23rd October 2015

All Executive Officers

MINUTES OF AN LMC EXECUTIVE OFFICERS' MEETING HELD AT THE LMC OFFICES ON THURSDAY 22nd OCTOBER STARTING AT 12:30

Present:

Dr P Fielding	(PF)	(Chairman)
Dr Sean Elyan	(SE)	(Medical Director, Glos Hospitals NHS Foundation Trust)
Dr R Hodges	(RH)	
Dr J Hubbard	(JH)	
Dr T Yerburgh	(TY)	
Mr M Forster	(Sec)	(Secretary)

Action/Lead

ITEM 1 – APOLOGIES

Nil

ITEM 2 – GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST ISSUES

Communications between primary and secondary care. Pressures on both sides meant that time and effort should be saved in making communications as slick as possible in both directions.

- Rebooking appointments. One particular stressor was that patients who miss a hospital appointment come to the GP for a fresh referral. The LMC wondered whether the patient might be allowed to rebook the appointment direct thereby saving significant numbers of GP appointments. Dr Elyan considered that patients missing a first appointment and those missing a follow-up appointment should be treated differently as the hospital's knowledge of the patient's condition etc was better in the latter case. However, he agreed to talk with consultants to find a simpler system ..... **SE**
- Intra-hospital referrals. The cases in which the hospitals were now allowed to refer from one consultant to another were strictly limited. Both sides could see that occasionally better treatment for the patient and more efficient use of time and resources might often be achieved by greater use of intra-hospital referrals. However this could only be negotiated jointly with the CCG..... **LMC – Negs**
- Delays in answering phones. Examples were provided from the Ophthalmology department of GPs having to hang on for half an hour before a phone was answered. There was a feeling that some times of the day were worse than others (e.g. at the end of morning surgery between 11:00 and 12:00). Dr Elyan would look into this..... **SE**
  From the other side Dr Elyan complained that frequently calls from a surgeon to a GP were not put through by GP receptionists. The reasons for this were understandable but frustrating. He felt that the hospital should have a phone number in each practice where they could be confident of getting through quickly and that calls from surgeons should be prioritised within practices. The LMC agreed to provide a list of such phone numbers and to suggest to practices that they might wish to

	Action/Lead
arrange for consultants' calls to be given suitable priority	**LMC**
• LMC Suggestions. The tabled list of LMC suggestions for improving communications between primary and secondary care had been shared by the Acute Trust with the CCG, whose GP members felt that the suggestions were inappropriate. The LMC would therefore take this up with the CCG	**LMC - Negs**
Winter pressures. Dr Elyan mentioned that the Resilience Group had prepared a winter plan but was surprised to hear that the LMC had not seen it..... Since the hospitals were occasionally at 105% bed occupancy already the prospect of increased winter pressures was daunting. There had also been a continuing increase in A&E attendances even after the new OOHs contract came into force.	**LMC - Negs**
Information Technology.	
• The new hospital IT system (Smartcare) had the ultimate aim of going to paperless records. It would be introduced in two phases, respectively in May 2016 and November 2016. The intent was that it should be integrated with JUYI. Historical data would not be ported across but would remain accessible. Since information was hard to obtain from the Clinical Priorities Forum Dr Elyan agreed to keep the LMC informed of progress	**SE**
• Imaging. Under the current system if a GP ordered some imaging then no-one in the Acute Trust could see it unless the GP requested GPCare to upload it. He asked the LMC to publicise this.....	**LMC - NL**
Other matters.	
• Seven-day working. While it would increase costs by some 2% the hospitals were already working 7 days a week in some departments so the change would be manageable.	
• End of life Care. There had been some 'heroic assumptions' about what primary care could deliver for end of life care.	
• Single Point of Clinical Access. The nurses running the SPCA were doing a good job within their training limitations. It was a pity that doctors were not often available in the SPCA.	
• Ambulatory Emergency Care. Dr Elyan hoped that this service would be publicised; it provided good service but was under-used at present.	
Dates of future meetings. Dr Elyan intended to bring with him in rotation the four heads of the clinical divisions to future meetings. The following dates for 2016 have been agreed:	**All note**
• 18th February 2016	
• 23rd June 2016	
• 22nd October 2016	
ITEM 3 – MINUTES OF THE LAST MEETING (17th SEPTEMBER 2015)	
Agreed.	
ITEM 4 – MATTERS ARISING	
LMC Vacancies. The Secretary agreed to sound out the Park Surgery in Cirencester to see if they could provide a replacement member once Dr Ian	

