

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 8th OCTOBER 2009

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 8th October 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, Patterson, Preston, Simpson, Siva, Tan and Yerburgh.

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

107/2009 APOLOGIES FOR ABSENCE

Dr. T Ulahannan, Dr. Rigby, Dr. Salter

108/2009 CHAIRMAN

The Chairman welcomed Dr. Tan, Consultant in Old Age Psychiatry, quarterly LMC attendance. Dr. Robbie Dedi would join the meeting later to report and take questions on Project Utopia:

Tea Rota: Drs. Bye & Siva

109/2009 MINUTES OF THE LAST MEETING

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

110/2009 REGISTER OF INTERESTS

There were no new declarations of interest to report.

111/2009 ACUTE TRUST ISSUES

Dr. Ulahannan was unable to attend the meeting but a number of the concerns raised in September were considered.

- **MRSA pre-operative screening**

Debra Elliott reported that she had heard nothing but was meeting with Dr. Philippa Moore the following Monday. Dr. Miller said that the same issue was of concern in Bristol (Frenchay); she would also pick this up with Dr. Moore.

- **Referrals and follow-ups**

Dr. Steinhardt illustrated the problem with the case of one of his patients who had undergone a hip replacement, attended an appointment for an x-ray to check all was well and was told that she needed surgery on her other hip and to ask her GP to make another referral. He gave the reason for a second referral as financially beneficial to the hospital! Dr. Simpson condemned that attitude!

Dr. Bye had concerns about the back pain clinic ceasing and who had the responsibility to patients when a service to patients was pulled? Debra Elliott was not in possession of the details but would investigate the terms and conditions.

Action: Debra Elliott to discover who should take over responsibility for these patients in the absence of an established clinic.

111/209(cont)

It was unfortunate that Dr. Sean Elyan was not at the meeting as members could have questioned him about follow-up appointments; it was hoped to further this discussion with him in due course.

Debra Elliott reported that she and Nikki Millin, Deputy Director Performance and Planning, were looking at the Foundation Trust contract for next year; this new contract would run for three years, but would have an annual break clause and financial penalties included.

112/2009 PROJECT UTOPIA

Dr. Dedi reported Project Utopia was up and running but possibly not yet as streamlined as ultimately hoped for. The Utopia badge was to be dropped and to be known as Unscheduled Care. The system was continuing to be developed; patients were largely being directed through A&E. Inevitably there had been some teething problems:

- Workload compressed through the front door had created problems
- Clarity of medical problems presenting
- Lots of technical issues coming to the surface

On the positive side:

- Consultant numbers had been bolstered
- Senior assessment managed much more successfully than before
- Patients who were assessed as fit enough to be discharged were discharged from A&E and not going into the system
- Generally progress had been made and was continuing.

Dr. Bye had concerns about bed pressure. Dr. Dedi explained that there was a peak period when patients were being admitted and patients being discharged which tended to overlap; they were trying to discharge patients earlier in the day so cross-over didn't occur. There was an escalating bed managing process in place: Trust/PCT/GPs. Dr. Fielding had heard that an unnamed consultant was thoroughly disillusioned with Utopia and felt patients should be sent through the system as previously! It was made clear that Utopia was proving to be a smoother path for patients, a detail which had undoubtedly upset some specialities; an ongoing specialty review was to be put in place.

Dr. Patterson had concerns about the discharge system, a patient had been discharged at 3 a.m. in the morning and had to find a taxi to get home. Dr. Dedi felt there was a certain amount of self-responsibility; the patient should have made some arrangements for transport in case he had not been kept in hospital.

Dr. Booker also had a patient sent home at 3 a.m. but had to return the next day. If a patient were directed to the wrong service what happened? Dr. Dedi felt this was where a letter from the GP giving more information was helpful. Letters were extremely useful; some patients had phoned their GP but told to go to A&E; a visit to their GP who could then assess them would be more helpful; the patient could perhaps be referred to Outpatients or to a Clinic the next day. Dr. Miller felt some patients lied about contacting their GPs; she had experience of this at her own practice.

