19TH February 2015

All Executive Officers

MINUTES OF AN LMC EXECUTIVE OFFICERS' MEETING HELD AT THE LMC OFFICES ON THURSDAY 19th FEBRUARY 2015

Present:

Dr P Fielding	(PF)	(Chairman)
Dr S Alvis	(SA)	
Dr R Hodges	(RH)	
Dr J Hubbard	(JH)	
Mr M Forster	(MF)	(Secretary)

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ITEM 1 – APOLOGIES

Dr Yerburgh

ITEM 2 – MINUTES OF THE LAST MEETING (22nd January 2015)

Agreed.

ITEM 3 – MATTERS ARISING

Gloucestershire LMC Conference 19th May 2015 at the Hatherley Manor Hotel. The theme was confirmed as The Future of General Practice in Gloucestershire. A warning about the conference had gone out to practices. Twenty five names were on the list of attendees so far.

- The Area Team were considering holding a meeting about the Prime Minister's Challenge Fund in the same place that morning, and the Executive thought that would be a good idea, particularly if:
    - NHS England could pay for some of the support (presentation equipment and a share of the lunch costs)
    - The CCG could pay for some locum cover as they do for Programmed Learning Time to enable practice representatives to attend.
- LMC Member attendance. LMC members should attend the afternoon ex officio and should therefore be paid at LMC rates to do so.
- Approach. To provide a balanced, positive approach to federation, and to clarify exactly what federation means and how it could be set in train.
- Comparison with the Avon LMC event 10th February. A quick report had been issued, *[and is attached at Annex A]*.

ITEM 4 – LMC BUSINESS

LMC Conference Motions. The fifth draft was considered, some minor amendments made and the result in its final version (Annex B) would go to the LMC meeting in March. **Sec**

February Newsletter. The content was agreed subject to minor editorial changes

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and deletions. LMC Finances. The Treasurer confirmed that there was a substantial excess of income over expenditure, and this was greater even than the previous year. The Executive discussed a number of options: • Raising the LMC Rate. Subject to discussion with the Office Manager and the Accountant the Treasurer proposed an increase to £77.50 an hour, which would roughly equate to the CCG rate. • Pay for office staff. This could be put to the full committee also. *{The Chairman arrived at this point.]* • Safe House. The committee had turned down the offer some years ago as it was too expensive. Now perhaps it would be affordable, and useful for our GPs. • Increased attendance at Negotiators meetings. The Chairman had found chairing the Negotiators Meeting as well as actually conducting the negotiations had been challenging. He therefore wanted to increase the size of the LMC delegation by one. • Branding of the LMC. Dr Hubbard agreed to work within his Executive Honorarium to design in detail the branding that should cover all aspects of the LMC's work o Folders. For use at formal meetings. o Website. Which, in the light of current experience needed a fresh look and overhaul. o Newsletter. Should be more closely linked with the website. o Pens etc. Co-commissioning. Gloucestershire GP practices had given a 90% vote in favour of the CCG taking delegated authority for co-commissioning. It was the only CCG in the south west that had had no votes against. The CCG was one of 64 in the country which had been granted that honour. There would be a need to establish new working relationships with the CCG and NHS England. Meetings with Sean Elyan. It would be enough if two members of the Executive, plus Dr Ian Bye, should attend. The best days were Tuesdays. Dr Elyan might wish to bring another Acute Trust representative, and that would be fine. The Secretary would arrange a suitable date with Dr Elyan in March.	**Sec**
Public Health Enhanced Services. April would mark the start of the second year in which the former enhanced services would be continued largely unchanged. For 2016/17 funding would no longer be ring-fenced and the LMC would need to discuss in great detail with Karen Pitney during the coming year to ensure that practices continued to receive adequately resourced work into the future.	**All**
Publication of Mean GP Net Earnings. One of the requirements in the new regulations was that practices would have to declare how many full time and part time GPs they had. There was no official definition of 'full-time'. Pragmatically 8 sessions of clinical time was taken by many practices as being full time (administrative work being in addition.) Dr Hubbard suggested that using 'sessions' was less accurate than actual timings, which might be derived from clinical systems or from smart card usage. The Secretary agreed o find out what	

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was available via the LMC Listserver.

