Approved minutes of 2 July 2015

LMC website: http://www.derbyshirelmc.org.uk

Local Medical Committee Ltd LMC LTD
DERBY AND DERBYSHIRE
"Representing and supporting GPs"

DERBY & DERBYSHIRE LMC LTD

Derby & Derbyshire Local Medical Committee Ltd Meeting
Higham Farm Hotel, Main Road, Higham, Alfreton, Derbyshire, DE55 6EH
Thursday 2 July 2014 – 13:30 to 16:30

PRESENT:	Dr Peter Williams (Chair)	
	Dr John Grenville	Dr Ruth Dils
	Dr John Ashcroft	Dr Jane Perry (Registrar)
	Dr Mark Wood	Dr James Betteridge
	Dr Jenny North	Dr Greg Crowley
	Dr Paddy Kinsella	Dr Murali Gembali
	Dr Brian Hands	Dr Zoe Perkins (Registrar)
	Dr Andrew Jordan	Dr Vineeta Rajeev
APOLOGIES:	Dr Peter Holden	Dr Gail Walton
	Dr Kath Markus	Dr Denise Glover
	Dr Peter Short	Hannah Belcher (Contracts Manager – Area Team
	Dr Peter Enoch	Graham Archer (Chief Officer - LPC)
	Dr Pauline Love	Rakesh Marwaha (Erewash CCG)
	Dr Sean King	Nwando Umeh
IN ATTENDANCE:	Hazel Potter (Minutes)	Dr Avi Bhatia (CCG Clinical Chair & Leader of Erewash CCG)
	Lisa Soultana	Jackie Pendleton (Chief Officer - ND CCG)

15/109 WELCOME & APOLOGIES

Hazel Potter asked attendees to ensure that the Fire Register for the Hotel and that the LMC attendance register are both signed. A reminder that there is no August meeting.

Apologies were received from Hannah Belcher, Rakesh Marwaha, Graham Archer, Nwando Umeh, Dr Peter Holden, Dr Kath Markus, Dr Peter Short, Dr Peter Enoch, Dr Pauline Love, Dr Sean King, Dr Gail Walton, and Dr Denise Glover.

Guest speaker today is Dr Avi Bhatia, the CCG Clinical Chair and Leader of Erewash CCG.

15/110 CLOSED SESSION (MEMBERS ONLY)
Report of the LMC Executive meeting

LMC Levy and Mandate
The letter to practices regarding increases to the LMC Levy and Mandate was checked and with a few minor amendments was confirmed as the final version. Dr Williams discussed the voluntary levy and explained that we are asking for a 5p increase in line with the current mandate but explained we need to also ask for the mandate to be increased to up to 80p to allow for further possible levy increases when considered necessary.
The LMC Constitution specifies 3 months' notice to practices of any levy increase but we are giving nearly 6 months' notice.

We have looked at our draft accounts and there has been an increase in non-recurrent and recurrent spending. This uses our reserves, hence the need to raise the levy.

Dr Grenville said it has been 20 years since the mandate was raised, and 10 years since levy was raised. Dr Williams asked if there were any questions. LMC members voted unanimously in favour of the proposals to increase the levy and mandate. If GP Practices phone the office or LMC members to ask about it or ask questions, pass them to Dr Grenville, Lisa Soultana or Nwando Umeh to answer.

The increases for members' practices' reimbursement are based on GPC increases. Lisa Soultana said we aim to pay everyone quarterly and not end of the financial year. Dr Williams said the 1st payment will be October 2015, and then it will be quarterly.

LMC Members were asked that if they attend a meeting, they send formal feedback to office.

Transition arrangements for Johns retirement were discussed. Going forward it is thought that having a medical secretary and deputy medical secretary provides better cover and support. Dr Grenville has been working full time, and if he could share this with another person they would be able to shadow him until his retirement. We are looking for somebody who would like to put his/her name forward to reply by 13 July with an expression of interest and we need to make decision by the end of August to enable the deputy secretary to shadow John. If interested please can email the office by 13 July. We will gather replies and after Lisa's annual leave at the end of July depending on response, if there is more than one applicant they will go through a selection process. We have received a couple of expressions of interest and you can speak to Dr Grenville if you are interested.