There was a feeling among some members that patients referred by GPs were being treated the same as A&E patients; Dr. Dedi didn't accept this description of the treatment of A&E patients and GP patients. Dr. Hayes felt that the system slightly ignored the fact that the GP had assessed the patient before sending them in. Debra Elliott reported she and Jill Crook had been looking at the through flow and were seeing patients getting to the right place from the outset and not being transferred within the hospital. Dr. Morgan had been very impressed with the telephone service; he had used the system three times, once for a family member, who had been admitted through the system, although on a separate note he felt the DVT area needed to be sorted out; Dr. Dedi agreed to look into that.

Action: Dr. Dedi to look at DVT

Orthopaedics and ENT were problem areas. The Specialities were not aware of problems that already existed which Utopia was trying to sort out.

112/209 (cont)

Dr. Simpson wanted the Casualty Discharge Summary to take the GPs referral points more seriously. Dr. Dedi thought the new IT system, due in Nov 09, should solve the problem.

Intermediate Care: was this closed to GPs? Dr. Dedi was not sure about that; Dr. Donald should be able to clarify.

The mobile phone signal was often poor at Cheltenham but GPs occasionally needed to talk to an appropriate person. This was part of an ongoing discussion - some specialities still preferred the bleep system.

Dr. Morton enquired about a single point of access for In-hours. Dr. Seymour felt that anything that made life easier would be a bonus.

The Chair thanked Dr. Dedi for his useful update on the project.

113/2009 MATTERS ARISING

• **Quality Improvement Scheme for Non-urgent Elective Referrals**

The paperwork sent out by the PCT stated that it had been shared with the LMC. Dr. Seymour asked members whether the paragraph (BMA view in italics) at the bottom of page 6 of the September minutes should be adopted as the LMC stance:

"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".

There being no objection the Chairman's proposal was adopted.

From an educational viewpoint it was good for GPs to be looking at their referral levels but at the same time not failing to refer patients as clinically appropriate. The PCT were supportive of practices doing research into their referral levels and appropriateness.

Dr. Bye felt it was about managing risk and clinical appropriateness; the underlying issue was about money. Dr. Bayley felt money was not an infinite commodity.

• **IAPT**

Following the presentation at the September meeting it had been agreed to consider at the October meeting areas where potential difficulties could lie:

The system had gone live, albeit with a telephone answering message!

○ **Premises Funding**

The plan to place IAPT workers in the primary care setting could place a burden on practices, as there was so little premises space; there could also be a funding issue. Debra Elliott reported that a rental system payable to GPs for hosting the service was being discussed with IAPT. They would have to build in these costs if they wanted GPs to host the service. At the moment the subject was parked with IAPT. Dr. Bye felt there was a fundamental flaw in planning how GP practices would be working with IAPT.

○ **PCATT**

Bring back to the November meeting.

○ **Choose and Book**

IAPT referrals were not counted against the denominator and no payment will be made.

It was agreed to make IAPT a rolling agenda item.

Action: IAPT a rolling agenda item

• **Breast Screening Steering Group**

It was agreed that those few practices that had not signed up to the Learning Disability LES should write to their patients asking whether their details could be shared with the Breast Screening service.

Action: Dr. Patterson to take decision back to the Breast Screening Steering Group

• **Support for Anger Management**

Dr. Patterson had raised concerns about support for anger management, unfortunately she had not been present at the September meeting but Jan Bagnall

113/209 (cont)

had commented that the service was not commissioned to work with anger management, although they could still accept referrals which would need to be signposted on.

Dr. Patterson felt the specific issue at her practice was that the GP wanted a bit of help but the response offered no support to the GP. Dr. Tan stated that his service could not offer an anger management service as there were no resources but if Dr. Patterson could forward the correspondence he would see what he could do to help.

Action: Dr. Patterson

Dr. Fellows thought there was a sad lack of counselling available, with which Debra Elliott agreed, as anger was often the symptom, not the diagnosis.

114/2009 FOR DISCUSSION/INFORMATION

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

As tabled.

Great Western Ambulance Service (GWAS) provided (OOH) primary care across the County of Gloucester and for patients who were registered with a Gloucestershire GP but lived outside the county, in conjunction with NHS Gloucestershire.

Specifically GWAS provided:

- Initial call handling and call prioritisation
- Telephone triage between 23.00 and 08.00
- Home visiting service
- Medical support to Community Hospitals and Minor Injury/Illness Units (MIIU) when no doctor was available on-site

The Mobile Service utilised GPs (General Practitioners) who were accredited to work in the service. These were either at levels one, two, three or four. Level one GPs were accredited to work in the triage centre only. Level two GPs provided the GP home visiting service and also provided medical support to MIUUs and community hospital wards. Level three GPs in addition attended 999 calls and provided pre-hospital trauma care. Level four GPs worked for the Helicopter Emergency Medical Service (HEMS).

