GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 17th JUNE 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, Gale, Good, Hodges, Miles, Morton, Ropner, Salter, Simpson, Siva, Welch, Yerburgh and Ulahannan.

Also present (2:00 TO 2:45) representing the PCT:
Mrs Debra Elliott, Programme Director, Primary Care and Community Services
Mrs Nikki Holmes, Assistant Director (Medical and Pharmacy) Primary Care Commissioning

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

Action

79/2010 APOLOGIES FOR ABSENCE

Drs Alvis, Fellows, Hayes, Miller, Patterson, Preston and Rigby and Jan Stubbings

80/2010 CHAIRMAN

The Chairman welcomed all attendees, and in particular three potential new members for co-option: Dr Will Miles, from the Portland Practice, Dr Jim Ropner, from the Berkeley Place Surgery, and Dr Jeremy Welch who, although from the Jesmond House Practice in Tewkesbury, was willing to represent practices in the Cheltenham area until the next election. The meeting co-opted all three to represent Cheltenham, thus bringing the LMC up to full strength.

- **Secretary to send each of them a welcome pack.** **MF**

Tea Rota: Drs. Good and Yerburgh

81/2010 MINUTES OF THE LAST MEETING

Agreed, subject to:

64/2010 being redrawn to reflect that the discussion had been on how many days-worth of dosette-boxed medication hospitals should be providing patients on discharge rather than how long it should take for discharge summaries to be produced.

67/2010 – second bullet point – Dr Bradley's first name was Simon.

- **Secretary to amend and Chairman then to sign** **Office**

82/2010 REGISTER OF INTERESTS

- **Secretary to obtain declarations of interest from new members.** **MF**

83/2010 ACUTE TRUST ISSUES

Prescription of medication on discharge. Historically GPs' prescribing budget had been top-sliced to allow the acute trust hospitals to provide 28 days-worth of medication on discharge. Anything less risked the patient running out of medication before the discharge summary had arrived at the GP practice. People in secondary care seemed to have forgotten this and were prescribing for lesser periods, usually 14 days but sometimes as little as seven days-worth.

83/2010 (Cont)

- **Dr Ulahannan to remind his colleagues from the Acute Trust that it should be 28 days.** **TU**
- **Dr Ulahannan also to check whether medication, if issued in dosette boxes, should also amount to 28-days' supply.** **TU**
- **PCT to check what is laid down in the contract.** **DE**
- **PCT will ask GHT to evidence that they are providing 28 days of medication on discharge and may ask a sample of practices to confirm that this is happening.** **DE**

Private v NHS Scrips. There was a rumour that the Winfield had no NHS prescription pads.

- **Dr Ulahannan to pass on that there was a shortage of NHS prescription forms at the Winfield.** **TU**

Secondary Care Liaison. Dr Ulahannan announced that he had now taken over as County Diabetes Research Lead, and would have to resign from the committee with immediate effect. He wondered whether a clinician or a manager from the Acute Trust would provide the best form of liaison. The Chairman thanked him for his long and helpful membership of the committee. The meeting discussed the issue of his replacement after he had left. It was agreed that, although the primary contact ought to be clinical, there was merit in having management input.

- **Secretary to contact Dr Ulahannan and ask whether both could be available** **MF**

84/2010 LMC ANNUAL CONFERENCE - REPORT

The Secretary tabled a written report of the proceedings, endorsed by the Representatives. Dr Yerburgh felt that the meeting, following so closely on a General Election, had still been in a state of euphoria at losing the last government and had not yet progressed to the inevitable next stage of worrying about what the new government was intending. He stressed the support of conference to sessional GPs, the power of conference in deciding future policy (e.g. voting (albeit narrowly) not to scrap the Summary Care Record scheme) and the concerns of conference about extended hours, dispensing, revalidation and choose and book. Dr Bayley drew attention to the very narrow margin by which GPs had voted in favour of being involved in commissioning out of hours services (but not, under any circumstance, to being the providers of last resort of that service.)

85/2010 MATTERS ARISING

The Chairman welcomed Debra Elliott and Nikki Holmes to the meeting, explaining that the agenda had been drafted on the basis the Chief Executive had been due to attend. He hoped Debra Elliott would be able to shed light on those areas.

CRB Checks and the Vetting and Barring Scheme. The government had put the Vetting and Barring Scheme on hold so that voluntary registration with ISA from 21 July 2010 would no longer apply.

- **In the light of this the PCT would re-issue its guidance to practices, copy to the LMC Office** **NH**

BMA Employers' Advisory Service Advice. No reply had been received. Action closed.

86/2010 PCT ISSUES

Changes to the NHS. There was to be an NHS Configuration Conference followed by a White Paper before the end of June. The PCT fully supported the devolution of commissioning (hence their appointment of, and reorganizing to accommodate, the 5 new locality directors.) Debra Elliott admitted that PCTs were being asked to make considerable savings, especially in management overheads, and the planning for this was causing some disruption, but it was hoped that redundancies could be avoided.