Position Profiles
These have been updated in an attempt to save the LMC money. There are different profiles for the different positions. It is really helpful to see what people do.
Lisa Soultana has her role formalised as "Director of transformational change and business development". Lisa was thanked for her work.

Dr Williams asked if all are happy to change the profiles as proposed and explain the Chair role has been reduced to 2 sessions. All of the LMC Executive will now be paid on a pay as you go basis.

15/111 GUEST SPEAKER – Dr Avi Bhatia, the CCG Clinical Chair and Leader of Erewash CCG.

Dr Bhatia is a GP in Long Eaton and Chair of Erewash CCG. It covers 12 Practices and most of his core work is done in primary care.

- **Vanguard Sites**

Dr Bhatia provided a PowerPoint presentation. The overarching aims of the Vanguard Project are to strengthen out of hospital care and to empower people in the community to maintain and improve their own health.

He has been looking at hubs for each locality. It is vital we get voluntary sector, social care and local government involvement. We also need to focus on self-care. There is a massive increase in demand. We need to have IT Support with dedicated services for different patient groups, and phone consultations. It is vital to look at the workforce, as we are more likely to get better results if we're are all working to a similar vision.

The CCG has looked at Estates. There are many buildings, some fit for purpose and some not. They have worked with DHU covering 2 sites and set up 2 hubs through the challenge fund, working 8 am to 8pm and weekends, which has led to decrease in A & E use. They are trying to remove the stress from general practice. They are also looking at the possibility of practices sharing resources to look at how primary care will work with decreasing numbers of GPs, but with increasing patient demand.

Question and Answer Session

Dr Williams asked how much was the funding to run the vanguard?
Dr Bhatia replied it was £130k to £140k for setting up the governance and getting everyone to work together and then deciding what are you going to deliver if appropriate, then to develop it from there.

Dr Williams said the challenge fund was initially funded but is not recurrent and asked how ongoing provision would be maintained it as it is funding 7 day clinics now but the funding will run out.
Dr Bhatia said if we can't find more GPs then we will use the funding to fund other things. They had to reduce the length of clinics from 4 to 2 hours and limit the time at weekends. Sunday is not used much and Saturday morning is very popular. It must pay for itself. If the hub is staffed properly, it reduces A & E admissions. If we want access to the NHS to be much more convenient we need to do it locally. We still have not got the proper shared care record. The practices can't book it into hub yet. The biggest problem is funding the staff to run it.

<u>Main Issues</u>

1) How do you recruit into hub?
2) How do you triage to get people to the appropriate place?
3) There is a model for GPs to see patients in multiple rooms.

The feedback from patients is they would rather see a GP.

Dr Betteridge said given the extended hours, how many extra staff have been bought in?
Dr Bhatia explained the extended hours hub is supposed to be an extension of Primary Care. It seems to be used by patients who have fallen ill that day or calling that day, and it is usually children. The funding is for GPs who work in the hubs. They had to draft people in.

Dr Betteridge said that it is not realistic for patients to see their usual GP on a Saturday or Sunday, if they are already struggling to provide cover from Monday to Friday.
Dr Bhatia replied the government needs to be more specific that you will not see your own GP. Not all practices can open until 8pm and provide weekend working. There is no shared care record.

It was noted that DHU is still running. Do we need to discuss integration with the existing OOH service?

Dr Grenville said there's a clear protocol for 111 calls to be directed to either OOH services or surgery, depending on time of day and urgency. Do you know who the repeat players are?
Dr Bhatia said yes, they know who goes to A&E and GP frequently. The hubs are still getting up to speed and they still need proper staff and admin.

