

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 13th MAY 2010

The regular meeting of the Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 13th May 2010 at which the following members were present: Dr. A Seymour (Chair) Dr. P Fielding (Deputy Chair), Dr Steinhardt (Treasurer): Drs. Bayley, Booker, Bye, Coker, Fellows, Gale, Good, Hayes, Hodges, Morton, Rigby, Simpson, Siva and Yerburgh.

Also present:

Representing the PCT:
Jackie Huck, Deputy Director

From the LMC Office:
Mr Mike Forster, LMC Lay Secretary

60/2010 APOLOGIES FOR ABSENCE

Action

Drs Alvis, Miller, Preston, Salter and Ulahannan.
Mrs Debra Elliott

61/2010 CHAIRMAN

The Chairman welcomed members, Jackie Huck as the sole PCT representative and Jane Jenkins of the BMA Employer Advisory Service. He also paid tribute to Dr Tom Morgan who had resigned his LMC post for Cheltenham.

- **Secretary to send a letter of thanks from the committee.**

MF

Tea Rota: Drs. Fellows and Hayes

62/2010 MINUTES OF THE LAST MEETING

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

63/2010 REGISTER OF INTERESTS

There were no new declarations of interest to report.

64/2010 ACUTE TRUST ISSUES

Medication on discharge. Dr Coker asked what the target amount for discharge medication in dosette boxes should be. Seven days had been mentioned. In the absence of Dr Ulahannan, Dr Yerburgh stated that the generally accepted compromise was 14 days.

Private v NHS Scrips. There had been a case of an NHS patient seen under the NHS at the Winfield private hospital who was given a private scrip rather than an NHS scrip for medication. Another case was reported where only 7 days-worth of medication had been prescribed, whereas the meeting understood that the GP's prescribing budget had been top-sliced precisely to allow hospitals to provide scrips for 28 days.

- **Jackie Huck agreed find out what the contract with the hospitals required and inform the LMC Office**

JH

65/2010 EMPLOYER ADVISORY SERVICE: A Presentation by Jane Jenkins of the BMA's Bristol Office

Jane Jenkins gave a short presentation in which she stressed that the part of the advisory service which she was responsible for was separated by Chinese Walls from the salaried GP and hospital doctors' advisory service run by her colleague Colleen Rothwell-Murray. The EAS were

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able to advise authoritatively on a number of topics, and did so more cost effectively than private companies. A print-out of her presentation is attached. Note that the well-established statutory dispute regulations have now been superseded by ACAS processes which are more flexible. She warned that although employees with less than one year's service had no protected employment rights they were protected against discrimination from the outset.

- **Newsletter item**

MF

Dr Fellows confirmed that the GPC was promoting the use of the EAS but asked whether the service was available to the partners if only one of them was a BMA member.

- **Jane Jenkins agreed to find out and inform the LMC Office**

JJ

He also wondered whether there was any help to be had for practices who were now faced with having to arrange CRB checks for every member of staff who might possibly have contact with children or vulnerable adults.

- **Jackie Huck agreed to find out what help the PCT could offer**

JH

The Chairman wondered how often partners in the county consulted the service

- **Jane Jenkins agreed to find out and tell the Office**

JJ

66/2010 MATTERS ARISING

Local Negotiating Committee (LNC). Dr Morton was unable to continue as a member of this committee but felt that the LMC had been invited onto the committee under a misapprehension of its role. It was not the representative body for all doctors, but only for GPs. On that basis it might be better to wait until the LNC had been reformed and the requirement for LMC membership was better defined.

- **Secretary to inform the LNC Chairman**

MF

PMS Practice Representation on the LMC. The Chairman pointed out that the Minutes of the last meeting, though they accurately reflected what had been said, had been overtaken by events. Since Dr Bye's practice (Locking Hill) had in fact remained in PMS the LMC had an active member from a PMS practice and thus had sufficient representation for PMS.

