DERBY & DERBYSHIRE LMC LTD

LMC Meeting

Santos Higham Farm, Main Road, Higham, Alfreton, Derbyshire, DE55 6EH
01 October 2015- 13:30 to 16:30

	AGENDA	
1.	**WELCOME & APOLOGIES** • Reminder to complete attendance register • Reminder to complete attendance register for Santos Higham • Jeffrey Collett - Chairman, Alexin	**Chair**
2.	**CLOSED SESSION (MEMBERS ONLY)** • Workplace Pensions – Automatic Enrolment • Levy and Mandate • Annual LMC Conference – 19 to 20 May 2016 • LMC Observers at GPC Meetings	**All**
3.	**GUEST SPEAKERS** • Ken Deacon – Medical Director, NHS England • Kate Brown – Head of Primary Care Commissioning, SDCCG • Helen Cawthorne - Head of Primary Care, SDCCG	**Ken Deacon** **Kate Brown**
4.	**MINUTES** • To confirm the Minutes of the meeting of 3 September 2015	**Chair**
5.	**MATTERS ARISING** • 15/138 DNACPR • 15/97 Health Visitors - Registered vs Resident • 15/97 Integrated Sexual Health Services • 15/117 Smoking Cessation Service • 15/137 New GMC Consultation – Changes to the information we publish and disclose about a Doctor's fitness to practice • Community Pharmacy Influenza	**Chair**
6.	**Liaison between LMC and GP Provider Organisations** • Jeffrey Collett - Chairman, Alexin	**John Grenville**
7.	**111 CLINICAL GOVERNANCE**	**John Grenville**

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8.	**PREMISES UPDATE REPORT**	**Chair**
9.	**INFORMATION MANAGEMENT TECHNOLOGY (IMT) UPDATE REPORT**	**Chair**
10.	**CLINICAL COMMISSIONING GROUPS (CCGs)** • Primary Care Development Group (PCDG) • Primary Care Co-Commissioning (PCCC) / NHS Hardwick CCG Corporate Performance Committee (A+B) • Drugs and Alcohol Team – Clinical Reference Group (DAAT – CRG) • Weekend Dressings • Dried Blood Spot Testing • Flu Immunisation for Patients with BMI < 40 • Tamiflu for the prophylaxis of influenza in nursing and care homes - England	**Chair**
11.	**NHS ENGLAND NORTH MIDLANDS**	**Chair**
12.	**CARE QUALITY COMMISSION (CQC)** • CQC Meeting Feedback • Challenging CQC Factual Inaccuracies and Inspection Process	**John Grenville** **Lisa Soultana**
13.	**PRIMARY CARE DEVELOPMENT CENTRE (PCDC)**	**Dr Paddy Kinsella/ Lisa Soultana**
14.	**LOCAL EDUCATION TRAINING BOARD (LETB) /** **LOCAL EDUCATION TRAINING COUNCIL (LETC) /** **HEALTH EDUCATION EAST MIDLANDS (HEEM) UPDATE REPORTS** • General Practice Action Group (GPTAG)	**Chair**
15.	**OFFICE REPORT**	**Chair**
16.	**GPC NEWSLETTER – SEPTEMBER 2015**	**Chair**
17.	**ANY OTHER BUSINESS**	**ALL**
18.	**DATE OF NEXT MEETING** Thursday 5 November 2015 – 13.30 to 16.30	

Unapproved minutes of 1 October 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 1 October 2014 – 13:30 to 16:30

