

# **GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE**

## **MINUTES OF THE MEETING ON THURSDAY 11<sup>TH</sup> FEBRUARY 2010**

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 11<sup>th</sup> February 2010 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, Hodges, Morton, Patterson, Rigby, Salter, Simpson, and Yerburgh.

Jan Knight, representative practice manager.

**Also present:**

Representing the PCT:

Jackie Huck, Deputy Director

From the LMC Office:

Mr Mike Forster, LMC Lay Secretary

### **ACTION**

#### **5/2010 APOLOGIES FOR ABSENCE**

Drs Hayes, Miller, Morgan, Siva and Ulahannan.  
Mrs Debra Elliott

#### **6/2010 OPENING REMARKS**

The Chairman welcomed members and Jackie Huck to the February meeting and Dr Alicia Halmshaw, Dr Morton's registrar, as an observer. He also welcomed Sallie Cheung, Local Counter Fraud Specialist, who would give a presentation on the work and remit of the local Counter Fraud service.

Tea Rota: Drs. Hodges & Salter

#### **7/2010 MINUTES OF THE LAST MEETING**

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

#### **8/2010 REGISTER OF INTERESTS**

There were no new declarations of interest to report.

#### **9/2010 ACUTE TRUST ISSUES**

Discharge Summary Update. Since the previous meeting the LMC Office had faxed a number of examples of inadequate A&E discharge summaries to Dr Ulahannan. A global e-mail had been received from the Acute Trust acknowledging the problem but little sign of improvement had been noticed. The committee felt it would almost be better not to receive such discharge summaries as they lacked basic information (e.g. diagnosis and whether the patient had been admitted). It was not as if there was no free text facility to allow this; the reports looked as though they had been generated by a machine with no care or human input. Some wondered whether blocking everything back to GPs after a 'single episode of care' smacked of 'gaming' but on balance the committee reckoned the fault lay with a lack of understanding at hospital registrar level.

On a broader subject, the committee wondered what should be done if concerns about secondary care grew to such a pitch that official complaints had to be raised? Jackie Huck stressed that the correct channel was through the contract quality group. There was some discussion on whether or not GPs would be best represented on that group by the PBC leads (who were commissioners, but might not be aware of the problem) or the LMC (who, though not commissioners,

**ACTION**

**9/2010 (cont)** did have the statutory duty to represent all GPs in the county and were well placed to do so). It was agreed that

- **Jackie Huck would take the matter up with the contract quality group.** PCT
- **All members were asked to send her any suspect reports, anonymised but including NHS number so that the hospital could trace it if necessary.** All
- **As a first step, the Secretary would write to the chair of the contract quality group, Dr Helen Miller, to request that the LMC be allowed to sit on that group.** MF

Zoladex Prescriptions prior to Gynaecological operations. Dr Salter was concerned that secondary care gynaecologists were requiring GPs to prescribe Zoladex prior to operations. He felt that this prescribing should more appropriately be done by secondary care. This was akin to the MRSA pre-operative screening issue, which was also not a primary care responsibility. It was agreed that:

- **The Secretary would write to Dr Ulahannan to express the committee's concerns.** MF
- **Jackie Huck would find out whether the prescribing of Zoladex was part of the Trust's tariff costs.** JH
- **The Negotiators would raise the matter of MRSA pre-operative screening again with the PCT** Negs

**10/2010 COUNTER FRAUD: A Presentation by Sallie Cheung, Local Counter Fraud Specialist**

The NHS Counter Fraud Service had been responsible since 1998 for discovering the scale of fraud against the NHS, what types of crime were involved and how much money was being lost to the NHS. Recent reports suggested that 6% of the NHS budget was wasted by fraud – an immense sum. Sallie Cheung was the manager, Lee Sheridan the investigator of reported suspect fraud and Roger Kibble the proactive inspector of likely, but as yet undiscovered, fraud. Her group would get involved if the NHS stood to take a loss or an individual stood to gain from the fraud. The main issues currently applicable to GP practices were:

- Multiple Registration with false identities. A typical case might be a temporary resident seeking 28 days supply of Zopiclone. One tablet had a street value of 50p so the whole consignment would provide enough money for a day's heroin fix. Of course, if tablets were issued on a daily basis it would not be worth the fraudster's effort but she recognised that although the Vaughan Centre had been persuaded to reduce the size of its prescriptions it would be impractical for general medical practices to do likewise.
- She had been very encouraged by the numerous practice representatives who had attended the seminar last summer. She was well aware that her department could not ask practices to police the system, but was grateful that many practice managers felt that a common county wide registration procedure should be developed. This would make it much harder for fraudsters to commit multiple registration fraud. A meeting was due soon.