Dr Bhatia said there have been additional district nurses. They have problems with community matrons and differing list sizes. They have funding for ANPs for all care homes which have been sent to those with greatest number of admissions. He would like more GP time spent in the community. You might not need a GP to attend home visit or care home. It could be an ANP. When the care home model was put in place, the admission figures went up initially but are now stable.

Dr Ashcroft said the funding is a lot less than we believed. There has been a lot of fine talk about vanguard sites but only £150k was used as set up costs. In reality only 2 hours are funded which is not very much in terms of additional appointments. If this is the 7 day, 8am – 8pm answer, the reality is it's trying to make a headline for the Prime Minister.

Dr Gembali asked what sort of contract there is with GPs, as there is a shortage of GPs in general. Moving GPs from one location to another does not increase the number of GPs.
Dr Bhatia said the recurrent money is supposed to come from reduced hospital admissions. But there's an increasing aging population with complex health issues. He noted that East Midlands has only filled 37% of its training places and approximately 1/3 leave before the end of their training. Of those that do finish the training, nobody is putting themselves forward for a GP Partnership. They only want to do locum work. We need to look at current model as it may not be fit for purpose if there are no GPs.

Dr Ashcroft said the Vanguard is supposed to be part of the 5 year plan. NHS England needs to look at the sustainability of NHS as its needs a radical upgrade. They are not putting funding into general practice and primary care. It is all with the hospitals.
Dr Bhatia said you could argue the challenge fund should have been spent better in practices.

Dr Grenville said it is interesting that the Vanguard is running on £1.30 per patient non-recurrently. This is is nowhere near enough funding but it reflects what is happening nationally in Vanguard sites.
Dr Bhatia said NHS England didn't mention how efficiency savings are going to be made.

15/112 MINUTES OF PREVIOUS MEETING
The Minutes of the meeting on the 4 June 2015 were approved and signed by the Chairman as an accurate and true record.

15/113 MATTERS ARISING

15/100 Endoscopy

JG spoke to SD CCG, who now have 2 pathways.

1. Referral under the 2 week rule if you suspect upper GI cancer.
2. Direct referral for endoscopy for specific symptoms to 'rule out' oesophageal or gastric cancer

They say that they consulted widely 19 months ago. Referrers need to make it clear if they are concerned about possible cancer somewhere in the upper GI tract, or whether they are happy that oesophageal and gastric cancer are simply ruled out (to a high degree of specificity).

Dr Williams reminded the committee that he has asked members to let the office know about letters from secondary care pushing work inappropriately to primary care. Dr Grenville said only Dr Markus, Dr Williams and Dr Betteridge have replied. He asked if there are any commonalities. Dr Grenville pointed out the difference between referring for an opinion (often to rule out unexpected diagnoses) and referring for diagnosis and specialist management.

Dr Ashcroft said a nurse specialist asked his practice to check more blood tests, and then to refer them to another service.

Dr Williams said his practice was asked to chase the result of a 24 hour ECG done in secondary care and treat accordingly. The Consultant apologised.

Consultants are also not issuing sick notes. They often say that there is no facility. They used to have pads but now that sick notes are electronic they can't do it. Jackie Pendleton said if they are NHS commissioned services they should do it. Dr Grenville said even a private provider should be able to provide sick notes. Dr Ashcroft said none of the hospitals provide sick notes. Dr Jordan said Notts and Derbys are as bad as each other. Dr Williams said it feels difficult to send a patient back to hospital for a sick note.

15/77 Community Pharmacy Influenza Service

Dr Grenville said the pharmacy is not going to do the influenza vaccination for elderly or pregnant women. If a pharmacy can't evidence that a patient is in a risk group they have been told that they need to involve the GP. He has managed to get this changed. A large number of pharmacies may take this up and we need to see if this impacts on practices. Hopefully GPs won't be left with significant amounts of unused vaccines. The pharmacy is to inform the practice within 48 hours when they have immunised an eligible patient.

