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LOCAL MEDICAL COMMITTEE
LMC
GLOUCESTERSHIRE

See Distribution

10th September 2015

MINUTES OF THE MEETING HELD ON THURSDAY 10TH SEPTEMBER 2015 AT THE GLOUCESTER FARMERS CLUB

Present:
Dr P Fielding (Chairman) and Drs Bhargava, Bunnett, Bye, Hodges, Mawby, Morton and Ropner.

Also present:

Representing practice managers:	Richard Marshall	(The Park Surgery, Cirencester)
Representing the CCG:	Dr Andrew Seymour	(Deputy Clinical Chair)
	Helen Goodey	(Dir. Locality Dev. & Primary Care)
Representing the Acute Trust:	Dr Sean Elyan	(Medical Director)
Representing GCC Public Health:	Karen Pitney	(Public Health Outcome Manager)
Prospective members:	Dr Hannah Lunn	(Trainee GP)
From the LMC Office:	Mr Mike Forster	(Meeting Secretary)

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53/2015 CHAIRMAN

The Chairman welcomed all present, especially:

- Dr Hannah Lunn as the prospective trainee GP representative. It was agreed that she should be so and that the numerous other trainees who had expressed an interest should be invited to attend as observers..... **Sec**
- Dr Chris Morton on his return to the LMC.
- Richard Marshall as the new practice manager representative.

54/2015 APOLOGIES

Apologies had been received from Drs Alvis, Ansell, Bounds, Hubbard, Miles, Moore and Simpson

Drs Roberts and Shyamapant did not attend.

55/2015 REGISTER OF INTERESTS

Dr Lunn provided her register of interests.

56/2015 MINUTES OF THE LAST MEETING

The Minutes were agreed as a true record and signed.

Action

57/2015 PUBLIC HEALTH GLOUCESTERSHIRE ISSUES

Implementation of NHS Health Checks. The Council had been mandated by Government to offer NHS Health Checks to the whole resident target population over a five year period starting on 1st April 2013. Gloucestershire had in fact been providing that service since 1st April 2000 so under the new national scheme (paid by activity rather than as a block contract) only the last two years ending 31 March 2015 counted towards the national five years.

The preferred provider of the service was general practice, but 4 practices in the area did not wish to become involved. Moreover, the Council thought it unlikely that the majority of practices who had engaged would reach their target within the remaining three years of the national programme. Karen Pitney was approaching localities to identify how to provide cover for those patients in the 4 opting-out practices and to improve throughput. For instance the invitation could now be verbal rather than written, so long as the fact of the offer was recorded. The long-stop solution was for the service to be put out to tender and a decision on this would be made early in 2016. Karen Pitney would keep the LMC informed. .. **KP**

The LMC suggested that more might be going on than met the eye. If a practice claimed for the offer then it was assumed that the offer had not been taken up. Separate claims for making the offer and carrying out the health check were not entertained. Some time might elapse between the offer and the acceptance, so practices naturally had not been claiming for the offer until they were certain that the offer was being rejected by the patient. Karen Pitney agreed to consider whether to change the claims procedure..... **KP**

The LMC also suggested that Registrar GPs should be alerted by the Deanery to the need to offer NHS Health Checks to all resident patients. Perhaps screen pop-ups could be devised to remind GPs and their staff to offer it to those who had not yet received the offer.

Sexually Transmitted Infections (STIs). A shared care pathway was being designed which would allow the results of chlamydia testing etc carried out in general practice to be shared with the Sexual Health Service advisers so that action could be taken to minimise further infections. Dr Alvis of the LMC was involved in the discussions.

Indemnity. Those fitting coils and implants had to be properly accredited to do so – it was a contractual requirement if a practice accepted the offer to carry out the service. Pat Reid, who had previously been the lead nurse for contraception in Cheltenham, was currently working with Karen Pitney to guide practices through the process of LARC accreditation. She should be the contact (patreid78@gmail.com) for practices who are unsure as to the accreditation status of their clinicians. Newsletter item ..... Sec

[Karen Pitney then left the meeting.]

