**WIRRAL LOCAL MEDICAL COMMITTEE**

**Minutes from the meeting held on Monday 3 October 2016**

**In the Lairdside Suite, Royal Standard House**

**PRESENT:** Dr R Williams Chair

Dr B Quinn Vice Chair

Dr A Adegoke Hon. Secretary

Dr B Ali Dr D Blackie

Dr K Cooke Dr G Francis

Dr L McGrath Dr A Mantgani

Dr R Millard Dr J Mottram

Dr F Newton Dr M Smethurst

**ALSO PRESENT:** Mrs M Carrol, Wirral LPC

Mr J Develing, Wirral CCG

Dr H Forster, GP Registrar

Mr P Lear – Wirral LDC

Dr J Perry, GP Registrar

Mr G Price, WUTH

Dr R Parhee, CWP NHS Foundation Trust

Ms S Quinn, CWP NHS Foundation Trust

Mrs S Lepts, Wirral LMC

67. **Welcome**

The Chair welcomed members and visitors.

Sarah Lepts was mentioned as the new Office Manager attending the first meeting on her own.

68. **Apologies**

Apologies were received from Ms Howell, Dr Jalan, Dr Sim and Dr Syed.

69. **Declarations of Potential Conflicts of Interest**

None.

70. **New Model of Community Mental Health Care**

Ms Quinn explained that she and Dr Parhee were here to talk about the Community Mental Health service as it is now and how they will be transforming services over the next 12 months. Due to the environment they are moving into, in terms of accountable care and service transformation planning, they feel there is a need to change the structure of the services to be more integrated with Primary Care. They very much wanted to hear the views of the LMC as they were currently in the process of designing the service.

Ms S Quinn and Dr Parhee gave a short presentation on Community Mental Health Transformation. ***See appendix 1a.***

Dr Parhee concluded the presentation and asked if there were any comments or questions.

A member asked what had happened to the quarterly meetings they used to have and if it was just them or every practice that didn’t have them anymore. They said they especially valued the meeting and knew colleagues did too.

Dr Parhee said that every practice stopped having them and actually some practices didn’t want them as they felt it encroached on their time and space. Other practices welcomed them and she was sure they could start them up again if the GPs valued it.

Another member stated the meetings were fantastic and they did not know who informed them but because of them it seems the meetings had been withdrawn for all practices.

The Chair said he thought the meetings had kind of fallen into disrepair, for want of an expression, because there had been a change in consultants over the last 5 years. In his practice there have probably been 2 changes in consultants. He thought the meetings were very valuable and would welcome them or at least for them to be offered to practices again.

Dr Parhee said they could redesign that meeting to be more like a MDT meeting aligned to each hub, as it would be quite difficult to get to each surgery individually.

A member said that talking about named patients in front of people that were not involved in clinical care was perhaps an issue with using the hub. They would’ve thought it would need to be done in the practice.

The Hon. Secretary agreed with the member. He suggested they could go along the lines of what they do for GSF meetings in practices where different practitioners get together to discuss individual patients.

Dr Parhee said they would be happy to join that group. She said she covers around 18 practices and couldn’t manage 18 every 3 months but she could do one a month; which would be an annual thing. She added that, without wanting to make excuses, some practices were constantly cancelling the dates but they would look at a slightly revised form of meeting.

Ms Quinn said they would talk about how they would do that as part of the new model.

A member stated it currently took around 6 months to get a referral to consultant based diagnosis of dementia, even though everybody knew a patient had a cognitive difficulty, and asked if there was any chance the new service could speed things up.

Dr Parhee said from the time of referral to diagnosis was 6 months.

The member agreed and added that, even though the diagnosis was known by everybody and stated by everybody, it might need to be stated a bit earlier in the process. It needed a more definitive diagnostic process, as even though it was happening it needed to be said.

Dr Parhee said she wasn’t aware of that and asked Ms Quinn to note it down.

Ms Quinn responded that one of the aims is bringing all the dementia services together to try and make them more community as they are currently quite fragmented, so bringing those services together would actually help with that.