	Action/Lead
Simpson retired.....	**Sec**
Locum chamber. It was agreed that the LMC should ease the path of GPs wishing to become locums. Dr Hubbard would let the Secretary have some wording for the Newsletter and a link for the website.	**JH**
ITEM 5 – LMC BUSINESS	
LMC October Newsletter. Still to be completed and checked.....*New action*	**Sec**
Reciprocal mental health cover across county boundaries. The Executive felt that it was important that those involved in providing mental health care in this county should, if they too needed such care themselves, be able to find it out of county. This would be taken to the CCG.....*New action*	**Negs (CCG)**
Gloucestershire Healthwatch Patient Experience Survey. The Executive felt that the very positive expressions about general practice should be more widely publicised, particularly by the CCG	**Negs (CCG)**
Junior Doctors' Issues. The Executive felt that it was right for the LMC to support junior doctors in all possible ways.	
Flu vaccination arrangements. The late introduction of vaccinations by pharmacists, and their sometimes too enthusiastic advertising of their own service to the denigration of those provided by GPs meant that there was a need for accounting and auditing of the impact on practices once the flu season was over. Even more importantly, arrangements for next year would have to be discussed with the CCG .....*New action* It should also be a matter for discussion at the next Regional LMCs meeting..... with the aim of creating suitable publicity on a regional as well as local basis.	**Negs (CCG)** **Sec**
Practices in difficulties. While appreciating that the CCG would like to have some unintrusive way of determining whether a practice was likely to be in difficulties the Executive felt unable to approve the approach tabled at the PCOG before the last meeting. The Negs would take this message back..... The main reasons were: • The impossibility of back-testing the criteria against the eventual outcomes. • The inherent unpredictability of when a sudden shortage of GPs would threaten the existence of a practice. • The difficulty of obtaining the information and of interpreting it. For instance, if a practice made every effort to claim every payment that was its due, or failed to do so, did either of these imply that there were problems, or the opposite?	**Negs**
Meetings. • Dr Fielding would attend the LES Review Group meeting on Tuesday 3rd November in place of Dr Alvis..... • There was to be a meeting on 5th November at Hatherley Manor run by the CCG to discuss options for change • Dr Yerburgh would attend the Regional Appraisers Group on 1st December to give a short talk promoting the Gloucestershire Safe House project.	**PF** **TY**

	Action/Lead
ITEM 6 – PREPARATION FOR A NEGOTIATORS MEETING ON THURSDAY 29TH OCTOBER WITH THE CCG	
Attendance. Drs Fielding and Alvis.....	**PF & SA**
Matters Arising.	
• Eating Disorders Service. ..... *Lead Dr Alvis* A letter had been sent to Dr Lench (the new lead in the CCG for mental health) by the Chairman explaining the problem (and coupling in mental health services and ADHD in adults). This completed the action on the LMC but it needed to be discussed at the Negs. Actions on the CCG from the last meeting were to bring Dr Lench to the October meeting and to assess the number of eating disorders cases involved.	
• Collaborative arrangements. Outstanding action on the CCG	
• Out of Area registrations. Outstanding action on the CCG to find out whether any home visits had actually been carried out under this service.	
• Practices in difficulties .....*lead Dr Fielding* o Action on LMC to consider how to identify practices liable to get into difficulties (see confidential list from PCOG). For LMC views see above. o Action on CCG to sound out NHS England (South West).	
• Proportion of health budget assigned to primary care. .... *Lead Dr Fielding* Action on the CCG to provide actual figures and proportions. Secretary to find out from the GPC whether there is any way that the figures, once given, can be cross checked .....*New action*	**Sec**
• Anticoagulation bridging enhanced service. ..... *Lead Dr Fielding* LMC needs a resolution as at present it leaves the practice in a moral cleft stick of whether to disappoint patients or do unpaid work on behalf of the hospital.	
• Minor Ailment Scheme. ..... *Lead Dr Alvis* Action on CCG to share the roll-out plan.	
• FP69 process ..... *Lead Dr Alvis* What is being done to ease the burden on practices? As a rider, the Exec noted that there had been no formal response from Debra Elliott to the Chairman's letters on this subject and that seeking closure of the Culverhay practice situation. This would have to be followed up, if necessary to the Chief Executive of NHS England (South). ...	**Sec**
• Transfer from @glos.nhs.uk to @nhs.net addresses. ..... *Lead Dr Alvis* There was a very useful automated system for forwarding emails to tide over the transfer, but the LMC wanted assurances that if this system should accidentally forward patient identifiable data between domains (which transfer was known to be insecure) then GPs were not to be held accountable.	
New Issues.	
• Intra-hospital referrals rules. (See above) ..... *Lead Dr Alvis*	

	Action/Lead
• Suggestions for improving communication with secondary care. Why have (allegedly) the GP members of the CCG disagreed with what we consider to be sensible suggestions ..... *Lead Dr Alvis*	
• Winter resilience plan. ..... *Lead Dr Fielding* Is there one? Why has the LMC not seen it?	
• Inter-county reciprocal mental health services. ..... *Lead Dr Fielding* See above for the LMC line.	
• Flu vaccination arrangements for 2016/17. ..... *Lead Dr Alvis* o Will the CCG underwrite GPs' risks in ordering flu vaccine when there is now doubt as to whether it will be used? o What about national, regional and local publicity?	
• Non-forwarding of patient records by Primary Care Support Services (PCSS). ..... *Lead Dr Fielding*	
• Progress on GP Resilience Fund (formerly the PM's Challenge Fund).	
• Gloucestershire Healthwatch Patient Experience Survey. . *Lead Dr Fielding*	
Date of next Negs Meeting. Needs to be on Tuesday 24th November as the LMC is now committed to a Regional LMCs meeting on Thursday 26th November.	
ITEM 7 – ANY OTHER LMC BUSINESS	
Cardiology waiting times. Practices needed to be reminded to let the Office know if they experienced excessive waiting times for cardiology patients	**Sec – N/L**
Faxes – especially to the Coroner. There were governance concerns at sending faxes to the Coroner, and the administrative work involved was not inconsiderable for each one and the number of requests was growing. The Coroner should be invited to a full LMC meeting.....	**Sec**
'Future of LRCs' meeting. The LMCs in the South West had been represented. The general feeling was that the NHS could not operate without Local Representative Committees.	
JUYI Implementation. The developer had not yet been selected.	
ITEM 8 - DATE OF NEXT EXEC MEETING	
Thursday 19th November 2015, preparing for a Negotiators meeting possibly on Tuesday 24th November 2015 (See above)	**All**

M J D FORSTER
Lay Secretary