Approved minutes of 1 May 2014

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DERBY & DERBYSHIRE LOCAL MEDICAL COMMITTEE Ltd

Minutes of a meeting of Derbyshire LMC and Derby & Derbyshire LMC Ltd held on Thursday 1st May 2014, Higham Farm Hotel

PRESENT:	Dr Peter Williams (in the Chair)	
	Dr John Grenville	Dr Murali Gembali
	Dr James Betteridge	Dr Sean King
	Dr Peter Enoch	Dr Mark Wood
	Dr Andrew Jordan	Dr Kath Markus
	Dr Paddy Kinsella	Dr Vineeta Rajeev
	Dr Pauline Love	Dr Peter Holden
	Dr Jenny North	Kate Lawrence
	Lisa Soultana	Dr Brian Hands
	Dr Gail Walton	Graham Archer
	Dr John Ashcroft	Dr Greg Crowley
APOLOGIES:	Jackie Pendleton, NDCCG	
	Dr Ruth Dils	
	Dr Denise Glover	
	Hannah Belcher	
IN ATTENDANCE:	Hazel Potter (Minutes)	Gail Walder (NDCCG)
	Nwando Umeh	John Hutchison (NDCCG)
	Dr Ramanathan (Trainee)	Dr Sasha Wheatcroft
		Jenny Doxey (DHU)

In attendance – Dr Williams welcomed Hazel Potter to take the Minutes, as well as Nwando Umeh from the Derbyshire LMC. Also Dr Greg Crowley introduced his guest Dr Ramanathan.

14/70 APOLOGIES

Apologies - received from Jackie Pendleton, Dr Ruth Dils, Dr Denise Glover and Hannah Belcher.

14/71 CLOSED SESSION (MEMBERS ONLY)

No items were discussed.

14/72 EXPENSES/ATTENDANCE REGISTER

Members were reminded to ensure that the Attendance Register was up-to-date for remuneration purposes.

14/73 MINUTES OF PREVIOUS MEETING

a) The Minutes of the meeting of the 3rd April 2014 were approved and signed by the Chairman as an accurate and true record, subject to the below amendments: -

b) Dr Ruth Dils Did attend.

c) 14/54: Dr Mark Wood covers North **and South**

d) 14/40: There had been a stormy opening meeting and another **meeting** was planned.

e) 14/63: CQC – Dr Wood **reported** on the new **In Hours** service inspection regime…

f) 14/68 2): Dr Love asked for the first sentence to be replaced with **Dr Love said that the area team have been holding meetings with various colleagues though out Derbyshire and Nottinghamshire with regards to DNACPR forms. When Dr James Gray worked with EMAS he discussed Nottinghamshire PCT paying approximately £20k to enable them to register patients who had a DNACPR in place. She is hoping that, as EMAS are moving to electronically seeing the Rightcare plans which will have the DNACPR attached that there will be some agreement for the DNACPR forms to be signed electronically.**

14/40 Community Hospitals

Dr Ashcroft is attending a meeting on Wednesday 7th May regarding GP contracts. Dr Holden said there might be redundancies involved. His practice has been sent a contract for services. DCHS are proposing to load all of the risks onto the GP and not pay any more for it. Dr Love said DCHS are keen to use Nurse Practioners. Dr Ashcroft said he would prefer a sessional rate to cover the wards as the money is better. Dr Grenville suggested that representatives from each community hospital should liaise to ensure that fair, transparent and equitable contracts were being offered. Dr King said that there is a suggestion that ward cover is to be provided by a lead practice. Dr Holden suggested escalating this issue to the BMA. Dr Williams agreed that GPs should talk to each other to make sure we get one uniform contract. Dr Grenville suggested that we should try to find one named representative from each of Buxton, Matlock, Ashbourne, Darley Dale, Bakewell, Ripley and Heanor Community Hospitals to work together to find a solution. Dr King wondered whether the provider federations could get involved. Dr Holden pointed out that this would involve acting as an employment service and that there would be a need to charge VAT. Dr Grenville discussed the need for all practices to consider their long term strategy. He said that they should consider either retrenching to their core services or pursuing the path of continual expansion. He pointed out that the NHS is in severe danger of failing and that politicians are seeking ways to ensure that doctors, and not themselves, are blamed by the public for this.

ACTION: Dr Ashcroft will send an invitation for a 1 hour meeting to discuss the community hospitals very soon.