PRESENT	Dr Peter Williams (Chair)	
	Dr John Grenville	Dr Ruth Dils
	Dr Kath Markus	Dr Murali Gembali
	Dr Mark Wood	Dr Vineeta Rajeev
	Dr Jenny North	Dr Greg Crowley
	Dr Paddy Kinsella	Dr Gail Walton
	Dr Brian Hands	Dr Pauline Love
	Dr Peter Short	Dr Denise Glover
	Dr Sean King	Dr John Ashcroft
APOLOGIES:	Dr Peter Holden	Rakesh Marwaha (Erewash CCG)
	Dr Jane Perry (Registrar)	Hannah Belcher (Contracts Manager – Area Team)
	Dr James Betteridge	Dr Peter Enoch
	Dr Andrew Jordan	
IN ATTENDANCE:	Hazel Potter (Minutes)	Jackie Pendleton (Chief Officer -ND CCG)
	Lisa Soultana	Graham Archer (Chief Officer - LPC)
	Nwando Umeh	Kate Brown (Head of Primary Care Commissioning, SDCCG)
	Ken Deacon (Medical Director (NHS England)	Helen Cawthorne (Head of Primary Care, SDCCG)
	Jeffrey Collett, Chairman, Alexin	

15/153 WELCOME & APOLOGIES

- Reminder to complete attendance register
- Reminder to complete attendance register for Santos Higham
- Ken Deacon, Kate Brown, Helen Cawthorne and Jeffrey Collett were welcomed as guests.

15/154 CLOSED SESSION (MEMBERS ONLY)

- **Workplace Pensions – Automatic Enrolment**

Hazel Potter reminded the LMC Members that the staging date for the auto-enrolled pensions is 1 October 2015 and all eligible employees will be automatically enrolled to NEST via the payroll team at Smith Cooper. NEST will send a welcome pack in due course. If LMC members decide to opt out this needs to be done within 4 weeks of being enrolled, so that any money paid can be reimbursed.

- **Levy and Mandate**

Hazel Potter reported that currently 42 practices have signed the new mandate. There is one practice that wants to cancel their subscription and Dr Grenville has visited the practice and sent a follow up email. There are 2 other practices that have queried the new mandate and Dr Grenville has emailed them. They have not replied yet. As the suggested date for signing the new mandate was 1 October it was agreed that a reminder email should be sent to practices.

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ACTION: Dr Grenville to compose an email to be sent as a reminder to practices.

15/155 Annual LMC Conference – 19 to 20 May 2016
Elections for LMC members to attend the Annual Conference will be held during the December LMC meeting.

15/156 LMC Observers at GPC Meetings
It was agreed that where possible LMC members should attend.
ACTION: Hazel Potter to email dates to LMC Members again for consideration.

GUEST SPEAKERS
- Ken Deacon – Medical Director, NHS England

Appraisal and Revalidation
Ken Deacon spoke about appraisal and revalidation and how to manage difficulties. Since taking over from Doug Black he has been concentrating on this and has reduced the number of queries.

Working with GPs in Difficulties
Ken spoke about rules, technicality and philosophy. There used to be local rules but now NHS England has a national policy and therefore more consistency. He discussed mechanisms for NHS England to support GPs who are having difficulties to enable them to continue in post. GPs can bring a representative with them to any meetings that NHS England may need to have with them, such as from the LMC. He recognised that LMC input can be invaluable.

Questions and Answers
Dr Williams asked how NHS England gathers intelligence about GPs who are having difficulties. Ken Deacon said that the GMC is receiving a huge number of complaints, as many as 10 to 12 per week, many of which are referred on to NHS England. He noted that the area he covers is very large and that it is difficult for him to have detailed local background knowledge about GPs now. He described how his team works within the legislative framework and the timescales involved.

Jackie Pendleton said that the link between CCGs and NHS England is working less well than before and needs to be strengthened. Jackie said that if NHS England starts to investigate a GP they should speak with the relevant CCG as the latter may well have relevant local knowledge and NHS England needs to build on that.

Ken Deacon explained that NHS England is no longer the only commissioner of GP services, in areas like ours where co-commissioning has been introduced, but they still take an interest.

Ken talked about the national pilot of pharmacists in practices and suggested that the idea is right but the scheme isn't. He noted that there are currently more Pharmacists than jobs. He moved on to discuss how it might be made easier for GPs to get back to work without having to do a returners scheme. Dr King asked how more senior GPs might be encouraged to remain in practice. Ken noted that the RCGP guidelines on revalidation are currently being revised and he anticipated that the required annual number of sessions in practice may be reduced. He noted, however, that there probably should be a minimum number as a GP who only does 20 sessions per year will find it very difficult to keep up to date with their skills. Dr King suggested that there should be training sessions in practices to achieve the training milestones and asked how we make CPD easier to achieve. Ken reminded the committee that he has sent an email to all GPs with suggestions on how to revalidate but he can't change the national guidelines. Dr King asked that he keeps it high on his agenda.