Practices can give immunisations privately to patients who are not eligible for NHS vaccination and who are not on their list. Pharmacies (especially the larger chains) might try to undercut practices. You must not discuss funding with other providers. You can give a non-eligible patient a private prescription to take to pharmacy to bring back to the practice for administration at no charge if you feel that this is necessary to preserve patient/practice relationships. We won't know the impact on deaths if people are not vaccinated. The pharmacists have to be properly trained.

Dr Gembali asked what is different between giving jab for yellow fever and flu vaccination. Dr Grenville said that yellow fever is a travel vaccine but it might change if yellow fever became endemic in the UK.

15/96 Dr Williams said there has been no response re DOLS and asked if Dr Grenville had heard anything from the Coroner. Dr Grenville said the bottom line is that if DOLS is in place it appears to be a legal requirement. If it is not in place, there is no legal requirement.
ACTION: Dr Grenville to write to the Coroner for a response.

15/78 GP Referrals to Adult Social Care – Letter from Alison Briddon
Dr Williams read the letter to the LMC members from Alison Briddon.

The letter stated that GPs can either make verbal referrals by phone on Tel: 01629 533190 or make routine referrals by using the online web referral form.

15/97 Services Commissioned by Derbyshire County Council
Dr Grenville read out a letter from Derbyshire County Council regarding new commissioning arrangements for children's services. He expects to hear from DCC and the CCG's to see how they will deal with this. Dr Williams had an email (all County practices should have received this), regarding the locality they will belong to under the new system and they will be getting a visit soon to discuss any concerns. Dr Grenville thinks we should predict problems and discuss pro-actively. There is a draft good practice guidance to refer to.

Dr Grenville said that Local Authorities commission only for their resident populations, even if they are commissioning at practice level. CVD checks and smoking cessation are now provided by DCHS, with sub-contracting to practices. The uptake is poor and he is not sure how these services will be universally provided.

Dr Williams asked Jackie Pendleton if the CCGs get any feedback regarding these services and Jackie replied that they do not.

ACTION: Dr Williams and Hazel Potter to write to the Health & Wellbeing Board pointing out our concern that the provision of smoking cessation services is poor and asking them to provide figures

15/107 GPDF Support for GP Networks and Federations
Lisa Soultana has submitted a £10k application; the maximum allowed and is awaiting a response.

15/114 LMC Conference Reports
You were sent these in advance of the meeting. Dr Hands said there is no great surprise. Dr Kinsella said it is interesting to hear. Dr Hands said there is low morale, and quality of life is more important than money and we need to reflect where we all are.

15/115 Working with the General Practitioners Committee - Survey
Dr Williams reported that GPC has sent out a survey about how GPC can work with LMCs. They have requested one response from each LMC. Brought here to see if any burning issues otherwise Dr Grenville will complete this on behalf of the LMC. Dr Kinsella said GPC still seems detached as this is something that happens in London. Dr Williams said for our particular interaction with GPC we have Dr Holden who is our representative. We hold the LMC meeting every first Thursday of the month but often Dr Holden is down at GPC. Maybe he will be able to attend more frequently in future so will be able to feedback on GPC matters

Dr Ashcroft asked how, even if Dr Holden was able to attend more often, we can feedback to practices what is happening at GPC. Lisa Soultana is trying to feedback more in the Newsletter. Dr Ashcroft asked if we can we do something different. Dr Grenville said if a

practice raises a query with us that is relevant to all practices, we will put information in the newsletter. Also we can raise issues with GPC via Dr Holden, as our regional representative. The LMC list server is very useful. We could have a discussion list involving every GP and doctors.net.uk could fulfil this function but only a minority of GPs find it possible to keep up with this. When he was on GPC he was getting several hundred emails a day.

