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LOCAL MEDICAL COMMITTEE
LMC
GLOUCESTERSHIRE

See Distribution

12th November 2015

MINUTES OF THE MEETING HELD ON THURSDAY 12th NOVEMBER 2015 AT THE GLOUCESTER FARMERS CLUB

Present:
Dr P Fielding (Chairman) and Drs Bhargava, Bounds, Bunnett, Bye, Hodges, Hubbard, Lunn, Mawby, Miles, Morton, Ropner, Shyamapant, Simpson and Yerburgh.

Also present:

Representing practice managers:	Richard Marshall	(The Park Surgery, Cirencester)
Representing the CCG:	Helen Goodey	(Dir. Locality Dev. & Primary Care)
Representing the Acute Trust:	Dr Sean Elyan	(Medical Director)
	Dr Philippa Moore	(Consultants' representative)
Observer:	Sean Corbett	(Business Manager, the Aspen Centre)
From the LMC Office:	Mr Mike Forster	(Meeting Secretary)

Action

66/2015 CHAIRMAN

The Chairman bade farewell to Dr Ian Simpson, retiring from the LMC after a record-breaking 31 years. In response Dr Simpson thanked the LMC for his gifts. He stressed the valuable and varied role that the LMC performed for GPs and their practices, now as ever. He felt less connected since the number of meetings had halved and the work, which he praised, was increasingly taken on by the Executive officers. However, he felt it was the right way to go. He hoped that a replacement could be found for him from the South Cotswolds.

Dr Fielding also welcomed Sean Corbett, the newly appointed Business Manager for the Barnwood and London practices in the Aspen Centre.

He also noted that Dr Tim Healy (from the North Cotswolds) had announced that he would be retiring in April 2016. The LMC would send good wishes for his retirement. **Sec**

67/2015 APOLOGIES

Apologies had been received from Dr Seymour and Mary Hutton who were in Manchester for another meeting

68/2015 REGISTER OF INTERESTS

No changes announced.

Action

69/2015 MINUTES OF THE LAST MEETING

The Minutes were agreed as a true record and signed.

70/2015 ACUTE TRUST ISSUES

IT Changes. The Trust intended to go entirely paperless. To avoid major changes during the winter – the time of greatest clinical pressure – the first phase (PADS replacement, maternity, A&E and operating theatres) would go live in May 2016, with the remainder in November 2016. Dr Elyan admitted that interoperability with GP systems had been assumed as the new system would interoperate with the JUYI system, but agreed to have the interoperability down to GP practice level fully tested before the 'go live' date. **SE**

The LMC agreed that all communication between secondary and primary care should, at least in the first instance, be electronic. But they asked Dr Elyan to check what the contingency plan would be should the new system not live up to expectations. **SE**

From his side Dr Elyan stressed that the Trust needed a dedicated email address and phone number for each practice. **LMC**

The Trust would be going over to @nhs.net addresses in the spring of 2016 but in the meantime GPs who had moved to that domain already were unable to access the Global Address List maintained in the @glos.nhs.uk domain. Helen Goodey undertook to see how this could be solved in the interim; Paul Downey was said to be a useful point of contact, and the LMC agreed to invite him to a meeting of the LMC Executive. Dr Hubbard agreed to feed this back to the IT committee. **CCG** **LMC** **JH**

[Drs Morton and Roberts arrived at this point]

Ambulatory Emergency Care Service. Initially a centre had been set up in the East and West of the county but because of staffing problems, and the tendency of patients to be referred after the centres had closed the service had temporarily been reduced to the Gloucester site with longer opening hours. This had improved attendance and had received good feedback. Other Trusts were following their lead. Dr Elyan admitted that there had also been staffing problems. GPs needed clarity on which patients should be signposted to the service; particular guidance was needed in the 'grey areas'. Helen Goodey agreed to make sure that the details had been posted on the GCare site. **HG**

Meeting of the LMC Exec with Dr Elyan. The first meeting had been held and had been productive. They would take place every 4 months and at each meeting he would bring one of the chiefs of the four clinical divisions to enable detailed discussions.

