

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 11TH MARCH 2010

The regular meeting of the Gloucestershire Local Medical Committee was held at the Witcombe & Bentham Village Hall on Thursday 11th March 2010.

Members present:

Dr. A Seymour (Chair) Dr. P Fielding (Deputy Chair), Dr Steinhardt (Treasurer):
Drs. Alvis, Booker, Bye, Fellows, Gale, Good, Hodges, Morgan, Morton, Salter, Simpson, Siva, Yerburch and Ulahannan.

Also present:

Representing the PCT:

Ms Jan Stubbings, Chief Executive (items 32 to 35 only)
Mrs Debra Elliott, Programme Director for Primary Care Development (not items 35 – 37)
Dr Helen Miller. PEC Chair

From the LMC Office:

Mr Mike Forster (Secretary)

Action

22/2010 APOLOGIES FOR ABSENCE

Drs Bayley, Coker, Patterson, Preston and Rigby and Mrs Jackie Huck.

23/2010 CHAIRMAN

Tea Rota: Drs. Gale & Morgan.

24/2010 MINUTES OF THE LAST MEETING

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

25/2010 REGISTER OF INTERESTS

There were no new declarations of interest to report.

26/2010 ELECTION OF OFFICERS

There being no other nominations, and the current officers being willing to serve for another term, they were deemed elected.

27/2010 ACUTE TRUST ISSUES

Discharge Summary Update. Despite strong criticism by GPs of the inadequacies of hospital discharge summaries, made over several months, there had been no response from the Contract Quality Group, or from the PCT.

- **Jackie Huck being unfortunately not available to answer the actions placed on the PCT in February, Debra Elliott agreed to get recognition of the problem from the Acute Trust, to find out what was going to be done about it, and when.**
- **Meanwhile practices would be asked to go on sending copies of any inadequate reports to Jackie Huck, anonymised but including the NHS number so that the hospital could trace it if necessary.**

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Newsletter
item

Zoladex Prescriptions prior to Gynaecological operations. Nothing concrete having been heard since the February meeting:

- **Debra Elliott agreed as a commissioner to look into the**

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(Cont)

primary care assertion that secondary care gynaecologists should be prescribing Zoladex even if the practice were to administer it (if willing to do so).

- **Dr Miller as PEC chair would also follow it up.**

HM

28/2010 MATTERS ARISING

Mental Health Nurses. Dr Salter told the meeting that there was no regulation that a referral from a practice to a mental health nurse had to be on any particular form. Whatever means of communication was agreed between them would be acceptable. He also warned of a potentially significant workload if long-term mental health patients were transferred to primary healthcare. He had been told that the more patients were directly referred to psychiatrists on the recovery team the more patients would be discharged to make room. Some questioned whether the 2gether Trust was really working at full capacity. Although it had been reported that as many as 2/3 of practices already gave depo injections to such patients the LMC felt that this statistic was a hang-over from the days when this work had been funded by QOF, which it no longer was, and that they were probably only providing the service for one or two patients each. The practices would probably be unwilling to take on new cases without adequate funding through a LES.

- **The Secretary agreed to include information about referring mental health patients in the Newsletter.**
- **Dr Miller agreed to find out what the real workload might be: how many patients and which practices.**
- **Matters arising agenda item for April.**

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Office

IAPT. The system was being swamped with reportedly 3-month waiting lists – but this was an improvement on the 18-month waiting lists which had preceded it. There were currently 5 ways of referring patients to mental health services; the LMC agreed that it would be better to have only one route.

District Nurse FACE Form filling. Trish Jay had answered the Secretary’s letter, but District Nurses were still required to fill in the FACE forms. There might be some benefit from the sharing of information, although the current method of gathering it (by paper forms) was very time-consuming. IT systems were on the way, but the LMC feared that if the systems used by the nurses were not interoperable with practice systems then there would still be a huge waste of time from double entry of data.