58/2015 GPC MATTERS

Dr Corcoran raised a number of issues exercising the minds of the

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58/2015 (cont)	GPC members:
	• <u>The future of general practice</u>. There was concern, but also a recognition that major changes were inevitable.
	• <u>Regional activity</u>. The GPC recognised that it was London-centric and was determined to do something to change that.
	• <u>Clinical pharmacists pilots</u>. The success of the pilots would much depend on the personality of the pharmacists involved.
	• <u>Failing practices</u>. The GPC was negotiating with NHS Employers for a practice stabilisation fund to be set up. Early days yet on how it would be used.
	• <u>Carr-Hill Formula review</u>. Going ahead, but unlikely to be complete before 2018.
	• <u>GP Pay</u>. The proportion of the NHS budget going to general practice had fallen yet again to 6.1%. This only went to show that:
	  ○ General practice was underfunded
	  ○ General practice was also highly efficient and effective.
	• <u>Politics</u>. There was at last some concern about the state of general practice among politicians (especially those whose constituencies were losing GP practices). There had also been a petition signed by 200,000 people for a vote of no confidence in the Secretary of State for Health, Jeremy Hunt. This was double the official threshold for a parliamentary debate.
	• <u>LMC Survey</u>. This was complete.
	• <u>Indemnity costs</u>. The GPC was discussing the punitively high costs of clinical negligence indemnity with the medical defence organisations. Crown indemnity might not be the solution as that only covered the costs of litigation. There was the further issue of indemnity for nurses – should the nurse or the practice pay the indemnity fee? Indeed, it would be worth practices checking that their nurses were insured .....
	• <u>GP Networks</u>. 3000 practices across the country were actively involved in developing relationships enabling them to 'work at scale'. The difficulty was to find and fund the manpower to run such projects.
	• <u>New models of care</u>. It was possible for primary and secondary care to work together in a number of ways:
	  ○ Secondary care taking over GP premises and leasing them back to practices.
	  ○ Vanguard projects experimenting with secondary care consultants carrying out clinics in GP premises.
	  ○ GPs in A&E.
	Again, the success of such ventures would rely heavily on the personalities of those involved.
	One issue raised by the LMC was that of no reduction on solo forms for self-employed GPs in respect of indemnity fees. Dr Corcoran
		Sec (N/L)

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	would look into it.....	**MC**

59/2015 CCG/LMC LIAISON ISSUES

DevoGlos. The CCG had joined with 9 other public centres, mostly councils, to make an expression of interest to Government to take greater control of finances locally. The details of the bid could be read at www.weareglos.com. The funding for healthcare would be ring-fenced. A national announcement was expected on 26th November. If granted, more work would need to be done, not least to ensure that:

- GPs were not given extra work to do without funding.
- Voting rights were arranged to prevent the ignorant from interfering with healthcare matters.
- Boundary aspects were properly considered.

Nurse training. The CCG was glad to announce that they had decided to engage three nurse facilitators who would provide training support to localities. The Deanery had also agreed to provide educational input. Avon LMC was also in discussions with Gloucester University.

GP Retainer Scheme. Since experience showed that more than 90% of retainer GPs stayed on in practices this scheme would be expanded.

IT Support for practices. The CCG would provide a laptop and dongle for each practice, primarily to enable GPs doing home visits to have remote access to their clinical IT system.

Flu jabs for GP staff and housebound patients. The CCG had authorised the same system as for last year. ..... **N/L**

Criteria for closing practice lists. The meeting agreed it would be useful to have objective guidelines against which to assess whether or not a practice was in trouble. Various criteria were suggested:

- The number of patients per whole time equivalent (WTE) GP,
- The overall list size,
- The number of sessions available,
- The numbers of partners as against salaried GPs,
- Premises limitations
- Recruiting and retention problems.

However each case had to be judged on its own merits and the dangers of a 'domino effect' had always to be kept in mind. There was a genuine and understandable fear among partners of the financial consequences of being the 'last man standing' which could lead to practices becoming unstable very suddenly. There was a need to reduce the risk to partners, especially as regards premises and redundancy payments. Merger of practices might provide security, but the procedure was complex and needed someone to run the project. In the meantime early warning and close cooperation between practice, CCG and LMC (as was already happening) was essential.

Level 4 anticoagulation review. Not discussed.

Eating disorders. To be discussed in the Negotiators meeting..... **Negs**

[Helen Goodey then left the meeting]

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60/2015 2GETHER TRUST MATTERS

In the unfortunate absence of Dr Ansell this item was not discussed.

61/2015 ACUTE TRUST MATTERS

Principles of shared care. The LMC provided Dr Elyan with a list of suggestions for future discussion. It had mostly been culled from a similar list followed (if not formally adopted) in Oxfordshire. Dr Elyan agreed that at first glance many of the suggestions made good sense and stressed that monthly reviews of each consultant's discharge summaries already took place. However the hospital was suffering major staffing problems and severe demand. For instance the Acute Care Unit had a bed turnover rate of three times in 24 hours.

The issue of pre and post anticoagulation was deferred to the Negotiators meeting ..... **Negs**

Communication. The LMC asked whether GPs could be informed when a particular consultant was off on long-term sickness or other significant absences so that communications from GPs could go to a more available person. Dr Elyan agreed to look into this ..... **SE**

Rapid Response team. Admission rates were steady at present. Dr Elyan believed that the team's activities had generally saved admissions. The LMC members commended the team on their attitude.