Infection control. Dr Elyan announced that the Trust was making huge strides in reducing the rates of *C diff* to a very low level, in no small part due to the work of Dr Moore and her team in Microbiology.

Flu. The LMC raised the marker that flu immunisation uptake appeared to have reduced this season, risking problems later on.

Action

[Drs Elyan and Moore then left the meeting.]

71/2015 CCG/LMC LIAISON ISSUES

Joining Up Your Care – 5-year forward view. Dr Fielding had attended a meeting about this. The CCG wished to be entirely transparent, aiming to refresh their operational plan with particular priority to primary care which was facing huge challenges in terms of workforce, premises and sustainability. The next steps were to have talks between the CCG and Localities. They would also offer the LMC a one to one meeting about it.

CCG

Novel Ways of Working. The underlying cause of the problems faced by practices was the difficulty of retaining and recruiting GPs. The latest CCG questionnaire revealed that of the 42 practices which responded 19 had long-term unfilled vacancies. The CCG had held a meeting on 5th November to address how to deal with this situation. The main speaker had been Phil Yates. There appeared to be an appetite for change and this now had to be taken forward in localities. The CCG was planning to resource such 'conversations'. Federation for federation's sake was not sensible but where geographical or other reasons for alliances existed it could be beneficial. Size might help recruitment. In discussion the following points were made::

- The meeting recognised that all practices, but particularly those with 5 GPs or fewer, were vulnerable.
- Dr Bye believed the three main issues were:
    - Premises were no longer an acceptable risk.
    - Incoming doctors did not wish to work full-time.
    - Professional negligence indemnity insurance premiums were unacceptably high.
- The eventual privatisation of GP services might prove inevitable.
- Sale and leaseback of premises had its own risks, unless reasonable break points were included in the lease.
- Perhaps we should be talking of 'Primary Care Centres' rather than 'GP Practices'.
- The ever-increasing levels of patient demand would have to be managed, ideally at all levels of government.
- Above all, if there were no leaders to bring in major change then nothing would be achieved. The CCG said that the impetus would have to come from GPs, though they would be prepared in principle to support it.
- Connected to that, some felt that GPs were too 'head in the sand' to take action.

Oakleaf Premises Survey. While not doubting that the CCG had had good intentions in setting this survey in train the results had been disturbing for practices – revealing many expensive things (e.g. asbestos surveys) which would come as very unwelcome news at such a trying time.

The CCG had produced a briefing for the LMC to circulate to practices. In essence, if a report pointed to a need for work then it was excellent authority when applying for improvement grants. In any event the reports were given to practices for guidance and would not be revealed to third parties, particularly the CQC. **LMC**

The LMC felt that if so many practices all needed a particular

Action

71/2015 (Cont) category of works service then some coordination should take place to obtain economies of scale. This would be discussed at the Negotiators meeting. **Negs**

Winter Planning. The intention was to concentrate on particularly vulnerable patients e.g. COPD. Details would be circulated. **CCG**

72/2015 GPC MATTERS

The last meeting of the GPC had been on 15th October. Much of what had then been private had since become common knowledge so Dr Corcoran felt able to talk about them, at least in general terms.

- Annual contract negotiations had started late this year. The Prime Minister's announcement of a new contract had been made without prior warning. A new contract working group had been formed to address it.
- Several suggestions had been made by various bodies to ease the situation in general practice and the GPC was considering them – some were more suitable than others.
- The BMA was now going to sponsor a PR campaign to promote general practice. The GPC would actually run it.
- It was clear that there would be a significant underspend on the Primary Care Infrastructure Fund, its complication and bureaucratic nature being largely to blame.
- The GPC was determined to reform itself, and was making good progress in its improved relationships with NHS Employers and the Government. But there was still room for improvement and Dr Hamish Meldrum had come out of retirement to head a working party addressing the situation.

