Approved minutes of 3 April 2014

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

DERBY & DERBYSHIRE LOCAL MEDICAL COMMITTEE Ltd

Minutes of a meeting of Derbyshire LMC and Derby & Derbyshire LMC Ltd held on Thursday 3rd April 2014, Higham Farm Hotel

PRESENT:	Dr Peter Williams (in the Chair)	
	Dr John Grenville	Dr Peter Short
	Dr James Betteridge	Dr Greg Crowley
	Dr Peter Enoch	Dr Murali Gembali
	Dr Denise Glover	Dr Sean King
	Dr Andrew Jordan	Dr Mark Wood
	Dr Paddy Kinsella	Dr Kath Markus
	Dr Pauline Love	Dr Vineeta Rajeev
	Dr Jenny North	Dr Ruth Dils
	Lisa Soultana	
APOLOGIES:	Dr Gail Walton	Dr Brian Hands
	Dr John Ashcroft	Dr Peter Holden
	Graham Archer	Kate Lawrence
	Dr Doug Black	
IN ATTENDANCE:	Jackie Pendleton, NDCCG	
	James Cutler	
	Dr Tasneem Tajbhai	
	Dr Maryam Nauman	
	Hazel Potter (Minutes)	

In attendance – Dr Williams welcomed Hazel Potter to take the Minutes, as well as Dr Tasneem Tajbhai and Dr Maryam Nauman (both GP Trainees) who were guests. James Cutler was introduced as a Liaison Officer who will start in June working alongside Lisa Soultana for the Derbyshire LMC.

14/50 APOLOGIES

Apologies - received from Dr Gail Walton, Dr Brian Hands, Dr Doug Black, Dr John Ashcroft, Dr Peter Holden, Graham Archer and Kate Lawrence.

14/51 EXPENSES/ATTENDANCE REGISTER

Members were reminded to ensure that the Attendance Register was up-to-date for remuneration purposes. Also as there are new forms members were asked to add their contact phone number.

14/52 KATE LAWRENCE IS RETIRING

Kate Lawrence is retiring in June after 12 years working as a Liaison Officer in the LMC and will be attending the next LMC meeting. James Cutler will be having a handover from Kate in June.

14/53 ELECTION OF CHAIR

Dr Peter Williams was proposed and elected unopposed.

14/54 ELECTION OF TREASURER AND EXECUTIVE OFFICERS
Dr Peter Holden (self-nominated) was proposed and elected unopposed as the Treasurer.

4 Executive Officers were required and all agreed it made sense to have 1 Executive Officer from each area.

6 people proposed to become Executive Officers as follows: -

Dr Sean King (North & South)	Withdrew but agreed to deputise if required
Dr Kath Markus (North)	Elected unopposed
Dr Jenny North (South)	Elected unopposed
Dr Paddy Kinsella (Amber Valley & South Derby)	Withdrew but agreed to deputise if required
Dr Mark Wood (Amber Valley & South Derby)	Elected unopposed
Dr John Ashcroft (Erewash)	Elected unopposed

It was noted that there was no representation from Hardwick.

Dr Betteridge as a trainee rep was co-opted onto the new committee and finishes training in August. He is sounding out a replacement. Dr Grenville discussed a letter he had received from a trainee GP which was sent to the Prime Minister and is delighted trainees are expressing concerns. Dr Betteridge commented only 40% of trainee GP vacancies had been taken up. He thought it would make sense to motion this for the conference that we need to generate new members from trainee GPs as they are now more politically motivated.

14/55 APPOINTMENT OF SECRETARY
No elected member of the committee expressed an interest in standing for this position. Dr Grenville was appointed to this position. He has been in post for 27 years and will retire in 2 years' time. It was agreed that it would be a good idea to find a replacement to shadow him closely before he retires from the LMC.

14/56 CLOSED SESSION
No items this month.

