4th January 2016

All Executive Officers

MINUTES OF AN LMC EXECUTIVE OFFICERS' MEETING HELD AT THE LMC OFFICES ON THURSDAY 17th DECEMBER AT 12:30

Present:

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

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ITEM 1 – APOLOGIES

Nil

ITEM 2 – MINUTES OF THE LAST MEETING (19th NOVEMBER 2015)

Agreed.

ITEM 3 – MATTERS ARISING

Nil

ITEM 4 – LMC BUSINESS

Feedback from LMC Secretaries' Conference. The Chairman gave a detailed briefing on the LMC Secretaries' Conference which had taken place the previous day. The meeting had seemed low-key and sombre. The main themes were:

- While the GMS contract would remain the cornerstone of general practice, practices were networking together and would continue to do so in order to improve their chances of survival.
- Improved coordination with other clinicians (e.g. secondary care and community nursing) was essential.
- Nationally, the creation of CCGs had not been completely successful.
- Mr Dave West, Senior Bureau Chief at the Health Service Journal believed that the NHS would inevitably move towards 'accountable providers' with a consequently diminished role for CCGs. However, it did not seem that either the CCGs or the provider groups were yet aware of any such impending change.
- He mentioned that the NHS would be receiving a £1Bn reimbursement for NIC and superannuation compensation, but no such benefit would be coming to general practice. However there was funding being provided for occupational health for primary care, and in particular for mental health of GPs.
- He also analysed NHS spending.
    - The UK spent a significantly lower percentage of its GDP on health than other developed nations.

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  - On average through the decade to end in 2020/21 the annual increase would amount to 0.9%, but the immediate expectation was that 2016/17and 2017/18 would have a greater increase, thus leading to financial squeeze in the remaining years of this Parliament.
  - The bulk of the increase had so far gone to secondary and tertiary care, creating an ever-widening gap in proportion of NHS spending between primary and secondary care. This surprised no-one.
- The GPC Chairman, Dr Nagpaul, spoke of a 'unified population-based capitation contract' and of a 'core service specification', but no details were given.
- Dr Hamish Meldrum, who is leading a study into reform of the GPC, addressed the conference. His target was to get the report out quickly, in any event by Easter 2016. To do this he had many sources of information but would be canvassing LMCs for their opinions in the New Year.
- The breakout groups were a mixed bag, and we could only attend four of the 12 available. The GPC might yet circulate their findings. Headlines from those we attended were:
  - Practice Finance (PF). The working group was too large for good meaningful dialogue and consisted of a talk by the practice Finance subcommittee as to their roles and responsibilities. Of important note was the fact that they were close to agreeing with the government a generic lease arrangement for NHS owned properties which practices should take note of and do not sign in to any other agreement until GPC announces the details.
  - Contracts & Regulation (MF).
    - The GPC Vice Chairman, Dr Richard Vautrey, agreed to take back to the GPC the group suggestion that self-certification should be extended from one week to two weeks, or even up to a month, but unfortunately such a change would have to be produced by primary legislation.
    - New models of care should be based firmly on GMS contracts – the inclusion of a 'reversion to GMS' clause in a different local contract should be viewed by LMCs with heavy scepticism.
  - Care of Individual GPs (PF). From the discussion all areas are dealing with increased individual practitioner health and well-being issues. It was agreed that the increased funding for London had made significant improvements to a more vulnerable group of the profession and there was wholehearted agreement that occupational health had to be boosted for the profession and that the south-west GP Safe House schemes were highly commendable.
  - Advising Constituents (MF). The services provided by a 'good LMC' were considered, and the general feeling was that we were all doing the best we could within the limitations of geography, time and resources. Some provided training; others did not. Particular suggestions from the group were:
    - That LMCs should produce and issue a leaflet etc to newly arrived GPs in their area explaining what the LMC is and

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what it could do for them.