Leg Ulcers. The Secretary would draft a letter for the Chairman to send to practices extolling the role of the LMC in negotiating the payment by the CCG of approximately £1500 per patient with leg ulcers per year, backdated to April 2014 and continuing until some other provider could be contracted to take over the service. All practices should note the definition of complex leg ulcers (which would be attached to the letter) and keep careful note of those treatments which they administer in future. **Sec**

Nursing Homes. The Chairman and Treasurer had been at a meeting with Dr Mearns and her superior officer to discuss the concerns the LMC had about the way a certain practice had bene treated. Dr Alvis agreed to feedback to the practice. **SA**

ITEM 5 – PREPARATION FOR NEGOTIATORS MEETING 26TH FEBRUARY 2015

Administration.

Attendee	Car parking space
Dr Fielding	109
DrHodges	110
Secretary	111

CCG Matters.

- Leg ulcers .....(PF)
- Practice nurse training – CCG to lead
- OOHs concerns over manning .....(PF)
- Dermatology and liquid nitrogen.....(RH)
- Occupational health service for GPs and their staff .....(PF)
- IFR funding – re-referrals.....(PF)

Joint Matters.

- Update on transfer to @nhs.net.....(PF)
- Out of Area registration.....(RH)
- Co-commissioning – the next steps.....(PF)
- Workforce issues (c.f. the RCGP's report).....(RH)

AT Matters.

- Collaborative arrangements – action on NH - .....(PF)
- Feedback on CQRS problems.....(PF)
- QOF payments – letter to practices?.....(PF)
- Appraisal for locum GPs.....(RH)
    - At least two months' notice needed
    - Procedure for assigning to different appraiser.

ITEM 6 – ANY OTHER LMC BUSINESS

Nil

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ITEM 6 - DATE OF NEXT EXEC MEETING Thursday 19th March 2015 preparing for a negotiators meeting on 26th March 2015.	**All**

M J D FORSTER
Lay Secretary

Annex:
A: LMC Motions – Final Draft

ANNEX A TO
GLOS LMC EXECUTIVE MEETING MINUTES
DATED 19th JANUARY 2015

NOTES OF A CONFERENCE ON THE FUTURE OF GENERAL PRACTICE HELD BY AVON LMC AT THE HOLIDAY INN FILTON BRISTOL ON TUESDAY 10TH FEBRUARY 2015

Above all look after your core GMS or PMS contract and its services; those contracts can last for ever. APMS (3 to 5 years, at most a 10 year span) is the default alternative and is very unattractive.

Define your aims clearly. 'United we stand…' but there is no such thing legally as a Federation. Care has to be taken to identify what exactly the potential participants want to achieve and then set up the right organisation to promote those aims. It is worth taking legal advice to get a watertight set of documents – off the peg cheap company shells are not appropriate for GP practices.

Advantages. Working at scale can:

- Include closer working relationships with other health and even social care professionals.
- Allow a degree of specialisation within different parts of the group to allow the group as a whole to bid for other rewarding work outside the current contracts.
- Take time and a lot of effort to put together, but it is worth it in the end. There were talks from the Midlands Medical Partnership (MMP) and the Vitality Partnership, both of which stressed that collaboration in the end increased job satisfaction and take-home pay. MMP, for instance, has taken 6 years to reach its current size.
- Work for geographically close practices; no solution was suggested for rural practices.