14/57 MINUTES OF PREVIOUS MEETING

a) The Minutes of the meeting of the 6th March 2014 were approved and signed by the Chairman as an accurate and true record, subject to the below amendments: -

b) Page 1 – Dr Jordan was **not** in attendance.

c) 14/40 e): Jackie Pendleton asked the text to state "all **North Derbyshire CCG** Practices will be receiving a letter regarding the future of Enhanced Services as some services which currently sit within the Basket of Services (BoS) **will no longer be commissioned by CCG's**. Every practice **that signed up for fairer funding has signed** a legal contract variation….

d) 14/40 e): Jackie Pendleton asked for the following addition to be made at the end of the last paragraph – **Income streams will change, especially Global sum and QOF and the effect on practices will not be known until the end of the 1st quarter. Current predictions of income are based on the assumption that practices will score the same percentage on QOF year on year, and that they will earn 100% of the recycled monies.**

e) After item 14/41 EPS NOMINATION, it was mentioned that Dr Markus left the room and she did not.

14/58 MATTERS ARISING

14/20 Child and Adolescents Mental Health Services (CAMHS)

The office continues to try to identify the appropriate people to invite to speak about CAMHS.

14/19 EMAS Response Times Interview

Dr Grenville had an interview with Radio Derby regarding the EMAS response times. It will be broadcast on Wednesday's breakfast show. EMAS have said that response times have improved significantly with 95% of targets being met. According to EMAS, when targets are missed it is only by a matter of seconds in most cases. Jackie Pendleton said that the targets are being very closely monitored and there are no major issues, although there is still a clear difference between missed targets in urban and rural areas. It seems likely that Radio Derby will present historical data and not current data. Dr Grenville had tried to make clear that performance has improved since we and Radio Derby requested information from EMAS. Dr Williams commented that the number of calls has been reducing and EMAS have actually been nominated for an award in Lincolnshire.

14/40 Community Hospitals

Dr Kinsella reported that DCHS was consulting on the future of Heanor Hospital. There had been a stormy open meeting and another meeting was planned. Dr Grenville pointed out that currently Community Hospitals are funded from the Parliamentary vote for Hospital and Community Care Services, which is separate from the vote for Primary Care Services and the vote for Local Authorities. If Community Hospitals are to be used in future for Primary Care or Local authority purposes there will be a need to ensure that money flows locally from one budget to another.

Dr Kinsella informed the Committee that Southern Derbyshire CCG had introduced a scheme whereby one bed in each Nursing Home had been designated as a rehabilitation/step-up/step-down bed. This was working well in terms of patient service but was creating extra work for GPs. Because of the scattered geographical location of the work it was very difficult to quantify the resources needed. She suggested that perhaps Alexin should get the contract for the beds created, as even though it's a small amount of money it is at least recognition of the GP's workload. Dr Grenville said that in the City there was currently one residential home that contained Intermediate Care beds. There was a contract in place for one practice to care for patients while they are in these beds. He pointed out that we are now looking at various different levels of beds in the Community. There are stable long term residents in beds in Nursing and Residential Homes, who tend to be frail and vulnerable with complex co-morbidities. This is partially recognised in the Carr-Hill formula and the extra pro-active care that can benefit these patients has been further recognised by the Care Homes Schemes in North Derbyshire and Hardwick CCGs. There is also respite care for patients with complex problems. Because these patients only occupy beds for short periods the GMS Global Sum and PMS Core Contract Sum do not compensate practices for their care. Similarly the complex needs of patients in Intermediate Care beds on a short term basis are not recognised by the GMS and PMS contracts. There is a need to define the types of bed that are required to implement integrated care and to ensure that they are properly resourced. Dr Short noted that the care of Care home patients is often very time-intensive and that this can impact on access for other patients to Primary care services. Dr

King said there are 70 private Care Home beds nearing completion in Buxton and he has concerns about how they will be covered. There has been no communication between the home's owners and the local practices. Jackie Pendleton reported that she has information regarding this and that an e mail conversation between the practices and the CCG might be appropriate. Dr King pointed out that the consequence of inadequate funding would be more old people admitted to hospitals inappropriately.