Purpose and Scope of the Policy:

To ensure high quality medical performance by GPs working for GWAS, all GPs working in the service were to be accredited as GPs with Special Interests (Out of Hours).

Dr. Gale had read through the weighty document on behalf of the Committee. Clearly unscheduled care in OOHs looked after patients for more time than in-hours. The care ranged from surgery setting, through home visits to roadside care. The document appeared to be boosting a basic GP role into a GWPSI role thereby making it a sub-speciality. Dr. Gale noted that the proposed Accreditation Panel would not include a current GP. Another area of concern was an assessment review in absentia involving four random cases assessed against the Royal College mandate.

The inference drawn from the document was that anyone who did a home visit had to be a Level 3 Doctor, but in-hours home visits were successfully carried out by ordinary GPs without this extra qualification. Over the 5 years that the OOHs service had been running those GPs who were not salaried had received no pay increase.

Dr. Bayley totally agreed with Dr. Gale. There was a great deal missing from the paper about GP home visits and it was felt that the document needed to go back and start from scratch with a frontline GP involved.

Debra Elliott would share the LMC comments with Jill Crook and Mike Roberts.

Dr. Fielding enquired when the OOHs contract was up for renewal; Debra would have to find out.

114/2009 (cont)

It was agreed that Mike Forster would feedback LMC comments to Paul Wilson and suggest to Paul that a small group meet with him.

- Action: 1) Debra Elliott to share comments with Jill Crook & Mike Roberts**
- 2) Debra Elliott to establish contract renewal date**
- 3) Mike Forster to feedback to Paul Wilson**

- **Focus on the Dispensing Doctors Fee Scale from 1 October 2009 – 1 April 2010**

The General Practitioners Committee (GPC) and NHS Employers had agreed a new fee scale for dispensing doctors, which began on 1 October 2009.

From 1 October the fee scale for dispensing doctors would be lowered by 8.7 per cent for the remaining six months of the financial year, representing a 4.9 per cent decrease across the whole year. From 1 April 2010 there would be an increase to produce a figure that was appropriate for the full new financial year.

Dr. Fellows was very unhappy about this move. Dispensing was under huge pressure. 28-day prescribing produced lots of work and scripts were not properly looked at.

Dr. Alvis said that it was costing his practice more to deliver a dispensing service. Manufacturers' discounts had been reduced so profit margins were very low.

Dr. Gale felt there was a danger of decreasing self-care; issuing scripts for say Paracetamol and thereby increasing profits!

- **'Let's Get Moving'**

As tabled.

Research has proved that the cost of getting people fitter is less than the cost of treating them if, having remained unfit, they then suffer from ill-health consequent on a sedentary lifestyle. Time spent in encouraging people to become active will thus pay off in the long-term as GPs will need to see them much less often. Getting people to be active is thus commissionable, and the DH has now issued guidelines which are applicable to PCTs and PBC clusters on what services need to be commissioned, and how that is to be done.

Dr. Hayes wondered what the costs of producing such a document were!

- **'Putting Patients at the Heart of Care'**

As tabled.

Patient and Public Engagement, which was based on patient experience, patient safety and clinical effectiveness. A positive patient experience has been defined as:

"Getting good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way; having information to make choices, to feel confident and feel in control; being talked to and listened to as an equal; and being treated with honesty, respect and dignity."

- **Implications of the Working Time Regulations for GP registrars**

As tabled. The important thing to note was that if a GP Registrar got involved in OOHs work during the week there would be a risk of breaching the maximum length of work (13 hours) if he worked during the previous day, and of breaching the minimum period of rest (11 hours) if he worked the following day. Some time off in the morning of each of the day before and the day after may be needed to avoid this risk.

115/2009 LISTSERVER

As tabled.

116/2009 ACTIVE TOPICS

- **Pandemic Flu**

Drs. Fielding and Seymour had attended a meeting to consider mass vaccination. The following week GPs would be in receipt of a box of 500 doses of GSK licensed vaccine.

District Nurses: District Nurse would vaccinate housebound patients. Practices would be paid for arranging this service.

