DERBY & DERBYSHIRE LOCAL MEDICAL COMMITTEE Ltd

Minutes of a meeting of Derbyshire LMC and Derby & Derbyshire LMC Ltd held on Thursday 6 February 2014, Higham Farm Hotel

PRESENT: Dr Peter Williams (in the Chair)

Dr John Grenville	Dr P Holden
Dr John Ashcroft	Dr James Betteridge
Dr Greg Crowley	Dr Ruth Dils
Dr Murali Gembali	Dr Brian Hands
Dr Andrew Jordan	Dr Sean King
Dr Paddy Kinsella	Dr Jenny North
Dr Paul Weston-Smith	Dr Mark Wood
Dr David Portnoy	Dr Kath Markus
Dr Pauline Love	Dr Peter Enoch
Dr Kaysia Gale	Dr Denise Glover
Dr Rachel Tinker	Lisa Soultana
Kate Lawrence	

Also in attendance were: Jackie Pendleton, NDCCG, Sue Noyes, EMAS and Graham Archer, LPC.

APOLOGIES
Apologies were received from the following people: Helen Watts, Hannah Belcher and Dr Brendan Ryan.

14/15 CLOSED SESSION (MEMBERS ONLY)
No items this month.

14/16 MINUTES
The data file taken on 9 January 2014 has corrupted on the laptop with the result that only scant details of the meeting are available. Dr Williams asked the committee to review the current draft and provide comment to the LMC office. The minutes will then be signed off as an accurate record at the next LMC meeting.

14/17 THE FUTURE OF GENERAL PRACTICE

- **The Guernsey Option**

Dr Williams reminded the committee that the Guernsey Option (GO) had been discussed before in a previous meeting. Since then we had asked all our constituents for their opinions via email. The LMC office received twelve responses. Ten responses were generally in support of the GO, one indicated it was a non-starter and one stated we needed a new model but not the GO. Many constituents shared their health care experiences from different parts of the world. The committee heard a flavour of the comments contained in the email responses.

Dr Jordan reiterated that a constituent had asked the committee to look at the GO. He said that this was just one particular model but we needed to talk about all potential options to include

thinking about a Plan B. The majority of GPs are not happy where they are and we need to do something before the system breaks.

Dr Grenville reminded the committee that the GO was written twelve years ago and it includes two different strands:

1. How is healthcare financed?
2. How are GPs remunerated?

He suggested focussing discussion on the underlying principles of the NHS, concentrating on which of them should, in the modern world, be considered absolute and which should be considered relative. He highlighted three principles:

1. Universal
2. Comprehensive
3. Free at the point of access

His personal view was that universality should be considered absolute as the principle of equality remains important.

He considered that comprehensiveness should be considered relative in the current political and financial climate. There was a pressing need to clarify what the NHS could and could not provide. He identified two areas that need to be looked at, namely, newly available high-tech expensive interventions that provide limited health benefit to relatively small numbers of people and existing low- or no-tech interventions that provide limited health benefit to relatively large numbers of people.

He concluded that, even if explicit rationing is introduced, the concept of care free at the point of access may well have to be eroded further than it already has been, eg, by the introduction of co-payments.

Dr Williams pointed out that there is a spectrum ranging from payments for items of service to inclusive contracts paying for a range of pre-determined services. He was concerned that the latter model (eg, the Basket of Services) carried the risk that the pre-determined services might be expanded without a corresponding increase in payment. He reminded the meeting, however, that the item of service system in the pre-2004 contract had generated a very significant bureaucracy.

Dr Hands noted that QOF is about to be radically altered, following significant government interventions over the years since 2004. Dr Ashcroft agreed, noting that some practices are questioning whether some QOF targets are worth chasing.

Dr King said at the moment we have only one employer and it would be very challenging to move to an insurance based system with potentially many organisations paying us for services. The 1948 model doesn't work anymore but he did not know of an alternative. Dr King did not think there was a single great idea/model and stressed that it's likely that this is because it does not exist. He emphasised that we should be looking at reform rather than revolution. Small changes in the way we operate should free up time. Federation may help us work in better ways but we all need to take responsibility to change things.

Dr Betteridge commented on the patient experience and was concerned about how this will change if we moved to an insurance based model.

Dr Kinsella recalled when her father worked as a GP in the East End of London prior to the NHS at a Shilling Practice saying it was a dreadful system if patients did not have the money. She felt that we should be moving towards better information for patients so that resources and services are used appropriately. She pointed out that there is a perverse incentive for patients to overuse NHS resources because they are free at the point of access.