- **Dr Miller agreed to look further into this, particularly the introduction to service of interoperable systems.**

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Health Visitors. Dr Fielding reminded the PCT that the LMC still had not seen a final version of the Health Visitors Study from last year.

District Nurses. The PCT was reviewing health needs and resources in the county. Part of this was to define the tasks and roles of district nurses. A draft service specification would be given to PBC cluster leads in the PEC in April. The LMC stressed how valuable District Nurses were, and how skilled nurses were a considerable asset.

ACR Specimen Collection. The new pots had been issued but the LMC felt strongly that separating urine specimens into 2 separate pots was laboratory work that should properly take place in the laboratory unless GP practice staff were being asked to do it as new

**28/2010
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work, in which case new money should be attached. The system might have been trialled with 3 practices, but the LMC felt that these practices' favourable reports were not representative of the general feeling among GPs.

- **Debra Elliott agreed to follow this up and decide how this work was to be commissioned.**
- **She also agreed to confirm as a matter of urgency that specimens sent to the laboratory in the traditional manner would continue to be analysed pending a final decision on who was to do the division of the samples.**

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

29/2010 LMC CONFERENCE

Motions. A second draft of prospective motions to the LMC Conference was considered. Three new motions were added and the wording of all motions agreed. (Attached as Annex A).

- **The meeting authorised the Secretary to submit the agreed motions without further modification.**

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30/2010 TREASURER'S REPORT

The Treasurer tabled the accounts, pointing out that the Benevolent Fund was now well placed to react quickly if needed, while the main LMC account had a reasonable surplus of income over expenditure, partly due to a refund from the GP Defence Fund and partly from a reduction in amounts paid to members for attending meetings. He proposed a 5.3% reduction in all levies for 2010/11 which would still allow the LMC to meet all normal expenditure with a sufficient reserve for the unexpected.

The Benevolent Fund account was accepted. Proposed by Dr Salter and seconded by Dr Good, and carried unanimously.

The LMC account and levy recommendations were accepted. Proposed by Dr Alvis, seconded by Dr Hayes and carried unanimously.

The Treasurer also passed on the Office Manager's thanks to all those members who had made the effort to put in their claims on time; it had helped her work considerably. The meeting thanked her for her efforts.

- **The office was tasked to put the reduction of the levies into effect.**

Office

31/2010 FOR DISCUSSION/INFORMATION

LMC Roles and Responsibilities. The Chairman told the meeting that the Executive wished to define, in conjunction with the PCT and PBC Clusters, the relationship between the 3 bodies. As a first step the Secretary had prepared a draft statement of the statutory and traditional roles of the LMC which the Chairman wished to share with the PCT.

- **All members were given until Friday 19th March to comment on the paper to the Secretary.**
- **Following this he would send the revised paper to the PCT for further consideration.**

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- **The Secretary would ensure that the paper would mention the need for the PCT to consult the LMC if there were any accusation of excessive prescribing.**

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999 Calls. The Great Western Ambulance Service had recently advised practices that it would be help to reduce ambulance response times if GPs were to use the special GP hot line to summon ambulances to their patient if they had made a diagnosis, even one over the phone. The LMC was not convinced by all the comments that had been raised by practices, but was concerned that the saving of time by this method might be illusory. Common sense indicated that in many cases it would be much better for the patient or someone helping them to call 999 themselves.

- **The Secretary was tasked to reply to the GWAS Medical Director, Dr Rawstone, to express these concerns and to ask that the advice be reconsidered.**
- **Debra Elliott also agreed to take it back on the commissioning side.**

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32/2010 LISTSERVER

Nothing significant to report.

33/2010 CHIEF EXECUTIVE NHS GLOUCESTERSHIRE

The Chair welcomed Ms Stubbings and pointed out that the agenda had been specially tailored to fit her busy schedule.