13/21 Health Visiting

Dr Williams said Health Visitors had been told not to make entries into software systems other than their own (TPP). He was concerned that this was a risk to good communication and presented real clinical risks. Dr Kinsella said she was surprised this has been taken so literally and there should be an arrangement in each practice for how crucial information is recorded and communicated. Dr Williams agreed and said even if "no concerns" are raised it should be recorded. Dr Grenville noted that the LMC had been involved in writing a protocol for communications between practices and Health Visitors.

ACTION: Dr Grenville to write a letter to Tracy Allen (Chief Executive of DCHS) to request that staff be made aware that they need to use discretion so that records do show when they have made contact with patients.

14/63 CQC

Dr Wood described the new system for CQC inspections of general practice. The inspection team consists of the Project Manager, a GP, a GP Registrar, a Nurse and a lay Inspector. Discretion is being used. There are 4 levels of quality, being Outstanding, Good, Requiring Improvement or Inadequate. Inspections are to be performed across localities and may last several days. Dr Betteridge has one to do next week. In the light of the professional time and expertise that would be required to undertake these inspections Dr Grenville informed the Committee that there are elements in the NHS England Area Team, led by the Chief Nurse, who are of the opinion that no application for list closure should be supported unless and until all the partners have relinquished any outside appointments and have committed to full time working within the practice. He feels that, with the increasing demands upon GPs in the NHS – e.g. to fill places on CCG Boards – and GPs' desire to balance their work and personal lives, this is outrageous. Dr Holden agreed and asked that GPC be made aware of the situation. Dr Wood noted that it was CQC's intention to inspect every practice every 2 years. Dr Hands commented that the Health Care Commission had been unable to maintain its inspection regime because of a lack of resources. Dr Grenville pointed out that the overwhelming desire for inspection was driven by well-publicised failings in the health and social care settings and it was unlikely to go away.

ACTION: Dr Grenville to write to GPC about list closure applications.

14/75 Kate Lawrence is Retiring

Dr King wished Kate good luck and said he was sad to be losing her. Kate has been a valued member of the LMC. Calm and competent, with a sense of humour and Kate was very efficient when he was the Chair. Kate has been a Liaison Officer covering North Derbyshire and has got to know a lot of GPs who hold Kate in high regard. Kate has represented the LMC and he has never heard a bad word said about her. He is sad that she is leaving but thanked her deeply and wished her a very happy retirement. Dr Williams echoed what Dr King had said. He said everyone speaks with Kate with warmth and she has been a huge help and support. Dr Grenville said he has worked with Kate for 12 years on a day to day basis and she has been his right hand person during a period when the LMC has had to face significant changes. Kate has been steady as a rock. He said that retirement comes to us all and he wished Kate and Dave all the happiness they can have in their retirement. Lisa Soultana read out a poem to mark the occasion and presented Kate with gifts from LMC members and others.

Kate replied that it has been a privilege and a pleasure to work with the LMC and great to be associated with her colleagues, including Melanie and Shelley when she first started at the LMC office in Derby. At that time all she saw at the LMC meetings was a sea of male faces, mostly in suits and older than herself, with one solitary female GP. It has changed enormously over the years. She said we have all been marvellous and it has been a pleasure working with us all. Kate thanked everyone for her gifts and wished us all the best for the future.

14/76 111 Futures Project – John Hutchison (NDCCG), Gail Walder (NDCCG), Dr Sasha Wheatcroft (Clinical Lead for 111 Commissioning in Derbyshire) and Jenny Doxey (DHU)

Gail Walton, Dr Sasha Wheatcroft, John Huchison and Jenny Doxey gave an overview of the national programme. Most areas have stand alone 111 services with separate out of hours providers. Derbyshire is almost unique, with DHU being the provider of a fully integrated 111 and out of hours service. DHU also provide the 111 service, but not the out of hours services, in Nottinghamshire, Leicestershire and Rutland and Northamptonshire.

Concerns have developed about the effectiveness of 111 nationally and a review is to be undertaken. It is being largely driven by Keogh's review of Emergency & Urgent Care Services A series of pilot projects are to be undertaken to explore the way forward and DHU has

volunteered to be a pilot site. The timeline for completion is September to October 2014. There are 8 different pilots/audits/reviews as follows:

1. GP early intervention
2. Increased publicity about 111 – smart call to make, prior to going to A & E
3. Expansion from telephone only access to 111 to a web access with symptom checkers. (similar to NHS Direct)
4. Increased understanding of the impact of 111 on out of hours services
5. increased understanding of the impact of 111 on ambulance services
6. Exploring the impact of the development of a "crisis record" for use across Urgent care Services
7. Exploring the possibility of better integration within community services
8. 111 Call Advisor and Nurse Advisor perceptions project