Dr Enoch stressed that in all his time working and as far back as the 1950's GPs have never been happy apart, perhaps, from during the time immediately following the Doctors Charter in 1965, when GPs were reasonably happy. He shared with the committee a snap shot of his time as a GPC Negotiator where 90% of time was spent on maintaining what we had and there was minimal time for blue sky thinking. He thinks the picture would be the same today for the current GPC Negotiators.

Dr Holden agreed with Dr Enoch and reminded the committee that GPC was made up of working GPs and anyone who thinks that it does not review the situation is mistaken. He said that if GPs wanted change they needed to recognise that there was likely to be pain to achieve the objective. If GPs wish to change to a model that involves patients paying directly for their care at an economic rate, demand may fall dramatically and practices will inevitably need to shed staff but will need to employ debt collectors. He pointed out that dentists have been through this process. It was likely that there would be a reduced need for GPs. He pointed out that the fundamental question is whether we agree with the three principles or are we ready to operate a Dutch style model where there are various payment systems in place.

Dr Holden emphasised that we have to start disinvesting in secondary care and shift the resources and workforce into primary care. This is one way we improve our lot but who decides which hospitals should close? Effectively over the years Governments have disinvested £10B in the NHS. He pointed out that if we move to an item of service-based system we will need to cost our time and services appropriately. Currently GPs have 60% overheads and 40% of gross income is their pay. He gave figures which suggested that a GP Partner working in such a system would need to be valued at £260 to £280 per hour in order to fund his/her infrastructure and make a living. The public and the Government need to understand that GPs are at breaking point. He questioned whether the public actually know that we are offering a service to each patient for £65 per year.

GPC has worked on maintaining a Plan B, but recent legal changes may mean that current alternatives may not be able to be implemented.

Dr Markus said that in the public's eyes GPs are fat cats and questioned how we could change this and how do we deal with raising patient expectation. Dr Grenville said that politicians are still fuelling patients' expectations by discussing patients' rights, rather than dampening down expectations by discussing the possibility of rationing.

Dr Grenville highlighted that only this week he has visited three practices within 24 hours that are in serious difficulties, operationally, financially and/or in terms of workforce. He stated that this is probably only the tip of an iceberg and that if general practice in Derbyshire has reached this stage it is likely that things are much worse in some other parts of the country.

Dr Ashcroft noted that many GPs are retiring earlier than has been the case in the past and that there has been a 15% reduction of doctors coming into the GP profession.

Dr Williams said the Institute of Fiscal Studies forecast a 9% decrease health spend per head of population over the next eight years.

Dr Grenville ended the debate by asking the Committee to consider motions to Conference on this matter.

- **AT Primary Care Strategy**

Dr Grenville informed the committee of a draft NHS Area Team Primary Care Strategy (due to be published in April 2014). We have not yet been asked formally to comment on this, although we have been involved in many meetings relating to it. The Area Team have said they need the buy in from each CCG. Committee members said things felt top down again and didn't feel involved. Dr Grenville encouraged our constituents to influence their CCGs in the shaping and delivery of the strategy.

Jackie Pendleton said that she had not seen the strategy and declared the need for an integrated strategy and plans, to include Social Care. The Challenge Fund was briefly discussed and it was agreed that £50m non-recurrent money nationally is not enough to make a sustained difference. The sum was contrasted with the £500m non-recurrent money for emergency care in the secondary sector.

14/18 PRIMARY CARE DEVELOPMENT CENTRE

Dr Grenville informed the committee of the proposal for a Primary Care Development Centre headed up by Nottinghamshire LMC, inviting Derbyshire LMC to be key partners alongside the East Midlands Leadership Academy and the University of Nottingham Business School. The Area Team had indicated its support (subject to formal ratification) with a view to gaining further support from each CCG in Nottinghamshire and Derbyshire. This was a great opportunity to develop bespoke training and resources to support GP practices in operational development, challenges, needs, business sustainability and growth. Dr Holden commended the Centre to the committee to commit a non-recurrent financial contribution of £15,000 in kind (LMC staff would work for the Centre) and/or in cash. The committee supported this initiative and agreed to the financial/workforce contribution. Further developments would be shared with the committee in future meetings. Jackie Pendleton highlighted the need for an integrated approach across the CCGs and with the Area Team.

14/19 SPEAKER – Sue Noyes – EMAS

Sue Noyes, Chief Executive of EMAS joined the Trust in October 2013 and explained that a paper outlining the improvement that EMAS are going through is available. Sue told us that her task was to address performance and to sort it out and that the process is outlined in their Improvement Programme which includes looking at resources, front line services and other things. She emphasised that engagement with other agencies is important. Sue said that EMAS needs to be "at the table". Erewash is the lead commissioner for the EMAS Contract on behalf of all the CCGs across the EMAS area.