## **ACTION**

**10/2010  
(cont)**

- **The Chairman asked Jan to keep the LMC informed of progress.**

**JK**

- Forgers. Typically a patient would add a zero to a handwritten prescription, but pharmacists were now on the look-out for this and had been most helpful in bringing such fraudsters to book.
- Scams. Recent examples had been approaches by bogus publishing companies to practices that had put genuine advertisements into recognised publications (e.g. BMJ or Nursing Times). E-mails ostensibly from these organisations asking for confirmation of bank details were common. E-mails ostensibly from HM Revenue and Customs could be detected as scams by the fact that HMRC never sends e-mails to 'undisclosed recipients'. She expressed interest in the 'boiler room scam' attacks recently experienced by our practices and asked for details.

- **The Secretary agreed to do so.**

**MF**

In closing, Sallie Cheung mentioned that a link to her monthly newsletter was sent out to all practices by Alice Mayhew, but if by chance a practice was not receiving it then they should contact the group to put that right. She also asked that if anything suspicious was seen it should be reported; if it later proved to be a false alarm the enquiry would cease at once. In answer to questions re cost-benefit of the service, she stated that her group in the past year had saved the NHS some £220K while costing about £100K.

## **11/2010 MATTERS ARISING**

Mental Health Nurses. In the absence of Dr Miller the Chairman asked Dr Salter whether it was now possible to make direct bookings by practices, as had been promised by Eddie O'Neil at our January meeting. Several members said they had been told they had to submit a booking form. On an allied point, the Chairman had received information that depo medication would no longer be paid for provided by the mental health service.

. It was agreed that:

- **Dr Salter would raise the issue of booking mental health nurse appointments at the next mental health strategy meeting.**
- **Dr Seymour would send Dr Salter a copy of the information he had received.**

**JS**

**AS**

District Nurse FACE Form filling. The Committee had hoped to hear from Dr Miller that common sense was now prevailing, and that district nurses were being encouraged to fill in only those parts of the form that were relevant to the case in hand. It appeared that there were now 2 forms; a short one and a long one. Theoretically no form was needed for a mere injection, the short one was to be used if no more than 3 visits was involved, and the long one was only to be used when required for more difficult cases and was to be filled in over a period of time as the information became available. However, the short form (at 7 pages) was still far too long and the threshold for using the long one (12 pages) was set far too low. Criticism from the committee included: that the form had been designed to be filled in electronically (and had worked as such in the pilot study) but now had to be filled in by hand because the systems

## **ACTION**

**11/2010  
(cont)**

did not interoperate; that it was unclear why the information was being collected if it could not be shared by social services; and that it took too long to fill in (1½ hours for the long form, which would be better spent tending to patients). As such it was accused of being an exercise in futility. The PEC was also carrying out a review of district nursing with the aim of matching resources to needs. Some redistribution of funding was inevitable. It was agreed that:

- **The Secretary would write to Trish Jay to express the LMC's concerns.**

**MF**

PCT Position Statement on IM&T. There had been no time at the previous meeting to discuss the PCT's position paper expressing their intentions with regard to IM&T over the next few years. The Chairman opened the discussion by welcoming the paper as a very positive statement. There was general agreement but concern was expressed that the current N3 internet links provided for practices were typically contending in a ratio of 1:60 so it was small wonder that the system was frequently slow.

Pay rise for GWAS OOH GPs. There was concern that doctors employed by GWAS had seen no pay rise since the system was set up. The Chairman requested answers from the PCT to the 2 questions raised at the last meeting: i.e. where the funding blockage lay and how any increases were passed on and any commissioning issues arising. The answer from GWAS to the PCT had been that the funding arrangements were under review. Dr Gale, who had originally raised the subject, was unsurprised as this was the answer he had been given for the last 3 years, but he wondered if the review would ever end? Jackie Huck assured him that GWAS would be running under a new contract from 1 Apr 10 and that they had a new management team in place. Nevertheless it was agreed that:

- **The Secretary would consult Dr Gale and send a letter to the appropriately senior GWAS manager about it.**

**MF/RG**

ACR specimen collection. The PCT had undertaken to find out whether the additional work of preparing urine samples for analysis was contractual. Jackie Huck replied that the question had been put but no reply had yet been received.

- **She agreed to bring the answer when received to the LMC.**

**JH**

Cameron Fund Donation. The LMC's contribution of £300 had been acknowledged by the Fund.

CRB Checks Backlog. Jackie Huck had discovered that there were currently 155 GPs on the county's performers list that did not have a current CRB check, but that they had been submitted. A further 72 would follow in March so that by the end of the financial year all 635 GPs on the performers list would have had a check within the last 3 years. There would then be an ongoing update programme.