Dr Ashcroft asked Ken whether he gets a lot of referrals from GMC as he has been involved in a case to do with hospital work. Ken explained that when the GMC receives a complaint about a doctor it writes to the employer, the Responsible Officer and the CCG to ask for information, so that the GMC can decide whether there may be a case to answer or not. 90% of complaints to the GMC are closed without action. People are not allowed to complain to both the practice and NHS England, only to one

or the other. There is a right of appeal from this level to the Health Services Ombudsman. The Ombudsman can award compensation.

Dr Ashcroft asked about removing patients who complain recurrently from a practice's list. Ken Deacon clarified that this is not, *per se,* an acceptable reason for removing a patient and that the practice would need to be able to evidence an irretrievable breakdown in the relationship between the patient and the practice. It would then need to follow the regulations precisely.

Dr Grenville noted that there is an increasing exodus of GPs from practices because of huge increases in professional indemnity premia. He asked whether NHS England was aware of the problem and wondered whether the extension of crown indemnity to NHS GPs might be a solution. Ken Deacon said that the problem was acknowledged, especially in relation to out of hours and urgent care and that the Chief Executive of NHS England is now involved in discussing this.

Dr Grenville spoke about the recruitment and retention crisis within General Practice. He noted that we need to act now as the situation is rapidly becoming unsustainable. There was further discussion about the methods used for revalidation and Ken reiterated that he expected some changes soon but that they would not be fundamental.

Dr Hands said that he is working his last month before retirement. He asked Ken if he thought that appraisals have produced information about poor performance. Ken said they haven't really as he's only seen three appraisals where there were serious concerns about GPs. Dr Hands asked if there was any value in appraisals. Ken said it's good for the appraisee's professional development but it doesn't necessarily capture bad GPs.

Dr Williams thanked Ken Deacon for attending.

15/157 MINUTES OF PREVIOUS MEETING

The Minutes of the meeting on the 3 September 2015 were approved and signed by the Chairman as an accurate and true record except for the following amendments:

15/134, page 2

Lisa Soultana asked that under succession and workforce planning it states, Lisa Soultana is keen to work collaboratively with other LMCs *in the East Midlands* including…

15/139 - Control of Practice Workload

…. patient is in the middle and *replace 'is receiving a poor service' with 'should be the shared collaborative focus.'*

15/140, page 5

Jackie Pendleton asked that under Christmas Opening Hours its states that Nottinghamshire *and Derbyshire* CCGs…

Also, The CCG will *not* be asking if NHS England wants practices to stay open…

15/158 MATTERS ARISING

15/138 DNACPR

Dr Grenville said that the UK Resuscitation Council is looking at producing a form that covers all situations. There is confusion about what is needed. People should be encouraged to make Advance Decisions to Refuse Treatment (ADTR). This would be better than waiting for an emergency to occur and having to make a best interest decision about a person who lacks capacity. People should make family and friends aware of their wishes. Dr Love discussed progress with the problem of transporting people who are near the end of life. It has been confirmed that the lack of a DNACPR form will not be a bar to transporting patients. She confirmed that ADRT is the preferred option.

Dr Ashcroft suggested people wear medic alert bracelets. Dr Love had suggested this but it had been said that this might create the opportunity for misunderstanding. Dr Short commented that if the NHS has a vision of a paperless NHS this is not the right way to go. Dr Ashcroft suggested a mandatory

field in the IT system Spine. Dr Dils said that one of the objectives of the care home enhanced service is for all patients to have a care plan to include any advance decisions but when someone collapses staff still have a tendency to phone 999. Dr North said that there is often a poor management structure and minimum-waged carers don't want to take the responsibility. Dr Ashcroft reported that he did a care plan on a 93 year old recently and the patient still wants to be resuscitated. Dr Grenville said there is one Derbyshire practice that is considering charging for additional copies of DNACPR forms. He noted, however, that end of life care is specifically included as part of Essential Services.