Jenny Doxey explained that DHU has agreed to explore GP early intervention. There is a suggestion that if there is earlier clinical input there will be a better patient outcome. Two scenarios are to be explored; firstly, direct passing of calls to GPs and, secondly, GPs 'walking the floor' in call centres to pick up quickly complex calls. It will be essential to prove the outcome and measure this in some way. Deloittes have been commissioned by NHS England to undertake the evaluation. There will be 2 GPs' from 06.30am to 10.30pm on Monday to Friday and from 08.00am to 08.00pm on Saturday and Sunday. However there is a risk that sufficient GPs may not be available. The GPs would be used for phone triage and would support the nurses in the call centre. This will only be undertaken in the Derbyshire area. There are difficulties with regard to VAT issues. There is also not much time to plan, train and recruit as the pilot is due to start at the end of May. Some GPs have been recruited but there is a need for more.

Following the presentation questions were asked:
Dr Holden declared an interest as GPC's national lead on 111. He pointed out that there may be significant indemnity issues for GPs undertaking this work. The Medical Defence Organisations are already loading the premiums of GPs who entirely or mostly undertake out of hours work. The MDOs may decide that significant extra amounts of telephone triage work present extra risks. He asked that DHU should clarify the indemnity arrangements for GPs involved in the pilot. Dr Grenville is concerned about the very short timescale for implementing and evaluating these pilot projects. Dr Wheatcroft agreed that the timescale was worrying and noted that it has been London-centric. London has been working on this for a long time. However, Derbyshire is a prime site for piloting new initiatives. Gail Walder was clear that the commissioners will not allow the pilot to start until it is ready. Dr Wheatcroft said that 111 is national but it is up to us to deliver it locally. Dr Holden said that he is having a series of meetings with senior officials nationally to explore the relationships between 111, ambulance services and emergency admissions to hospital. Gail Walder agreed we need to work to get the interface right; that is why the DHU work is so important. Dr Holden said the model is right and we must build on Derbyshire's unique integrated model. Jenny Doxey explained that we need evidence to show that experienced clinicians can safely downgrade a significant proportion of calls where the use of the NHS Pathways algorithm by call-handlers results in an ambulance or emergency department disposition. Dr Hands asked how sufficient numbers of GPs can be recruited for this. He pointed out that there are not many available as most are already working 12 hours per day. Dr Grenville said that we need to find ways to incentivise GPs who are not working full time in practices to take this on. He suggested that GPs at the end of their careers might be ideally placed to take on this work. The barrier is regarding revalidation and indemnity. Dr Holden said that the GPs they need should have at least 10 years' experience to take this on as it is mostly clinical lead experience that is required. Dr Wheatcroft does not think the indemnity will be covered by the 111 contract. Dr Holden pointed out that if we avoid one hospital admission we save £2000 and one ambulance not used saves £300. It should therefore be possible to cover indemnity costs.

Jenny Doxey said there are already 7 GPs willing to take this on but 3 to 4 more are required. Dr Holden drafted a resolution supporting the DHU pilot but urging caution to ensure the best outcome:

That, concerning 111 Futures Pilot 2 - GP early intervention, Derbyshire LMC

1. Supports DHU in its operation of 111 services within the East Midlands
2. Supports the fully integrated existence of DHU Out of Hours service with 111.
3. Insists that such an integrated service is the only way to go in the interests of seamless quality care of patients
4. Believes that the DHU 111 pilot on GP early intervention is a valuable, essential test of potential substantive service, which
    a. requires proper piloting and evaluation
    b. requires involvement of GPs with very significant experience (20 + years) rather than recently qualified GPs
    c. needs to harness the valuable experience of peri-retirement GPs by addressing the revalidation appraisal and indemnity issues to enable their participation in such work
5. Understands that a number of very significantly experienced GPs are willing to work on the pilot but that a few more remain to be recruited to make this essential pilot work and that it may take another 4-6 weeks to initiate the pilot fully
6. Recommends that DHU/111 clarifies of the indemnity issues for doctors undertaking such work

This was passed unanimously.

ACTION: Hazel Potter would forward the resolution on 2nd May 2014 to Lindsey Wallis Chief Executive of DHU, and Jackie Pendleton, Chief Operating Officer of NDCCG.