Sue informed us that the senior manager and contact point for Derbyshire was now Paul Ferguson and that she would ask him to attend an LMC meeting in the future. Sue reported that the positive news in January 2014 was that EMAS's performance against most of its targets had improved. Dr Ashcroft commented that there was still considerable room for improvement.

GPs present today outlined a number of problems and comments:

- A patient requiring an ambulance and the GP was told that none were available
- Four hour GP Urgent target times failing to be met
- Response times are not good
- Now that ambulances have been moved to urban centres, rural areas have to wait much longer for an ambulance to arrive

- It seems that EMAS look at numbers and not people
- It was noted that EMAS has a budget of £137 million covering 4.7 million people but that it was difficult to compare this budget with other areas because some included 111 so these were not absolute figures across Trusts
- With the development of paramedics as highly skilled health care practitioners Acute Trusts may feel more comfortable in leaving patients in ambulances outside A&E departments, increasing handover times. Grossly excessive times were reported
- It was noted that patients are generally delighted with the quality of care that they receive in ambulances. There was, however, a tension between this and the time taken for a response to arrive and the time taken to reach hospital, if that was appropriate
- The balance between the previous "scoop and run" method of doing things and the current emphasis on out-of-hospital and pre-hospital treatment was discussed with several GPs feeling that it needed recalibrating
- GPs were concerned that the flexibility for indicating timescales within which GP Urgent cases should be dealt with was decreasing
- Concern was expressed regarding the practice of referring GPs being contacted by EMAS when agreed target times (especially 4 hours) were in danger of being missed and being asked for extensions to the target. This could cause significant clinical risk for the patient.
- GPs present today enquired as to what EMAS was commissioned for, Sue replied that this is to see and treat in order to reduce emergency admissions, this is how the commissioning contract works
- It was emphasised that paramedics need to understand that when they feel that a patient does not require conveyance to hospital and they contact the patient's GP it is for the latter to decide whether a home visit is necessary. It was noted that a paramedic cannot bring a patient to the surgery, even when the GP decides that this would be appropriate.
- An incident was described when a GP made a formal complaint regarding a crew's attitude towards joint working with other agencies but felt that the response had not addressed his central point.

Sue outlined the way in which she was starting to deal with the problems and felt that everyone would benefit from a clinical discussion about the issues outlined by the GPs present at the LMC meeting today. She informed the meeting that they would be introducing HALO, which operates from Acute Trust Hospital sites to develop new practices for effective Ambulance Turnaround by implementing changes to benefit Ambulance and Hospital Trusts in the effective management of patient streams. Sue commented that she was looking at the rotas, the number of hours that staff work in a shift, clinical assessments and staffing levels to ensure that the most appropriate level of skilled staff are used for the benefit of patients. She advised the GPs that she was working closely with 111 and working with local GPs. Sue told us that an Estates and Management Strategy is being looked at and core response times, which will be examined on a case-by-case basis with assurance to GPs that they will be clear about the service model. Sue informed the meeting that EMAS have skilled paramedics who are good value for money and that there needs to be a more meaningful discussion between the GPs and the consultant paramedic and posed the question as to how they could keep less sick patients in the community. Sue conveyed to the LMC that she is seeing signs of improvement but that lots of things need to be done. Dr Williams thanked Sue Noyes for attending the LMC Meeting.

ACTION
It was agreed that the LMC write a letter to EMAS outlining the problems that the GPs were encountering.
JG

14/20 MATTERS ARISING

The Practice Nurse Project

Lisa Soultana was thanked again for all her hard work on the Practice Nurse Project that is coming to an end on the 14th February 2014. Dr Kinsella said that the Practice Nurse Competency Framework (PNCF) could be useful for other nursing provision to include District Nursing.

CAMHS

Dr Williams informed the committee that his practice had met with CAMHS (North) where they raised practice issues and concerns around access to service and patient outcomes. He had been informed there are two CAMHS providers (the Royal Trust in the North and Derbyshire Healthcare in the South). Triage is different in each model. They discussed referral criteria to include the meaning of serious self-harm. CAHMS said they would prefer it if GPs would call them about potential referrals so that CAMHS could understand the problem. They also discussed the distinctions between behavioural and psychiatric harm. There is a one day non-clinical education programme that GPs can attend to help them understand this better. They also discussed the crisis cover for 16 to 18 year old cases. CAMHS said if they have, say, 12 referrals per week it would take them approximately 90 minutes to decide on the care and service pathways, and approximately 1/4 to 1/3 would be bounced. The practice did not feel this was appropriate. The practice asked for each referral to be appropriately signposted.