- That the BMA website should host an LMC Forum to discuss issues in more depth than the LMC Listserver.
- There would be merit in constructing a matrix of LMC services which must, should, could and might be provided against those that actually are being provided.

In discussion afterwards the Executive decided that:

- The LMC should establish much closer ties with GDOC, to the extent of getting an Executive Officer onto the GDOC Board.................................... **Exec**
- The Negotiators should raise with the CCG whether they were aware of the extra funding for GP mental health and what were their intentions for using that money for that purpose?.. **Negs issue**

<u>GPC Special Conference for LMCs (30th January 2016)</u>.

- <u>Attendance and administration</u>. Dr Hodges would not be available, so the representation was confirmed as being Drs, Alvis, Hubbard and Yerburgh (paid for by GPDF) and the Chairman and Secretary (paid for by the LMC). The Treasurer authorised claims for:
  - First class rail travel for:
    - The journey to London if it could be obtained relatively cheaply in the middle of the Friday. .... **Shelina**
    - The return trip in any event.. **Shelina**
  - Accommodation and the reasonable price of an evening meal on the Friday night. .... **Shelina**

  All attending had to book their own accommodation................................. **All attending**

- <u>Motions</u>. The motions were agreed , and support (or otherwise) for the motions of the other South West Region LMCs was considered. The top two motions from each of the LMCs would be submitted as a regional list by Somerset LMC. The Secretary would submit Gloucestershire LMC's motions (including the top two) to the Agenda Committee. .... **(Sec)**
  [This has now been done.] The updated list is at Annex A.
- <u>Views of Constituents</u>. The interest in this special conference among our constituents had been unprecedented, to judge by the quantity and quality of the suggestions received. These had been collated and, once anonymised, should be circulated to practices for information .... **Sec**
  They should also form the basis of a local press release in the lead up to the Conference in the New Year... **Sec**

<u>LMC Representation at the Regional LMCs Conference (21st January2016)</u>. Agreed that Dr Fielding and Dr Hodges, supported by the Secretary, would attend. .... **PF/RH/Sec**

<u>Enhanced Services Group feedback (SA)</u>.

- Disturbingly, one practice had claimed for 2014/15 some £120K on the basis that they believed the service specification allowed them to screen all patients over the age of 65 for dementia. The Exec felt that the LMC could not condone this; the amount of money available for this service was finite so this practice was adversely affecting what other practices might reasonably claim. If the CCG challenged the Practice the LMC should in this case support the CCG against this Practice.. .... **Sec (N/L)**

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- The group was revising the Learning Disabilities service. The Chairman emphasised that the message must go to the group that the proper way to introduce any new service was to bring it to Negotiation and to have it RAG rated by the LMC... **SA**
- The general feeling was that last year's Primary Care Offer was too complex. It had led to practices not taking full advantage of it. For instance half the practices in the county had nor participated in the Emergency Department referrals audit. The LMC would raise with the CCG that so important a document as a service specification should be copied to senior partners as well as being distributed for action to practice managers. .... **Sec (Negs)**

Primary Care Operations Group (PCOG) feedback (TY). Dr Yerburgh felt that the PCOG, however well intentioned, was not functional. He would continue to attend but had nothing to report from the last meeting.

Feedback from the Negotiators. Only Helen Goodey had been there from the CCG at the last meeting. He hoped that this did not reflect that the CCG considered the meetings unimportant. The Minutes of the meeting contained all the main issues.

LMC Organisation.