The member also asked how Primary Care would be affected by the changes, with moving stuff back to Primary Care where people already felt pressurised.

Dr Parhee replied that they hoped the follow up clinics for patients would be done in Primary Care, maybe not in every surgery but one major surgery. At least once a month, in one major surgery, CMH would run a clinic where a nurse practitioner could assess patients for 3 or 4 surgeries at a time. It would amount to that much amount of work and that’s it really. Dr Parhee said that actually they don’t see patients on a weekly basis but once in 4months and once in 6months and in a review team some are seen only annually. She said at the moment they have 4 nurse practitioners with a caseload of about 100 patients, so talking about 400 patients being reviewed in primary care. 400 patients and 52 surgeries, making it around 8 patients per surgery. They are looking at a maximum number of 15 patients, not hundreds of patients, per surgery being discharged and reviewed in the GP surgery but would be giving an exact number for each practice.

Dr Parhee added that these are the people that have been stuck in the system for so long; for over 10years. CMH are unable to move them on as they get dependant on the service and want to see somebody. CMH need to give them the message that they are well enough to manage largely by themselves but with a little support in their local area.

The member asked what the impact would be on them personally.

Dr Parhee said for the GP it would be exactly the same. The patient is seen and the nurse practitioner or consultant send a fax to the GP. She said there should be no difference but what they would like is to be able to remove those patients from their case load. She said this was Phase1 and in a year or two she would like to somehow join up the physical health review of those patients, as she is finding so much duplication from GPs and Consultants. Patients are being called for bloods by GPs and then consultants are asking for bloods too. She would like to streamline this for the patient in a once a year review, whether done by the consultant or the GP.

The member said they were worried as there are currently such major problems getting blood tests done on the peninsula and it was quite a serious issue.

The Chair said he would come back to Phlebotomy later on and agreed it was a certainly an important point.

Another member said they were still not sure and asked Dr Parhee if there would be one nurse practitioner to each practice that would come into the practice to do a review or examination and if they would do bloods.

Dr Parhee responded that there would be 1 nurse practitioner for about 10 practices, a community not individual clinic, as there weren’t many patients in each surgery so it wouldn’t be worth going to each surgery. She suggested maybe 3 or 4 surgeries get together and the nurse practitioner use one site.

The member then asked what would happen after that. They said in reality the GP would start to get requests to do this and that as the nurse practitioner won’t want to take responsibility and that is how it will be dumped on GPs. Taking patients back and then going through single point of access all over again with patients that were already in the system, having to go through the referral process again. They added that the mental health services were very good at shielding behind protocol and that GPs had a 10,000 patient caseload and they suspected that this would be another thing dumped on general practice with no resource.

The Chair said he wanted to go over the point which he thought important. So, the nurse practitioner would go and do the reviews and maybe review patients from a number of different practices at a central location, maybe one of the larger practices that has room space. He said GPs were going to be anxious and they were defensive about their workloads as they were huge at the moment and fit to bursting. He said GPs would be anxious that it would snowball into them being asked by the nurse practitioner to do a physical check or see the patient later if the patient had another problem. He agreed with the members point above and said it was a worry.

Dr Parhee replied the worry now was that consultants sometimes see patients who tell them about other physical problems and they tell them to see their GPs, but if the nurse practitioner was in the practice it would be easy for her to book an appointment with the GP for them.

The member stated that the patient was welcome to attend the practice for any of their problems like any other patient and asked why they should have a special way for them to attend.

The Chair said the other way of looking at it was that it was easing things for the patient and mental health services so that they were in a position to offload those patients into the community and concentrate on the patients that needed the service most. He added that general practice had to get something in return though. If the access to mental health services becomes easier for a patient to be seen and an opinion given, even if they don’t enter into the service as a long term patient, then Primary Care would be getting something back in return for easy access for that type of patient.

Ms Quinn said part of the redesign would be putting more resource at that front door to allow mental health services to respond better.

