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MINUTES OF THE OPEN MEETING HELD AT 7.00pm ON MONDAY 4th FEBRUARY 2019:

DONCASTER GOLF CLUB, 278 BAWTRY ROAD, DONCASTER DN4 7NY

Present:

Dr R Shah (Chairman) Dr D Eggitt (Medical Secretary)

Dr C Vicary Dr A Bray Dr V Kumar

Dr K Singh Dr D Mackenzie Dr K Rowell

Dr S McHardy Dr A Oakford Mr Emovon

Dr A Locking (GP Reg Rep) Dr R Nayar Mrs R Fells (Non-medical)

In attendance:

Laura Sherburn (PCD)

Dr N Alsindi

Jane Torn – LMC Executive Officer – Minutes

* 1. **CHAIRMAN’S ISSUES**

The Chairman welcomed everyone to the first meeting of 2019.

Apologies were received from Dr Lee, Dr Crichton, Dr Sheikh, Mr Anthony Fitzgerald, Dr Suckling

The committee were invited to lodge any new declarations of interest with the executive officers – none lodged.

* 1. **MINUTES OF THE LAST MEETING**

The minutes of the last meeting held on 12th November were approved as an accurate record.

**2019.03 MATTERS ARISING FROM THE LAST MEETING - none**

**2019.04 PRIMARY CARE STRATEGY –** Anthony Fitzgerald was unable to attend the meeting. Dr Eggitt gave an update in which he informed the committee that on behalf of the LMC he had been working closely with Dr Alsindi and Anthony Fitzgerald from the CCG and Laura Sherburn from PCD. Strong relationships have been developed enabling good progress and with the publication of the Long-Term NHS Plan it has evident that Doncaster has a clear idea of where it is heading and why. SM stated that following reading the plan practices are concerned as to how it will affect them as independent contractors. DE made assurances that this has been addressed at every meeting and practices will be able to maintain their sovereignty. VK commented that he didn’t think Doncaster CCG had led as other CCGs had and felt that it was important that change happens early and not to just follow others. DE said that discussions had been based on cutting edge ideas which were focused on what would be suitable for Doncaster and not following on with what other areas were doing. RS asked for examples. DE spoke about the concept for SMI Health Checks that had recently been discussed at the Primary Care Committee. Doncaster has previously provided these as part of a LES. A contract will be offered in April for RDaSH and Primary Care to work to together to deliver it in an innovative way with RDaSH working with groups of neighbouring practices to deliver the care. Previously the checks have been done three times as secondary care has CQUIN, primary care has QOF and then RDaSH has ad hoc checks. These will be consolidated into one check with genuine joint partnership working from hubs. CV stated that this is a vulnerable group of patients who would be more likely to engage with their own GP rather than attend another practice. DE confirmed that the PCC had given feedback about the negative sides of what was being designed. The positives are that over time relationships will be forged with a new strong team of mental health nurses who understand these patients and pharmacists who will not be moving along enabling the team to get to know the patients. DE gave an example of how it would work for practices – instead of taking time out to do an SMI health check this will be done by a specialist team at a hub. This will free up GP time also RDaSH won’t have to see the patient freeing up capacity for them. The results will be fed back and this will qualify for QOF. If the patient fails to attend the practice will record this as failed attempt 1, failed attempt 2 and then they will be exempt from QOF. Laura confirmed that there would be an outreach element meaning that if they failed to attend on the first 2 appointments offered a home visit would be offered reducing the DNA rate. The CCG will be commissioning this and as part of the contract psychiatric consultant care will be included. The same model can be used for different specialities and DE is experimenting with heart failure clinics being delivered in hubs. This is non-evidence based and cutting edge with no one else doing this. If benefits can be proved by joint working, innovative working, good patient outcomes and GPs time is reduced then the CCG is more open to investing in this sort of care.

Dr Shah asked if this was money that was coming outside of the Transforming Primary Care money.

Dr Alsindi confirmed that the Transforming Primary Care money which became the Proactive Care money will still be there. Although there is a slight change on the amount because the overall budget is the same, but list size has gone up meaning it is now £4.88 per patient rather than £5 per patient. He went on to say that this is a good example of Doncaster being innovative and given a good amount to do proactive care without knowing if it will deliver intervention. It is hoped that it will reduce A&E attendances and emergency admissions, although it is hard to tie into this the CCG has continued to ring fence the investment for general practice whilst other areas haven’t.