## **12/2010 LMC CONFERENCE**

Motions. A first draft of prospective motions to the LMC Conference had been circulated. The wording at this stage was not debated – just the appropriateness of the subject matter. Two draft motions

**12/2010  
(cont)**

were excluded and a new one added. It was agreed that:

- **Suggestions for word changes or new motions were to be sent to the Office.**
- **Wording would be discussed at the March meeting, with final sign-off at the April meeting.**

**ACTION**

All

Office (for Agendas)

Attendance. The Chairman pointed out that the BMA only paid for the 3 elected representatives to attend. As in previous years he hoped the committee would agree to pay the expenses of the Secretary to attend both days and for the Chairman to attend one day.

- **This was agreed.**

Office

**13/2010 FOR DISCUSSION/INFORMATION**

**Report on General Practice Out-of-Hours Services (extract)**

Background. Dr David Colin-Thomé, National Director for Primary Care in the Department of Health, and Professor Steve Field, Chairman of Council in the Royal College of GPs, had just published a joint report into the local commissioning and provision of out-of-hours (OOH) services. They had visited 5 sites and surveyed a wide variety of individuals. They had found predictably varied levels of achievement. Their report highlighted lessons in 3 main areas: the commissioning and performance management of GP OOH providers; the selection, induction, training and use of OOH clinicians (including locum GPs); and the management and operation of PCT performers lists. An extract of the report was circulated to members for information and comment.

Discussion.

- OOHs Language Skills. Were there any national guidelines on how good the OOH's doctors' command of English should be? What should be required in Gloucestershire?
  - **To be discussed at the OOH WG meeting on 24 Feb.**
- Note of Caution. Dr Gale warned that OOH should not be talked down too strongly; patient surveys expressed considerable satisfaction with the service in Gloucestershire.
- OOHs Appraisals. Dr Fielding, Appraisal Lead for Gloucestershire, warned that a storm was brewing. The rules for getting onto the performers list demanded that GPs be appraised. New regulations coming into force on 1 Apr would demand that they perform at least 30 sessions in general practice per year or they could not be appraised. There were some GPs that then worked full time for GWAS on OOHs, and some, particularly female doctors with young families that could only work in OOHs, even if only part time. Without appraisal they would be removed from the performers list and would thereby lose the right to practice, in OOHs or otherwise. The GWAS suggestion had been that GPs should take it upon themselves to get the extra work in normal hours. Dr Fielding thought there ought to be some other solution. In any event there should be consistency of treatment for those working for GWAS and those working for the PCT. While it was right that the government should expect a similar standard of training and care from GPs in-

Office

**13/2010  
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hours and OOH, one solution did not fit all. There was general agreement that OOH GPs should not be regarded as a separate class of doctor, nor even as specialists. But clinical governance had to be maintained.

- **No decisions were reached or actions assigned.**

**Appraisal Toolkit Downtime.**

Background. The Appraisal Toolkit had been taken down for security reasons for about 3 weeks from 9 Feb. It seemed that patient identifiable data might have been entered in some of the records, despite advice not to. This came at the busiest time of the year for appraisals; some 150 would be affected in this county. Dr Fielding had sent out briefing e-mails to all concerned.

Discussion. Although it would be good to avoid a slippage of this year's appraisals into April or May if it had to be done then the date of the appraisal would be entered as 31 March 2010 so that no GP was disadvantaged. For revalidation it had been agreed that the 5 year period started in 09/10 so the lack of appraisals 3 years ago would also not have an adverse effect on GPs. If any GP needed the details from the toolkit in the next 3 weeks they could be requested and sent out by registered post. For the future there would be a choice of which toolkit to use. The PCT's current toolkit was one option, but Severn Deanery had acquired another from Wales, and there were other contenders.

- **No decisions were reached or actions assigned.**

**14/2010 LISTSERVER**

Nothing to report

**15/2010 ACTIVE TOPICS**

Project UTOPIA. The Acute trust was reported to be relatively happy with the performance of Project UTOPIA, despite a shortage of consultants and some disquiet about increases in readmission rates. There was to be a new 'single point of access' introduced on 1 March outside of Project UTOPIA but which would dovetail into that project. It was being introduced to meet new tariff charges, designed to reduce non-elective admissions by 10 a day, in which 70% of the tariff would be put into a regional fund. This changed tariff would not apply to community hospitals. It was pointed out that only a third of non-elective referrals came from GPs.

Pandemic Flu. Much less in the public eye as the incidence was very much milder than had been feared. Tamiflu should now be prescribed on prescription pads endorsed 'NOT FOR PAYMENT' but vouchers could still be used if preferred. District Nurses were still not vaccinating housebound patients, in breach of the national agreement. The committee wondered if this was connected to the filling in of FACE forms and asked the Negotiators to bring this up with the PCT.

- **Negotiators to pursue the issue of FACE forms with the PCT.**

**Negs**

PBC.