15/97 Health Visitors – Registered vs Resident populations

Dr Grenville had attended a meeting arranged by the Designated Doctor for children's safeguarding, with health visiting commissioners and providers where this was discussed. Following the Health and Social Care Act and in the light of the various statutory obligations of Local Authorities there is nothing that we can do to resist this change. The risks had been highlighted and discussed. Dr Grenville clarified the (in his view, flawed) thinking behind the changes, namely that Local Authorities have a duty to their resident populations; that by commissioning geographical health visiting services they can more efficiently ensure that the large numbers of families in need can be identified and helped and that this benefit outweighs any risks to the smaller number of families that are in crisis. Dr Grenville asked that it be recorded that there are risks that are foreseeable and foreseen.

15/97 Integrated Sexual Health Services and
15/117 Smoking Cessation Service

Dr Grenville said DCHS have confirmed that the situation is that the commissioning of both of these services has been transferred from Health to Local Authorities. Both our LAs have commissioned packages of Lifestyle changes and Integrated Sexual Health Services. LARCs is within Sexual Health Services and Smoking Cessation is within the Lifestyle packages. DCHS has successfully bid for both elements from both LAs; it was already providing many of the services within the bundles and could not afford to lose them.

The way that the packages have been tendered means that the main provider (DCHS) is committed to sub-contracting elements of the LARCs provision and the Smoking Cessation services to General Practices. The prices for the sub-contracts are specified in the main contract and DCHS have no discretion to vary them. They are not permitted to top-slice them to pay for the administration of the sub-contracts. Dr Grenville advised that each practice needs to decide for itself whether it its worth providing the services for the price offered. This will be a commercial decision that may be influenced by the partners' views on the desirability of offering the services to their own patients. If practices decline to offer the services DCHS will be obliged to seek other providers to take on sub-contracts for patients of those practices. Dr Grenville pointed out that the current version of the sexual health services sub-contract still says that the IUCD and IUS price is for fitting, management *and replacement*, which would imply that the fee is payable only once during a woman's reproductive life. He has been assured, however, that this is not what is meant and that replacement refers only to replacements required shortly after the original fitting because of complications and not to routine replacements. The wording will be altered.

Dr Ashcroft said that Smoking Cessation has been commissioned in a poor way. There will be fewer people taking up Smoking Cessation. Both Smoking Cessation and LARCs are big health issues. Dr Grenville said the CCGs have a responsibility to bring these issues up at Health and Wellbeing Boards. Dr Williams said that Public Health has been given the responsibility to lead on this. Jackie Pendleton has raised this everywhere but it is Public Health's way of working. Dr Grenville noted that Local Authorities face even bigger cuts in funding than Health does. Dr Markus confirmed that in North Derbyshire the sub-contract has been awarded by DCHS to the Provider Federation to pass on to the practices.

15/137 New GMC Consultation – Changes to the information we publish and disclose about a Doctors fitness to practice

ACTION: Dr Grenville will compose a response as none of the LMC members have commented.

15/77 Community Pharmacy Influenza

Dr Williams asked why GPs are paid less than Pharmacists for the flu injections. Graham Archer replied that the fee is £1.50 more for pharmacies to cover the cost of waste removal etc. as GPs are already set up to do this in practices. The NHS consider it is cheaper for pharmacies to deliver the flu injections and are aiming to increase the uptake, give more patient choice and access and remove discrepancies across the country. He explained pharmacists had had to wait for the Secretary of State instructions and had only received this by email 2 weeks ago. NHS England has worked out a scheme but there is no IT support. There are 146 providers in Derbyshire. Dr Williams said if there is a significant decrease in the uptake from general practice, some practices may pull out in subsequent years as they might end up with too much vaccine this year.