The Hon. Secretary asked why stable patients were still on the consultant’s workload when GPs see them in their practices.

Dr Parhee replied it was notoriously difficult to discharge them. MHS want to give the message to the patient that they will be discharged but with the support of a community nurse.

The Hon. Secretary said he would rather the patients be discharged and for the GP to manage them the way they do in primary care and if they can’t manage them then they refer the patient back in the usual way. He said the problem is that nurse practitioners will do things that creates extra workload for GPs.

A member asked if from Phase 1 where the mental health service get a group of patients and after a year of going swimmingly well, would they then discharge them all back into general practice.

Dr Parhee said members would be amazed at the number of people encouraged to go back into primary care that were stuck in the system with OCD and depression. MHS were trying to give them the message they are well enough to be on their own with a little stepping stone. She said the nurse practitioner was working well in other areas and is a shared care model in London.

The member added that the point at which GPs refer into the SPA is a bit of a vacuum. For example, when GPs have ticked the standard contact within 2 days, sometimes nothing happened for days or even weeks. It was suggested that when triage and assessment is made by the mental health team, GPs should be given feedback on when the patient is expected to be seen to avoid the current chasing of outcome by GPs.

Ms Quinn said she would feed that back. Dr Parhee said that there should be an acknowledgement letter sent out and Ms Quinn said she would check to make sure that was happening.

A member asked if in the community, the nurse practitioners were confident and competent to prescribe and change medication.

Dr Parhee confirmed the nurse practitioners were confident and were doing it now. When they prescribe, increase a dose or change medication they make a formal request and get the consultant to sign the prescription and the consultant then sends a fax to the GP.

The member asked if they would continue to do this and Dr Parhee said no. The nurse practitioner, for the small group of patients, would instead go to the GP. They would do the same thing as they do for the consultant; make a formal request to change the medication but they would take it to the GP.

The member said that if the GP knew the patient they may feel that it was not the appropriate type of medication. They may have already told the patient in the past that they couldn’t have that medication and it would make it difficult for the GP but they would be left with the responsibility of prescribing.

Dr Parhee said that everyone would have non-medical prescribing qualifications.

Another member mentioned resource and said that MHS wanted to shift activity into general practice but the resource was still in a block contract with mental health. They said that if the MHS wanted GPs to assess and manage these patients, GPs would but they wouldn’t take on work while resources remained with the Trust.

Dr Parhee said she completely saw the members point and wished Christine Campbell was here today. She explained that the block contract for adult services was 1900 and at the moment there were 2300 on the books, so MHS don’t have the resources either to look after those extra 400 patients. She said there is a need for the commissioners and GPs to work together to talk about resources. She added that she could refuse to see the extra patients but she isn’t saying that. She is asking to work together for the stable patients who aren’t going to cause the GP any problem. If the patient relapses, they will immediately go back into the service. They will all have an entry back into the consultants care.

Ms Quinn made the point that there were some opportunities here; that MHS were starting to work with the CCG to actually look at what they spend on mental health across all services for the whole of the Wirral. She said that actually where they can make some efficiencies by working together they can start to look at where they can develop mental health. So there are opportunities as well as challenges.

Another member made two points. Firstly, that GPs would have a handful of patients that they wouldn’t have seen in years but would read the many psychiatric letters and think that actually it related to a lot of their patients that they see regularly. The member envisaged seeing those people and thinking that they would be getting the right care and that was a good thing. Also lots of people need blood pressure checks but GPs don’t get to see them.

Secondly the member said they had a lot of patients with complex needs and found the complex needs team to be very helpful and that patients once picked up were suddenly in a better place and seem to be really well looked after. The member asked how this fitted in the new structure.

Dr Parhee explained that the patient is seen by the Central Access Team, assessed at that point and referred, picked up straight away and sent to the complex needs services.

The assessment takes 1.5 to 2 hours; the discussion with the consultant takes place and they decide whether the patient has complex needs. The current caseload is about 120 and they have very complex needs.

Ms Quinn said there were opportunities to develop that service.

