible post would be created for one GP to work with the team. More of a worry was that there were no consultants attached to the new primary care service formerly known as PCAT and GPs needed to be aware of this when referring. This meant that the nurse had to refer on, which was seen as a retrograde step. There were no plans to develop and evolve the service further. Dr. Alvis was concerned that stable, long-term patients would no longer have a CPN attached to their case to monitor/look after them. A patient of Dr. Good's who worked for IAPT told him that they had been asked to downgrade every patient one step, as they did not have the level of service to cover. Dr. Simpson agreed; one of his patients had been downgraded from 2 to 1 and told to read a book.

Dr. Bayley was shocked to learn that the amount of investment in the 2gether Trust was on a similar level to primary care!
To base psychological therapies in practices was not practical as per the Committee's advice at the October meeting. One member had learned that the Mental Health Nurse role was ceasing at the end of November. This was a question for Eddie O'Neil; Jackie Huck felt there was a paucity of communication as to what was happening with this significant change: Dr. Fielding wondered if it was a rebadging exercise.
It was agreed to invite Eddie O'Neil to the December meeting; Dr. Salter to liaise with the Secretary for items to discuss with Eddie O'Neil and to make it a substantive item.

Action: Invite Eddie O'Neil to December meeting

- **Policy for the Management of Medical Performance of General Practitioners working for the Great Western Ambulance Service**

The Secretary had responded to the Committee's suggestions made at the October meeting; in response GWAS had indicated they would take the Committee's useful points on board. We awaited further information.

- **Appraisals**

Dr. Fielding reported that during the coming month Dr. Jonathan Steel, the PCT's Medical Director, would be conducting interviews for the new Appraisal Lead. It was critically important that an appointment was made as soon as possible to avoid slippage in Gloucestershire's gold standard Appraisal system. The Chair, with member's agreement, felt Dr. Steel should be invited to the December meeting.

Action: Invite Dr. Steel to December meeting

- **'Let's Get Moving and Putting Patients at the Heart of Care' – cost of publishing and preparing the two documents.**

Under the Freedom of Information Act the Secretary had learned that the cost of publishing the two documents amounted to:
Let's Get Moving: £59,232.00
Putting Patients at the Heart of Care (which formed part of a wider project and therefore not possible to separate out the cost).
The whole project: £113,385.90 (Plus Vat)

127/2009 FOR DISCUSSION/INFORMATION

- **UTOPIA – GP in A&E**

Dr. Bayley reported that GHT and the PCT were arranging for a GP to be based in A&E from 4pm - 7pm, which was very different to the original business case and service specification as proposed by the Gloucester and Forest PBC Clusters.
Dr. Bayley was extremely concerned that the response to the problems in A&E caused (at least in part) by Utopia was to throw more resources at the Acute Trust; why were they not simply telling them to stop sending all admissions through A&E, to stop the breaches. It was understood that there was an imperative from the SHA to act, but the Acute Trust should be taking responsibility for the problems, not having its poor management 'rewarded' with extra resources.
A bottleneck in A&E was impacting several services; GHT's response would be to put a GP in A&E to deal with GP referrals; should resources in GHT be provided by Primary Care? Dr. Good felt it was up to the Foundation Trust to assess skills of people they employed in A&E.
Jackie Huck said there was an onus on Providers to reach targets. There was a range of very complex issues:
Project achievements against targets:
- £2.1m had been spent out of a £2.4m budget.
- Only 32% of the bed spaces savings target had been met.

Dr. Morton was concerned that in his area GPs could not get their own patients into their Community Hospital because of patients from Cheltenham. He wondered if any other Community Hospitals had a similar experience. The members reported

there had also been an influx of patients from Cheltenham and Gloucester into Lydney.