As the proactive primary care contract was on the closed agenda Dr Eggitt asked for permission to cover it at this point. He stated that many discussions had taken place with the commissioners who were wanting to see a outcomes for the £5 per head they were investing. He explained that there is a move towards outcome-based commissioning meaning when a contract is given changes needed to be evidenced, unless this is proven payments will not be made. Dr Oakford commented that the care plans needed to be tied in with the protocol based first contacts, 111 etc.

Dr Shah stated that colleagues had expressed concerns regarding the 111 contract being given to Yorkshire ambulance service as at present many calls to them end up as 999 calls with ambulances taking patients to A&E. However, with targets being tightened there is the worry that paramedics will contact GPs during surgery or in out of hours they will request ECPs to go out. He asked what could be done collectively to prevent this affecting the targets set by the CCG to obtain payment. Dr Alsindi confirmed that a draft had gone to the Primary care committee several months earlier which would have prevented practices qualifying for payment if A&E attendances had increased. However, following discussions with the CCG/LMC and PCC it was recognised that despite doing the work it may not prevent the A&E attendance, this was why it wasn’t put into the contract for this year.

He noted that changes will take time and the hope that the local care networks will help by bringing all the partners into the system as a whole.

Discussions took place on the new contract which states that 25% of GP appointment should be available for booking via 111 and some of the ways to make this work without impacting on practices.

Dr Alsindi concluded ­­– the CCG is committed to take the strategy to the governing body for sign off in April. An update will be presented at the CCG event on 20th February, Primary Care Doncaster board at the end of February and then the LMC meeting in March following circulating a report to enable full discussion.

To give an understanding of the positive forward thinking of the CCG Dr Eggitt stated that in discussions regarding a primary care strategy there was a genuine realisation of a need to create capacity in primary care to deliver chronic complicated care which would mean removing minor illness to a certain extent. Although there isn’t a solution to remove all minor illness the CCG has a willingness to discuss options and how to engage with 111.

Open discussion took place around 111 and the NHS England pathways software which cannot be varied.

Dr Kumar referred to the Primary Care Strategy and the minor illness scheme. He spoke about schemes/funding available in the past including pharmacist training and providing a service/nurse practitioner training/first contact practitioner. He asked with the new contract now in place is this something that the CCG would look at to expand the front-line workforce and reduce the load for GPs. Dr Eggitt confirmed that these things had been prominent in recent discussions and that they are also prominent in the NHS plan and GMS contract reconfiguration. It has been recognised that to free up GPs time enabling them to give chronic complex care minor illness patients need to be seen elsewhere. He confirmed that there was a commitment within local partnerships to discuss and create solutions.

**DCCG UPDATE –** Dr D Crichton wasunable to attend, Dr Alsindi updated the committee. Population Health Management – this involves segmenting the population around age and wellness and doing risk stratification within those segments. Because Doncaster is in the ICS for South Yorkshire some non-recurrent funding has become available to start some work around that with the expectation that some ICS transformation funding next year.

Locally the CCG has been asked to do some clinical engagement with cardiovascular disease risk being the first clinical area to be picked for Bassetlaw and South Yorkshire. This is at the early stages and communication will be going out regarding clinical engagement.

Commissioning for outcomes - an audit programme has been ongoing at the hospital which involves looking through notes and going through clinic and referral letters to see if there is enough information to see if they have hit the criteria. More audits will be taking place over the next few months with the results going to general practice to see how the process can be streamlined.

**2019.05 PRIMARY CARE DONCASTER UPDATE – Laura Sherburn**

At the recent PCD board meeting a refresh of the board strategy was approved. Strategic priorities are aligned as previously discussed in the minutes. This will be sent out to practices later in the week and published on the website. They include: -

Extended access – developing, extending and expanding it. A full 6 month evaluation is contracted and will be issued at the beginning of April, feedback will be taken on board from staff delivering the service along with patients using the service and quantitively data. There are plans to expand what is being done and trials of different way of delivering capacity with more innovation inclusion health which is quite a different delivery to what is used elsewhere. Ways to integrate with community pharmacy with virtual medication reviews. There are also proposals for working in the family hubs that the council are running.

Integration – how the federation can support all member practices with the primary care requirements of the new GP contract. PCD will be working closely in the coming weeks with the LMC executive team and the CCG to ensure this works in the best possible way for Doncaster. More neighbourhood integrated workshops have been run to determine how practices work together across the system.