15/116 Representation of recently qualified LMC members onto GPC

Dr Grenville said that GPC would benefit from a higher percentage of younger members. The LMC is keen to encourage younger GPs to try to get on to GPC and we can advise on the various means of doing this. We need to see send younger LMC members to the Annual Conference of LMCs. Dr Betteridge made an impact at last year's Conference. We need to think about this when we appoint reps in January but we only have 4 seats. There needs to be experience as well as younger members. GPC have made a "nod" towards this as they have created an extra seat for a younger or less experienced member this year. Dr Williams said if you want to consider this speak to Dr Grenville.

15/117 Smoking Cessation – Derbyshire County Council

Already addressed under **15/97.**

15/118 PREMISES

Dr Grenville and Nwando had a meeting with Martin Royal regional Director of NHS Property Services. He said all the right things but it remains to be seen whether he delivers. NHSPS are required to act in a commercial way. Somehow, someone has to take on less fit for purposes properties. Derbyshire is not as bad as other areas. It was agreed that the LMC will act as a conduit between NHSPS and those Derbyshire practices that are affected by their decisions.

Jackie Pendleton said all CCGs have been instructed to prepare a strategy for how estates need to develop. This is to include Primary Care. The next tranche of the Infrastructure Fund should become available soon. Dr Grenville was concerned that the lead time for preparing bids and spending the money will again be unreasonably short. He also feared that bids would have to be passed up to regional or even national level for priorities to be decided and this could reduce Derbyshire's chances of receiving funding.

15/119 INFORMATION MANAGEMENT TECHNOLOGY (IMT)

Dr Grenville noted that central funding for SMS messaging services from practices to patients is to be withdrawn from September and CCGs are to become responsible for funding and procuring these. We have written to our CCG's to ask what plans are when the service stops. Rakesh Marwaha from Erewash CCG has responded to say they are procuring from EE. Dr Grenville said if the service ceases in September it could make life difficult for Prime Minister, who thinks that all NHS problems can be resolved by IT.

15/120 CLINICAL COMMISSIONING GROUPS (CCGs)

- Basket of Services (NDCCG)

The LMC is concerned to know why CCGs have been told that they must use the NHS standard contract and would like to see the statutory basis for this. It was noted that NHS England have used a SLA to commission flu immunisation from pharmacists. Many clauses in the standard contract make no sense when applied to General Practice. Many practices have requested an explanation. We have not previously had CQUINs in the basket of services. The sums involved in these could be significant. There was concern about some of the targets, for instance; a 5% reduction in emergency admissions care homes. This may be beyond practices' control.

Jackie Pendleton reported that the CCG had received from Dr Holden raising a significant number of queries about the BoS and about the contractual process .She noted that CCGs had received firm instructions from NHS England that they must use the standard NHS contract when commissioning anything other than GMS, PMS or APMS from practices. This year's iteration of the standard NHS contract was issued very late by NHS England, which explains why there is now so much pressure to get the contracts signed quickly. The CCG held drop in session with practices. Jackie confirmed that the use of CQUINs is mandatory under the standard contract. She emphasised that the CQUINs that are included relate only to the capture of activity data relating to certain parts of the BoS and that these data are required to evidence the contention of practices that workload is increasing and that the value of the BoS should therefore be increased.

Dr Williams emphasised that this is a complex legally binding document and that practices must therefore give it very detailed consideration.
Jackie Pendleton said that the CCG has tried to keep it as simple as possible. But she noted that some practices have previously signed up for various services and are being paid for them but are not delivering.

Dr Williams said there is a 2.5% claw back from the entire basket of services, if a practice defaulted on only one area. Jackie Pendleton reiterated that the CQUIN relates only to data collection.

Dr Ashcroft is keen for services to be commissioned on an item of service basis so that each party can see exactly what is being delivered.

Dr Ashcroft noted that injections and minor surgery have been taken out of the BoS but have been reintroduced as standalone services. Dr Grenville has accepted that clinically the basket of services is sound (although parts of it need updating) but the is concerned that there is no more money and is worried that this contract commits practices potentially for five years.
Dr Williams will report back on the discussion from today.
ACTION: Dr Grenville and Dr Holden will do some work on this and will report to practices.

