**Nottinghamshire Local Medical Committee (Ltd)**
**Minutes of the LMC Open Meeting**
25 November 2014
LMC Offices, 5 Phoenix Place, Nottingham

**Present:**

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| Dr G Place (Chair) | Dr S Holmes |
| Dr F Armitage | Dr C Johnson |
| Dr J Ambrose | Dr A Khalique |
| Dr M Bicknell | Dr S Kinra |
| Dr J Bilkhu | Dr A Bilkhu |
| Dr K Butt | Dr W Mikhail |
| Dr M Elliot | Dr B Pathak |
| Dr J Greenwood | Dr A Sharman |
| Dr P Holden | Dr O Sharma |
| Dr K Sharma | |

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| Ms A Khalique | Practice Manager |
| Ms N Willis | Practice Manager |

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| Mr C Locke | Notts LMC Ltd Secretariat |
| Ms H Shuker | Notts LMC Ltd Secretariat |
| Mr M Wright | Notts LMC Ltd Secretariat |
| Ms A Bolton | Notts LMC Ltd Secretariat |
| Mr S Jones | Notts LMC Ltd Secretariat |

**36/14 Apologies**

Apologies for absence had been received and were reported to be available from the LMC offices.

**37/14 Minutes**

The minutes of the previous 'Open' meeting of the LMC held on 30th September 2014 were approved as a correct record.

**38/14 Matters Arising**

i) HM Coroner

The Chief Executive reported that the Coroner's office had acknowledged amendments to their guidance relating to the agreement that a patient whose details were recorded in EPACCS and on "special notes" could be treated as an expected death. He reported that, following discussions with NEMS, it was agreed that they would act as an intermediary to facilitate discussion of the LMC's concerns. He expressed his disappointment at the lack of a direct response from the Coroner to the LMC's written statements and he indicated that the LMC would consider taking further action if necessary.

Dr Holden suggested that the LMC should acquire comparative data regarding Coroners in other areas. Dr Butt reported that the Coroner would be attending a PLT event in Mansfield and Ashfield February.

**NOTED**

**39/14 Personal Wellbeing of GPs**

The Chief Executive introduced his presentation on the services already provided by the LMC to support GPs' wellbeing, the recent expansion of the pastoral network and the LMC's capacity for further developments. He began by explaining that the LMC's Pastoral Network had existed for over a decade with the underlying rationale to support GPs undergoing any kind of personal difficulty or crisis. He highlighted that the service provided by the network was free (paid for by the LMC), confidential, and provided by retired GPs who had time, the necessary empathy and listening skills, to spend with those in need. He highlighted that pastoral advisors provided telephone advice, face to face advice and short term, long term and more often intermittent interventions. He reported that pastoral advisors could liaise with other agencies including clients' own GP, NHS or Occupational Health Services where health was an issue, or the LMC regarding advocacy when facing performance review. He highlighted that there was various means of access to the network including self-referral, referral by concerned partners, colleagues or relatives, and by the Area Team. He said that problems dealt with included domestic or family matters, for example, marriage break up or bereavement; professional matters such as patient complaints, Area Team performance review or referral to GMC; break down in relationships at work with professional partners, employers or staff; and health problems, for example, coping with illness, depression, serious mental health issues or addiction. He indicated that details of how to access the network could be found on the LMC's website, in its "It's your LMC" brochure and the forthcoming pastoral network leaflet.

The Chief Executive then reported on recent external changes to occupational health services. He highlighted that funding for GPs to access Occupational Health had been withdrawn other than in cases deemed appropriate by the Area Team. He highlighted that there was evidence of high numbers of GPs on anti-depressants and self-referring to NHS IAPT services.

He reported on the recent expansion of pastoral services provided by the LMC. He reported that the LMC had signed contracts with four specially chosen psychotherapists to whom pastoral advisors could refer cases where appropriate. He highlighted that the network had added a practising GP to its ranks to provide an alternative to Occupational Health for physical health problems, as well formulating a list of approved providers of life coaching. He indicated that the network was also planning to create a bespoke career counselling service and those discussions were ongoing.

He indicated that in recent discussions with the pastoral advisors, a gap in the network's services had been identified as regards the needs for mentors, as well as a gap regarding remediation services for those with serious under performance issues. He also noted that GPs were under increasing work pressures with little time for reflection and self-development and as a consequence there had been reduced opportunities to consult and share burdens with colleagues. He also highlighted that appraisers had become increasingly concerned with performance measurement rather than development. He reported that funding for GP tutors had been withdrawn other than in cases deemed appropriate by the Area Team.

The Chief Executive referred to recent discussions with colleagues in Derbyshire about coordinating a mentoring service and he indicated that there was the possibility of obtaining

non-recurrent funding from HEEM and LETC to pilot new services from the underspend incurred from a shortage of GP registrars, due to a 40% vacancy rate in the East Midlands.

Michael Wright then presented a draft survey which would be used as a scoping exercise to identify ways to support GPs' personal wellbeing and to inform the development of the proposed mentoring service. He invited comments and suggestions from the floor.

Dr Armitage stated that a disclaimer would be helpful to assure GPs that they would not be obliged to answer any of the questions in the survey. Dr Bicknell suggested that the basic identity questions should be placed at the end of the survey.

Dr Pathak suggested that the survey should ask where the GP in question initially qualified. Dr A Sharman concurred and noted that this would be helpful to identify GPs who had only recently arrived in the UK; however, Dr Butt demurred.

The Chair suggested that the satisfaction question should be reformulated as a 1-10 rating. It was suggested that the survey should be identifying the root cause and not merely the symptoms of any concerns. Dr Johnson stated that the purpose of the survey should be to tackle local issues and the Chief Executive concurred and highlighted that the purpose should be to mitigate effects locally and to support the existing workforce. The Chair added that if problems were identified early, the LMC would be able to utilise resources effectively.