There is a new behavioural pathway for the North and the South which is more integrated.
Dr Williams encouraged the committee to ask for their CAMHS worker to attend the practices multi-disciplinary meetings.

Jackie Pendleton said the commissioners have realised a problem in provision and there are a number of issues to be addressed, in particular, around childrens' services. An options paper has been raised to be discussed on the 5th March 2014 and can be shared with the committee.

Dr Betteridge said when he worked at RDH the protocol was that a child presenting with self harm must be seen by a consultant before being discharged.

Kate Lawrence has invited Dave Gardner from Hardwick CCG (mental health lead commissioners) to an LMC meeting but no response yet. Jackie Pendleton said that he may not be the most appropriate person so will identify the most appropriate person and will inform the LMC office.

The committee offers its help in designing new service pathways.

ACTION

Request a Freedom of Information request to include the following:

- The costs of the service
- The amount of referral bounce backs

ACTION

Jackie Pendleton to circulate options paper with the committee
Jackie Pendleton to inform the LMC office of the most appropriate person from CAMHS to attend an LMC meeting.

Sexual Health

Graham Archer said that County were rolling over their sexual health services whilst city were tendering for a whole new service from the 1st April 2014 and were also out to consultation.

Dr Grenville mentioned that a practice had approached us after completing the online tendering process and were not happy after been asked for 2 years or accounts and 2 years financial forecasting. A letter was sent to Derek Ward (DPH, City) to raise concerns with the process.

Jackie Pendleton said it was the same approach for all providers.

Dr Williams had spoken to the provider of such a service in Teeside who said they could not see all the patients on the fixed budgets and fixed clinics, they could not respond to service demand and they could not get out of the contract without penalty.

14/21 LMC CONFERENCE 22/23 May 2014, Barbican, York

LMC Conference Reminder – Motions have to be in to the GPC by Monday 24 March 2014, so these will have to be known at the next LMC on 6 March 2014. Dr Grenville will put them into a suitable form of words for submission to GPC.

14/22 LMC ELECTIONS

The LMC Office is in the process of updating the databases of all practitioners whose names appear in the list of the Area Team. The office will send out a letter in late February or early March requesting nominations for membership. It is proposed that the officer structure will change; apart from the Chair, Treasurer and LMC Secretary, there will be four Executive Team Members, preferably one from each CCG area. Current members were asked to consider whether they wished to stand again and to encourage colleagues to stand as well.

14/23 PREMISES

Dr Holden informed the committee that there is currently no capital funding for premises.

Nobody should sign a new lease with NHS Property Services without taking professional advice and involving their LMC. Nobody should pay monies unless they are clear what they are paying for and without involving their LMC. Until the Premises Costs Regulations 2014 are finalised the GPC are advising practices to involve their LMC and GPC if faced with a change of lease. So the message is: ***DON'T SIGN ANYTHING OR PAY ANYTHING WITHOUT SEEKING PROFESSIONAL ADVICE AND INVOLVING THE LMC AND GPC.***

Dr Holden advised that where a practice receives notification of a static or downward rent review it should consider responding immediately to the Area Team in the following terms*:*

The practice acknowledges receipt on [date] of notification of notional rent payable in respect of the practice premises situated at [address] for the period [date] to [date] following your valuation visit on [date].

Before the practice can accept this downward/static valuation we require two further written confirmations from the valuer.

1. The basis and reasoning upon which his professional conclusion was reached and

2. a signed declaration by the valuer that his/her professional opinion was
   - *i) freely made and*
   - *ii) unfettered by any health service managerial instruction to abate or reduce values in any particular manner and*

iii) was conducted and reported in a manner consistent with current professional advice, conduct and standards as issued by the Royal Institute of Chartered Surveyors from time to time.

Until such information is received the practice gives notice of appeal against the valuation. Failure to provide the declarations in 2 will result in the practice making the presumption that the valuation was:

a) neither made freely nor
b) without unwarranted health service management interference and
c) not in accordance with the advice from the RICS and
d) not undertaken within the bounds of the conduct and standards expected of Members and Fellows of the Royal Institute of Chartered Surveyors.

Such information will form an integral part of the practices appeal.

NHSPS have a massive cash flow problem. There will be reform and GPC will get involved.

Dr Grenville said the structure of LIFTCo's has changed due to the Health and Social Care Act 2012. Local health authorities are no longer shareholders. The shares and the Head Lease Plus Agreements have been transferred to Community Health Partnership (CHP).