Income generation – current pathways include the SMI health check, a partnership is in place with Street Lane Skin Services who attended TARGET recently. This is around dermatology and how local GPs can deliver the service in future. Plans are in the pipeline around pathways for DVT/ENT etc.

An election will be taking place following the resignation of Dr Eleanor Pamphilon who has taken on a new role with the Deanery. Expressions of interest to be sought from the north neighbourhood to represent practices. To try and make the board more inclusive the role will be available to GPs/nurses/practice managers etc. The need to make this more obvious was discussed along with the voting structure for candidates.

The board has decided not to go ahead with a full AGM due to a lack of appetite from practices wanting to attend. Instead the March board meeting will be open to the public wishing to attend. The email invitation went out the previous week to nominated shareholders and practice managers.

A survey will be going out to nominated shareholders to give their views of PCD with the results being fed back at the March meeting.

Dr Kumar stated that there are practices in Doncaster that are in dispute with Doncaster CCG regarding Proactive Care because they felt the guidelines were not clear regarding what was passable and what was not. Moving forward he asked if the federation could work with practices and perhaps hold workshops to ensure that all practices succeeded in obtaining payment. LS stated that she thought this would naturally happen as part of the network agreements and network DES in the GP contract as there are certain requirements to meet the DES.

Dr Eggitt spoke about the work that the LMC did when the £5 per head first came out to try and get practices to work together by putting the money into a pot to buy patient advocates to enable a level playing field. Only 50% of practices were willing to do this and it became clear that practices wanted autonomy.

DE reminded the committee of the discussions they had held when the £5 per head first came out regarding the issue of using the money to employ staff and the risks this would entaile when the money stopped. This had been discussed at great length with the CCG and the LMC had requested a slow transition so as not to destabilise practices.

RF reminded the committee that in the south west there are a group of 8 practices who have been pooling the money and working collaboratively over the past 4 years to provide a service by employing 5 nurses.

Dr Kumar asked LS if the dermatology contracts had been put out for tender and are they getting value for money. He then asked about GP training. Dr McHardy stated that he had met with them initially and stated that there were local GPs who were keen to be trained. The company were more than happy to provide the extra supervision with a view to them taking over the service. The Cardiff diploma is one of the things needed.

Dr Kumar asked how they were doing value for money wise. LS stated that the CCG is commissioning them and working out the contractual obligation. Meetings were being held with the finance team at the CCG as this is only a pilot it will not be a full contract.

VK was concerned that there would be something put in place to ensure that local GPs didn’t lose out on minor surgery income to the practice. LS said that she had spoken to the company representative following the TARGET session and she confirmed that Street Lane will not be able to do the minor surgery as they haven’t got the suites. Laura also pointed out the local minor surgery LES and the need to refer specialist things to the hospital or anything covered by current commissioning arrangements back to the GP.

Dr Vicary asked who retained liability regarding the dermatology service. LS confirmed that the GP would retain liability. Questions were raised regarding the correct pathways for dermatology services and it was noted that further clarification was needed for practices.

***Action: Laura Sherburn agreed to provide further information on the services and pathways.***

**2019.06 PUBLIC HEALTH UPDATE – Dr R Suckling was unable to attend**

**2019.07 DISCHARGE TO ACCESS BEDS – Andrew Russell will attend at a future meeting**

**2019.08 CORRESPONDENCE FOR INFORMATION ONLY**

**LMC minutes: Sheffield, Rotherham, Barnsley**

**APC Minutes**

**2019.09 REPRESENTATIVE REPORTS OF MEETINGS – (For information only)**

13.11.18 – LMC Practice Managers

13.11.18 – Meeting with 2 x practice mangers – IG Toolkit

13.11.18 – SMI Health Check

13.11.18 - TARGET curriculum

15.11.18 – GPC

16.11.18 – Dr Lee attended GPDF workshop

21.11.18 – Safeguarding event (evening)

27.11.18 – Practice manager meeting IG toolkit

28.11.18 - Heart failure pathway

29.11.18 – APC – Dr Shah

29.11.18 – PCD meeting

04.12.18 – PCD/CCG/LMC meeting

04.12.18 – Pharmacy Support meeting (evening)