QIPP. The essence of QIPP had been adequately summarised in the Minutes of the recent Negotiators' Meeting. PEC clinicians would be sitting on the QIPP Programme Board to ensure that savings when identified were clinically supportable. The PCT had to report every 2 weeks to the Chief Executive of NHS South West (Sir Ian Caruthers) on the progress of the implementation plan. The PCT was leading three-way co-ordination of effort between the PCT, Gloucestershire Hospitals Trust and the Ambulance Trust. The plans would be shared with the LMC Negotiators as soon as possible. In answer to questions Debra Elliott confirmed that the public and Gloucestershire County Council were also being kept informed.

Long-Term Conditions Audit. As part of the QIPP effort the PCT had asked practices to fill in a skills-set audit with the aim of identifying the support practices may need for the future. It was intended to tailor the support via provision of appropriate training. The same audit had also been sent to the Acute Trust. Unfortunately the helpful reasoning behind this work had not been made clear in the covering letter, and practices had complained to the LMC. Since the PCT had not explained to the LMC when the queries were raised, the LMC had felt obliged to advise practices not to complete the audit until there had been a chance to discuss it with the PCT. Practice concerns had centred around:

- A fear that they would have to pay for compulsory but unnecessary training.
- A fear that well-qualified staff might be 'poached'.
- A fear that this audit might lead to extra work being shifted to primary care without extra resources.
- That as independent contractors it was no business of the PCT to lay down how GPs trained their staff, so long as the contract was properly performed, and they questioned whether there was any evidence to prove it was not.
- That they had not been told the purpose of collecting the information.
- That some of this information was commercial in confidence.
- That the form needed to be simplified.
- Had there been clinical input to the form?

- **The PCT agreed to seek internal clinical input, to simplify the form and re-issue it with much greater clarity on why the information was required, how it would be used and the overall intention behind it.** **DE**

PCT/LMC Liaison.

On a linked, but wider, issue there was a divergence of opinion between the LMC and the PCT on matters of practice. The LMC made clear that as the representatives of GPs, and as the organisation practices turn to when they have a problem, and as the champions of patients, they were well placed to offer valid, county-wide and impartial advice on any aspect

86/2010 (Cont)

of primary health care. The LMC reiterated that this advice was offered free to the PCT and that this advice might well allow PCT initiatives (unlike the one above) to go through much more smoothly. The PCT perceived, wrongly in the LMC's view, that the LMC was attempting to set up as a 'rubber-stamp' organisation with some power of veto over PCT business; this they could not accept. The PCT also felt they had adequate advice from internal clinical resources and from PBC clinical leads. The LMC feared that such advice was not properly representative or sufficiently broad-viewed. Unfortunately, time did not permit further discussion to sort out these mutual misunderstandings and conflicts of views.

Debra Elliott confirmed that her Chief Executive, Jan Stubbings, had it in her diary to attend the LMC quarterly, and that in all normal circumstances Debra Elliott would attend every month, though she would appreciate not having to stay for the entire meeting as she was very busy. She felt sure that the PEC Chair, Dr Helen Miller, would attend whenever she could.

<u>PCT Reorganization</u>. Debra Elliott took the point that it would be very useful for the LMC and other organisations to be given details of the new PCT organisation and contact lists, starting with the locality directors, their responsibilities and their staffs. She confirmed that there would be no local offices for these directors – they would be based in Sanger House – and staffing levels would reduce. A new medical director was due to be appointed in July.

- **PCT to distribute these details.** **DE**

<u>Plans for Health Visitors and District Nurses</u>. The PCT said the plans would be complete by October. They had been presented to the PEC and to PBC leads. Some members expressed doubt about this as the PBC cluster in Cheltenham had been planning how best to use District Nurses in their area and now, unexpectedly, their plans were being shown to be nugatory work. Communications were not right yet and needed to improve. The PCT assured the LMC that they had had clinical input to the plans and agreed to share the names of those doctors they had consulted.

- **PCT agreed to provide those details to the LMC.** **DE**

<u>Timetable for Publication of New LESs</u>. The PCT confirmed that the Vascular Screening LES would be issued that week and the LESs in support of the Joint Strategic Needs Assessment services would be out in July or August.

<u>Requests for Re-referral after first Did Not Attend (DNA)</u>. It had been agreed some months ago that a patient would have to fail to attend the secondary care appointment twice before the GP could be asked to re-refer. GHT were now changing it to one DNA only, which increased cost, wasted time and was unfair to the patient. The PCT was unaware.

- **PCT to investigate what is in the contract** **DE**

Debra Elliott and Nikki Holmes apologised that other duties were demanding their presence and then left the meeting. Members expressed regret that they had had to leave before all the items of concern to the PCT had been discussed.

87/2010 SPECIFIC PCT DISCUSSION/INFORMATION POINTS

<u>Direct Paper Referrals to Orthopaedic Appointments</u>. The Committee felt that the regulations were unlikely to give hospitals or the PCT the right to forbid the making of referrals on paper.