CHP subcontracts most of its work to NHS Property Services. Invoices relating to premises in LIFTCo buildings and Health Centres for both non-reimbursable and reimbursable costs are administrated by SBS. The process over the past 10 months has been a shambles. There was an event on Tuesday organised by Nottinghamshire LMC, Derbyshire LMC, CHP, NHSPS and LIFTCo for practices in LIFTCo premises to raise their concerns and issues and listen to CHP, LIFTCo and NHSPS. The event was very successful. The LMC would like thank to Joe Lunn NHS Area Team, Angela Roberts CHP, Dave Smith Nottinghamshire LMC and Lisa Soultana for helping to facilitate and organise this event.

14/24 PERFORMERS LIST DECISION PANEL REPRESENTATIVE

Expressions of interest were invited from the Chair to sit on the Preliminary Screening Group (PSG) and Performers List Decision Making Panel (PLDP). There will be payment from the Area Team to sit on the PLDP but the amount has not yet been confirmed. The LMC will pay for those GPs who sit on the PSG.

Dr Hands explained to the GPs present today that sitting on the PLDP is a very responsible role and that experience is required to do the job but that he had quite enjoyed it. Dr Hands said that he will continue to make himself available for the PLDP on an as required basis until a successor can be found. The following members put their names forward for consideration:

PSG - Dr Ashcroft, Dr Williams, Dr Crowley and Dr Markus
PLDP - Dr Ashcroft and Dr Crowley. Dr Crowley informed the meeting that he would check with his partners over the next 3-4 weeks.

14/25 AREA TEAM

- **Area Team Meeting Report**
  It was highlighted to the Area Team that Derbyshire have two Practices with financial problems and it was reported that the Area Team were being as helpful as they can be. We will be having further discussions with them and hopefully we will see some progress.

- **List Closures**
  List closures were not discussed at the meeting with the Area Team on 4 February due to time constraints. This will be discussed at the next meeting with the Area Team.

14/26 PHARMACY LES WITHDRAWALS – INR AND MAR SHEETS

Dr Grenville highlighted the clinical risk that will ensue if arrangements are not put in place to renew the arrangements for Medication Administration Record (MAR) Sheets. It was noted that the Area Team would contact CCGs to ascertain what the arrangements will be for quality and care continuity and the re-commissioning of the service. NHSE have given assurances that the MAR enhanced service will not fall over.

Some Pharmacists are providing INR Services and these services will need a 6 month notice period if contracts are to be withdrawn.

14/27 CCGs

There were no specific items relating to CCGs (Jackie Pendleton having had to leave early due another meeting).

14/28 LETB/LETC

Dr Love reported that her team had been awarded a £38,000 fund for end of life education.

14/29 DERBYSHIRE AND NOTTINGHAMSHIRE LMCs JOINT LIAISON MEETING REPORT

- Derbyshire LMC have had a joint meeting with Nottinghamshire LMC and the following items were discussed:
  1. PMS Funding
  2. MPIG changes
  3. Future Contract Changes
  4. Primary Care Strategy
  5. Changes to extended hours (now back to a DES)
  6. Concerns about procurement
  7. Premises

Dr Grenville reported at the Joint meeting with Derbyshire LMC and Nottinghamshire LMC that there have been two Practices who have wanted to close their Lists without having a Policy in place. Michael Wright, Head of Liaison and Office Administration at Notts LMC, raised a scoring system which is being looked at by the Primary Care Panel.

This was a productive meeting and we are developing a good working relationship with the Area Team. Hannah Belcher is very approachable and couldn't attend our meeting today as she had to attend a crisis meeting relating to a local practice.

14/30 CQC

There was nothing new to report today, however, it was mentioned by Dr Love that a Practice had received a "mini inspection". Kate said that she was aware of this and understood that the Practice concerned had recorded that they were not compliant with a couple of Outcomes at Registration.

14/31 ANY OTHER BUSINESS

Dr Betteridge informed the meeting that he is now a Specialist Advisor to the Care Quality Commission.

Dr Weston-Smith informed the meeting that the Community Delivery Team at Littlewick Medical Centre was having difficulty in linking in with the heart failure nurses in Erewash. It was not clear if this was due to lack of provision or a failure to engage. This is not a problem in the north. After discussion it was agreed that this was a commissioning problem and that Erewash CCG should be informed of the problem.

Derbyshire LMC Ltd website – Lisa informed the meeting that the Treasurer has agreed to fund £299 plus VAT for a new modern platform for the website.

Dr Ashcroft informed the meeting that two enhanced services, Smoking Cessation and Contraceptive Implants, have been rolled over to March 2015 in the County.

14/32 DATE OF NEXT MEETING - 6 March 2014

The Meeting closed at 4.55pm.