Premises. There was a general feeling among practices that progress in improving practice premises and building new ones was slow, possibly because of a PCT insistence on paying no more than £150 per square foot for development. Jan Stubbings admitted that developments were taking time to progress, but denied that it had anything to do with a limit on development costs; it was much more to do with the complexity of the negotiations between the many parties involved. In times of financial hardship it should be easier to force developers to accept lower fees. The Board was committed to a 10-year programme of premises upgrades and renewals and would not walk away from it. The priorities set in 2007 still stood. The funds to cover the capital costs and running costs had been planned for. The PCT shared practices' frustrations and would attempt to quicken the pace.

The Gloucester Health Access Centre, which had recently opened in its new premises, had come in well under budget and the costs had not eroded the funding for the other development projects.

The District Valuer was independent of the PCT. Practices, and indeed the PCT, had the right to question the DV's valuation if they had good cause to do so.

PMS/GMS/Investment. The LMC were concerned that inward investment to primary care, and in particular to GMS practices, had not been made in 2009/10 because of the on-going PMS review. Debra Elliott repeated that this had been a conscious policy decision but that she expected that by 1 April this review would have reached a conclusion. Fourteen of the 30 PMS practices had elected to move to GMS from that date, and she fully expected the other practices to make an early decision. The PCT considered their current offer to those practices moving to GMS to be generous, and could not guarantee it would still be available after the current financial year.

- **Debra Elliott agreed to look into why, when more**

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patients joined a practice, the amount per patient was significantly greater for GMS practices than it was for PMS practices.

Debra Elliott reiterated to the meeting that once the situation with PMS practices had been stabilised the PCT would be able to put in train a number of improvements, such as reduction in wasteful paperwork, preparing and working to a primary care strategy that provided new money for work being transferred from secondary care, and rewarding good practice across the county.

The LMC questioned why the PCT had decided to hold back the whole of the QoF Achievement Payments until the PE7 and PE8 figures became known in June. Surely it should be possible to pay everything else promptly at the end of the financial year, even if the levels of payment would be less than in the previous 2 years?

- **Jan Stubbings agreed to consider this.**

The Future of PBC. Jan Stubbings accepted that PBC had not made the progress it might have done, but that the reorganisation of the PCT, which she had ordered and which Dr Helen Miller was leading, would result in a dedicated, high quality director with supporting staff looking after each PBC confederation of clusters. Not only would this reorganisation be carried out within the current management cost envelope but by the end of 2011/12 this envelope would have shrunk by £1M (the 4-year target set by the Department of Health).

Dr Morgan expressed the concern felt in Cheltenham that PBC savings would never amount to enough to pay the increased running costs of improved premises and asked that this policy be rescinded. Jan Stubbings said that the Board that had made that decision was still in place and was unlikely to change its mind. She felt that the Cheltenham clusters would have a stronger voice if they actually nominated a representative to attend the PEC. All other confederations had done so.

The PEC would not be enormous; Dr Miller anticipated there being 10 multi-disciplinary clinicians, supported by the executive officers and would be in place from 1 Apr.

QIPP. Jan Stubbings warned that although firm financial forecasts were available for 2010/11 the grim economic forecast meant that the future would be one of retrenchment and a drive for ever more cost-effective working. It seemed unlikely that all other spending departments of state would agree to a 19% cut in order to keep the NHS at its current funding level. The QIPP programme (quality, innovation, prevention and productivity) included primary care as one of its 10 streams; the first time that primary care had been specifically targeted to make savings. While accepting that the PCT had to implement government direction the LMC was concerned at the threat of 'micromanagement' of practices by the PCT. Jan Stubbings assured the meeting that if there was absolute evidence of micromanagement and it could be changed it would be. She wanted what was best for the 600,000 patients in Gloucestershire, and was going to find it hard enough to meet government targets and the PCT's challenging clinical aspirations in the expected financial climate without spending money on unnecessary work. She welcomed Dr Miller's reinvigoration of the PEC, which would allow clinical leads to shape policy.

