GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

MINUTES OF THE MEETING ON THURSDAY 10th JANUARY 2008

The regular meeting of Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 10th January 2008 at which the following members were present:
Dr. A Seymour, Chair, Dr. P Fielding, Vice Chair, Dr. S Steinhardt, Treasurer
Drs. Bayley, Booker, Bye, Coker, Fellows, Gale, Good, Haseler, Hollands, Morton, Patterson, Rigby, Salter, Simpson, Siva, Stone, Ulahannan and Yerburgh.

Also present:
Representing the PCT:
Mrs Jackie Huck, Deputy Director Community Services & PBC
Mrs Sue Adams, Assistant Director, Primary Care & Development
Dr. Tony Walsh, PEC Chair
Mr Stuart Sedgwick-Taylor, Head of Commissioning Gloucester & Tewkesbury Locality

LMC:
Mr Mike Forster, LMC Lay Secretary
Mrs Sue O'Sullivan, Administration

1/2008 APOLOGIES FOR ABSENCE
Mr Simon Hairsnape. (See also 10/2008)

2/2008 CHAIRMAN
Dr. Seymour welcomed Stuart Sedgwick-Taylor (for the Choose & Book discussion), Jackie Huck, Tony Walsh and Sue Adams to the first meeting of the New Year. A few colleagues would be joining the meeting as observers later in the proceedings (Dr. K P Bhargava and Ms Eve Beard, Practice Manager).
Dr. Seymour apologised for his absence from the December meeting due to a very painful dental condition.
A letter of thanks had been received from the Cameron Fund acknowledging receipt of the £300 donation from Gloucestershire LMC.
Tea Rota – Drs. Fellows and Booker

3/2008 MINUTES OF THE LAST MEETING
The minutes of the December meeting were accepted as a true record and duly signed.

4/2008 REGISTER OF INTERESTS
No member present had any interests pertaining to the January agenda.

5/2008 ACUTE TRUST ISSUES
Dr. Ulahannan had no issues to bring to the Committee from the Acute Trust and the Committee had no burning concerns for him to take back. Dr. Seymour thanked Dr. Ulahannan for attending, if only briefly!

6/2008 MATTERS ARISING
- **LMC Revised Constitution**

The Lay Secretary had amended the Constitution in line with concerns raised at the December meeting i.e. paragraph 10. A copy of the final draft was in members' packs and had also been sent to the PCT for consideration at their Board meeting on 31st January 2008. Sue Adams and Jackie Huck saw no reason why the PCT should not accept the changes.

The LMC Election based on the new Constitution would be held on 6th March 2008 and the new Committee would convene for their first meeting on 10th April 2008.

7/2008 FOR DISCUSSION

- **Extended Opening Hours – Government policy**

The Chair announced that the discussion on Extended Hours would be held in the Closed Session, but he reported that the PCT wished to keep a close working relationship with the LMC. Dr. Simpson agreed that the PCT did have a role to play in Extended Hours, to which Dr. Walsh responded that the PCT had tried to think out of the box with some innovative work along the lines of Walk-In Centres, how to hit targets without impacting on Primary Care etc. However the Government agenda on Extended Hours had changed and all that had gone out of the window.
Dr. Fielding said that the LMC would be vital in the survival of the PCT; Dr. Bayley hoped, using the Titanic analogy, that the LMC were not just the orchestra on the PCTs sinking ship.

Choose & Book

This item had been moved up the Agenda to enable a lengthier discussion. Mr Stuart Sedgwick-Taylor opened the debate by drawing attention to a paper circulated to members at the start of the meeting. A few minutes were allowed to enable members to digest the essence of the paper. Stuart Sedgwick-Taylor pointed out that there had originally been 4 Methods to consider but he had taken the decision to remove Method 3 (i.e. the Hospital operating a booking service), as he did not consider it viable. There were thus only 3 methods for discussion.