15/121 Neonatal Hepatitis

Dr Grenville reported that the office has sent 2 emails to practices since the last meeting and he has had a huge response. 3 practices said yes they will do this, for payments between £1 and £15. 2 said they can't answer yet as they need to call a partners' meeting. 7 might be interested but need more information and want to know about consumables. 1 said yes they would do this free of charge. 14 said they would not do it. So the overall majority is no. Dr Grenville is concerned that the numbers are so small that clinicians in individual practices will not do sufficient procedures to keep their skills up. Dr Williams suggested that DCHS commission this via Health Visitors.

ACTION: Dr Grenville to send an email to say there is no appetite to take on work and there are safety issues.

15/159 Liaison between LMC and GP Provider Organisations

- **Jeffrey Collett, Chairman, Alexin**

Jeffrey Collett spoke on behalf of Alexin Healthcare, which has now become a Community Interest Company (CIC). He said the message from Alexin is that it was set up by GPs a few years ago to provide a vehicle for ensuring that patients had access to services. We need to use Alexin or lose it. The board had thought that after 2 years of operation contracts would have been coming in but this has not happened. Therefore there is only a small cash flow. If the NHS is going to deliver services and save money, some of the money that is going into secondary care needs to be put into primary care. The vehicle to deliver services is still going to be needed. If Alexin is not used, it will not survive.

Dr Grenville said that since he had attended Alexin's AGM last night, he has spoken to the Chair of SDCCG and pointed out that conflicts of interest can occur or can be perceived but they can be dealt with by dealing with people in an open and transparent way. There has been talk of practice federation and there is still a place for back office functions to be merged. It will need practices to decide what Alexin needs to do and they also need to look at succession planning.

Guest Speakers

- Kate Brown – Head of Primary Care Commissioning, SDCCG
- Helen Cawthorne - Head of Primary Care, SDCCG

Kate Brown said that sometimes CCGs need to procure things and the issue is about collaboration and clinical skills etc. There's a demand for collaborative support.

Dr Markus fears that CCGs might take something we do in primary care and put it out to procurement.

Dr Ashcroft said that PCTs were set up as primary care trusts for Primary Care. After more than 10 years, PCTs failed to invest in primary care. CCGs have been created to move the resources. He felt, however, that career managers retain too much control in CCGs and that the ideas of GPs are still not being implemented. He noted that Alexin are not getting any funding and he continues to see under-funding into general practices. The numbers do not match the words. Dr Williams said that things are being removed from general practices such as Smoking Cessation and Sexual Health Services by a central government directive, not CCGs. He asked if CCGs can achieve any movement in the current climate

Jackie Pendleton said that ND CCG is one of the highest investors in Primary Care. Dr Short said that for organisations to feel part of something they need to have faith to give up some control. Dr Williams said that in their practice they do 24 hour ECGs. If it works out savings will be made, but they have provided it without funding. Dr King said that practices in the future will need to work more collaboratively perhaps by using provider federations who might be the vehicle to do this. HR functions in practices are remarkably similar. It is the same with training, appraisals, premises etc. It is madness that we get external groups to provide this when we already provide it for ourselves.

Jeffrey Collett said Alexin are a large federation. If practices want help with back office functions they can provide the services that are requested. He sits on a forum for Primary Care and there was recently a presentation about co-operation between CCGs. The conflict of interest needs to be managed. Challenges under procurement laws are extremely rare and there's never been a successful challenge to an NHS procurement.

15/160 111 Clinical Governance

Dr Grenville said that at the last 111 Clinical Governance meeting no major issues had been raised. As usual there were a small number of new and ongoing complaints to be reviewed. Dr Hands commented that the complexity and repetitiveness of the reports generated by 111 and DHU to practices should be regarded as a clinical governance issue as it is very easy for the receiving clinician to miss the nuggets of information buried in the lengthy reports. Dr Grenville confirmed that this is recognised by all parties concerned except the Department of Health and NHS England who insist on the reports containing vast amounts of redundant information. He noted that pressures on the Department of Health and NHS England had led to incremental improvements but the situation remains unsatisfactory. Dr Grenville reminded members that practices now have a contractual duty to monitor their local 111 and Out of Hours services. He said that the LMC's attendance at the clinical governance meetings should be perceived as helping practices to discharge their duty but that individual problems should be raised directly with DHU and flagged to CCGs as commissioning concerns.