Transforming Community Services. Jan Stubbings said the PCT had been tasked to provide the SHA with proposed options for separating the provider arm from the commissioning arm without forming a

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new NHS body. There were several possibilities, not all of them attractive, but a plan would be in place by the end of March 2011.

Other Issues Raised.

- Inadequate N3 Connection Speeds. There were numerous complaints that any program requiring access over the N3 broadband connection at practices, especially Choose and Book, was very slow, to the point of embarrassment, and imposed severe delays. Some 5 patient appointments per day per GP were being lost through delays in the connection. Jan Stubbings asked that LMC suggestions for justifying the £5M cost of GP COIN be forwarded to the PCT.

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

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- £500K Investment in General Practice. The LMC wondered, since the investment in GMS practices had not occurred in 2009/10 despite the money being granted by the DH, what had happened to the money and when it would be invested with practices? Jan Stubbings assured the meeting that the money had been spent, and in the area of primary care, but it was not possible to say exactly on what. Next year, once the PMS contract issues had been sorted out, it would be possible to target the spending more precisely.

34/2010 ACTIVE TOPICS

Project UTOPIA. There had been a mention in the media of bed closures at the Gloucester Royal Hospital, triggered by a premature announcement made without consultation that Project UTOPIA was to be paid for by such closures. The plan was now on hold pending review. The only ward change now authorised was a combining of the Stroke and Neurology wards which would 'close' 11 beds. The LMC reiterated that they had questioned the viability of Project UTOPIA from the outset. They also doubted whether the community hospitals could cope with the extra numbers. GPs could admit patients directly to community hospitals but needed to do so with proper referral letters and adequate drug and treatment records.

Pandemic Flu. No change – Dr Fielding reported that clearly the right process had perhaps been applied to the wrong virus.

PBC. Already covered above.

Choose & Book.

- IT Issues. The IT failings of C&B were well known and were again rehearsed. It was hopelessly cumbersome and slow, suffering from some fundamental flaws. Perhaps a speedier connection, and control of appointments by commissioners rather than the hospitals, would make for a more usable and useful system.
- Draft LES. Discussion was moved to the Closed Session.

IM&T. Dr Siva had attended the IM&T Strategy meeting that morning. The meeting discussed the implications of the Summary Care Record (SCR). Gloucestershire had been given a pilot status. At this stage the PCT intended to select a PBC cluster whose practice areas fed into a particular OOH provider, thus testing whether the information on the SCR was useful to the OOHs medical staff. A letter would be coming out on 19th April. The only information to be uploaded at this stage would be about allergens and medication. In discussion several points were made:

- Would patients be informed and offered the chance to opt out

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when future uploads of further information were being considered, or would the first decision not to opt-out be taken as being consent to share the whole medical record?

- The GPC had advised the LMC that practices did not have to get involved with this scheme. The PCT were unaware of this, and doubted it. The GPC had also advised that practices must tell patients the implications of their failing to opt out.
- Dr Gale quoted the Defence Medical Services as a shining example of how medical records for all service personnel and their dependants were held and shared electronically with great benefit to all concerned.
- Others feared that putting so much information on one system would risk losing what was, in effect, commercial-in-confidence information to potential rivals.
- **The Secretary was asked to find out the basis for the GPC advice that practices need not engage with SCR.**
- **The Negotiators were asked to discuss with the PCT the issues of:**
 - **Opt-outs for children under 16.**
 - **Payment for the extra work involved.**

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Negs

QOF. Those practices that had been due a QOF visit in 2009/10 but had been prevented by the work on Swine Flu from having one would have it in 2010/11. For those practices the Contract Framework meetings would be scheduled for the same day wherever possible. Again the aim would be to reduce the paperwork involved in QOF reporting to an absolute minimum. All other practices would still be visited for contracts Framework Meeting.