67/2010 FOR DISCUSSION/INFORMATION

QIPP

Background. Drs Seymour and Alvis had attended a meeting in Taunton on 8th April to receive 2 presentations on QIPP and to raise questions for 2 hours. Although there was not much detail to report at this stage there was no doubt that QIPP would be driving much of the NHS agenda for the next few years. Indeed PCT staff had been told that 80% of their work should be directly involved in implementing QIPP initiatives. It was a serious national programme in 11 parts, 8 of which had implications for primary care. Gloucestershire was looking at Mental Health for the South West. Dorset was responsible for primary care initiatives. The likely course would be to use existing funds more carefully in order to meet the growth expectations of the population. Changes had to be made, savings had to be found, but it had to be done with consideration rather than as a knee-jerk reaction. Sir Ian Caruthers had stated that LMCs could help or stand against it, but it would be better to channel the savings sensibly rather than risk a slash and burn approach.

Discussion.

- Front-Line Services. The Committee sought a definition of front

line services. It seemed that there was no such definition, although PCT management costs had a significant reduction target to meet. It was certainly hoped that administrative posts and organisations would be pruned before clinical staff. The whole healthcare picture would need to be looked at carefully and the consequences of any change thought through to ensure that by saving money in one area costs were not disproportionately increased elsewhere; the easy and obvious solution was not necessarily the right one (e.g. podiatry kept many people active at home, thus saving money not only in healthcare but in the social care budget areas.) It was important that decisions should be based largely on clinical rather than financial grounds.

- The Role of the LMC in QIPP. Patients would undoubtedly be unhappy as services reduce and even if the decision to cut services had been taken nationally it would be the patient's practice that would get the blame. A joint strategy was needed to address this. The LMC's role was probably that of the honest broker, aiming to drive up consistency and fairness. Unfortunately the ethos of practice based commissioning was for particular areas to come up with new and beneficial pathways or treatments which would be bound to increase the 'postcode lottery' in the NHS. Dr Fellows told the committee that in Avon they were developing a complete commissioning group for the whole area, and he recommended that the office keep in touch with Dr Simon Bradley in Avon LMC about it.
- Referrals. Dr Simpson suggested that as a large proportion of the NHS's money was spent or committed by GPs through referrals it would be sensible to scrutinise referral rates and patterns. Some practices were grossly overspent on their referral budget and one had to question why. Discussion on how to improve the situation brought up 3 possibilities:
 - Peer review
 - Consultant feedback in terms of 'smileys' or 'grimaces' or even 'growlies'. This was not universally liked, but it was recognised that it was useful to be able to call on a consultant to help reassure patients that a referral was unnecessary. It was a pity that Choose and Book did not facilitate this.
 - Feedback of community referral patterns to all practices. It had been tried before in the Forest over a number of years and had brought outliers to a realisation of their positions such that they had changed to get nearer to the average in the functions being measured. The PCT's Medical Director would do well to examine existing statistics carefully for patterns.
- Real Budgets. The general view was that smaller practices would be at the mercy of vagaries in patient presentation. If real budgets were brought in they should be kept separate from practice income.
- **QIPP was to become an active topic in future meetings.**

MF

Quality Accounts.

The PCT had requested inclusion of Quality Accounts on the agenda but Jackie Huck felt inadequately briefed to do more than give an overview. The PCT was preparing to examine the quality accounts provided by the Trusts for last year and it was possible that from April 2011 the same might be required of practices. This was being piloted elsewhere and the results of this experiment might affect the roll-out. The PCT assured the

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meeting that the scheme would be launched sensibly and sensitively in this county.

Unscheduled OOHs Care Committee.

This did not seem to have met for a while.

- **Jackie Huck agreed to find out and feed back to the Office.**

JH

Annual Report

The Chairman thanked the Office for producing a comprehensive report for 2009. Agreed unanimously to accept the report.