- **Co-Commissioning**

The LMC has been invited to sit on the co-commissioning committees (PCCCs) at North Derbyshire, Hardwick and Erewash. Lisa Soultana has a teleconference on 3 July for Hardwick. PCCCs will be the final decision makers regarding the commissioning of Primary Care and the LMC will provide non-voting members. The LMC can inform PCCCs who will be on steep learning curve. These committees take on a number of functions that NHS England used to exercise, for example applications for list closures and branch closures. They also look at more strategic elements of how the CCGs want Primary Care to develop in their areas, also the quality. Some have suggested preparing a score card for general practice. Dr Grenville noted that this is not a new idea, having been around for many years but never properly achieved.

Dr Wood reported back from the NDCCG primary care development group. It had discussed procedures of limited clinical value. There is an intention to educate patients and also to support clinicians. He also spoke about wi-fi access in practices. DHIS are spending money to make this available. Dr Williams said although his practice now has wi-fi the need to have a password is creating a barrier.

Dr Ashcroft asked about PLCV. Jackie Pendleton said that the policy remains in place; it has been refreshed but there are no major changes. It is designed to use evidence based

information to treat the right patients at the right time. Dr Williams described the anger of a patient who could not get varicose veins done for second time, as it was regarded as cosmetic. Jackie Pendleton said that the Map of Medicine has been updated and it is much easier to use. Dr Ashcroft was concerned that standards should be set nationally and not left to local discretion.

Winter Pressures
Dr Wood reported that the Northern Derbyshire System Resilience Group will meet tomorrow.

Dr Wood noted that all North Derbyshire localities are represented at PCDG but he has pushed for all minutes to be sent to all practices. Dr Grenville commented that if one email is sent to each practice there may be a problem if that email is not circulated to all who need to see it. Dr Dils described her practice's system whereby one clinician and one manager look at all incoming emails to decide what needs to be circulated to other members of the team.
ACTION: Newsletter Item describing this system.

Holywell
Jackie Pendleton reported that NDCCG are exploring with NHS England the options for continuation of services at Holywell.
Dr Betteridge asked if the care offered by CRH delivers a good service to patients. Jackie Pendleton said it does. Approximately 600 patients have moved to other practices,
Dr Ashcroft said that if a branch surgery closes there could be workload issues for neighbouring practices.

15/121NHS ENGLAND NORTH MIDLANDS (formerly AREA TEAM)

- **Mechanism of collection of Levy Payment**

Dr Grenville believes that the mechanism of levy collection remains with NHS England. He will speak to Joe Lunn about it. We are relying on agreements signed between practices and former PCTs.

- **Neonatal Hepatitis B Pathway**

Dr Grenville noted that the new pathway mandates a heel prick blood test after the final injection to check whether the baby has sero-converted. He has had an email from the Vaccs and Imms department at NHS England North Midlands to say that feel that it would be advantageous if the blood was taken in practice, where vaccinations were given. He emphasised that this is not part of the nationally commissioned pathway and it would need to be commissioned locally. CCGs are required to commission a service from someone but we do not yet know how our CCGs propose to do this. He was concerned that, with the predicted low numbers, there was a danger that the clinicians who would do this if it was commissioned at practice level would not do enough to keep up their skills.

15/122 CARE QUALITY COMMISSION (CQC)

- **Notification of CQC scheduled inspection document**

Lisa Soultana said there are subtle changes about what you need to do prior to an inspection and you can find this on the LMC website. There is a list of documents required. Dr Williams said that notification of an inspection can sometimes be less than a week. This gives three working days to submit. He emphasised that it is important to be clear about what CQC is asking and to submit the relevant evidence. The original email request goes to the Registered Manager with only a few days' notice so it is vital that that person's inbox is monitored when they are away. The pack comes by post addressed to

the Registered Manager by name. Lisa Soultana said it is important have procedures in place to pick up communications to the Registered Manager when s/he is on leave.