- Method 1 – PCT Booking Service
- Method 2 – PBC Cluster Booking Service
- Method 4 – Mixed Model

Time was not on the PCT's side; they had to be seen to be delivering on C&B. They were getting weekly phone calls from SHA enquiring about PCT achievement of targets. This underlined how important trying to attain the 90% goal was. Quite a lot of practices were doing well, attaining 60% - 70%. Something needed to be done rapidly for practices achieving only 30%. It might be that only 1 or 2 partners within the practice were actually using C&B!

Dr. Rigby, the LMC representative on C&B was asked to voice his thoughts. He felt that the proposed stamping of every single referral with an UBRN had nothing to do with C&B but everything with being seen to meet a paper target. The PCT were trying to achieve this without any collateral damage but there would be errors because of the limited timescale.
A table circulated to members during the discussion showed that no Gloucestershire practice had achieved target.
Stuart Sedgwick-Taylor agreed that any practice achieving 70% was probably doing all they could. Dr. Hollands again raised the question of lack of feedback from the PCT on practice figures. How could work be done to improve areas if practices had no guidance on where they were falling short? Dr. Salter totally agreed with Dr. Hollands: how could he improve on the unknown! Perhaps the PCT Booking option was a good option. Dr. Bye stated that he was a total C&B unbeliever! Dr. Good said his practice was all C&B but had only achieved 50%; if the hospital stamped a UBRN on every referral would his figures improve? Dr. Rigby replied that less than 85% of referrals go to GHT.
Dr. Fielding felt that the Methods (1, 2 & 4) tabled were perhaps a way of streamlining the process.
Mr Sedgwick Taylor said that converting paper referrals to UBRNs was a debate to have with Clusters. Referrals out of county to, for instance, Worcester would not be counted.
Dr. Haseler thought that sending a fax referral to the PCT involved the risk of it going astray, but if sent to the hospital the risk would be reduced. Mr Sedgwick-Taylor felt the PCT employed competent people who could manage such a system. On costs he stated:

- £8 per converted UBRN
- A booking service would be less costly, approximately £6.

7/2007 cont.

Dr Bye's personal view was that siting of the UBRN stamp at GHT would make little difference. If the PCT didn't achieve the target then the whole process had undermined GPs and was doomed to failure.

Dr. Yerburgh believed that if the 90% target were reached by the PCT for only a day or a week, then they would be seen to have hit the target. Mr Sedgwick-Taylor agreed that though they might achieve the target momentarily on the 31st March a dramatic fallback come April 1st would worsen matters. Jackie Huck said she would like to see the PBC route taken; Dr. Salter asked whether that fudge would be acceptable. It would because it was all about UBRNs.

Dr Gale, with his cynical hat on, thought that the PCT booking route would be a centralised referral management under another name!

Following further discussions around the table, Dr. Fielding's view was that Option 1 seemed to be the only way forward. The same system had been trialled successfully in Somerset. Method 1 could be adopted to the end of March 2008 and then taken to Clusters and negotiated.

All practices currently engaged would be paid in full but practices not doing so would not get paid.

To summarise, Dr. Seymour stated that Model 1 was the most acceptable proposal, certainly in the short term. Mr Sedgwick-Taylor would take this back to the PCT.

Action: Mr Sedgwick-Taylor

- **NHS Finances**

This item had arisen out of a PBC Clinical meeting. Mike Forster had prepared a short paper covering the salient points.

Last financial year Gloucestershire Health Community was identified as having a £40m projected overspend and many draconian decisions and statements were made on that basis to try and save money. This year GHT were projecting a £5m surplus, and the PCT were projecting a £2.8m surplus plus a £3.7m contingency.

Jackie reported that questions had been asked as to how the PCT got from a deficit position to the position it was in now. The PCT had perhaps been remiss in not communicating this to practices.