Summary Care Records

Background. Dr Fellows expressed considerable concern that the cast-iron assurance received by the GPC that the SCR rollout would be halted wherever there was still time to stop the patient information packs from being posted had not been fulfilled. He felt that it would have been possible to stop the issue in Gloucestershire but the PIPs had still been posted out. The GPC objections had been many: that there should have been an opt-in rather than an opt-out; that there was inadequate information on the possible consequences; that unauthorised people could too easily gain access to the records; that inferences could be drawn from the lists of medications; that it presented a risk to GP practices, particularly if there was a move to short term contracts; that the records could acquire commercial confidentiality if private providers of healthcare tried to take over; that there could be a risk that the information would be or become inaccurate or incomplete; and finally that there was no guarantee that when more information was due to be uploaded fresh permission would be sought from patients. In the light of these concerns the GPC considered that the roll-out of SCR was precipitate.

Discussion. Several members said they were each experiencing an extra appointment a day just to answer questions about the SCR. The numbers opting out varied considerably from very few to quite a few – but never a majority. It seemed that the more well-to-do were more likely to opt out than those from deprived areas.

Advance Care Planning

The committee suggested that the draft paper concerning advance care planning should be slightly re-phrased to emphasise that although next of kin would as a matter of good form be consulted, unless they actually held a valid Lasting Power of Attorney for Health Matters they would have no right to make decisions about medical treatment of their relative who was making the advance care plan.

- **Secretary to reply on behalf of the LMC accordingly**

MF

68/2010 LISTSERVER

The Chairman reminded the committee that elsewhere in the country PCTs were imposing more severe contracts on GPs than here:

- Merging Choose and Book into contract services in an effort to get it done for nothing. He praised NHS Gloucestershire for recognising that it was work that deserved to be paid for.
- We had been through our PMS review and had obtained reasonable terms. Elsewhere practices were being forced to engage with LESS and DESS.

69/2010 ACTIVE TOPICS

PBC.

Background. Jackie Huck informed the committee that all 5 confederation directors had now been appointed but that at this point she was unable to release who would be responsible for each area.

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Those appointed were:

- Linda Prosser, Service Director for Bristol City Council and NHS Bristol. Starting 1st June.
- Susan Morgan, currently Head of Performance at West Midlands Strategic Health Authority. Starting 1st June.
- Mark Walkingshaw, currently Director of Planning and Strategic Development at East Lancs Hospitals NHS Trust. Starting 12th June.
- Dr Peter Reader, the Chief Medical Officer and PEC Chair at NHS Hillingdon. Start date to be confirmed.
- Sarah Hughes, currently Deputy Director Clinical Development at NHS Gloucestershire will be taking a one-year secondment as a locality director, starting sometime before the end of July.

These directors would report directly to the Chief Executive. Jackie Huck said that she would not be accepting one of these posts and would instead move to part-time work from 1 July.

Discussion. The relationship of the PCT, the LMC and PBC Confederations was still undefined. The Chairman told the committee that at an earlier meeting he had suggested to Debra Elliott that these directors should be able to liaise directly with the LMC over matters of their concern, but she had been strongly opposed to this, wanting all communication to be via herself. He felt that there would be times (e.g. with the discussion of vascular screening in the Gloucester City Cluster, that the issue should be expanded to a county-wide audience through the LMC) and unless members knew of what was being suggested many good ideas would not be allowed to spread as they should.

The meeting hoped that under the new arrangements valuable initiatives would not be allowed to die through lack of support from the PCT.

They also hoped that the PCT would provide consistency of attendance at the LMC meetings. They thanked Jackie Huck and applauded her for her long and positive association with the LMC.

Choose & Book. The co-ordinating committee had been disbanded and a replacement 'Primary Care Group' which would cover PBC as well as C&B had yet to meet. It was not clear that any LMC membership of this group was envisaged, which led some to wonder whether the sidelining of the LMC was deliberate. There was one practical concern: that some orthopaedic referrals were still being sent directly to hospitals who felt they had to keep back appointments to cater for that demand. The LMC considered that as hospital staff already had to make bookings internally to C&B it should be no problem for them to input the details of these referrals and not hold any appointments back from C&B.