14/77 AREA TEAM

- **Challenge Fund**

Dr Grenville said that the challenge fund bid by Nottinghamshire and Derbyshire Area Team had been successful and had been awarded the second largest share of the £50m fund. Each CCG had participated and the bids for each had been accepted, except for North Derbyshire. He noted that if the pilots were successful it was expected that they would be continued and expanded into 2015-16 and beyond but that no new money would be made available. He was very concerned about how this might be achieved and gave as an example Erewash's intention to expand 8-8,7/7 access from a few of its practices to all of them. Dr Ashcroft agreed that this was likely to be a major problem.

- **CQRS**

Dr Markus discussed CQRS as she had received an email from the Area Team regarding CQRS and DES payments. It stated that only shingles vaccination can currently be claimed online. There is no way that the other DES payments can be claimed manually. She has checked with the Area Team and made them aware that this is a cash flow issue for practices. Dr Grenville informed the committee that he had emailed the Area Team regarding this a few days ago. He has had a subsequent meeting with the Area Team at which he mentioned the issue. The Area Team are equally unhappy with CQRS. Dr Grenville noted that CQRS is a central government funded IT project and appears to have suffered all the problems that are characteristic of such projects. Dr Markus also said claims for sexual health services should be claimed monthly but her practice had received a cheque today which covered the previous 11 months. She felt that

practices need to check that they are receiving payments. However, Dr Kinsella thinks they are paid quarterly.

ACTION: Dr Grenville to ask Practices to check if they have received payments.

14/78 CCGs

- **£5 per Head for Frail and Elderly Care**

Dr Grenville said this is a national problem. The CCGs are expected to find £5 per head to support practices to provide services for frail elderly patients. However, there has been no extra money provided. CCGs will need either to look at the current spend and rebadge it, or to disinvest the £5 from other services which would involve going to Health and Wellbeing Boards to explain the changes. The only alternative is to tell the Secretary of State that it can't be done. The GPC wants to know what is happening in each locality as they need to inform the public about what has been proposed and what is happening. There is a GPC survey for all GPs to complete regarding their experience of CCGs after 1 years existence. He asked that all GPs do complete this as a matter of urgency. Dr Ashcroft commented that he thinks CCGs will just rebadge and Dr Grenville confirmed that some CCGs have already done this. We need to make the case that the money should have gone into general practice, which is currently starved of resources. Dr Grenville stated that GPs can bid to the CCGs for the money. As long as CCGs are not getting bids they will say there have been no bids and therefore they have spent the money in other ways. The difficulty is that if people on the ground make bids for money that is not there, CCGs will struggle to break even. This confusion is an inevitable result of the Health and Social Care Act. Dr Gembali recently attended a CCG meeting and was told the £5 does not exist. Royal Derby Hospital has a £9m deficit so the CCG will concentrate on sorting out the deficit. Dr Grenville suggested putting forward schemes publicly so that when it does not happen you can say you have done what you have been asked to do and it still didn't happen. Dr Ashcroft said that his practice had asked for an extra community matron and they weren't allowed to have one. It was agreed that all agencies would have to work together and that it was likely that money would be rebadged to identify it as the £5 per head.

14/79 Primary Care Development Centre (PCDC)

Lisa Soultana spoke and said the PCDC is a not for profit organisation and the LMC is one of the founding partners.

There has been a "soft" launch of the PCDC but the formal launch will be held on the 26th June 2014 at the Belfry, Nottingham - on an invitation only basis, due to the large number of potential stakeholders.

The Governing Body has now been established with the following appointments for Derbyshire - Dr Kinsella, Vice Chairman, Sarah Longland, Workforce Development Lead and Lisa Soultana, Organisational Development Lead. There are several advisory groups mostly consisting of GPs, Practice Nurses and Practice Managers including the following Practice Managers - Anne Armstrong, Rebecca Orgill, Nicola Bromurski, Helen Foster and Michele Slimm and the following Practice Nurses - Hayley Disney. The PCDC are still looking for further members - if you are interested in joining please contact Lisa.

Dr Grenville said we are still talking to all the Derbyshire CCGs to gain their support and associated funding. Southern Derbyshire CCG fully supports the PCDC and has made a financial contribution to support its development. Lisa has sent a letter to the other 3 CCGs and we are awaiting their response. The Area Team fully support the PCDC and have awarded funding towards its development. (Post meeting note - Erewash CCG now fully supports the PCDC and will be making a financial contribution to support its development).

Lisa recommends practices to start thinking towards developing a workforce development plan and undertake a training needs analysis to bridge any future workforce and training gaps. The LMC will be undertaking a survey to capture some data and information related to this.

Lisa said the PCDC will offer good practical training workshops and offer access to resources to help equip practice managers, GP, GP provider companies and any future collaborative working models with the skills, to help them cope with the changes, challenges, threats and opportunities that Practices are currently facing.