116/209 (cont)

Dr. Fellows reported the DES was designed to reimburse GPs at £5.25 per vaccination. 70% of the population would be immunised; all GPs would need both vaccines: one grown in eggs and the other in pork as some patients had an egg allergy. Patients' religious beliefs should also be taken into consideration.

The government had agreed concessions next year on QoF.

The expected second wave of infection had been pushed back to the end of November. It was not clear when the Emergency SFE would be triggered because of the mildness of the disease.

Patients with severe respiratory problems may need nebulising.

Clear guidance had not yet been received on whether vaccination of pregnant women should be Midwife-led or GP-led? The GSK vaccine could be a risk to pregnant women.

Renal Disease patients: CKD 4 or 5? Coding was an important issue for these patients and required accurate data collection.

Occupational Health: Patients could have their vaccination there but the service would not go out to patients.

Dr. Hayes had concerns recommending people to be vaccinated; she wondered how many LMC members intended to have the jab! On a show of hands opinion was fairly evenly divided, a small minority intending to have it.

The Vice Chair and Secretary had attended a planning meeting held at Shire Hall to consider death certification changes in the event that Swine Flu should result in a significant rise in the number of deaths locally. Among the agencies attending were GPs, Coroners Office, Gloucester Crematorium, Emergency Planners for the County and City and local Councillors.

It was agreed to keep Pandemic Flu as a rolling item.

Agenda: Pandemic Flu rolling item

• PBC

There had been a meeting the previous week, which Dr. Fielding had unfortunately been unable to attend.

Jackie Huck reported that it had been the first of three sessions to help and support clinicians taking part in PBC. It had resulted in positive feedback, which had served to shape the January and March sessions. Dr. Alvis had found it very useful.

• Choose & Book

Dr. Fielding reported a very relaxed meeting; Gloucestershire PCT was the 5th best PCT in the country. The South West region had done very well in comparison to other SHAs. SNOMED, it was agreed, had not improved things but had rather made them more complicated. There were also unresolved issues over peripheral clinics and what happened when clinics disappeared from the system?

There were still significant concerns over C&B usage; was there to be a quarterly review or cumulative?

IAPT – the information that it had gone live and was on the system had come as a complete surprise.

Dr. Alvis reported that consultants unexpectedly taking leave when booked appointments had been made led to sudden and unexpected cancellations.

Dr. Fellows stated that virtually 100% of bookings at his practice were through C&B but the figures from the PCT did not reflect that. He felt the difference amounted to about 30%; Dr. Fielding agreed to take this further: it was important that trust in the system be established.

Action: Dr. Fielding

• IM&T

Email Communication: Dr. Rigby was not present and Dr. Siva had been unable to attend the last IM&T meeting. It was agreed to bring back to the November meeting.

Action: November agenda item

• QoF

Very quiet because of the activity in Pandemic Flu.

116/209 (cont)

Nikki Holmes was preparing a letter to send out to practices expecting a visit. There would be a quick check of outliers if the PCT thought they were exceptional in any way.

Dr. Fielding felt that a Depression 2 seminar was needed; Debra Elliott agreed; Dr. Fielding and Katie Stonall would sort this out.

Action: Depression 2 Seminar: Dr Fielding to sort

Dr. Seymour enquired about World Class Commissioning visits. The PCT had completed approximately 20 practices. PMS practices needed retailoring. Jan Knight said that practice managers had found the framework visits very helpful. Jackie Huck reported that the PCT would be coming out to PBCs and practices with up-to-date information; a helpful tool and she urged practices to make enquiries. Dr. Simpson enquired about Christmas Eve practice closing times; the Chair reported that it was on the agenda for the next Negotiators meeting but as Dr. Simpson had raised it, he asked Debra Elliott for a view. The PCT had asked the OOHs service twice for a response and they had finally come back to say that it was not feasible because of costs etc. Debra's view was that practices should switch over as they do now but slightly earlier on Christmas Eve. She would contact practices formally about it later in October.

Action: Debra Elliott Christmas Eve closing

117/2009 REPORTS

• **Report of Negotiator Meeting 21.09.2009**

As tabled.

Dr. Bye was disappointed that MRSA Screening had not yet been commissioned by the PCT.