Dr Parhee said that first episode schizophrenia goes to the early prevention team. The MHS have had a couple of first episode schizophrenic patients who were discharged back to primary care and who relapsed after 5 or 6 years so returned to MHS care. She said there are a lot more bipolar cases, with GPs picking up a lot more bipolar patients and a lot of patients self-diagnosing but she said to be fair 9/10 are genuine cases. These patients need specialist mental health services so they have to keep hold of them.

The Chair mentioned two things. He said one was not MHS responsibility but the backbone of the psychological services on the Wirral; inclusion matters and he was making the comment to share with everybody and that maybe the CCG would like to pick it up as well. He said despite coming to a members meeting, 2 or 3 meetings ago the waiting list is still very long. He then asked if Inclusion Matters Wirral is one of the services patients are signposted to by SPA as earlier mentioned by Dr Parhee at the beginning of her presentation.

Dr Parhee replied that there would be telephone contact first and then an offer to meet face to face and after that they go to inclusion matters. She said she didn’t think anybody was being sent off and confirmed they had stopped looking at and making decisions based on referral letters.

*Some detail lost due to background noise on the tape.*

A member said that care homes currently requested mental health assessments for patients in nursing homes via the GP and asked if the care home themselves could refer patients directly for this assessment, suggesting that the community nursing team or ICCT could be asked to do it instead of the GP.

Ms Quinn said that one of the benefits of aligning with ICCT is better relationships and that once they had done the piece of work she didn’t see any reason why CWP couldn’t facilitate it.

The Chair stated that the design of the new service must proceed with caution and take on the views and concerns of the LMC, otherwise it would not work. He added if safeguards were in place for a two way service it could work.

Ms Quinn concluded that this was the reason they were here and it was the start of the conversation rather than the end.

The Chair thanked Dr Parhee and Ms Quinn for coming.

71. **Clinical Commissioning Update**

The Chair invited Mr Develing to give an update.

Mr Develing gave an update on:

CCG AGM Meeting

The CCG had its AGM meeting last week and 57 members of the public attended which Mr Develing found very encouraging as he knew other CCGs had held their AGMs with single numbers.

Governing Body Consultation

The next CCG governing body, 4th October 2016, will be considering 3 areas of public consultation: gluten free products, over counter products and homeopathy. Supporting papers in relation to these areas are included within the Governing Body Agenda and published on the CCG website. It is expected that this will attract significant media and public interest as this concludes the consultation process.

£9m deficit

The CCG met with NHSE last week and agreed a `control` total for the year end 2016/17 that amounts to a deficit of £9m. This means the CCG is in breach of its license and as such will be considered as being under NHSE ‘directions’. This requires the CCG to develop a Financial Recovery plan within the 4 weeks. .

The CCG also met with NHSE and NHSI, the regulator for foundation trusts (WUTH/WCFT/CWP) and the Local Authority (Social care). This joint meeting being held to discuss the wider economy issues as it is clear that the financial challenges faced by the Wirral system were evident across all sectors.

Mr Develing explained that the £9m deficit had primarily arisen from the way the Better Care Fund was created in 14/15. At that time Wirral CCG allocated new money into the fund on the premise that developments would deliver savings in the acute setting. As these savings had not be realised the £9m in effect became a double running cost.

In addition Mr Develing reported that due to a national guidance on funded nursing care the CCG now had to pick up the additional costs of FNC (40%) backed dated to April 2016. The total cost of this in year pressure is circa £2m.

Mr Develing also referred to activity increases at the following hospitals Liverpool Royal, Countess of Chester, Spire Hospital, Alder Hey and Aintree. Each of these organisations has been contacted with the instruction to manage back overspends to the 2016/17 plan so reducing expenditure.

Mr Develing outlined the timetable for the contracting process as per the National Planning Guidance for 2017/18 noting that the timetable had been brought forward by three months to December 23rd 2016. Specifically in relation Primary Care, Mr Develing referenced the Five Year Forward View for Primary Care and the additional funding arrangements in 2017/18 and 18/19. Mr Develing referenced that this would be discussed at the next members meeting and that he would very much welcome an LMC discussion about a primary care response to the five year forward view so as to develop a shared view as what general practice will look like in the future.