35/2010 REPORTS

Minutes of the Foundation Trust Contract Quality Group 3rd February 2010. As tabled. Once again it was noted that the meetings of the LMC and the FTCQG were so timed that the minutes of the FTCQG always arrived in the LMC just too late to be tabled at the LMC and were thus at least a month old when seen by LMC members.

Minutes of Negotiators Meeting 22nd February 2010. Noted as tabled. The PCT had some amendments to suggest, and would do so out of committee.

OOHs WG 24th February 2010. Dr Fielding, the chairman of this working group, reported that he had been informed that the chairman of GWAS would be responding positively to the LMC's letter which had been drafted by the working group. He did not think that the working group would need to meet again until a further matter should arise.

Executive Meeting 25th February 2010. As tabled

GPC News February 2010. Dr Fellows took the meeting through this report but expanded his talk to cover a recent lecture evening on pensions given in Gloucester by Andrew Dearden, a long-standing member of the Contracts and Performance Sub-Committee of the GPC. Important points to note were:

- Revalidation. Appraisals from this year would count towards revalidation, which would start roll-out in 2011. It was likely that successful engagement in 5 successive annual appraisals would be the main contribution to revalidation. The issue of funding remediation (when up to one in 20 might require it) was still

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unsettled.

- Tax Changes. The erosion of the basic tax allowance for those earning more than £100,000 would affect many GPs, but there were ways to mitigate the effect. Consulting the accountant was an obvious first step.
- Partnership Agreements. It was important that partnership agreements covered the entitlements of partners who did not wish to contribute to the NHS pension or were thinking of taking 24-hour retirement, in particular that the 14% superannuation contribution paid to the practice in the global sum was theirs to use as they wished, and was not intended to form part of practice income.
- Loss of the Square Root Formula. The BMA website now had a calculator for practices to judge the effect of the changes. Dr Simpson wondered whether anything had resulted from earlier promises that badly affected practices would be offered some sort of financial 'parachute'?
- Sessional GP Survey. Dr Fellows encouraged all sessional GPs to participate in the survey.
 - **The Secretary would cover these points in the Newsletter and provide web links as necessary. (*Secretary's Afternote: This has been done in the February 2010 Newsletter.*)**
 - **The Negotiators would raise the issue of the financial parachute for practices severely affected by the loss of the square root formula.**

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Negs

36/2010 FORTHCOMING MEETINGS/EVENTS

Negotiators meeting 15th March 2010.

South West Regional LMCs meeting and GPC Negotiators update 25th March 2010.

SW Region BMA Meeting 25th April 2010

SW Region BMA QIPP Study Evening 8th April 2010. The Chairman felt the LMC should be represented at this meeting and asked for authority to attend. This was granted.

LMC Meeting 8th April 2010.

37/2010 ANY OTHER BUSINESS

Nil

There being no further business the meeting closed at 16:51

FINAL LIST OF MOTIONS FOR 2010 LMC CONFERENCE

No	Motion
1.	That conference sympathises with the government over its need to provide health services ever more cost effectively, and accepts that this will best be done through expansion of general practice, but emphasises that this will only succeed if it is adequately funded, both as to capital and running costs.
2.	That conference recognises the increasing role in general practice played by salaried, freelance and part-time doctors and seeks strong representation for them.
3.	That conference recognises the value of replacing retiring partners with new partners, and urges practices to do so whenever possible.
4.	That conference believes the resourcing of general practices should not be based on political whims and unfairly-based patient surveys but rather on more evidence-based criteria.
5.	That conference wants extended hours to remain optional.
6.	That conference urges government to learn from the recent pandemic that adequate resourcing of practices is essential when delivering a co-ordinated pandemic flu plan.
7.	That conference believes government must invest to obtain and maintain adequate, quality OOHs services.
8.	That conference believes NHS cuts, if necessary, should fall on SHAs and PCTs rather than on front-line clinical staff.
9.	That conference holds practice boundaries to be essential, and urges that they be retained.
10.	That conference requests the extension of the Merit Award system to include primary care.