Jackie Pendleton raised the matter of a story in the Daily Mail this week that had purported to show that the 111 service run by DHU was unsafe. There were grave concerns about the accuracy of the reporting but NDCCG, as lead commissioners, had opened an inquiry into the allegations.

15/161 Premises Update Report

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ACTION: Nwando Umeh to get as many leases as possible to look at regarding cleaning.

15/162 Information Management Technology (IMT) Update Report

..\Nwando's Update Report\IM&T\October 2015.docx

Dr Williams spoke about the sharing of data between providers of Primary Care and Out of Hours services. There is a solution called "MIG" (Medical Interoperability Gateway). It is a bit like sharing information with the SPINE but is not the whole medical record. It is important to roll out MIG but we first need an agreement to share information which will assure general practices that they are not sharing anything that is not permitted and information is shared in a safe manner. MIG has been implemented in Nottinghamshire and is working well. It has been agreed that Derbyshire CCGs will buy it and it costs less that £80k. Nwando Umeh suggested when it is up and running, the providers of the service attend the LMC to show us how it works. Dr Williams said we are finally making some progress.

Dr Short said it's like the wheel being reinvented. It has had a high national priority and there have been a lot of different sharing agreements. He is attending a meeting in Leeds on 2 October with data controllers to discuss working models. They need to make sharing work locally but it has to fit in with the national model, particularly sharing with social services both ways. EMIS and TPP have very

different approaches to this. Dr Williams said that this is because it started from a point where each practice had their own sharing agreement. Dr Short agreed but said that we want a national model. It may be different from EMIS and TPP and the Information Commissioner's Officer has concerns.

Dr Grenville said the Information Commissioner's Officer prefers that there is written informed consent or as a minimum that there is a robust implied consent model. Dr Short said that practices need to be aware that it is their duty to inform patients of any data sharing and give them the opportunity to opt out.

Dr Williams said that the CCGs are planning to do a press release with posters etc. Dr Short said that if you go for explicit consent it takes a great deal of time. It needs a consistent communications package. Dr Grenville suggested a form of words such as "we will share information with regulated health and social care professional involved in your care". He pointed out, however, that "regulated Professional" excludes HCAs.

15/163 Clinical Commissioning Groups

This will be Jackie Pendleton's last LMC meeting after 10 years of attendance. Jackie thanked all for being so welcoming. Mark Smith will be acting as the Chief Officer of NDCCG. Jayne Stringfellow will attend the LMC meetings as the Primary Care Executive Lead. Dr Williams thanked Jackie Pendleton for all of her hard work and wished her well for her future.

Kate Brown asked to be invited to the LMC.

ACTION: Hazel Potter to add Kate Brown to the distribution list.

Kate Brown spoke to the LMC members and explained that she is new to co-commissioning and can look at the specific issues and help support practices. Everything is becoming increasingly more difficult. So she is developing a route map with aims and issues, such as IMT, premises, Commissioning and Contractual Intentions, and what all of these issues mean for providers and primary care. She would like to articulate this with some practices to get a more coherent view.

Dr Williams said that Primary Care is always being told that it needs to change, yet it's the streamlined part of the NHS that actually works. Kate Brown said it is all about keeping the core functions in place whilst sustaining delivery.

- North Derbyshire Primary Care Development Group (PCDG)

Dr Wood spoke about Diabetic Foot Care which was discussed at the last meeting. It is all about alignment between primary and secondary care. Practices are not required to use Dopplers. If the primary care clinician can't feel the pulse then the patient needs to be referred back to secondary care.

Dr Wood also spoke about plans to set up a primary care dashboard. He noted that there is always a long delay between activity occurring data being captured and reviewed. Currently the CCG uses Gemima but if the data is not current it means very little.

Dr Wood reported that the PCDG is now a bi-monthly meeting.

- Primary Care Co-Commissioning (PCCC) / Hardwick CCG Corporate Performance Committee

Lisa Soultana said that if anything needs to be discussed please let her know and she will raise it at the next meeting. Dr Grenville said that he recently attended the Erewash PCCC meeting where they discussed how co-commissioning is implemented in that area. The LMC is invited to attend. He hasn't received an invitation to attend the SD CCG PCCC meeting yet.