- Elections.
  - Immediate feedback from Executive members was that the distribution of invitations to nominate on 11th December had been incomplete. The Secretary agreed to check and re-issue as necessary. *[This has now been done.]*
  - There were GPs working for the South West Ambulance Service NHS Foundation Trust (SWAST) who worked in Gloucestershire but did not fall into the Constitutional definition of a 'freelance GP' in that they were employed, but not by a practice. It was agreed that the LMC should support them, but as they were too few in number they should be included in the freelance constituency for the purposes of the election. Dr Hubbard would provide the names and contact details .... **(JH)**
    The Secretary would then send out the invitations to nominate..... **(Sec)**
    [Both these actions have now been completed.]
    The Secretary would also inform the current members of the Freelance Constituency of the addition of these GPs to the list of constituents .... **Sec**
- Executive Structure Revision. Following discussions between the Chairman, Vice Chairman and Treasurer after the last meeting, the Executive discussed and agreed that , subject to the results of the election:
  - The Chairman would cease to be the chair of the Negotiators but would retain the option to attend.
  - Chairing the Negotiators meeting would be done by the ViceChair.
  - LMC Representatives at the Negotiators meetings would be the Treasurer and, in rotation as available, one of the other Executive officers.
  - Consequently some revision of the Constitution might be required. The Secretary would examine and make proposals .... **Sec**

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Support Issues.

- There was funding available nationally for support of vulnerable practices. The Executive decided that a specific meeting with the CCG was needed to discuss how that should be spent.. **Sec**
- Safe House Website.
  - Concerns were expressed that messages to LMC Advocates were not getting through. It was suggested that a test message should be sent to all Advocates to check that the system was working..... **Sec**
  - Dr Yerburgh and Dr Fielding needed reminding of their LMC Advocate passwords. These were held confidentially by Dr Roger Crabtree, who had set up the site. The secretary would pass on the requirement. *[This has been done.]* .... **(Sec)**
  - Dr Yerburgh gave the names and details of two of the three GPs who had expressed an interest in becoming Advocates:
    - Dr Andrea Gibson.
    - Dr John Linsell.

    He would encourage the third to make a decision. .... **TY**
  - Dr Hubbard expressed an interest in becoming an Advocate, perhaps not immediately, as the troubles affecting locum GPs were best understood by a fellow-locum GP.

FP69. The CCG had announced an extension of the time limit by three months and promised some supporting payment to practices. The LMC should carry thanks back to the CCG.. **Sec (Negs)**

Flu vaccinations audit. The LMC would carry out an audit with practices on how the vaccination programme had run. The questions would need to be agreed .... **Sec** and some liaison with Gloucestershire Public Health might be helpful.

Culverhay Surgery investigation. NHS England had still not provided closure on its investigation. This would be chased again in the New year.................................... **Sec**
Allied to this was a general concern about the workings of the PAG and PLDP which the Chairman would take forward as necessary... **PF**

LMC Website amendments. The developer would be coming in on 5th January to explain in his own words to the Secretary what he thought the LMC was asking for. This should identify any inconsistencies of viewpoint and lead to a better implementation.

ITEM 5 – ANY OTHER LMC BUSINESS

JUYI. Dr Atkinson was still seeking a letter from the LMC to practices. The Chairman ruled that:

- The LMC needed to see the final draft of the JUYI letter to practices. .... **Sec**
- The LMC would not be lending its 'brand' to the launch of JUYI. JUYI could truthfully and acceptably say that the LMC had been involved in discussions about the project but the LMC would not be issuing a letter to practices about it. .... **Sec**

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ITEM 6 – DATE OF NEXT EXEC MEETING **Tuesday** 26th January 2016 – preparing for a negotiators meeting on Thursday 28th January.	**All**

M J D FORSTER
Lay Secretary

Annex
A: Final version of Gloucestershire LMC's draft motions to the Special Conference

