CLEVELAND LOCAL MEDICAL COMMITTEE

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Minutes and report of the meeting of the Cleveland Local Medical Committee commencing at 7.30 p.m. on Tuesday, 17 January 2006 in the Committee Room, Poole House, Nunthorpe, Middlesbrough.

Present: Dr J P O'Donoghue (Chairman), Dr W J Beeby, Dr K P Bhandary, Dr A R J Boggis, Dr J T Canning, Mr J Clarke, Dr L Dobson, Dr K Ellenger, Dr T A Gjertsen, Dr A Holmes, Dr K Machender, Dr T Nadah, Dr J R Nicholas, Dr A Ramaswamy, Dr N T Rowell, Dr R S Sagoo, Dr M Speight, Dr J R Thornham, Dr R J Wheeler, Dr C Wilson

In attendance: Mrs C A Knifton : Office Manager, LMC
Mrs L Corkain : LMC/PCT Liaison Officer, LMC

06/01/1 INTRODUCTION OF NEW STAFF MEMBER

Mrs Lorraine Corkain was introduced to members, as the newly appointed LMC/PCT Liaison Officer. As time went on she would be visiting practices and introducing herself and also meeting with PCT officers.

06/01/2 APOLOGIES

Apologies had been received from Dr A Gash, Dr I A Lone, Dr R F Roberts and Dr S White.

06/01/3 MINUTES OF THE MEETING HELD ON 01 November 2005

These had been circulated to members and were **AGREED** as a correct record and duly signed by the Chairman.

06/01/4 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

06/01/4.1 Enhanced Services – Influenza Immunisation 2005

Ref Minute: 05/09/8.1
(Responses from LPCT, MPCT & NTPCT taken on 13 September 2005)

Response from Richard Harrety, Contracts Manager, Hartlepool PCT
"Hartlepool PCT has expanded the current Service Level Agreement for Influenza Immunisations to include patients with chronic liver disease and who are the main carer for an elderly and disabled person whose welfare may be at risk if the carer falls ill. We informed our practices of the change to target groups on 15 September."

RECEIVED.

06/01/4.2 Enhanced Services – Phlebotomy

Ref Minute: 05/09/8.2

Response from Yvonne Watson, Primary Care Service Manager, MPCT
"I would like to point out that Phlebotomy is covered within the Treatment Room Service LES."

Response from Richard Harrety, Contracts Manager, HPCT
"With regards to a phlebotomy enhanced service, HPCT has been providing support to practices since April 2002. Practices receive an additional resource for providing this service; the cost of this service is approximately £70,000 per annum. This payment is in addition to the Global Sum and MPIG and was agreed as part of the enhanced service floor for 2004/2005."

Response from Jill Harrison, Head of Primary Care, NTPCT
"NTPCT funds phlebotomy services for almost every practice within the PCT. The small number of practices that employ phlebotomists directly did so prior to the new contract being introduced, and the funding for these posts will, therefore, be included within the practice MPCT / global sum. In view of these local circumstances, it is not considered necessary for a local enhanced service to be developed. I hope that this is satisfactory in terms of an update on the local position, and the reason why a LES is not considered appropriate."

Response from Langbaurgh PCT
No response received.

RECEIVED.

06/01/4.3 Insulin Initiation
Ref Minute 05/11/18.2
Responses from LPCT and HPCT taken on 13 September 2005

Response from North Tees PCT – Jill Harrison, Head of Primary Care
"Insulin initiation within NTPCT is routinely carried out by the Community Diabetic Service and the PCT has no plans to request that this work is taken on by local GPs. We, therefore, do not feel that it would be appropriate to develop a LES for insulin initiation at the present time. I hope that this is satisfactory in terms of an update on the local position, and the reasons why a LES is not considered appropriate."

Response from Middlesbrough PCT
No response received but insulin initiative being encouraged via GPs, not as a LES.

RECEIVED.