- **Antenatal Children's Centres – Relocation of Midwifes**

Dr. Hodges had concerns about a move to place midwives in Children's Centres and had been robust in his disapproval. Jackie Huck agreed to find out what was happening in Gloucestershire. The Chair enquired what had happened to the Health Visitor report commissioned early in 2009; HVs moving into Children's Centres could be a disaster, a plan which appeared to have temporarily stalled but the intention was to move people out in the future. Jackie Huck agreed to find out the current situation and would speak to Trish Jay. It was agreed to have this item under Matters Arising for the December meeting.

Action: 1) Jackie Huck to get information on: Children's Centres – Midwives & to provide the HV report to the LMC
2) Agenda item under M/Arising December

- **Changes of Responsibility**

The Committee unanimously agreed that the duty of providing a link between the local BMA Committee and the LMC should pass from Dr. Siva to Dr. Hodges.

Action: Inform local BMA of change of LMC representation

- **Support for District Nurses**

Dr. Coker reported that a Cheltenham-based District Nurse was approached by Cheltenham General regarding the setting up of an intravenous antibiotic service in the community for a patient with chronic osteomyelitis, requiring once-daily teicoplanin for 10 weeks. It had been agreed on the basis that the hospital drug budget would be used, but had involved one of the practice's district nurses spending an hour with the patient every day, which obviously removed her from other duties.
Dr. Alvis thought this could be a growing problem; most GPs were not up-to-date with IV drugs. The increased workload for District Nurses and the planning involved could not be done unsupported. Jackie Huck would speak to Debra Elliott.

Action: Jackie Huck to speak to Debra Elliott

Dr. Gale said that military patients as young as 20 had been taught to self-medicate; could this be an option? IV cannulation changing could be a retraining issue. Dr. Morgan felt commissioning should be at PCT level not at PBC level.

- **Competency Framework for Accreditation of GPs in MIU service**

Dr. Good reported, as a member of the Competency Framework Panel, he had been asked to bring the framework for LMC comment. He worked at the Dilke and all he had to be was a GP! Dr. Salter drew attention to item 13 '*What was the minimum number of sessions to be carried out per year?'* (Level 2 only). He wondered if that was working in OOHs, if so, not many people would fulfill IAS and felt the framework should be shared with OOHs people. Dr. Hayes thought it was a sensible PLT programme; if a GP attended they would be accredited. Dr. Morton had had six appraisal/ reaccreditations on sub-specialties in a year! In Stroud and Tewkesbury GPs had to be Level 2 to do any sessions. Dr. Gale thought there had been quite a bit of cutting and pasting from the GWAS document. It was agreed that Dr. Good would contact Mr Paul Wilson with members' thoughts.

Action: Dr. Good contact Mr Wilson

- **Use of GP Premises by other Organizations e.g. Independence Trust and diabetic retinopathy**

The Secretary stressed that GPs could raise a service charge representing a fair estimate of the costs involved. The important thing was that a service charge should not aim to turn a profit for the practice. It was possible to charge rent, but risked falling foul of the regulations: a rental amounting to more than 10% of practice profits would force the PCT to cut back on rent reimbursement payments to balance. Dr. Fellows thought it not unreasonable to charge for heat and light.
Dr. Yerburgh reported that the Diabetic Retinopathy programme had another test which they were trying to integrate into the existing test; they were now looking at

using a Mobile Retinopathy unit, as it was found not physically possible to integrate into practices.
The Chair felt that GPs should stand together and not house the screening service; a mobile service would be a much better option. Jackie Huck agreed to talk to Duncan Thomas regarding the screening service.
The Chair asked that Diabetic Retinopathy be put on the December Agenda under Matters Arising.

Action: 1) Jackie Huck to talk to Duncan Thomas re screening service
2) Agenda item for December meeting

IAPT Business Plan:
Jackie Huck had agreed to come back on this after discussions with Eddie O'Neil: an unoccupied room in a practice for a period of 2/3 weeks was not practical for some; it would be incredibly disruptive. This could be addressed at the December meeting when it was hoped Eddie O'Neil would be present.

128/2009 LISTSERVER

As tabled.