Options. There are many different approaches to working at scale or (to use the latest jargon) in 'Collaborative GP Networks'. (The BMA has just issued a guide with a full description and a list of advantages and disadvantages of each):

- Super partnerships (e.g. MMP)
- Companies limited by shares (e.g. the Gloucestershire GP Provider Company Ltd)
- Private company limited by guarantee (theoretically applicable but unlikely to be appropriate)
- Limited Liability Partnership (LLP) (not currently available to GMS practices)
- Social Enterprise Organisations (which usually have to plough profits back into the organisation rather than being returned to members.

Note that organisations of different types can be 'nested' within each other.

Off the Shelf IT Assistance to overloaded practices. There are new IT applications or web-based programmes which can help practices reduce the current overwork. 'WebGP' provided by the Hurley Group was particularly striking and is about to be trialled in one Avon locality.

Avon LMC. Avon LMC announced out of the blue at the meeting that they had formed a shell provider company, likening it to a car in the garage with the engine running and lights on but without a driver or navigator. They invited feedback and got blank amazement instead.

ANNEX B TO
GLOS LMC EXECUTIVE MEETING MINUTES
DATED 19th JANUARY 2015

LMC CONFERENCE 2015 – FINAL DRAFT

	Motion	From
1	That Conference is not surprised at the low uptake of flu immunisation among staff working in General Practice, and once again insists that: i. A full, comprehensive occupational health service that provides appropriate immunisations be reinstated for all primary care staff. ii. Protection of NHS staff be included as a valid reason for immunisation under the flu programme and be matched with an appropriate fee structure.	TY
2	That Conference notes with concern the increasing incidence of Hepatitis B in the UK and, whilst welcoming the fully resourced package for high risk neonates, calls on the GPC to: i. Explore and negotiate whether a fully resourced immunisation campaign is now necessary in the UK as it is in many other countries. ii. Insist that Hep B immunisation for high risk patients, healthcare workers and exposure-prone workers be properly funded.	TY
3	That Conference calls on the GPC to negotiate improvements to NHS Choices so that it becomes fair and fit for purpose: i. Only registered patients or previously registered patients of the practice should be allowed to make comments. ii. Those commenting should be identifiable to the practice to enable comments to be followed up. iii. Comments should be limited to one per patient per year. iv. A much greater emphasis should be placed on the risk of defamation and robust action should be taken against the perpetrator where defamation occurs.	MF/TY
4	That Conference believes the people of the UK will never forgive the government that brings about the collapse of General Practice and calls on the GPC to increase and improve communications to support General Practice as much as possible.	WM / TY
5	That Conference believes patient care would be improved were practices to be allowed to offer 'top up' private services to their NHS patients and requests that the GPC include this in their contract negotiations.	JH
6	That Conference believes that Limited Liability Partnerships could reduce the stress involved in running a practice and would encourage GPs to become partners.	JH
7	That Conference suggests that some of the fines levied on banks should be used to improve NHS funding, specifically in primary care, rather than donating it all to charities.	

8	That Conference has no confidence in CQC and i. Believes they have demonstrated time and again their inability to act effectively within their remit in a fair and proportionate manner. ii. ii Consistently demonstrate an intimidating and uncaring attitude towards practices. iii. iii So requires GPC to seek the withdrawal of CQC inspections from General Practice.	TY / MF
9	That Conference believes the practice of medicine has moved too far from being an art and too far towards being a science and asks the GPC to explore ways to reverse this trend.	IM
10.	That Conference is dismayed that since 2008 Coroners have demanded reports from GPs yet the GPs have had no right to adequate or appropriate payment for the work involved, and calls on the GPC to seek correction of this injustice.	IS
11.	That Conference is very alarmed both at the detail that has been demanded in the Workforce Minimum Data Set and also at the short time being allowed to complete it and so: i. Questions the expected validity and benefits of the survey. ii. Wonders why more extensive use is not being made of existing workforce data. iii. Seeks the withdrawal of the Workforce Minimum Data Set.	TY/MF
12.	That Conference believes that allowing GP partners access to the goodwill in their practices would be the most effective way to enable general medical practice to evolve to meet the challenges of the future.	RH