Mr Develing spoke about accountable care and the work he has commissioned from the Advancing Quality Alliance (AQUA) in this regard.

**Sustainability and Transformational Plans (STP)**

Mr Develing made reference to the STP and the leadership role he is undertaking across Cheshire & Wirral. He emphasised that the STP was a bottom up process and built on local initiatives, such as Healthy Wirral,

Mr Develing also recognised that the CCG and Providers need to work across a wider footprint to gain the maximum benefit it and traction in sharing collaborative functions.

Mr Develing was aware of media stories of closure of hospital sites and redevelopments in other areas but gave assurances that this was not part of the STP Plan. Rather the plan itself focusses on:

1. Managing care in the most appropriate setting (Demand management)
2. Taking out unwarranted variation and reconfiguration if and where appropriate
3. Reducing back office expenditure
4. Different ways of working (new models of care, governance arrangements and accountable care)

Mr Develing ended his update and the Chair asked if anyone had any questions.

A member raised the point that the £9m overspend was only about 2% of the overall £490m budget.

Mr Develing recognised that but reaffirmed that whilst this appeared to be a small sum it did mean that it was in breach of its statutory functions. It was also noted that against the national allocation formulae the CCG was below its distance from target (DFT) by £11.4m.

The member asked where the battle was that is needed in winning against that national formula.

The LMC Hon. Secretary expressed support for the CCG and expressed the view of members that whilst it was recognised that we as a system need to do everything we can to bring the budget back into balance the current position with regards to DFT was unacceptable and that an invite to NHSE from LMC would be sought.

The Chairman added that this had been previously discussed at LMC, and with Sue Wells, about asking somebody from NHSE senior management or the Medical Director, Kieran Murphy, to attend an LMC meeting. He said he was in the process of writing a letter to Kieran Murphy and running it past James Sowery to ask somebody from NHSE to come and be present at the members meeting to answer exactly these questions. He added that it seemed very unfair to be put under huge pressure to not refer, not prescribe and not admit when there is a fault in the budget. The Chair said he knew the CCG were doing their best and that they were all in it together but that it was now also time for the NHSE to show some support and backup. He also said the public should be made aware of the situation.

Members agreed that more could be done to share the position with the public. A member added that GPs were personally paying the price by taking personal pay cuts, spending ridiculous hours in the surgery and the public did not yet realise properly the extent.

The Chair responded by saying he thought that GPs were sometimes between a rock in a hard place with deciding on whether to refer or not, being very much aware of saving and trying to explain that sometimes or to massage that with patients.

Another member said that reducing demand due to variation, trying not to refer, not to admit and not to prescribe brought a certain amount of risk. GPs are taking a risk every day when trying to decide not to make a referral which also brings with it an increase in patient complaints. These are often not justified but are the patient’s perception of inappropriate care. They added that it came up at a meeting a week ago, that in the foreseeable future there is going to be a capacity problem in general practice and that one thing limiting capacity, apart from being overworked, are MDU fees. Taking on extra sessions for the average GP may not be financially worthwhile when MDU fees are factored in and this was a stress in life. As Mr Develing talked about the bigger footprint of five CCGs, the member asked if these five CCGs could get together in some way to try and do a deal with indemnity organisations; to negotiate across the board indemnity for all GPs across a patch and try to work out a fair way of getting reduced fees.

Mr Develing responded by saying it was entirely possible and was good to come to this sort of meeting to hear these ideas. He needs this to come from the LMC and can use it. He said that he couldn’t promise anything but would certainly look into it.

A member asked if other CCGs were underfunded and if the Wirral was worse off because of their deficit.