Kate Brown said they decided to have no clinical involvement at the SD CCG PCCC meetings as it's all about delegated functions and discusses things like list closures and not much else. Dr Grenville said that he had been able to contribute to discussions about list closures (among other things) at ND PCCC and he believed that the voting members had found it useful. Kate thought that LMC

attendance at PCCCs was optional and not mandatory. Dr Williams asked Kate to report back that the LMC are invited to all of the other CCG PCCC meetings. Dr Grenville emphasised that the LMC can help in apprising an individual PCCC of how other PCCCs have dealt with issues with which it may be struggling.

- Drugs and Alcohol Team – Clinical Reference Group (DAAT – CRG)

Nothing to report.

- Weekend Dressings

Lisa Soultana said a practice raised a concern that in SD CCG there are issues related to weekend wound dressings and the CCG have received an email in the last week. Dr Grenville said that as care is being fragmented we are beginning to find loopholes.

- Dried Blood Spot Testing

This was discussed under matters arising.

- Flu Immunisation for Patients with BMI > 40

Dr Grenville said that the Joint Committee on Vaccination and Immunisation has recently said that people with a BMI above 40 and no co-morbidities might benefit from a flu vaccination but NHS England has not been prepared to inject extra funding into the flu DES to pay for this and has suggested that CCGs might be prepared to commission it. Dr Markus has sent a letter to our CCGs. She noted that almost everyone with a BMI over 40 has type 2 diabetes and so is eligible for an immunisation anyway. At a cost of £7.65 per injection this should not be a huge drain on CCG resources. This is new work which should be done and it should be commissioned from Primary Care. The fact that NHS has declined to commission it needs to be taken up nationally.

Jackie Pendleton said that NDCCG will look into this. Dr Markus thinks it's very likely it will be on the national specification by next year.

Dr Williams said that if a GP's clinical opinion is that someone should have the flu jab, the cost of the vaccine can be claimed under the Personally Administered Drug Scheme.

Dr Ashcroft said that flu immunisation has been identified as cost effective but he noted that because the prediction of circulating strains had been inaccurate last year, it was estimated that there had been an additional 5000 deaths from flu. Dr Grenville said we need to be patients' advocates, hence the request to CCGs to find the funding.

- Tamiflu for the prophylaxis of influenza in nursing and care homes

Dr Grenville said the GPC has sought legal advice. The advice (disputed by NHS England) is that this is not included within the definition of Essential services and it should be commissioned separately. GPC's advice is that practices have no obligation to respond to requests from Public Health England to prescribe Tamiflu prophylactically to unaffected residents in nursing and care homes where there are cases of flu.

15/164 NHS ENGLAND NORTH MIDLANDS

Dr Grenville said that CCGs are being assisted by the Primary Care Hub (headed by Jonathan Rycroft), which is useful. The contract ends on 31 March 2016 so possibly a lot of skill and knowledge will be lost.

15/165 CARE QUALITY COMMISSION (CQC)

- CQC Meeting Feedback

Dr Grenville gave feedback from the meeting he attended. LMCs from across Midlands and East had been invited but mostly people from the East Midlands attended. The CQC team discussed the new inspection regime. One LMC Secretary present came from a practice that was in Band 6 according to the 'intelligent monitoring' process and was branded by the Press as providing unsafe care. The practice's subsequent inspection graded it as 'outstanding' but its reputation remains tarnished. The CQC team seemed to find it difficult to understand why this may be a problem and were resistant to

the suggestion that 'intelligent monitoring' data should not be published by the CQC but should only be used internally by CQC to determine their inspection timetable. There seems nothing that we can do about this.

Dr Grenville had highlighted the adverse effects on patients of the CQC's enforcement notice to our Passenger Transport Service regarding DNACPR forms and the CQC team agreed to feed this back to CQC centrally.

