**NOTTINGHAMSHIRE LOCAL MEDICAL COMMITEE (Ltd)**
**MINUTES OF THE LMC OPEN MEETING,**
held on 27 January 2015,
at the LMC Offices, 5 Phoenix Place, Nottingham

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| **Present:** | **Dr G Place (Chair)** | **Dr A Harrison** |
| | **Dr K Anandappa** | **Dr P Holden** |
| | **Dr K Butt** | **Dr H Patel** |
| | **Dr L Foxwell** | **Dr M Tadpatrikar** |
| | **Dr J Greenwood** | **Dr K K Tumurugoti** |
| | | **Dr M Stevens** |
| | **Ms J Birch-Jones** | **Flo** |
| | **Ms A Ellis** | **LPC** |
| | **Ms M Brooks** | **Practice Manager** |
| | **Mr M Ebb** | **Practice Manager** |
| | **Ms A M Kew** | **IT Manager** |
| | **Ms L Owen** | **Practice Manager** |
| | **Mr C Locke** | **Notts LMC Ltd Secretariat** |
| | **Mr M Wright** | **Notts LMC Ltd Secretariat** |
| | **Mr S Jones** | **Notts LMC Ltd Secretariat** |

**43/14 Apologies**

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

**44/14 Minutes**

The minutes of the previous 'Open' meeting of the LMC held on 25th November 2014 were approved as a correct record.

**45/14 Matters Arising**

There were no matters arising

**46/14 Flo**

The Chair introduced Ms Jayne Birch-Jones, Nottinghamshire Assistive Technology Programme Manager, who would be providing a short presentation and update on Flo Simple Telehealth. Ms Birch-Jones began by highlighting that there were three main uses to Flo, namely to record vital signs and other readings; to give reminders on medication, ADL and appointments; and to provide motivational messages. She highlighted that the service was free to use and that patients could operate the service on their mobile phones and landlines. She indicated that the service did not require frequent monitoring by a clinician and that the onus would be on the

patient to follow Flo's advice. She reported that the local Area Team had identified that Flo could be used for the unplanned admissions DES for active, ongoing clinical monitoring and provision of care. She highlighted that clinicians had access to a clinical dashboard which provided an audit trail and graph.

Ms Birch-Jones reported that Flo had received 866 new patients since April 2014 and that all Nottinghamshire CCGs used the service along with Sherwood Forest Hospital, NUH and commissioned charities. She highlighted that 87% of practices in Newark & Sherwood were using Flo, 46% in Mansfield & Ashfield, and 43% in Nottingham North East.

She highlighted that Flo had many uses for GPs, including to monitor long-term conditions and to provide medication reminders. She reported that PICS had used the service for heart failure patients on behalf of Nottingham North & East CCG. She reported that the service had also been utilised in a care home context, where it had facilitated medication reviews; reduced the risk of falls; improved medical titration; and increased understanding of vital sign parameters.

Dr Tadpatrikar highlighted that, from his experience of using Flo as a GP at Roundwood Surgery, the service had empowered patients to be in control of their health by inputting their own parameters and receiving medical feedback and recommendations. He indicated that GPs were able to view patients' readings through SystmOne and he reported that the service had helped to reduce admissions. He added that Flo could be used with Skype to carry out virtual consultations and he indicated that this had been approved by the standing operating procedure. He indicated that Skype consultations helped to support care home staff; were more timely and regular than face-to-face consultations; and reduced exacerbations. He added that the Prime Minister's Challenge Fund had recommended that practices utilise assistive technology and he highlighted that the Coroner had stated that Skype consultations were acceptable.

In response to a question about who would pay for the license costs, Ms Birch-Jones highlighted that CCGs would pay and she added that 6 CCGs had agreed to fund Flo as a mainstream service.

In response to a question from Mr Wright about the low uptake in Nottingham City, Ms Birch-Jones highlighted that Nottingham City CCG had their own telehealth service.

In response to a question about the uptake of Flo in Bassetlaw, Ms Birch-Jones indicated that Bassetlaw CCG had encouraged their practices to operate under the Bassetlaw model.

The Chair expressed concern that the current NHS IT infrastructure would not support a Skype facility.

Ms Birch-Jones highlighted that the positive outcomes for patients from using Flo were an increased understanding of symptoms; reduced anxiety and exacerbations; an increased ability for self-care; and an increase in quality of life. She highlighted that, for GPs and the wider healthcare community, the positive outcomes were an improvement in monitoring information; an increase in the availability of clinical appointments and visits; increased patient compliance and a reduction in non-elective admissions. For the NHS, she highlighted that there would be a better utilisation of NHS resources by patients; a reduction in hospital admissions; productivity savings; and a transformation in the pathways of care. Dr Tadpatrikar added that Flo had helped to reduce patient contacts with chronic conditions and Ms Birch-Jones reported that she had received very positive feedback form practices to date.

Ms Birch-Jones indicated that further evaluation would take place in due course and would be completed by March 2015. She reported that Flo in Nottinghamshire would be mainstreamed from 1st April 2015 and that a transfer process was under development between providers to support the MDT patient pathway. She highlighted that system functionality was being developed along with a multi-user platform for care homes.

There being no more questions, the Chair thanked Ms Birch-Jones and Dr Tadpatrikar for their informative update.

**NOTED**

**47/14 NHS Five Year Forward Plan**

The Chief Executive presented his personal observations on the NHS *Five Year Forward View* (FYFV). He highlighted that one of the key themes was "prevention" following the failure by the NHS collectively to address the Wanless challenge to "take public health seriously". He drew attention to a potential solution documented in the report, which would involve incentives, "local democratic leadership" such as the involvement of local authorities in Public Health issues, NHS and employer support for health at work, and keeping people well while at work. He expressed concern, however, about the effect of cuts to Public Health's budget.