Dr Ashcroft said we might have to bid for Councils LES's.

14/80 ANNUAL CONFERENCE OF LMCs - 22nd to 23rd May 2014, Barbican, York

Dr Grenville said the agenda will be published tomorrow. He asked the representatives to look at the motions to see what will be debated. Also to see if there are other motions that they want to speak for or against. Dr Ashcroft said they should also look to see if they want to amend any motions.

14/81 LETB / LETC

Dr Grenville said the he and Lisa had attended a meeting to pitch PCDC to Derbyshire LETC. There has not been a LETC meeting since the last LMC meeting. Dr North has agreed to act as Dr Grenville's deputy for LETC. Lisa said that LETB and LETC have pockets of money to go out to service providers. Lisa has information regarding what might be available for practices across Derbyshire.

14/82 OFFICE REPORT

Dr Williams mentioned the possibility of the Derby LMC office relocating. Dr Enoch was not keen for the LMC meetings to take place in Derby City as it is not a central location. Dr Williams explained that we need improved office accommodation as there is no proper kitchen facility and we can't invite too many people for meetings. We will be investigating alternative office accommodation before the lease ends in October 2015 and it will be discussed at the LMC Executive meeting. Dr Grenville said we are still in the early stages of discussing the office accommodation and we need to think about what is reasonable for everyone. Dr Holden mentioned the current office accommodation is not ideal but it may be a possibility to stay in the same building in a larger room with better facilities.

Dr Kinsella mentioned the SAGE training. Dr Holden explained the payroll has been outsourced. Nwando is new and needs to be trained. Dr Kinsella mentioned that SAGE online would allow remote access to accounts.

14/83 ANY OTHER BUSINESS

1) Dr Ashcroft talked about the Avoiding Admissions DES and said we need to identify patients at high risk of admission as we need to do care plans. Dr Williams said it is different in different parts of the county. Where risk stratification is already in place it can be continued but where it has not been there are Information Governance issues about whether it can be introduced. Practices may have to do their own risk stratification. Dr Markus noted that if there is a Right Care plan in place it should be accepted that the practice has identified that the patient is at high risk and that a care plan has been put in place. Dr Holden informed the committee that discussion were ongoing at national level about the timescales attached to this DES.

2) Dr King mentioned that the BMA has today commenced an e-petition asking for repeal of the Health & Social Care Act and he read out a link to all of the LMC members. Dr Grenville said that a number of the newly elected members of the BMA Council are opposed to this act. Dr Holden said that it is the nature of democracy that we have to work with the government and although we can try to change this there is now very little time before the next election. Dr King disagreed and said that in a democracy the e-petition is there to raise concerns about the current government. Dr Holden considers it is more important to get short term problems, such as cash flow and premises sorted out now. Dr Holden said the BMA is supposed to be a non-party political organisation and at the moment trying to get rid of the Health & Social Care Act may not be a good use of its resources. Dr Grenville said that in the past the NHS was a service provided by the government. In future it will be a franchise provided to people by independent providers with a degree of regulation. It is not strictly a party political matter, but more of a question of peoples' fundamental attitudes and beliefs. Since about 1980 there has been a shift away from the notion of governments directly providing services to citizens and we need to learn to live with that in a way that best serves our patients.

3) Dr Williams said that Dr Rebecca Hall is organising a GP Registrar awards ceremony across East Midlands and is asking if the LMC will sponsor the event. Dr Holden suggested giving £500 and Dr Betteridge thought it was a good idea as anything that can be done to celebrate general practice especially at deanery level is a good thing. Dr Holden said we need to get the message across that the LMCs are a crucial support for the daily work of a GP so therefore we should support it. He also said we should think about the information that needs to be given out and explain why all practices need to pay the levy. Dr Wood said that he is a member the RCGP Vale of Trent Faculty Board, which is in contact with about 60 new trainees per year. Dr Holden suggested advising the course organisers that trainees should be encouraged to attend LMC meetings as they need to know what the LMC is. Dr North said that most trainees think they will be sessional GPs and have no interest in the LMC. Dr Markus said we need to plant the seed so they are more likely to attend. Dr Grenville said that trainers need to be told that learning about the LMC and the medico-political structure of the NHS is crucial for their trainees. He also mentioned that he will be speaking at the half day release programs in both Derby and Chesterfield in the next few weeks.

14/84 DATE OF NEXT MEETING – 5th June 2014

There being no further business, the meeting closed at 4.45pm