73/2015 DISCUSSION ISSUES

Special Conference for LMCs. There was considerable discussion on whether this LMC would support a proposal that the GPC should call a special conference to address the parlous state of general practice. In the end it was agreed that we should, with provisos. The points raised at the meeting are encapsulated in the letter to be sent to the GPC. (See Annex A.)

Healthwatch Gloucestershire Patient Experience Report. This report had been very favourable about General Practice in the county and had not been publicised at all by the CCG's PR department. The Chairman had drawn this report to their attention urging that in future such good news should receive suitable publicity.

JUYI. No further news, but Dr Hubbard was in close contact.

GP Resilience Fund (formerly the PM's Challenge Fund) progress. Choice Plus was being rolled out across the county, run by GHAC. The fast roll-out was causing some shortages of locum GPs. There was also concern that the initial funding was non-recurring and there was a risk that the CCG might not fund it in future if it was not seen to be a success this year.

LMC Elections. The invitations to stand for election would be sent out on 11th December. All were invited to seek fresh blood to fill our existing vacancies, and those interested in standing for office

Action

73/2015 (cont) within the LMC to talk informally with the Chairman.

Cameron Fund. The Treasurer proposed, seconded by Dr Miles, that the LMC should make its usual donation of £300. This was carried.

74/2015 REPORTS

	Document		Uploaded to website on:
Executive and Negotiators Meetings.			
a.	Executive meeting	17th September 2015	*23.09.15*
b.	CCG Negotiators meeting	22nd September 2015	*29.10.15*
c.	Executive meeting	22nd October 2015	*29.10.15*
d.	CCG Negotiators meeting	29th October 2015	*06.11.15*
GPC.			
a.	GPC News Issue 2	18th September 2015	*23.09.15*
b.	GPC News Issue 3	16th October 2015	*21.10.15*
Miscellaneous.			
a.	LES Review Group (Verbal – Dr Fielding) The Chairman had stood in at this meeting in Dr Alvis's absence. In the unfortunate absence of Helen Goodey the group had returned the working group's proposals for further work, due to be reconsidered today.		
b.	PCOG October Meeting. Dr Yerburgh had nothing to report.		

75/2015 FORTHCOMING MEETINGS AND EVENTS

Executive meeting	19th November 2015	
Negotiators meeting	24th November 2015	
SW Regional Meeting	26th November 2015	
LMC Secretaries Conference	16th December 2015	
Executive meeting	17th December 2015	
LMC Meeting (Farmers Club)	**14th January 2016**	**All note**

76/2015 ANY OTHER BUSINESS

Dr Bye was concerned that the Acute Trust was ignoring NICE guidance on cancer treatment and had raised it with the Trust. He asked that any feedback be forwarded to him.

There being no further business, the meeting closed at 16:42

Mike Forster
Lay Secretary

ANNEX A TO
GLOS LMC MEETING MINUTES
DATED 12 NOVEMBER 2015

12 November 2015

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SPECIAL CONFERENCE

Gloucestershire LMC debated this issue today and decided to support a call for a Special Conference of LMCs to be held to debate the crisis faced by general practice and to consider what actions could and should be taken, provided:

1. It is held very quickly, to build on the momentum created by the junior doctors.
2. It focuses on how general practice can assist the Government to preserve general medical practice as we fear it will otherwise collapse during the current Government's term of office.
3. The emphasis is put on the need for proper resourcing (time, premises and people) for general practice.
4. There is a concerted and protracted national campaign, led by the Government, to encourage a major change in public attitude – to self-help rather than being encouraged to 'go to your GP'.

REASONING AND SUPPORTING REMARKS

THE VIEW OF GENERAL PRACTICE

We are experiencing much the same pressures as in the rest of the country; previously we optimistically hoped we would be one of the last to do so.

- In Gloucestershire this year we have had two practices close, two are very nearly about to close (we are working with the CCG to try and save them) and many more are having enormous difficulty in recruiting when GPs leave. No practice is safe from these pressures.
- Fewer and fewer GPs are prepared to take the risk of becoming the last man standing as partnerships dwindle.
- Working hours for the partners that remain are becoming such that the joy of providing care is much outweighed by the lack of work/life balance.