Mr Develing explained that all the CCGs in Cheshire & Wirral where equally challenged in terms of finance and were also below the DFT Target. He went on to explain the classification of CCGs as `Good`, ` Requires Improvement` and `Inadequate` noting that those CCGs currently classed as inadequate were all below target and those classified as `Good` were all significantly above target.

A member asked if primary care budgets would be going to the CCG and if so, would they be ring-fenced.

Mr Develing said the CCG would welcome the co-commissioning of primary care at a time when this was right for its membership, recognising that this is a national direction of travel. He noted that where co-commissioning had taken place in other CCGs this was indeed a ring-fenced budget.

Another member stated they were very pleased the CCGs were working together and that it was very important for the public to be made aware of the position as they thought they were getting the wrong message and needed to be made aware of the deficit.

Mr Develing said the CCG have done, and continue to do, public engagement events. He also stressed that whilst the position appears to be very difficult, it’s not that we don’t have any money. Indeed the CCG has an allocation of £490m which needs to be spent in a different way.

The Hon. Secretary stated that it was very important for the public be told GPs were not adequately funded and asked for the CCG to inform them. He gave an example of a patient who complained, when they couldn’t get an appointment, and made the comment that the GP was paid to see them. He added that public perception is that GPs are adequately funded when they are not.

The Chair added that the public should certainly be made aware of the £11.4m as it is tax payers’ money that could be spent on their healthcare. They should be made aware that Wirral is underfunded because of NHS accounting. He knew that the governing body meeting, which was to be held the next day, was a public meeting and that this was not in any way being hidden but it wasn’t being put out there either.

Mr Develing recognised that more could be done to create a clear narrative on the challenges ahead.

A member referred to demand and managing referrals differently and asked why they are not saying that the 18 week target is unsustainable. They asked why GPs couldn’t break those guidelines.

The Chair added that he wasn’t sure clinically that could be advocated as would make patients wait longer and longer and asked Mr Develing to respond.

Mr Develing referenced the statutory duties of the CCG to meet the planning guidance on the 18 week RTT target. He noted however a reference within the guidance about exceptionality to this. .

The Chair thanked Mr Develing for coming.

**ACTION:**

72. **WUTH Update**

The Chair invited Mr Gary Price, Associate Director of Strategy, to give an update.

Mr Price gave a brief update on WUTH specific headlines:

* Dr Susan Gilby has been appointed as the new Medical Director and will be starting in New Year. Dr Mark Lipton is covering at the moment. Dr Gilby is an anaesthetist by background and currently Medical Director at Wye Valley NHS Trust. Mr Price will put her in touch with the LMC next year when she starts.
* Finance and Performance plans are on target for Q2.
* In terms of STP’s, to reinforce what Mr Develing said, that despite the article in the Echo, Arrowe Park and Countess hospitals were not closing and not forming a new hospital. The article talked about that idea as one of many, many ideas and if anyone wanted the Chief Executive’s response, it was in that article. Many options have been discussed including that over time the estate will age and it will start to cost more too. WUTH is working together with the Countess via LDSP and STP.
* That is one of the themes picked up through the STP which Dr Develing spoke about. Only one of four. So demand management, clinical variation, back and mid office; joint working are other areas discussed in the STP.
* The Wirral and Cheshire works currently being done needs to involve all stakeholder instilled through Healthy Wirral Partnership Group which Mr Develing mentioned and which has Primary Care representation on.

In terms of more local things:

* A few weeks back Sue Wells led a re-engagement event with Primary Care, which was well attended with about 40 people there altogether. With those sorts of conversations and STP, thoughts were more concrete and need to keep sharing all the thoughts with all the partners and getting views from all those different areas including the LMC.

In practical terms:

* WUTH is engaging with Primary Care and CCG through Healthy Wirral, new Respiratory and Diabetes Model are being developed and will hopefully be delivered next year.
* VSA’s, older people with frailty which is being met by the CCG and specific work around them, end of life etc.
* WUTH spent time engaging with the Federations – been out to see both federations, recognising and welcoming the independence of the federations and the need for WUTH to get more involved, to be helpful to get an understanding of the direction travelled from each of the federations. Other opportunities for WUTH to work with Federations with some immediate opportunities maybe around back office, procurement and GPSI opportunities at the moment.