There had been significant deficit across the 3 former PCTs; a lot of the deficit was non-recurring. Everyone was aware how the PCT put painful/difficult measures in place to try to turn the situation round. Since going from 3 PCTs supporting 3 Boards and 3 PECs, to 1 PCT cost savings had been made. Dr Fielding said that the LMC had asked on a few occasions to be more inclusive concerning audit trails. Jackie reported that the PCT Financial Director, Sarah Truelove would be very happy to attend an LMC meeting to give a 10-minute presentation on the PCT position. The offer was accepted.

Action: S Truelove to be invited to attend LMC meeting

Dr. Rigby moved on to question the PCT reps about PCT buildings, Victoria Warehouse, Highnam, Arle Road, and Brockworth (temporary) and now yet another was currently under construction at Brockworth.

Jackie replied that there was a strategy of reducing residual leases and shoehorning everyone into buildings that were still leased. They would be gradually losing leases and eventually move over to the new Headquarters at Brockworth. Victoria Warehouse (the Docks) was a bit different. Each floor had a separate 20-year lease.

- **OOHs**
  - **Complaints to Ambulance Trust**

  Dr. Patterson reported to the Committee 2 complains, one from her practice and one from a constituent (Cirencester):

  - One involved a 40-minute wait for an Ambulance

7/2008 cont.

The patient had been treated with IV Frusemide and needed urgent transfer to hospital for further treatment and monitoring. An ECP responded to the patient, and an ambulance was called but arrived with only 1 paramedic. The patient, who was seriously ill, could not be managed by 1 paramedic so had to wait for a further ambulance manned by two paramedics.

- Another event involved a 999 call

A patient collapsed in the surgery and following assessment staff were asked to call 999. After 20 minutes the ambulance had still not arrived and on enquiring where the ambulance was they learned that the call had been downgraded as the patient was at a GP surgery.

Dr. Patterson had since had a response from the Ambulance Trust denying that the 999 call had in fact been downgraded. Dr. Walsh reported that he had had similar experiences and asked that Critical Incident Forms be completed and forwarded to the PCT every time such an incident occurred. It was well documented that the Ambulance Trust was severely understaffed and the PCT were keen to move this forward: completion of Critical Incident Forms was vital. Members wondered whether the Critical Incident Form could be made available on the PCT website? *[Secretary's Afternote: a copy of the form has been scanned into the Office server and can be copied to you if required. Paper forms can be obtained in bulk from the PCT, Jennifer Thomas at Governance and Risk, GPCT HQ Brockworth.]*

Dr. Bayley said there appeared to be much more on-site treatment in Gloucester City, this, she felt was inappropriate; patients should be taken to A&E to free up ambulances. Dr. Fielding quoted an incident where a bottle containing an innocuous substance was dropped at his surgery and the Ambulance, Fire and Police arrived in minutes!

Dr. Hollands agreed to feed back concerns to the next Clinical Governance meeting. It was also decided to invite Ossie Rawstorne to the April LMC meeting.

It was agreed to write to the PCT with the Committee's concerns.

Action: Letter to the PCT
Invite Dr. Rawstorne to the April meeting

- **Motions to Annual Conference – gathering topics**

The Lay Secretary and Chair drew attention to the 2008 Annual Conference and the need to consider any Motions Gloucestershire wanted to put up to the GPC. Members were asked to think about any issue they wished to raise in the period between the January and February 2008 meetings.

- **Forthcoming Elections**

Noted.

8/2008 ACTIVE TOPICS

- **PBC**
  - ***Clinical Leads Meeting***

Dr. Haseler reported on a meeting she had attended on 20th December 07.

Risk sharing

There was a pool of money set aside for high cost patients. However it is not clear which sort of conditions are appropriate to call on this money.

- One-off high cost e.g. bone marrow
- Chronic disease with frequent admissions
- Unusual patients e.g. regular injections for porphyria

Stuart Sedgwick-Taylor and Dr Graham Wilson would look at the patients initially over £20k and if this pool is too large, patients over £30k to try to identify the types of conditions involved.

8/2008 cont.

Fair share allocation
The rules last year were that there was a national tool and that 10% margins had to be ignored. This highlighted about half a dozen practices and ignored a lot of others that were wide of fair share.