Dr Holden suggested that there should be additional questions relating to OOH, how many sessions a week GPs are contracted to work and which local management systems were causing GPs problems. Dr Khalique suggested that factors such as financial stress, performance of practice and KPI deficits should be included and it was suggested that there should be a question about the stress caused by CQC inspections. Dr Elliot suggested asking about alcohol and use of prescribed drugs. Dr J Bilkhu suggested that a question should ask what would stop GPs seeking support. Dr Holmes noted that pride and infallibility were pertinent factors and he emphasized the importance of the LMC providing a mentoring service to compensate for the limitations of the appraisal system as regards personal support.

Dr Johnson said that childcare issues and work/life balance were often causes of stress and Dr Khalique noted the detrimental effects of family illness on GPs performance.

The Chair suggested that a question should ask if the GP in question was treating any colleagues and at what frequency and if there were any communication issues. Dr Butt emphasized the importance of professional courtesy in giving GPs priority appointments.

Dr Holmes reported that a number of GPs appeared to be unaware of the pastoral services provided by the LMC and that advertising the network needed to be a priority. He stated that CCGs needed to ensure that there was funding allocated for pastoral services in primary care. The Chief Executive indicated that he would be liaising with CCGs on this matter. He highlighted that the directory of pastoral services would be circulated in due course and that discussions were ongoing about the creation of an additional website, or a further section on the LMC website, devoted to pastoral services.

Dr Khalique suggested that a local, dedicated helpline could be developed by the LMC to provide immediate and easy access when required. The Chief Executive said that the practicalities of such a service would require further thought and he commented that the LMC would not have the resources to run a 24 hour service with a dedicated call handler. Dr A Sharman highlighted

that there were national lines already available and that the LMC could sign-post these services on their website.

Dr Johnson emphasized the importance of raising awareness of the LMC's support services for GPs in need, particularly those who were considering leaving the area or the profession. She highlighted the importance of contributing to efforts to retain GPs and that work should be done on developing a business model for this purpose.

The Chief Executive invited suggestions from the floor on the development of the mentoring service. Dr Kinra suggested that the service should be tailored to suit GPs at different stages in "the pyramid" by providing buddying for younger GPs and support for those with more serious issues. Dr J Bilkhu highlighted that the pastoral network was a filtering and referral system and it required a number of agencies to sign-post, including trained mentors.

Dr A Sharman invited comments and suggestions from the floor in relation to what a mentoring service would need to cover. Dr Elliot stated that talking therapy was vital by helping clients to organise their thoughts and he acknowledged the benefits of trained mentors able to address deeper issues. Dr Armitage said that mentors were beneficial to help VTS trainees and Dr A Bilkhu emphasized the importance of the mentor being of a similar age to the GP they were helping.

In response to a question from the Chief Executive about the differences between a mentor and a pastoral advisor, Dr J Bilkhu highlighted that a mentor had more experience and qualifications to act as a guide; whereas, pastoral advisors acted primarily a "listening ears".

The Chief Executive reported that there was an East Midlands mentor network and that all their mentors had been trained in the EGAN method. He noted that the LMC had considered sign-posting their services but from feedback received it had been agreed that this approach would not suit GPs' needs.

Dr Johnson asked about the capacity of the pastoral network to maintain a service in periods of high demand. It was suggested that the demographics of the network needed to be widened to meet the range of GP backgrounds.

The Chief Executive suggested that there could be a reciprocal arrangement to match "buddies" to GPs which would not require funding. Dr Kinra highlighted that the cost of a facilitator would need to be taken into account. Dr A Sharman noted that she had been discussing opportunities for a buddying system and other services and that she needed to find out what GPs would want from the service. Dr A Bilkhu commented that the VTS system would benefit from a buddying component. Dr J Bilkhu commented that the LMC's survey would act as an awareness tool for GPs and that the buddying system and mentorship would be beneficial. He added that there was still a need for a network of tutor-led or locality groups to provide the opportunity for GPs to "let off steam" and share ideas.

Dr Johnson commended the work completed to date and highlighted the importance of advertising the menu of services currently available. She said that the proposed plan for further pastoral services would need to be flexible and ambitious in order to meet demand and attract funding. Dr A Sharman suggested that the proposals be initially implemented in pilot form and the Chief Executive highlighted that if the pilots were successful, the LMC would then be in a strong position to lobby for funding. The Chair recommended liaising with appraisers to help spread the message.

The Chair highlighted that the survey would be circulated to all practice managers in due course and the Chief Executive indicated that the LMC's newsletter would be utilised to advertise the proposal discussed.

**NOTED**

**40/14 GP Contract Issues**

The Chief Executive highlighted that that the LMC were in ongoing discussions with CCGs about use of the PMS premium and that the LMC's liaison team would provide an update when appropriate. He indicated that something like the old PCT liaison arrangements would be reestablished as CCGs would start to resemble PCTs.

In response to a question from Dr Butt about Christmas and New Year closing, the Chair reported that the GPC felt that CCGs and ATs were not interpreting the contract details correctly and they could therefore be challenged. Dr Butt reported that Leicestershire LMC had negotiated a 1.30pm closing time for their practices on Christmas Eve. The Chief Executive expressed surprise at this and agreed to investigate.

**ACTION: LMC SECRETARIAT**

**41/14 Any Other Business**

There was no further business.

**42/14 Date of next meeting**

The Chair reported that the subsequent meeting would be on 27 January at the LMC's office, Phoenix Park, Nottingham.

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**Chairman**
**27 January 2015**