129/2009 ACTIVE TOPICS

- **Pandemic Flu**

Dr. Fielding reported that most practices had received supplies of the GSK vaccine. For the time being GPs have been asked to only immunise 'at risk' patients. Supplies were being controlled centrally; District Nurses would be supplied with their own vaccine. There would be enough vaccine in the system but the question was what the uptake would be!
The GPC had stated that all practices would need a small supply of egg-free vaccine.
GPs would be paid £5.25 for every H1N1 vaccination for 'at risk' patients on their list. This had been calculated on a cost-neutral basis, to cover the overall time and postage etc costs involved in setting up and carrying out the vaccinations.
Practice Staff: GPs would only get paid if staff were within the 'at risk' group. The same criteria applied to Locums.
Dr. Fielding felt vaccine wastage would be inevitable. To the question of available websites to establish when delivery was imminent, he felt the information would probably be incorrect and GPs should wait until they actually saw the vaccines.
All GPs would be affected by experiences over the next few months. Dr. Fellows felt that patients might take the opportunity of raising other health issues when visiting the practice for their vaccination; the PCT should be aware of extra costs incurred.
There was still concern surrounding vaccinating pregnant women – the BMA podcast had informed that worldwide 90 women had been vaccinated in their first trimester not knowing they were pregnant and all had delivered safely.

- Seasonal Flu Vaccination

Last year practice staff either received seasonal flu vaccination from Occupational Health or practices were given the vaccine by OH and did it in-house. This year the second option didn't appear to be available. Dr. Seymour reported that Dr. Rigby had written to Jan Stubbings; Jackie Huck would look into this, surely it was much more efficient to do it in-house. **Action: Jackie Huck to take back to PCT**

- **PBC**

Dr. Fielding reported a well attended meeting the previous day. A new consultant-led Maternity Services /Women's Centre would be created at GRH costing £29m. A midwife–led service would remain at Cheltenham and Stroud.
Kevin Brett had reported that GP referrals were getting down to more normal trends; the cost calculations because of changes in the tariff, leading to a projected overspend of £1m. Commissioning Leads needed to learn how to balance the books and a Clinical leadership-training programme jointly funded by the DoH and PCT which were each investing £33k was planned. There were 3 events next year, each accommodating 10 clinicians.
When asked about Clusters becoming Confederations, Jackie Huck was able to report that as far as staff were concerned there had been no objections to the proposed structure.

linking into Local Authority areas. There was an issue around the Tewkesbury area and where it should sit; i.e. Forest of Dean. The PCT were not forcing links and preferred a natural flow. Jan Stubbings was attending a meeting that very afternoon to put this proposal to Sir Ian Carruthers and was hoping to put it into action soon after.

- **Choose & Book**

As Dr. Rigby was not present, Dr. Fielding spoke to C&B.
There was a masterclass taking place in Bristol but no one had volunteered to attend. Comments had been requested to pass on to the masterclass via Phil or Jackie. Two issues:
Advice Button (this was not available at present, the service was very variable)
Dr. Fellows' concern was inability to get back to the named consultant when the next appointment was requested. Another concern was that choice meant choice of Provider not geographical location.
Report last year showed that when GPs had been unable to make a booking in surgery, one in ten self-booked appointments through C&B were not being made. There did not appear to be any evolution of the C&B policy; three C&B meetings a year rather than the previous six, even though the system was seen not to be working at ground level, had caused more problems. Dr. Alvis felt that if a patient did not book their appointment after the GP had given them the contact number; it was the same as a patient not collecting a prescription.

- **IM&T**

Dr. Siva reported that a planned meeting that morning had been cancelled but he had managed to establish that the email communication project was on target and a pilot would begin in December.

- **QoF**

A Depression 2 debate would go ahead in the following week. Those practices with unusual Dep 2 QoF results would be invited to attend. The Secretary was asked to ask the GPC for a national solution to the Depression 2 question. QoF inspections due this year had been delayed because of Pandemic Flu; there would be a light touch questionnaire coming out. Moving forward, it was not yet clear how any future QoF visits would be handled.
As Dr. Hollands had some time ago reported, there were lots of gremlins in the system; his advice at the time had been to make a list of them.