06.12.18 – Meeting with practice Dr Eggitt/Dr Shah

11.12.18 – Safeguarding follow up

11.12.18 – Community led support – integrated working

13.12.18 – Primary Care Commissioning Committee

20.12.18 - Dr Eggitt / Dr Crichton

03.01.19 – Lydia Briggs – Macmillan Cancer

03.01.19 – Executive meeting

08.01.19 – LMC/CCG/PCD meeting

08.01.19 – IG Toolkit presentation of practices at Sandringham Road

09.01.19 – SYLMC

10.01.19 – Karen Tooley – Piloting system 1 as proof of concept in care homes

10.01.19 – Primary Care Commissioning Committee

15.01.19 – Clinical Leadership event – The Source, Sheffield

17.01.19 – GPC

22.01.19 – Andrew Russell – Discharge to Access Beds

22.01.19 – Q Doctor presentation – Private GP service rolling out in Doncaster

24.01.19 – Integrated Neighbourhood event – Castle Park

24.01.19 – CRG – Presenting the SMI Healthcheck

25.01.19 – GP Selection Centre training

31.01.19 – APC

Dr Eggitt was asked for further information regarding Q Doctor. He stated that this is an audiovisual remote GP service that has been set up by an NHS clinical fellow who now works in NHS innovation. The service is similar to a locum service in that the service can provide GPs who can remotely provide care for patients in the area needed. Patients would not need to de-register from their existing practice to use the service. Dr Eggitt felt that this system may be beneficial for a minor illness service and worth exploring.

***Action: Dr Eggitt and Laura Sherburn to discuss the use of Q Doctor for a minor illness service.***

**2019.10 OFFICERS’ ACTIONS**

**Cameron Fund Christmas appeal donation £200**

**2019.11 FORTHCOMING MEETINGS:**

To supply information to the Executive Officer on any forthcoming meetings

**2019.12 Shared Care (antipsychotic monitoring) Dr Kumar –** Dr Kumar asked for guidance regarding complex Shared Care and out of area Shared Care. Dr Eggitt confirmed that Shared Care agreements had been negotiated and the Shared Care LES meaning it becomes a contract that GPs can decided not to deliver. Even when delivering the Shared Care LES GPs still have the opportunity to say no if they cannot deliver the level of care required. Because there are gaps in care the SMI Healthcheck could work for this. Dr Eggitt went on to state that if GPs are signed up to the treatment room LES they are getting paid to do the ECGs and blood tests so results could be forwarded to the specialist to interpret.

**2019.13 Preparation for a no deal Brexit – Rose Fells –** RF informed the committee that information keeps arriving at practices requesting them to nominate someone to do certain tasks. Also Falsified Medicines Directive information is being sent to practice and no one is prepared. Dr Eggitt confirmed that FMD technology and software doesn’t exist yet so although that is supposed to come in in April is irrelevant at present. Rose asked for either the CCG/LMC or CCG to take a lead and give practices the information. Dr Eggitt said that if/when FDM comes in there will need to be GMS/PMS contract negotiations. Regarding a no deal Brexit, this will effect everyone differently and he suggested that practices come up with worst case scenarios and think about how they would handle this before it actually happens.

***Action: Dr Eggitt to give an update to practices***

**2019.14 Alcohol and older people** – Dr Eggitt asked for feedback from the committee on their thoughts prior to attending a meeting with Doncaster Council regarding how to address the issues of alcohol and older people. The committee held open discussions which covered cultural differences and education for GPs and Dr Vicary stated that an education session would be beneficial via TARGET before giving feedback. Dr Mackenzie asked for the session to include DVLA rules.

**2019.15 Data Protection and TPP -** Dr Eggitt explained that as part of his role as Data Protection officer for the majority of Doncaster practices he has breeches reported to him. During a breech it became apparent of wider repercussions regarding a software provider where 2 patient records from totally different areas had been merged and 1 patient received a copy of the records with the other’s details. The local practice asked the service provider to close the record but they refused and insisted that they were dealing with the problem. It took several weeks before the record was closed. According to GDPR if a company cannot deliver the requirements of GDPR an alternative supplier must be found. To ascertain the scale of the problem Dr Eggitt asked if any of the committee were aware of problems with the company. Problems with other companies were discussed and it was noted that all systems are open to human error but the issue in this case was failure to act.

Discussion took place around GDPR and the service Dr Eggitt provides as the DPO. The second training session for practice managers had just taken place and following feedback from them further sessions were being organised for staff to attend.