- **Jackie Huck agreed to discover the size of the problem and pass on this proposed solution.**

JH

IM&T.

- Dr Rigby announced that CfH had developed new software to be compatible with the new generation of smart cards, but GP practice systems had not been upgraded, although it had been introduced 9 months ago. There was now an urgent need to upgrade practices. He advised that the main thing was not to lose the smartcard.

- o **Newsletter item**

MF

- Neither he nor Dr Siva would be available to attend the next IM&T steering group on 17th July from 10:00 to 12:00 (the same day as the LMC meeting)
- Smartcard Processing. The PCT had recently decided to change the system for production of smartcards. Either practices would create their own (at a small cost in time and effort but with greater flexibility and convenience) or would have to send those needing a card to Sanger House to be processed. The PCT would no longer provide a peripatetic service. A practice had asked for the LMC's opinion on whether this represented new work for no extra reward.

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The LMC decided that on balance they welcomed the new arrangement.

o **Secretary to convey this to the practice**

MF

- Smartcard Access. Dr Gale, on behalf of those doctors working in a number of places wondered whether a smartcard would give access to a number of systems? Dr Rigby said that there were moves afoot to allow single logging on instead of the current multiple log-on system.
- Access to Hospital Test Results on-line. Nothing further had been heard.

QoF.

- Dr Fielding provided some comfortable, but off-the-record, words about the recent QOF validation process. However there had been some prevalence anomalies which in due course PBC clusters should also investigate. Depression2 was now on an even keel, with exception reporting below the national average and prevalence above the national average; in other words, people were acting responsibly.
- Aspiration Payments for 2011. Members pointed out that 34 practices had errors in their QOF achievement returns for 2009/10 which therefore affected their aspiration payments for the current year. The reduction in aspiration payments had been done by the PCT without notice or consultation and the LMC viewed this as unacceptable. The LMC felt strongly that no fault was involved, that it was wrong to penalise practices and the situation should be set right as soon as possible. They referred this to the Negotiators to discuss with the PCT on Monday 17th May.

o **Negotiators to action**

IB

70/2010 REPORTS

Glos Controlled Drugs Local Intelligence Network (GCDLIN). Three points had been raised:

- The prison service reported that the abuse of Subutex [buprenorphine] is rising rapidly
- It would be in everyone's interests if returned controlled drugs could be destroyed in the presence of a witness. There was no statutory regulation demanding it, but it would protect all concerned.
- There had been several examples of non-Home Office-approved wording on instalment prescriptions. It would be helpful to pharmacists and recipient patients that the correct wording etc is used to ensure that safe and timely dispensing can occur.

• **Newsletter item**

MF

Report of Negotiators Meeting 26th April 2010. Noted as tabled.

Executive Meeting 29th April 2010. Noted as tabled

Cervical Screening Steering Group. Dr Coker reported that uptake by Learning Disability Patients of cervical screening was only 20%. Although responsibility for invites, on the whole, had been taken over centrally, it was still the responsibility of the GP practice to send targeted information to LD patients. PCCAG had asked whether they could have access to lists of patients from the LD DES so that they could send targeted information.

• **The meeting agreed – Newsletter item**

MF

GPC News April 2010. The whole proceeding of the last GPC meeting had been embargoed, Dr Fellows could not see why. He was also concerned at a lack of clarity in the PCT's intentions regarding the

devolvement of the provider arm. His particular concern was the risk involved in grouping community hospitals with the hospital trust.

71/2010 FORTHCOMING MEETINGS/EVENTS

Negotiators meeting 17th May 2010.

Executive Half-Day Meeting 27th May 2010.

LMC Conference 10th-11th June 2010.

LMC Meeting 17th June 2010. NB this is one week later than normal

72/2010 ANY OTHER BUSINESS

nil

There being no further business the meeting closed at 16:50