He highlighted that the FYFV aimed to promote self care, support carers, and to make use of the third sector, such as Red Cross ambulances. He reported that the report was promoting the NHS as an employer (acting as a "social institution") and aimed to roll out personal budgets for Health and Social Care.

The Chief Executive stated that integration had become a mantra for the NHS but he commented that it was unclear what this actually meant due to the various permutations, such as general practice and community, primary and secondary care, and health and social care. He highlighted that the plan was to abolish "artificial boundaries between primary and secondary care that get in the way of coordinated services" and he indicated that there was an emphasis on out of hospital care and integrating services for physical, mental and social care around the patient. He said that there would be a focus on nationally approved models and that there was a plan to pilot a number of different models of care. He commented that the boundaries and divisions the plan aimed to abolish had been compromised by the provider market and he indicated that there seemed to have been a shift in the NHS' policy from competition and choice towards collaboration and cooperation. He commented that this approach could be reviewed after the general election.

He then drew attention to two new models of care, namely "Multi Speciality Community Providers" (MCPs) and "Primary and Acute Care Systems" (PACS). He highlighted that MCPs would involve GPs as expert generalists working with other primary care professionals through federations, networks, larger practices or larger groups (a form of horizontal integration). He said that MCPs could take over ambulatory care and community hospitals, and that they would take on a budget as the accountable provider. He commented that the model owed much to examples like the vitality partnership in Birmingham but that the evidence was not overly convincing. Turning to the PACS model he said this would entail vertical integration between primary and secondary care and involve lead providers, and joint ventures or single organisations who would run acute, primary and mental health services with a single capitated budget as a accountable provider. He referred to the Alzira model in Spain as an example of

PACS and he highlighted that the NHS would want to see the model being piloted and evaluated in order to be assured that there would be no "unintended consequences".

The Chief Executive continued that, with the advent of co commissioning, CCGs had been given freedom to invest in primary care and that there was a recognition that GPs were under severe strain. He highlighted that the various solutions referred to in FYFV included a move to "stabilise core funding", which might involve a streamlining of core contracts; use of the Challenge Fund to support new ways of working and increase access; increasing the number of GPs and expanding funding for infrastructure. He indicated that there would be an "information revolution", with a focus on key systems that provide the "electronic glue" necessary for different parts of the system to work together and that measures would include implementing fully interoperable health records from 2016; online patient access to records by April 2015; an increase in EPS; and structured coded discharge summaries by October 2015. He indicated that there was a requirement to close a £30 billion funding gap by 2020/21 by a combination of efficiency, demand management and more investment.

The Chief Executive drew attention to the Mid Notts transformation programme (Better Together) which he said was an example of PACS but was more horizontal than vertical. He stated that the model was horizontal in that organisations were working together and vertical in that there would be a pooling of budgets from primary and secondary care. He reported that the South Notts transformation programme had yet to engage GPs and he indicated that a challenge for GPs would be to be organised in order to become engaged as an active participant (as opposed to a passive recipient) in both programmes. He reported that the PCDC was aiming to facilitate the transformation of general practice from the "bottom-up" and to encourage collaborative working with the aim of establishing alliances of GP local groups to enable engagement in system-wide transformation. He highlighted that the focus of NHS policy would be subject to the outcome of the general election but he noted that there appeared to be a shift in focus from commissioners to providers.

The Chair thanked the Chief Executive for his presentation and highlighted that the NHS Five Year Forward View was available to read in full on the BMA website.

Dr Butt expressed concern at the disparities in funding between GMS and PMS. The Chief Executive responded that inequalities in GP funding around the GMS and PMS contracts continued to exist but would disappear over the next 6 years.

Dr Tadpatrikar commented that the FYFV could be a positive step to address the fragmented health system and he highlighted that he would encourage horizontal integration. As the author of his CCG's primary care strategy, he stated that he recognised the need to recruit more GPs to ensure a sustainable future for general practice and he emphasized the importance of the University of Nottingham advertising general practice effectively. The Chief Executive highlighted that there were no "quick fixes" and he suggested that if Nottingham was flagged as an area in need then it could attract funding. He reported that he had written to the Dean of Nottingham's Medical School to ask for an increased exposure to general practice among medical students.

It was reported that there had been much negative press about general practice and that this had been detrimental for morale and the attractiveness of the profession. The Chair added that the issues relating to the partnership model and premises had hindered GP recruitment and retention.

**48/14 Co Commissioning of GP contract and related issues**

The Chair reported that all CCGs, with the exception of Bassetlaw, had opted for level 3 co commissioning responsibilities. Dr Butt highlighted the importance of the LMC providing independent advice to practices and CCGs and Dr Holden emphasized the importance of protecting the core contract and to challenge unreasonable demands on the profession. The Chief Executive expressed concern at the limited CCG engagement with GPs during the process of expressing interest in co commissioning and he reported that there had been little consultation with the LMC and limited time to comment on documenting changes.

**49/14 Primary Care Development Centre**

The Chief Executive reported that the Centre had organised a bespoke leadership programme for GPs which would involve personal coaching sessions to develop leadership skills. He noted that locum backfill cover would be provided. He also drew attention to vocational training for practice managers created by the Institute of Healthcare Management, which the PCDC had agreed to fund as a pilot.

Finally, he reported that the Centre had been running a series of "learn over lunch" seminars for GPs across Derbyshire and Nottinghamshire on business skills and non-clinical topics such as Consent and Confidentiality on which that the Centre had received very positive feedback to date.

**50/14 Date of next meeting**

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

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**Chairman**
**31st March 2015**