Dr Williams said that CQC reports are starting to come out more swiftly. However, Dr Ashcroft said that his practice is being inspected next week and the CCG didn't know they were going to be inspected. Dr Williams said that CCGs are supposed to be given 4 weeks' notice.

Lisa Soultana said that a Derbyshire practice had recently been inspected and rated inadequate. She is working with the practice alongside Dr Markus, Dr King and Dr Grenville to challenge any factual inaccuracies in the CQC draft report. The practice is also paying a LMC Associate (Bravery Consultancy) to help with the challenge. Lisa Soultana and Dr Markus said that the practice is definitely not inadequate and Dr Ashcroft encouraged Dr Markus to keep challenging the CQC. Dr Williams said that since April 2015 the CQC have employed a new methodology and there seem to be differences from practice to practice. We need to discuss with the CQC their perceived inconsistency.

Lisa Soultana reported that a practice in the city had received a telephone call from CQC at 2pm, followed up with an email at 5pm on a Friday, following an inspection on the Tuesday, that required a response from the GP partners/registered manager by 9am Monday. The issue related to health and safety of the premises (GP practice). There was a strong indication that the premises would be closed by CQC. By 08:30 Tuesday regulated activity was been carried out at another location in the city for this provider (GP partners/practice). The providers (GP partners) are unable to carry out any further regulated activity at the old premises and notice has been served to the landlord.

Dr Ashcroft said that the CQC had asked about checks for over 75 year olds. Dr Williams said they are looking at what practices do over and above their core contract. Lisa Soultana gave a top tip that practices should market themselves as a provider and the services offered and ensure that they present CQC with paperwork to evidence everything they say. Dr Williams said that his practice had insisted that the CQC inspection team attend a regular multi-disciplinary meeting on the day of inspection. He also reported that the CQC continued to ask the practice for data until the day before they published their inspection report.

15/166 PRIMARY CARE DEVELOPMENT CENTRE (PCDC)

Dr Kinsella said there had been a review of where the PCDC is going and where it will get funding from. There had been discussion about the future structure of PCDC.

15/167 LOCAL EDUCATION TRAINING BOARD (LETB) / LOCAL EDUCATION TRAINING COUNCIL (LETC) / HEALTH EDUCATION EAST MIDLANDS (HEEM) UPDATE REPORTS

- The General Practice Transformation Action Group (GPTAG)

..\Lisa's Update Report\HEEM\October 2015.pdf

..\Lisa's Update Report\GPTAG meeting update for LMC October 2015 meeting.pdf

- CEPN

Lisa Soultana said HEEM have been unwise to seek proposals for Phase 2 getting practices to submit a proposal and they haven't considered scoping out CEPN. Lisa will be active with HEEM over the next few weeks.

Dr Love said that she had been told there would be £150,000 allocated to End of Life but they still have not received the funding. It will be split between north and south Derbyshire.

Dr Crowley asked what the feedback from CEPNs was. Lisa Soultana said there is not enough funding to sustain them in the future and they have yet to understand what they have achieved. HEEM had said they need to progress to Phase 2 so that they do not lose the funding.

15/168 OFFICE REPORTS

Lisa Soultana said that on 16 October 2015, our apprentice Corinne Allen will be leaving us and she has been exceptionally good. We will recruit a replacement.

15/169 GPC NEWSLETTER – SEPTEMBER 2015

No items were raised.

15/170 ANY OTHER BUSINESS

- **Junior Doctors Contract**

Dr King asked that we support the petition for junior Doctors, regarding the proposed contractual change in their normal working hours. This will be equivalent to a 15 – 30% drop in pay for the same job. Also part time and returner doctors will have slower pay increments. There have been huge applications to the GMC for certification to work abroad. Scotland and Northern Ireland are not following suit. Dr Markus commented that Monday to Saturday is already the normal working week for GPs and in the House of Commons they only work Monday to Friday and finish early on Fridays.

Dr Ashcroft asked whether the government are also changing the contract for nurses as casualty will be particularly affected.

ACTION: Hazel Potter to circulate the online petition as soon as Dr King emails it to the office.

The meeting was closed at 17:30.

15/171 DATE OF NEXT MEETING – 5 November 2015