Dr Grenville said that if you are asked to register a patient as a temporary resident in your practice area you must do so unless you can show a non-discriminatory reason for not taking them and this includes short term admissions to Care Homes. Dr Gembali asked about the Area Team's proposed responsibility for arranging the visiting of patients who are registered with a practice but who live outside the practice area. Dr Grenville said that we have no details yet but that he thought that it was unlikely that it would apply to Temporary Residents. It would take a concerted national effort to instigate a blanket scheme for visiting patients in Care Homes to be decoupled from Essential Services. Dr Enoch reminded the meeting that concerted action by GPs in Ilkeston 50 years ago had brought about change in the financing of beds in Community Hospitals. Dr Williams said that action could involve the provision of immediate and necessary care and nothing more. Dr Grenville said that if GPs feel that a patient's needs are so complex that they cannot be dealt with in Primary Care a referral should be made, as an emergency if appropriate. But GPs frequently do have the skills to meet patients' complex needs – it just takes an inordinate amount of time. However GPs have to realise they will eventually burn themselves out and also if the practice is insufficiently funded the other patients will suffer. Practices must exercise their powers as members of CCGs and ensure that complex patients in the community are adequately resourced. There was discussion about the demand from Care Homes for visits because of their logistical problem in getting patients to surgery. The same obligations apply as for other patients and Dr Jordan mentioned the Staffordshire LMC home visiting algorithm. Unfortunately GPs are often put in the position that a patient's needs can only be met by making a visit that is medically inappropriate.

13/21 Health Visiting

Dr Williams asked if there has been any response regarding this and Jackie Pendleton said that the CCG are aware that we are worried about this.

14/59 OFFICE REORGANISATION

Dr Grenville explained that Helen Watts has left the LMC's employment and a statement has been issued in the Newsletter. Hazel Potter has replaced her as a temporary clerk to the LMC and PA to himself. Kate Lawrence is retiring at the end of June and Lisa Soultana will be promoted to Director of Business Development and Liaison. James Cutler will be joining as Assistant Director of Business Development and Liaison. These changes will be discussed at the LMC Executive meeting, which will follow this meeting. He plans to continue but will retire halfway through the 4 year term. There is more work to be done regarding finances and HR and soon we will be stable and able to develop. All of this is not cost free and the levy has been stable for 10 years. The level of the levy will be discussed at the LMC Executive meeting. He is aware of the financial pressure practices are under.

Dr Enoch said that Dr Grenville would have to be shadowed before he steps down as the job is very complex and Dr Williams said plans have been made for a successful handover.

Lisa Soultana suggested that new members should be "buddied up".

14/60 CONTRACT CHANGES

Dr Grenville said the contract has been changed from 1 April 2014. NHS England got the SFE out by 31 March 2014 but was likely to be heavily criticised at the LMC Conference for only giving 24 hours' notice.

The options for the new contractual changes are as follows: -

1. Look at the contract and retrench to delivering core primary care as there is a rough idea of what you will earn, enabling you to look at resources.

2. Look outside the core contract at how much might be expected from practices or groups of practices and try to bid for this against other Qualified Providers. Once you decide to do this you will have to continue to try to expand. You could either try this alone or seek support from provider groups such as Alexin. These groups will be in competition with big corporations. The contract changes are the most sweeping since 2004 and in association with the changes introduced by the Health and Social Care Act 2012 change the landscape of the NHS. Patients will notice a difference by October 2014. Lisa Soultana reminded everyone there have been 4 workshops set up by the Area Team at different venues on 7th, 8th, 15th and 16th April to discuss the various funding changes.

ACTION: Hazel Potter to send an email to practices with details of workshops.

There was discussion about the new DES for avoiding unplanned admissions. Details were not yet available but practices could, as a rule of thumb, assume that if they completed it successfully it would be worth about the same as 100 QOF points.

14/61 AREA TEAM

A. PRIMARY CARE STRATEGY

Dr Short could not download this document as it's too large.

ACTION: Area Team need to be told the Primary Care Strategy document is too large for the NHS mailbox

Dr Grenville discussed the Primary Care Strategy. There are different components for each of the 10 CCGs. The document is big on ideas for change but short on identifying the resources needed to implement them. Jackie Pendleton noted that the components in the overall strategy document for each CCG reflect their bids for the Primary Care Challenge Fund. It was noted that there did not seem to be a wider picture and the fragmentation of primary care into multiple functional contracts had not been addressed. Dr Markus questioned whether the data presented in the strategy document are correct. Dr Williams asked if the plan to produce care plans for everybody over 65 was realistic. Jackie Pendleton said Tracy Madge has developed a new care plan template. Dr Grenville suggested that the plan could be seen as emergency service care for the acutely ill at risk of imminent death, GP and Practice Nurse care for people with long term conditions and non-medical clinician care for all categories in between. He queried whether there is a sufficient supply of Urgent and Advanced Care Practitioners. Dr King believed this is a high risk strategy and Dr Grenville expressed concern that if things go wrong there will be no way back. There was discussion about the tension between the need for longer appointments for people with multiple problems and the demand for instant access. GP's should be more assertive about not taking on non-medical issues. Patients' expectations are unrealistic and they ask for things that should not be dealt with by GP's such as

asking for food vouchers. Dr Grenville empathised as it's easier to say yes than say no and risk being investigated.