Rose Fells asked about the new GP contract that states GPs will be able to access a DPO via their CCG. Dr Eggitt stated that as the contract had just come out this hadn’t been discussed the CCG so far, he pointed out that the contract states that the CCG has to fund a DPO and this will be their choice.

***Post meeting note****:*

*Dr Eggitt has now received an email from the Clinical Director & DPO at TPP confirming that the DPO email is monitored and that they do respond. He apologised for the delay in this case and stated that the route for any urgent communications / issues is always though their helpdesk and asked for contact to me made via them in the first instance*

**2019.16 Request for checkups for MS patients on medication from Sheffield –** Dr Mackenzie said that a Sheffield clinic had provided a patient with blood forms and informed them to go their GP for the tests. They also required proteinuria checks which the practice was being asked to feed back to Sheffield on a monthly basis. Dr Eggitt stated that as part of the Treatment room LES practices should provide lab investigation services but not necessarily actioning the result. Results should go to the MS nurse Unmani Nock so the patient can be put on her case load.

**2019.17 ANY OTHER BUSINESS**

**2019.17.1 IRMER Training Update**

Mr Singh has held discussions with the clinical lead and general manager in Imaging.  Following discussions, they agreed that the training required to request imaging was more than just completing the IRMER course.  It involves some consideration of the appropriateness of modality requests in addition to radiation safety.  As such, the Trust run course is a pre-requisite. They intend to deliver the course far more often to shorten the time to being credentialed.

The updated policy notes a change in the training required i.e. it is now ‘Radiology Referral Training’ rather than IRMER training as previously.

This is to ensure other notable considerations regarding referring for imaging are included e.g. contraindications to MRI; eGFR results & contrast CT & MRI exams.

The aim is assurance of both patient & staff safety e.g. appropriate follow up action on review of an imaging report; minimise the risk of radiation incidents.

Dr Bray asked how recent this update was as his practice was still experiencing problems. Dr Eggitt expressed concerns with the costs surrounding the training. Laura Sherburn stated that PCD have negotiated a discount on group bookings for the course and they were proposing that through non-recurrent funds they could fund 50% of that. However, there is now a possibility that they could get it free. Laura was waiting for the outcome of a meeting taking place later that week.

***Action: Laura will feedback on the outcome of the meeting re IRMER training***.

**Electronic signatures**: Dr Bray related an issue with an electronic signature on a form being sent to SPA which had been sent via a secure NHS email to another secure NHS email. The form came back stating that that they would not accept it. He highlighted that there was no standard response from the service with forms with typed names being accepted on some occasions and rejected at other times. Dr Vicary pointed out that this is also an issue with the Care of the Elderly service. The different ways of producing a signature on forms and what should be acceptable was discussed and it was thought that if the form is sent via secure email to anther secure email any type of signature whether it be a scanned signature or a typed name should be accepted.

***Action: LMC office to take up with the services***.

**MECS service:** Dr Kumar spoke about an email he had received regarding AQP MECS consultation response. He felt that there were numerous errors in the process and was surprised that the LMC hadn’t been involved. He stated that GPs should be informed 6 weeks before a service begins and practices should be made ready for this to take place, he said none of these things had taken place. Dr Alsindi stated that he hadn’t been involved with this piece of work but part of the procurement process was testing out the market and then going out with the specification. The CCG would then see what the response was, if there wasn’t a response then this would mean there wasn’t the capacity and the CCG would have to look again and what they were trying to commission. Dr Kumar stated that he was concerned about the clinical information and suggested that the CCG re looked at this.

Dr Kumar reminded the committee that Dr Sheikh had also emailed concerns around reported of the GOS 18 optiican report triage and processing service. As the executive had no knowledge of this it would be taken up with the CCG at a later date.

***Action: The LMC will pick both concerns up with the CCG and feedback.***

Dr Oakford commented on the article in the LMC Update regarding the new x-ray pathway for the Same Day Health Centre and UTC. He commented that he works there and was not aware of this. He had contacted the organisation and they were not aware of the process either.

***Action: Dr Shah to investigate this.***

Dr McHardy said that he had become aware that IAPT have been able to access patient record and code depression. Dr Eggitt said that you cannot have read/write access to a record that you do not own. There should be a bolt on module which is separate to the main module. Somewhere in the system something has been switched on to allow them access if this is happening.

There being no further business the meeting was closed at 9.15pm

**The next meeting will be held on Monday 4th March 2019 at 7:00pm**

**Signed……………………………………………………………………**

**Dated………………………………………………………………………**