- **Enhanced Services**

Members were concerned that there was inequity across the county in that some areas were being paid for some services such as Implanon insertions. The Negotiators needed to address this issue.
Dr. Good reported that there was a problem with the anticoagulation enhanced service. Dr. Good's current contract was at Level 2 but he could do Level 4 work but would not be paid for it. Equalising a LES across the county was essential. Jackie promised to feedback but discussions would be through the Negotiators.

Action: 1) Negotiators to discuss Enhanced service LES
2) Jackie Huck to feedback

130/2009 REPORTS

- **Report of Negotiators Meeting 19.10.2009**

Noted as tabled. Most of the items had already been covered during the course of the meeting. Dr. Bye acknowledged that PMS negotiations were dominating discussions.
Christmas Eve surgery opening/closing hours:
Practices could close from 4 p.m. onwards; OOHs would not kick in until 6.30 p.m; practices would have to arrange some point of contact in the interim. Every practice in the county could close their doors at 4.00 p.m. if they wished to. As far as New Year's Eve was concerned, Jackie would have to raise it with Debra Elliott. GPs should be aware that QoF access points could be affected although it was pointed out that practices closed their doors for PLT. The Chair suggested that perhaps pro rata opening times for Christmas week could be considered.

Action: Jackie Huck to find out about New Year's Eve opening

GPC Newsletter September 2009

Dr. Fellows reported on:

DDRB evidence: There was no money in the system. The Department had recommended a 1% uplift for salaried GPs and GP trainers and retention of a 45% supplement for registrars.

Abolition of Practice Boundaries: The Minister was adamant that this should happen within the next 12-months to boost Darzi clinic usage. Under the proposed boundary changes patients in Scotland/Wales could come into England but not the other way round.

Revalidation: Sessional GPs – not resolved.

- **Foundation Trust Contract Quality Group 8th October 2009**

Noted as tabled. Dr. Haseler had been a part of this Group when she stood down as an LMC member. At that time it was not thought necessary to make an LMC appointment to this group. The Chair asked that since the Contract Quality Group were discussing Utopia was it now time for the LMC to have a representative? Dr. Hayes would be prepared to take on the role and it was agreed to approach Sarah Hughes if we could have formal representation.

Action: Contact Sarah Hughes re formal representation

- **BMA SW Regional Council Meeting 23rd September 2009 – verbal update**

The Chair reported that the Minutes had been received but were to be treated as confidential. Utopia had been discussed and it was learned that other South West regions were considering following suit. This further underlined the need for a successful GRH project; it could not be seen to fail.

- **Report Cervical Screening Steering Group Meeting 29/9/09 & Follow up Meeting 12/10/09**

Dr Rachael Coker reported that the main issue was again sample-taker training.

- At present, 42% of cervical smear takers were up to date for 3 yearly training
- There did not appear to be a way round this as it was a national guideline.
- At present there were 4 sessions/year in Gloucestershire. 3-hour training sessions tended to be in afternoon. These were currently free to attend. The meeting considered reducing time to 2 hours and holding it over lunchtime; also may consider increasing the number of sessions to 6.
- An alternative was online training, which cost £35 a person, at cost to the practice. It was not definite yet that this would meet the standard necessary for sign-off.
- There was a possibility that in the future practices would have to pay for training sessions themselves.

Dr. Coker in conclusion felt:

GPs who were not regularly taking smears should consider removing themselves from the register.

A show of hands round the table confirmed that very few GP members undertook taking smears; Dr. Seymour felt that it would sort itself out; if GPs didn't take smears they would be taken off the list. Dr. Salter asked if there was an 'International smear certificate' in existence! Had anatomy undergone a change that he was not aware of?

131/2009 FORTHCOMING MEETINGS/EVENTS

- LMC/PCT Negotiators 16.11. 2009
- Executive meeting 26.11.2009
- **LMC Meeting Thursday 10th December 2009**

132/2009 ANY OTHER BUSINESS

None.

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