Dr Betteridge said when he inspected a Mental Health Trust they had spoken with A&E staff to see what liaison is like. Dr Williams said CQC spoke with 5 different care homes so they interact with other agencies to get feedback. Dr Grenville said CQC must be rattled, as last week they set up a 7pm teleconference at two days' notice. Unsurprisingly, no one attended. He doesn't think CQC is fit for purpose to regulate Primary Care and this is reflected in resolutions from both the Annual Conference of LMCs and the ARM of the BMA.

15/123 PRIMARY CARE DEVELOPMENT CENTRE (PCDC)

Lisa Soultana said subject to agreement with Hardwick CCG, all CCGs have committed to year 2 support. PCDC has published a survival guide for practices. On 24 August there is a stakeholder event including CCGs. It will "Confirm, Challenge and Shape" the future development of the PCDC future and debate what success looks like. There are a number of skilled facilitators who can assist practices with their development needs.

ACTION: If interested in becoming a facilitator see Lisa.

Dr Ashcroft noted that PCDC has a programme of learning for general practice, and asked if the PCDC doing anything more radical. Lisa Soultana has been pushing to get investment for a couple of years. Dr Ashcroft said the CCGs are giving money for this.

Dr Williams asked if we really want 'lean general practice'. He cited contracting out home visits, for example, and taking a slight cut in funding. He thinks keeping things in-house and doing them well is better and more efficient.

Lisa Soultana thinks that there are savings to be made in administration processes but practices need the right kind of people to understand how to do this. She would like to parachute retired GPs into practices to try to improve efficiency and reduce costs.

15/124 LOCAL EDUCATION TRAINING BOARD (LETB) / LOCAL EDUCATION TRAINING COUNCIL (LETC)

Dr Betteridge said that the GP TAG first meeting took place last Wednesday with a re-energised Derbyshire workforce group organised by HEEM and key stakeholders from across Derbyshire. Jackie Brocklehurst had explained how workforce planning all ties together. Dr Betteridge said this group gives a GP perspective for delivering work. Lisa Soultana says it is tied into 10 point plan. Also it takes into account a new trainee GP perspective. There are more medium and long term work streams which will be developed. Dr Paula Crich the Dean from Derby University is also there to make sure that they are meeting Derbyshire Health needs. Dr Betteridge will be chairing the meetings. Representatives for every organisation attended, except Hardwick CCG and the two acute hospitals. The challenge is to maintain engagement and, going forward, to challenge LETC's and LETB's to move resources into the community.

Lisa Soultana said the Strategic Workforce Group meeting was held this week and it was identified that it was important to invite representatives from CCGs. She noted that this was a decision-making body and feeds up to LETB/C how the £1.5m transformational budget plus £0.5m budget to train 10 ACPs should be used. There is £150,000 to train for end of life care.

£750,000 is shared across provider organisations across Derbyshire and that includes 116 practices. But we need to challenge HEEM to develop a formula as we serve 1 million

people and only got £10,000 in 2014. Lisa had made the point that it is in everyone's interests that general practice is supported and recognised as part of the solution.
Dr Grenville noted that ACPs are unregulated as a professional group.

15/125 OFFICE REPORTS
No items were raised.

15/126 GPC NEWSLETTER – JUNE 2015
No items were raised although Dr Ashcroft noted that the Secretary of State has announced a 'new deal' for general practice and we gave it the discussion it deserved..

15/127 ANY OTHER BUSINESS

- **Provision of private meningitis B vaccine to children outside the scheduled programme**

Dr Betteridge asked about the private provision of Meningitis B vaccination. Dr Grenville said that the NHS provision is being phased in by age groups. Practices can give it to other age groups if a clinician believes that it is indicated but cannot charge their own patients.

The meeting was closed at 17:05.

15/132 DATE OF NEXT MEETING – 3 September 2015