Ambulatory Care Services. The commissioners were looking into how best to bring the attention of GPs to this new service, probably via Localities.

[Dr Elyan and Dr Seymour then left the meeting.]

62/2015 DISCUSSION ISSUES

GPs' incomes and expenses. The latest figures had just been published, revealing:

- A fourth successive year of cuts.
- A real cut in income of about 20% since 2004/05.
- The proportion that practice costs bore against income had increased over the same period from between 45% and 50% to the current 63.5%.

It was small wonder, therefore, that older GPs were retiring early, that experienced GPs were emigrating and that newly qualified GPs preferred not to become partners.

The Future of General Practice. Circumstances (larger population with increasing average age, increasing demand and proportionately reduced resources) would drive significant change.

- If recruitment and retention were to be improved then the system should be altered to attract GPs. As a first step the LMC should find out what the ambitions and intentions of Trainee GPs should be ..... **HL**
- Dr Lunn believed that when deciding which practice to join, her contemporaries would rate the personalities of the team

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62/2015 (cont)	as more important than premises or even profitability. • More female than male doctors were becoming GPs. This was fine, but because many went part time more GPs would be needed to provide the required number of sessions. • There was an observable trend for GPs to become locums, not only at the start of their career but also towards the end, as GPs sought to avoid the pressures of partnership while still carrying on as performers. • The idea of working at scale through federation and merger might be easier to achieve in urban areas. The LMC would have to study how best it could be done in rural areas. • What terms and conditions would be needed to bring GPs into a failing practice? • There was a need to manage patient expectations, for instance if a GP were away on holiday. • Some questioned whether the medical schools were biased towards taking in students more on academic achievement than on interpersonal skills. • The LMC bemoaned the fact that the public attitude to the profession, moulded by adverse press comment, was also having an adverse effect on recruitment. GPs would soon have rarity value. The consequence could be the end of independent GP practices and their replacement with a salaried service and/or private practice.	
	Ophthalmology Helpline. Dr Yerburgh reported that he had found it impossible to access the helpline in under half an hour at peak periods (11:00 to 12:00). He had been advised to give a note to the patient with the suggested diagnosis and ask the patient to ring the helpline. It did not help that the helpline message stated that this line was not for patients to ring! This was clearly a systems issue and would need to be discussed with Dr Elyan at his next meeting with the Executive.....	**Sec**
	CareUK Cirencester/Emerson Green contract. This telecare block contract was ending in October and it was unclear what would take its place. After a brief discussion the LMC concluded that CareUK would still be able to provide services via choose and book like any other provider and that this would be more cost effective than a block contract.	
	Denusomab. The LMC considered that if GPs were asked by consultants to start patients on Denusomab (an 'Amber' drug) then, since the work was not commissioned from general practice; they should politely respond that they were unable to do so as there was no budget for it.	**N/L**
	Pharmacists in GP practices. The Chairman had attended a presentation at the SW Regional LMCs' meeting in Taunton of how successful a pharmacist could be in a GP practice. It turned out that the example quoted had been of an outstanding individual who had not only reformed the dispensary of the dispensing practice but had also undertaken practice management work and had sought to be a partner. This was clearly unrepresentative. The tapering funding was also a limited incentive.	

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63/2015 REPORTS

	Document		Uploaded to website on:
Executive and Negotiators Meetings.			
a.	Executive meeting	16th July 2015	*23.07.15*
b.	CCG Negotiators meeting	23rd July 2015	*05.08.15*
c.	Executive meeting	20th August 2015	*26.08.15*
d.	CCG Negotiators meeting	27th August 2015	*02.09.15*
GPC.			
a.	GPC News Issue 1	17th July 2015	*21.07.15*
Miscellaneous.			
a.	PCOG report (Verbal – Dr Yerburgh) The last PCOG meeting had been cancelled.		
b.	SW Regional LMC Meeting report (Verbal – Chairman). The sustainability of general practice was coming under severe pressure, particularly in Cornwall and Somerset. The Somerset experiment last year of abandoning work on QOF had been evaluated on the basis of how well they had done against QOF targets… (understandably poorly.) The next regional meeting would take place on 26th November, which would necessitate a rescheduling of the LMC/CCG negotiators meeting		**Sec**

64/2015 FORTHCOMING MEETINGS AND EVENTS

Executive meeting	17th September 2015
Joint Negotiators meeting	24th September 2015
Executive meeting	22nd October 2015
CCG Negotiators meeting	29th October 2015
LMC Meeting (Farmers Club)	**12th November 2015**

All note

65/2015 ANY OTHER BUSINESS

Assisted Dying. On a show of hands only one LMC member believed he would assist a patient to die.

There being no further business, the meeting closed at 16:20

Mike Forster
Lay Secretary