- **Secretary to seek GPC endorsement of this view as a** **MF**

87/2010 (Cont) **matter of urgency**

Filtration of GP Urgent Admissions via the Single Point of Access. The PCT had already explained in a second e-mail how this system should work, and it seemed to make sense. It would come into effect on 1 July, so the meeting felt that it should be monitored then to see how it worked in practice.

Screening of GP Urgent Admissions from Care Homes to Hospitals. The committee considered this plan and thought it sensible and helpful.

Unscheduled OOHs Care Committee. At the May meeting the PCT had been tasked to find out whether this committee still met; no answer had been received.

88/2010 GENERAL DISCUSSION/INFORMATION

e-Discharge Summary Project. The project was to provide community hospitals with an electronic system that would generate discharge summaries within the required 48 hours. A trial in June would involve a few practices for 4 weeks after which the scheme would be considered for roll-out to hospitals. The paper had been circulated to the LMC by NHS Gloucestershire Care Services with a request to note the progress and endorse its continuance. The Chairman asked those members who worked in community hospitals to consider it and make comments to the Secretary within a week, after which the paper would be deemed unexceptionable and the Secretary would so confirm to the originator.

- **Comment to Secretary – nil returns not required.** **All**
- **Secretary to confirm to originator** **MF**

Out of Hours (OOHs). Dr Haseler had written to the Office expressing her concern that the LMC was not properly representing GPs involved in OOHs. The LMC acknowledged this, but considered that with the likely return of OOH responsibility to GPs in the near future the LMC would, inevitably, take a greater interest in it. They felt it would be prudent to await the government's proposals before making firm plans.

89/2010 LISTSERVER

The new Medical Director in Kent had suggested that GP's income figures should be shared in a spirit of openness. The LMC was not convinced. Debate on the ListServer had been divided.

90/2010 ACTIVE TOPICS

PBC.
Dr Fielding had been dropped from the circulation on this subject and would try to get back onto it, but at present had nothing to report.

Choose & Book.
There had been no formal meetings. Dr Fielding had heard that in other areas the PCT had tried to remove the C&B funding with the aim of making practices go on using it as part of their normal work. The LMC considered that this was not right and that any such move should be resisted.

IM&T.
Dr Siva said that there had been no meetings and he had nothing to report.

QoF.
Dr Fielding stated that the QOF Spot Checks programme had now been issued and he understood one practice would be asking for LMC support

90/2010 (Cont)

via the Office. He asked all members to be ready to answer the call.

Appraisal.
98% of appraisals were completed last year (2009/10). The rules for getting onto the Gloucestershire Performers List was that a doctor must have worked at least 30 four-hour sessions in an environment with a robust clinical governance framework. Though arguable, this definition probably ruled out doctors from Europe. All appraisers would have to meet this standard also. Similarly, if a GP were to go abroad for 2 years the Deanery would have discretion on whether retraining would be needed. He had it on good authority that the rules would be applied with sensitivity and good sense.

Revalidation
The government had deferred revalidation until 2012 but the first year for the 5-year revalidation count was still 2009/10. We were now in the second year. It was also clear that, for better or worse, the Responsible Officer would be the Medical Director at the PCT.

- **Dr Fielding to issue by the end of June a checklist of evidence for revalidation** — **PFld**

The current appraisal toolkit was still valid but would not be suitable to support revalidation. Although the SHA was funding it, the Deanery's toolkit has not yet been approved for use as the preferred provider.

91/2010 REPORTS

Report of Negotiators Meeting 17th May 2010. Noted as tabled. The next major tranche of work would be to sort out the Miscellaneous LES, as should have been done 2 years ago.

Executive Half-Day Meeting 27th May 2010. Noted as tabled.

GPC News May 10. In the absence of Dr Fellows on leave, noted as tabled.

Deanery Meeting 15th June 2010. The Secretary gave a brief outline of the meeting. It had been called to define a common method within the whole Deanery area (Gloucestershire, Avon and Somerset) of providing support for those few GPs found by appraisers to be in need of that support. The levels of support, the target population, the costs etc had yet to be defined. The Executive would consider it further and bring it back to the LMC.

- **Executive Agenda** — **MF**

92/2010 FORTHCOMING MEETINGS/EVENTS

Chairman 1:1 meeting with Debra Elliott – 29th June 2010.

Executive Meeting 1st July 2010.

Negotiators meeting 5th July 2010.

LMC Meeting 15th July 2010. Unusually, this is one week later than normal.

93/2010 ANY OTHER BUSINESS

Dr Isaac had raised the question of a new computer system in Stroud Hospital that would only support the discharge of patients and did not cater for those occasions when clinically the A&E or MIU should be taking a second look at the patient's condition (e.g. complicated dog bites). The main issues were clinical governance and funding. Since Care Services were the commissioners and the terms of the contract must

93/2010 (cont) govern the development of any computer system the LMC wished to write to their Chief Executive to express its concern.

- **Secretary to draft a letter to Paul Wilson, copied first to Dr John Salter.** **MF**

There being no further business the meeting closed at 16:40