ANNEX A TO
MINUTES OF AN EXEC MEETING
HELD ON 17TH DECEMBER 2015

FINAL VERSION OF GLOUCESTERSHIRE LMC'S DRAFT MOTIONS TO THE SPECIAL CONFERENCE

G1	That Conference calls for a sustained and significant increase in core funding for general practice
G2	That Conference requires the launch of a major, sustained, Government-backed, evidence-based public relations initiative to reduce demand on general practice.
G3	That Conference seeks recognition by the Government of the present crisis in general practice and that this recognition must lead quickly to a 'back to basics' approach within general practice with the aim of: (i) Putting priority on continuity of care. (ii) Extending nominal appointment times to 15 minutes. (iii) Reducing considerably the level of micromanagement currently imposed. (iv) Providing extra funding beyond the capitation fee if patients exceed 6 appointments a year. (v) Reducing practice boundaries to safe limits.
G4	That Conference believes that: (i) CQC inspections should be replaced by peer review, thus promoting mutual help and a sharing of ideas rather than bureaucratic focusing on 'hotel' aspects (ii) Or, in the alternative, that: a. CQC should target those practices which merit their attention. b. The costs of such inspections should be borne by those who wish the inspections to take place, not by practices.
G5	That Conference understands the benefits to patients of having certain services moved from secondary care to primary care, and strongly suggests that the Government should ensure that such services are directly paid for by the hospital devolving those services.
G6	That Conference urges the GPC to negotiate for the burden of professional indemnity premiums to be borne centrally rather than by individuals.
G7	That Conference requires the excessive workload of general practitioners to be alleviated by one or more of the following measures: (i) Defining what services can be regarded as outside the core contract. (ii) Supporting GPs who decide to provide only those core services. (iii) Encouraging the NHS to set a fair rate for non-contractual work. (iv) Limiting 7-day opening to the provision of urgent care only.
G8	That Conference believes that practices should have the right to insist that their practice premises be owned by the State.
G9	That Conference believes that the costs of CQC registration should be centrally funded to protect the limited resources available for patient care in General Practice.
G10	That Conference urges that continuity of patient care would be better achieved by increasing resources for practices rather than by politically motivated impositions.
G11	That Conference believes general practice's ability to focus on people who are unwell and on those with chronic conditions would be enhanced by removing some tasks (e.g. contraception, antenatal care, vaccinations, dementia screening, unplanned admissions case management, travel advice and routine patient requested health checks) or by moving them to a separate service or services.

G12	That Conference believes the role of paramedics should be enhanced to include all home visiting, except terminal care visits.
G13	That Conference believes the root cause of the current crisis is a loss of morale in primary care and urges that steps be taken to improve it.
G14	That Conference believes the costs imposed on General Practice should be reviewed and wherever possible reduced.
G15	That Conference believes greater funding of Information Technology, in particular for sharing data with secondary and tertiary care colleagues, would ease pressures on general practice.
G16	That Conference, while eagerly seeking a reduction in pressure on practices and a general reform of the system, wants all concerned to recognise that, because individual practice circumstances vary, varied solutions will be needed for each.
G17	That Conference considers the government must recognise that understaffed practices are at risk of collapsing due to increasing work load performed by ever fewer clinicians, and in particular that: (i) General practice is struggling to retain and recruit doctors. (ii) The majority of patients do not want 7-day access and therefore to ease pressure on general practice continued roll-out of the scheme should cease. (iii) The time taken to train a GP and the reluctance of graduates to become GPs means that promises of 5,000 extra GPs by 2020 are unachievable. (iv) Money would be better spent on supporting GPs than on schemes that may sound good in theory but which in practice complicate further the delivery of services and do not necessarily reduce the pressure on general practice. (v) Until adequate numbers of clinicians have been recruited and trained there is no point in introducing services that are supposed to improve health care but really take staff from an already shrinking pool. (vi) Enthusiasm to join the profession is inversely affected by media denunciations and the converse may also prove true.
G18	That Conference, in the interests of equality of treatment for patients and the preservation of the NHS, believes the time has come for NHS services to be rationed and calls on the Government: (i) To decide what should be included and what excluded from core services under the GMS Contract. (ii) To permit clinicians to charge privately for whatever work falls outside the agreed NHS provision.
G19	That Conference wishes to see an increase in the number of medical school places.
G20	That Conference believes that being able to sell 'goodwill' would encourage GPs to take up partnerships.