The Chair thanked Mr Price for his update.

A member commented on the new model of care for respiratory and diabetes care and opined that the care models were done very quickly and the wrong models were used. The member added that it should be primary care led and not led by secondary care. It was reported that currently a number of practices that had nurse practitioners are already doing that type of care subsidised by their own practices.

*Some detail was lost here due to not being able to hear the members clearly and background noise.*

The Hon. Secretary said he attended the meeting where this was demonstrated and didn’t get the feeling it was secondary care led. It was more around intermediate care programme which is led by specialist nurses, part of whom are GP nurses trained to deliver. He asked if they were talking about a different model of service and if they were saying that there is a problem with the diabetic model set up, where it was discussed at the Wirral CCG members meeting and all agreed with it.

The member replied that general practice should be given the first opportunity to take the service, as the profession was screaming for resources and asked what happened to practices that could manage the service.

The Chair accepted the comment and said that there hadn’t really been any involvement with respiratory and diabetes as an LMC but there had been GP reps, so coming at it as a GP there has been involvement.

A member asked was it possible to have it both ways. They personally were too busy and somebody else is saying they are happy to take it on.

*Some content lost to movement in the room and not able to hear the member.*

Mr Price responded that both the Diabetes and Respiratory Care cases had now been written into a proposal and he would ask the CCG to share. They have absolutely been co-produced and co-designed on an integrated approach to care which is absolutely in line with the shared accountability approach of accountable care but more importantly it was designed with patients. The pathway was mapped with patient groups, they said what they got from diabetic care now and this is what good looks like and it was absolutely designed around the patient. Mr Price stated he could show the pathway before and after, the pictures drawn and all the work. None of it was done carelessly but with a great deal of thought. It was actually a patient insight to driven initiative. He added that if there was any opportunity, as always, that WUTH could work with Primary Care they would look at that but that this was very much an integrated model as the Hon Secretary described.

A member commented that both services were very good.

The Chair asked if Mr Price would like to add anything further from the WUTH perspective or if the members had any further questions. There was nothing further to add and the Chairman thanked him for coming.

**ACTION:** **Invite CCG to give broader update on diabetes and respiratory work programmes.**

73. **Matters Arising**

**Retirement: Office Manager**

The Chair mentioned that that Mrs Thelwell was away today to allow Mrs Lepts to do this first meeting on her own. Mrs Thelwell would be back in the office on Tuesday, Wednesday and Thursday, with Thursday being her last official day and that hopefully she would be attending the LMC dinner with her husband. The Chair then passed around a retirement card for those members that wished to sign it and an envelope for donations toward Mrs Thelwell’s retirement gift. He added that he and the Hon Secretary would be presenting Mrs Thelwell with flowers on her last day and a leaving gift; maybe some M&S or John Lewis vouchers, or something similar to that as a retirement present. The Chair said that Sue had been a very able, hardworking and loyal member of LMC for the last twelve years as some of the members would know. He knew Mrs Thelwell from when she first started and there had been a lot of changes in the committee over the years so others may not have known her so well. She often trouble-shooted and kept the LMC out of danger dealing with all sorts of problems; she was very efficient and stepped into the breach arranging last minute meetings. He said that the Hon. Secretary would agree.

A member asked if, in addition to the collection, there could be a cash sum given to Mrs Thelwell from the LMC; representative of all GP’s. Due to her level of service it would be a nice thing to do.

The Chair agreed and said he and the Hon. Secretary were thinking of something in the region of £250 as a leaving present in vouchers and flowers, if that felt right with members, and that vouchers rather than money would be very acceptable and more personable.

**ACTION: Chair and Hon. Secretary to present flowers and gift voucher to Mrs Thelwell.**

**Meetings**

The Chairman informed members that he and the Hon. Sec had been involved in several meetings or non-meetings:

Phlebotomy

They were disappointed to find this morning that the Phlebotomy meeting with the Community Trust, which was scheduled for first thing tomorrow morning, was cancelled. No reason or other date was given, so Phlebotomy problem is still on-going.