No one can see an improvement in this situation unless something radical is done both in the short (two years), medium (5 years) and long (beyond that) timescales. Federation for federation's sake will do little; the chronic shortage of clinicians (not just GPs) faced with a 'Tsunami of Ill-Health' (as one of our members put it) is the main problem and the perception among medical trainees (and there are too few of them anyway) is that they generally don't like the sound of general medical practice, especially in this country.

We also noted that the proportion nationally of the NHS budget allocated to general practice has fallen yet again, now to 6.1%.

The view was expressed that we may now have gone so far that current GPs working for the NHS may feel obliged for the good of their mental and physical health and well-being to leave the NHS and work privately in one capacity or another. Certainly the recruitment and training of many more clinicians

will take longer than many GPs are now prepared to wait. From a recent survey of 32 of our trainee GPs only one intended to work full time, and only 6 said they would consider becoming a partner in the next 10 years.

While the fate of the NHS is important, general practice will continue in some form or other whatever happens to the NHS. This Special Conference should not concern itself unduly with anything other than rescuing general medical practice.

PUBLIC PERCEPTIONS

There can be little doubt that in the public eye GPs are paid well. Any argument that is pitched on the poor level of wages is bound to fail. What stands more chance is the argument on quality – that so much non-clinical or inappropriate clinical work is being loaded onto GPs that the safety and quality of service given to patients is suffering. Similarly, let us not talk about 'income' but rather of 'resources'.

The precarious survivability of practices is well understood by the profession but the public has little idea. That needs to change, and change fast. It may lead to some understanding and greater self-reliance and self-discipline.

The idea of a healthy diet and a healthy amount of gentle exercise should be sown; it will take root occasionally.

A recent MORI poll showed that the majority (87%) of respondents place GPs as the most trusted professionals. Junior doctors' action has gained considerable public sympathy. Properly handled we should be able to use this to aid our survival.

POLITICAL IMPERATIVES

The current Government was elected with a mandate to extend access to 7 days a week. Any overt opposition to that policy is doomed to fail; it just has to be managed to best effect. It should be a cogent argument for more resources.

The Government is determined to balance the budget and indeed to move the public finances into surplus. Asking for more money will not get very far, unless it can be found by compensating reductions elsewhere in the public purse, possibly from the moneys allocated to secondary care or even from other Departments of State. The fear that general medical practice will implode in the next 3 years (i.e. while this Government is in power and will therefore take the political consequences) should be stressed.

The CQC may be unpopular with GPs but the Government sees it as necessary. Perhaps it can be persuaded to ameliorate its excesses.

SUGGESTIONS TO PUT TO THE GOVERNMENT

Pressure.

- Major public relations initiatives to reduce the demand on primary care.
    - It can be done (don't drink and drive, smoking, seatbelts)
    - Positive PR about the value of General Practice – and how the country is about to lose it.

    - Modification of the 7-day access policy to mean 7-day urgent access.
- We have a Human Rights Act. What about a Human Responsibilities Bill?
- Target the CQC inspections at suspect practices, not at all practices.

Resourcing. Despite the shortage of money resourcing is an issue that must be addressed. Primary care must be properly resourced. Suggestions:

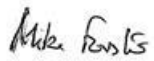
- Secondary care to pay primary care for any work delegated to them, at secondary care rates.
- Crown indemnity, or at least a recouping of all or most of the very expensive professional indemnity insurance premiums now being charged.
- Central funding for the CQC.
- Look at a new contract (e.g. 'The Guernsey Option') based on activity levels rather than a capitation basis.
- GPs should be able to form Limited Liability Partnerships.
- GPs should be able to build up and trade in goodwill.
- 7 day access is new work and should be paid for.

Premises. Potential partners are being put off by the need to buy into the practice premises. There should be a national ownership of premises with suitable break clauses in the leases.

SUMMARY

All our GPs want is:

- To do the job they have been well-trained for.
- To be adequately supported in terms of resources.
- To maintain a reasonable work-life balance.



M J D FORSTER
Lay Secretary

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