The PCT had, since the Negotiators' meeting, decided to adopt a softer, more consultative, approach than the notice of termination to PMS practices which they had announced at the meeting. They hoped that unilateral termination of contracts would be unnecessary if practices would consent to move to a common PMS contract, or back to GMS.

The PCT were endeavouring to unpick the reasons why practices went to PMS in the first instance. There was much work to do in the Negotiating Committee to find a common solution.

Dr. Bye requested early sight of any proposal; rather than having it tabled on the day of the meeting.

Debra Elliott responded that everything had to be stripped out of PMS/GMS so they were comparable, so clarifying how the budgets were built up and then presented in a number of ways and subsequently presented to the Negotiators.

Dr. Fellows reported MPIG was now being threatened and recognised it might be financially difficult for PCTs to achieve equity by levelling up not down. Debra felt MPIG was the wrong term to use.

Appraisals: Dr. Fielding was concerned that Shirley Elliott should be replaced in order to maintain the steer she had given to Appraisals. Resource had to be in place to ensure that quality was maintained; he felt that the organisation had slipped.

It was agreed to have Appraisals under Matters Arising at the November meeting.

Agenda: Item for November agenda

• **GPC Newsletter September 2009**

Among items reported:

Registration: The Committee was badged as GPC UK but essentially was a Committee dealing with England only. The practice boundary issue had been considered; the NHSE felt it was a non-runner and had not been thought through. Patients registering with any practice of their choice could be viewed as a way of bolstering Darzi Centres.

Patient Experience Survey Appeals: Laurence Buckman reported that £22m had been lost from general practice simply from the change from a DES to QoF.

Doctors, Dentists Review: A 2% increase was the target for the GPOC Negotiators but Dr. Fellows felt doctors were unlikely to get it.

Revalidation: Funding issue. A document would appear in Spring 2010; it envisaged that there would be a 20% increase in the level of doctors being

117/209 (cont)I

investigated. Apparently 1.5% of doctors were under investigation at any given time. Pilots had already been taking place and many PCTs had expressed an interest. 'Soft knowledge' could be of concern, especially for Sessional and part-time doctors. Dr. Simpson felt it was unacceptable for letters to be written by PCTs to doctors over issues of performance; using information gained through 'soft knowledge'.

Full revalidation would probably be deferred until 2011.

- **Report of Regional LMCs meeting and GPC Roadshow 1.10.09**

As tabled.

Drs Fielding, Good, Steinhardt and Mike Forster attended the meeting at which LMC representatives from Cornwall to Wiltshire were present. The issues of the day were discussed, it was reassuring to discover that many of those faced in this county were also faced elsewhere: the problem of increasing referrals and the unsettling influence of PBC on the relationship between PCTs and LMCs were among common experiences.

Considered were:

- Swine Flu
- Claw-back of Seniority payments
- Exeter system
- Vascular Screening

Among the topics the GPC speaker Dr. Richard Vautrey talked about were:

- MPIG
- QoF
- Swine Flu
- Clinical DESs
- Patient Survey

It was agreed that the Secretary's précis of the day should be circulated with the Minutes (see Appendix 1)

118/2009 FORTHCOMING MEETINGS/EVENTS

- LMC/PCT Negotiators 19.10.2009
- Executive meeting 29.10.2009
- LMC Meeting Thursday 12th November 2009

119/2009 ANY OTHER BUSINESS

- **Orthopaedics – Moving to another Provider service**

Jackie Huck reported that there were still problems of capacity with the Orthopaedic service at GHT and they were looking to commission another two providers in the next couple of weeks to help ease the problem; (BMI Healthcare Swindon and Bath). This was alongside the established alternative providers. Jackie asked if the PCT should write to all the practices to establish whether they could contact a patient who was awaiting a procedure. Members agreed with this approach. Patients could of course defer and be treated at GHT but they would have to understand there would be a wait.

Dr. Gale had concerns about follow-up; Jackie would take that important point back; money would follow the patient. The new Director was addressing these issues, the PCT were not destabilising the service at GHT.

- **CRB Checks**

Dr. Gale enquired about CRB checks. Debra Elliott was able to report that all would have a CRB and she would be writing to the LMC about this and would copy in Dr. Gale.

Action: Debra to write to LMC re CRB and copy in Dr. Gale

- **Pain service**

The PCT were trying to establish an alternative service for the time being.

120/2009 CLOSED

[INTENTIONALLY DELETED FROM THIS VERSION]

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