Consultants and GPs

They attended the Consultants and GPs meeting which was quite well attended, with more GPs than Consultants, and nothing was discussed really that hadn’t already been heard.

NHS England

They were due to meet with NHS England last week but NHSE cancelled, so they are awaiting reschedule.

**LMC Levies**

The Chair informed the members that there was finally good news on the unremitted LMC levies. An email had been received stating payment would be made this week of around £30k which included back pay. He reminded members there was a hiatus of about 3months because Capita who had taken over the recoup of GP levies to then pay to the LMC account, had got it wrong and messed it all up so there were 3 to 4 months where the LMC hadn’t received any money. Fortunately, as there was considerable surplus in the bank account, the LMC could operate as normal.

The Hon. Secretary added that the levies were incorrectly paid to Liverpool LMCs account.

The Chair confirmed that Liverpool had a double payment but that it was finally heading in our direction and there was an email to confirm that.

A member asked if the LMC were charging interest.

The Hon. Secretary replied that Capita would not be paying any interest. They had to be threatened with court action to find out where they incorrectly paid the levies to; they knew they had paid but didn’t know who they paid them to. So, Capita weren’t going to pay interest.

**ACTION:**

74. **Sub Committee Reports**

**Support Group Meeting: 3 August 2016**

Dr Gillian Francis provided a written report from the Support Group meeting on 3 August 2016. See appendix 1b. The report was taken as a reference.

The Chair invited Dr Francis to say a few words.

Dr Francis said that everything was in the report and if anybody had any questions or concerns she would be happy to take them to the group.

The Chair said it was great to consolidate and refresh people’s memories that this was what should be happening and the service was out there for GPs if necessary. He added the Hon Sec is directly involved with PAG meetings over in Liverpool. He added that some of the cases GPs found themselves embroiled in could be relatively minor or seemed to be relatively minor but PAG really went to town on them.

Dr Gillian agreed and said that really was her fear. Cases were being brought to PAG which probably shouldn’t have gone there and when they do get there they are quite draconian in the way PAG deal with them, especially in terms of certain things like record keeping. She said everyone knew that it was quite hard for a busy surgery to keep up record keeping to a high standard. She added it was appalling that GPs were not permitted to be in the meeting and the LMC should fight for GPs to be there.

Members discussed this further.

*A lot of detail was lost due to surrounding noise, movement and a mobile phone ringing.*

The Chair agreed that it was wrong but that it was national thing and that GPs should be able to attend and respond on the day with support but they could represent themselves at the next level.

The Hon. Secretary suggested the LMC raise the motion along those lines at the next LMC Conference. He added that it used to be common practice to ask a GP first and it only went to PAG if it was serious. He said he had already raised this with GPC and NHSE and went through the training so knew it was the national guidance that any named practitioner on the performers list who had a complaint against them, no matter how small, had to be looked at by PAG. He added that unfortunately this was only in England and not Wales. In Wales the GP was allowed to attend the first meeting and fight their case.

The Chair said this was another issue to raise with someone senior that as long as a patient has come to no harm they shouldn’t go near PAG.

Members discussed this with examples of stories they had heard.

A member suggested that maybe an LMC observer should attend those meetings.

**Drugs and Therapeutics Meeting: 21 September 2016**

Dr Fred Newton provided a written report from the Drugs and Therapeutics Meeting on 21

September 2016. See appendix 1c. The report was taken

75. **Correspondence**

Nothing to report on correspondence.

76. **Any Other Business**

No other business.

77. **Minutes from Previous Meeting**

The minutes from the previous meeting were noted to be a true and accurate record and were proposed by Dr Rupert Millard and seconded by Dr Abel Adegoke.

78. **Date of next meeting**

The next LMC meeting is Monday, 7 November 2016, commencing at 1.15pm and finishing at 3.15pm.