AREA TEAM

B. PREMISES

Dr Grenville said there is no sign of the new premises regulations. Dr Holden told us they would be signed off this month. You can't provide care if your premises are inadequate. He noted that there remain unresolved questions about the times that rent re-imbursement is supposed to cover and regarding re-imbursement and abatement if other agencies use space in GP surgeries. There are still huge problems for practices in premises which were formerly owned by PCT's. Kate Lawrence had attended the last premises meeting and reported that little progress is being made with NHS PS.

14/62 CCG's

Jackie Pendlelton said there was new nothing new to report. Dr Grenville said he has been doing 360 degree feedbacks for CCGs. Many GPs still see CCGs as a direct successor to PCTs which is incorrect. Problems relating to GMS and PMS contracts need to be discussed with the Area Team, not CCGs. CCGs should continue to work with practices to help them to understand the new relationships. Dr Kinsella asked if CCGs are being dumped on by the Area Team. Jackie Pendleton said there are insufficient staff in both the CCGs and the Area Team. Dr Grenville said much Primary Care expertise lies within the CCGs. The Area Teams have an immense staff shortage, although our AT seems more responsive than many in other areas of the country. We can only hope changes at NHS England Board level will rectify some of these problems.

14/63 CQC

Dr Wood reported on the new In Hours service inspection regime which is being introduced in May.

14/64 PCDC

Dr Grenville asked if anyone would be interested in being a GP Board member. Dr Kinsella and Dr Betteridge would like to be considered. There is also a GP Advisory Panel that needs GP representation. It made sense that Dr Kinsella takes the Board position and Dr Betteridge will cover the position on the GP Advisory panel. Lisa Soultana mentioned that Practice Managers are also needed on the Advisory Panel.

ACTION: Lisa Soultana will be advertising for a Practice Manager. Please forward any suggested names to Lisa.

14/65 LMC CONFERENCE – 22nd to 23rd May 2014, Barbican, York

The motions have been circulated.

ACTION: Dr King asked for the last page of the motions to be amended to:
On the last page, item 27, (i) the responsibility for considering **and** advising on contraindications, side effects and **interactions**…

14/66 LETB/LETC

Dr Grenville said there has been a lot of discussion regarding this. Primary Care is represented by us on the LETC and also by Jackie Pendleton, who is also the voice of the CCGs. It was suggested that the CCGs should press for more representation to ensure that Primary Care has a stronger voice. Secondary Care is very heavily represented.

14/67 OFFICE REPORT

This has been tabled and no items were raised.

14/68 ANY OTHER BUSINESS

1) Jackie Pendleton said Midwifery ICE Reports are to be discussed at the Royal Derby Hospital.

2) 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. The question of mandatory appraisal of End of Life skills has been raised. Dr Grenville noted that it is important that GPs can demonstrate their skills in end of life care as appropriate to their role – some part-time GPs hand over patients who are approaching the end of life to more full-time colleagues because of the issues around continuity of care. If an appraisal highlights there may be a problem this needs to be added to the PDP.

3) Dr Short discussed the new GPSOC contract. This is not yet signed off with TPP. There are new modules for patient facing services. It is important that Practices keep up to date with developments.

4) IT problems and data sharing, especially care data, were discussed. Dr Short said that there is much confusion within HSCIC and NHS England re the legal basis and ethical issues and what the public will tolerate. As most Administrators, GPs and Practice Managers also do not understand this, how can we expect patients to make decisions? There is recognition that this needs clarifying within the next few months. We need to balance the risks and benefits of data sharing. It has been poorly communicated centrally and there has been a failure of trust. Therefore it cannot be implemented until NHS England and the Department of Health have undertaken further work. Caldicott 2 covers this and should put patients in control but patients are unaware what they are supposed to be in control of.

14/69 DATE OF NEXT MEETING – 1st May 2014

There being no further business, the meeting closed at 4.20pm