Dr. Hodges raised a concern that PBC clusters should not dictate what core work was. The Gloucester cluster had decided that if every practice did its own ECGs and endometrial biopsies the

**15/2010  
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cluster could save the £110K's worth of business that a minority of their practices sent to secondary care each year. The principle was agreed, but the issue was one of practicality. If the ECG result was hard to understand it could always be sent by C&B and secondary care asked for an opinion, rather than an appointment. It was not the only area in which primary care was taking a lead in what had hitherto been secondary care work – Cirencester operated a 24 hour arrhythmia service, for instance.

It was also recognised that the relationship between the LMC and PBC clusters was 'opaque'.

#### Choose & Book.

The PCT was determined to make C&B work. They would be introducing new training sessions and had produced a laminated flowchart diagram of what to do if things went wrong with the system.

There were, however, still suspicions that the availability of appointments was being massaged to meet secondary care targets, and that what was shown on C&B might not necessarily reflect reality.

#### IM&T.

A new merged Patient Administration System (PAS) was due to go live that coming week-end. It involved the transfer of 1.2 million records.

The most important IM&T issue for general practice was the poor contended connectivity on N3, and how to justify a business case for moving to GP COIN, which would resolve those problems. The responses from practices to the questionnaire sent out by the LMC were proving helpful. Various ways of reducing the expected annual maintenance costs of £620K were being considered: e.g. voice over internet protocols (VOIP) and offline storage.

On the horizon practices should note that Summary Care Records would be introduced by the end of the year, putting more pressure on the internet links.

#### QoF.

Diabetic Retinopathy Screening – QoF points. Dr Yerburch was concerned that if the screenings were carried out late in the year and the results were not available until after year end then the practice would be penalised through no fault of their own. Jackie Huck reassured him that such practices would not be penalised.

Diabetes Indicator 20. The NICE guideline G (dated 2002), on which QoF DM20 was based, stated that the ideal HbA<sub>1c</sub> should be between 6.5% and 7.5%. A Gloucester based GP had drawn Dr. Fielding's attention to recent research which indicated that pursuing HbA<sub>1c</sub>s to less than 7.5% resulted in as many deaths as no treatment. This followed a similar BMJ leader in 2009 which had argued strongly against that QoF indicator on the same grounds. If this was the case then most GPs would feel very uneasy in these circumstances in trying to achieve the above target (worth 17 points) and wholesale exception reporting was likely to occur to avoid financial loss. Concern had not gone unnoticed nationally; however, there were some doctors who believed lowering the HbA<sub>1c</sub> to 6.5% was the gold standard. The recently revised NICE guidelines also supported this view.

## **ACTION**

**15/2010  
(cont)**

However, it could appear that funding was being linked to a potentially harmful practice. Similar issues existed around blood pressure monitoring in CKD. The QoF assessors would be meeting in March to discuss these issues and give guidance to practices.

The assessors hoped that the PCT would continue with the educational/verification QoF visits to practices next year to spread good practice and guidance in the interests of 'high trust - low bureaucracy'.

## **16/2010 REPORTS**

Report of Negotiators Meeting 18<sup>th</sup> January 2010.

- Background. Noted as tabled. Dr. Bye particularly stressed that premises development was being hampered by the PCT's unwillingness to budge from a £150 - £160 per square foot figure for development. This figure was markedly lower than the assessments made by the District Valuer, and it seemed illogical to ignore the DV's advice. The PCT's website had an impressive list of premises improvement projects but it seemed that only the minor ones were making progress. He wondered if a survey of practices could be carried out to see whether the PCT's premises webpage was a fair reflection of actual and anticipated progress.
- Discussion. The Moreton in Marsh development was cited as a typical example: it was only viable if the land could be obtained exceedingly cheaply. Approval for a project did not always mean that a project would go ahead; there were many things that could go wrong, particularly where money was involved. It was important to be able to act quickly when land became available. The meeting agreed that the PCT was right in principle to ensure value for money for the taxpayer, but there came a point where driving costs down would convert to driving developers away.
- Actions.
  - **The Secretary was to ask all those practices featured on the PCT premises project webpage for their opinions.**

**MF**

## **17/2010 FORTHCOMING MEETINGS/EVENTS**

Negotiators meeting 22<sup>nd</sup> February 2010.

OOHs Working Group meeting 24<sup>th</sup> February 2010.

Executive Meeting 25<sup>th</sup> February 2010.

LMC Meeting 11<sup>th</sup> March 2010.

## **18/2010 ANY OTHER BUSINESS**

Dr Fellows mentioned that Andrew Dearden, a member of the BMA Pensions sub-committee, would be visiting the county in March to explain 24-hour retirement.

- **Dr Fellows would circulate the details.**

**PF**

***(Minutes of the Closed Session are here intentionally deleted)***

**There being no further business the meeting closed at 16:47.**