This year's formula had not yet been released but was locally adapted by Ruth Wain, informed by feedback from the Improvement Foundation afternoon.
Dr Drysdale was unhappy about the use of this data in this way, as it had been said it would not be used for policy decisions. The fair share formula would be brought back to the Clinical Leads meeting for explanation then widely disseminated.

Dr Foster Tool
It was important to focus, because otherwise it took too long to achieve too little. There had been a debate about use of consulting agency to help focus and the use of this data for this purpose. The PCT would check on confidentiality issues.

There had been a question regarding Public Liability Insurance for decisions made by commissioners that was not really answered.

The Committee felt that PBC should be part of the accountability framework – clarification was needed from Jackie Huck.

Jackie Huck responded that National Fair Share had come out but she had not had time to look at it. Work was being done at the dry business end and would then move onto clinical issues.

Planning
The Strategic framework and LDP had been presented and discussed.

The National Operating Framework had 5 key areas

1. **Improving cleanliness and reducing Hospital Acquired Infections** – MRSA and C Diff.
2. **Improving access** – 50% GP practices with extended opening. The PCT was trying to negotiate for 50% of population with more creative solutions. The 18-week target is for 90% admitted patients and 96% of non-admitted. There were also targets for dental services.
3. **Keeping adults and children well** – cancer prevention/HPV immunisation/extending screening/NICE/smoking and obesity/CVA – lot of work.
4. **Experience satisfaction and engagement** – whole host of things to raise confidence.
5. **Preparing to respond to a state of emergency.**

- **IM&T**

Dr. Rigby urged practices to show the PCT Assessors all their out-of-date hardware when they visited. Dr Bayley said her practice was unable to run any searches at all; and they were not the only ones.
Sue Adams had not received any information on the IM&T DES.

- **Choose & Book**

Dr. Salter stated that he was no longer allowed to choose a gynaecologist; it had to be generic. He had phoned Mark James to complain but Mr James had not heard of the new rule. Mr James reassured Dr. Salter and asked that he still indicate which consultant he wished his patient to see and the booking office would try to set the appointment with the nominated consultant. In essence ignore the letter.
Dr. Salter wasn't sure what happened with bookings for paediatricians. It was felt that this must be a Hospital Trust issue i.e. trying to fill up all consultants' bookings. It was agreed to liaise with Dr. Ulahannan and Dr. Bayley would take to the Medical Staff meeting on 17th January.

Action: Pass to Dr. Ulahannan
Dr. Bayley to take to Medical Staff meeting

- **Access -** Would be covered in the Closed Session under Extended Hours.

9/2008 REPORTS

- **GPC M5**

Noted,

- **Office Report**

Noted.

10/2008 ANY OTHER BUSINESS

Jackie Huck informed the Committee that Mr Hairsnape had been temporarily seconded to Worcestershire PCT from the 1st of February for 1 year. Interim arrangements had to be agreed to cover his role. Nikki Tew would cover Sue Adams' role during her maternity leave. Dr. Seymour, on behalf of the Committee, wished Sue Adams good luck for the future, as this would be her last LMC meeting for the time being.

11/2008 FORTHCOMING MEETINGS/EVENTS

- 15th January 08 – LMC visit Gloucester
- 28th January 08 – LMC/PCT Negotiators meeting
- 29th January 08 – LMC visit to Churchdown
- 31st January – Executive meeting
- 5th February – LMC visit to Tewkesbury

Following a closed session, the meeting ended at 4.45 p.m.

OFFICE REPORT JANUARY 2008

Retirement from the Medical List for superannuation purposes

Dr. K W Curtis, Principal GP, Winchcombe Medical Centre, Winchcombe, Cheltenham intends to retire from the practice for superannuation purposes. Last working day 3rd January 2008 and Dr. Curtis will return to the practice as Senior Partner on 7th January 2008. Dr. Tribley will assume the role of Senior Partner from 4th to 6th January 2008.