06/01/4.4 Choose & Book and Electronic Referrals (JCUH)
Ref Minutes: 05/09/4.7 & 05/11/6

Response from Mick Hatton, Head of Performance Management & Business Planning, MPCT (1 November 2005)
"The two issues you have raised both pre-date Choose & Book per se, but do relate to 'electronic referral' in the wider sense and, therefore, do need to be resolved.

Triage of referral letters
The purpose of the current Tier 2 services e.g. musculo-skeletal, skin service, is to try and ensure patients are seen as soon as possible by a professional who can appropriately manage their clinical need. This may be in a primary or secondary care setting.

While the professionals who provide these services do not have direct accountability to a consultant, the protocols the service work to have been agreed with secondary care consultant colleagues as part of the service development. In addition these protocols have been approved via MPCT Clinical Governance and Professional Executive Committee routes.

The issue was raised recently (again via the LMC) where reference was made to the PCT sending patients to 'cheaper' services. These comments were taken to all the Practice Based Commissioning Locality groups where the feedback received did not support the LMC assertions that local GPs were unhappy with the situation.

There is also a 'fail safe' built into the Tier 2 system whereby if the Referring GP writes on the referral something along the lines of "I want this patient to be seen by a Consultant" – that request would be honoured by the service. As confidence in the Tier 2 services has grown this is seldom used.

The current Tier 2 services will be moving from manual processes to being available via the Choose & Book Directory of Services shortly. This should help improve the flow of referrals through the individual services.

There is an ongoing requirement to manage demand in the local health economy as we have to move toward delivery of the '18 week rule' from referral to start of treatment – by 2008. To achieve this will need significant input from primary and secondary care clinical colleagues. MPCT has a sound basis to take this work forward but will need ongoing support from the LMC and PBC colleagues.

'Registered' versus 'Referring' GP
I have started looking more closely at this issue because it has been about for some time but does not seem to have improved at all. Also, it has potential implications under Payment by Results when OPD activity 'goes live' from April 2006.

While the information about Referring/Registered GP is available to administrative staff at JCUH the existing working practices are not supporting the use of the 'Referring GP'. Instead the default piece of information used in 'clinic letters' tends to be the pulled off the Payment Administration System – and that is the Registered GP.

I originally thought that Choose & Book would overcome this problem but I am now less convinced that this is the case in the short term i.e. until JCUH upgrades its PAS system towards the end of 2006.

Following on from your letter, I have now taken this issue up at senior level within JCUH as part of the work around implementing Choose & Book, as on the face of it there appears to be no reason why any letter should not go back to the 'Referring GP'. It will require a change in working practice to be introduced across JCUH to achieve anything in the short term, but more importantly we need to ensure that any new PAS system supports this requirement.

I would find it helpful if you would let me know (a bullet point email will suffice) the key difficulties this causes for individual practices as in the past JCUH have tended to revert to the position that "any letters get to the right practice even if the GP is incorrect"."

The Secretary explained that following an email he had sent to all GPs on 21 December giving LMC advice on Choice, Mick Hatton had written to all Middlesbrough GPs as follows:

"John Canning has offered some advice around Choice, in the form of questions and answers, in his recent LMC email circular. I think this advice needs to be responded to from a PCT perspective

1. It is acknowledged that inclusion in Choose and Book & Choice is not mandatory for GP colleagues – however feedback nationally is already showing that patients like the Choose and Book process. Despite the current foibles of the system (and I accept John's comment about current 'fitness for purpose' being out of synch with the DH rhetoric) failure to take part will introduce inequity into the system for patients in practices that do not participate.

2. The need for additional resource to support the C&B agenda was recognised some time ago by MPCT and we have responded by the introduction of the MARS team to support Practices through what we originally anticipated would be a long transition process to electronic booking. The MARS team has worked closely with practices to ensure the referral process is managed in a clinically safe way, and will continue to do so.

3. The DH has also recognised the concerns expressed at 'Grass Roots' level about the need for additional resource in practices to make C&B a reality. They have responded by the introduction from April 06 of a new DES scheme. It must be made clear though that the £600,000+ needed in MPCT to fund the new C&B + PBC DES schemes has to be taken out of baseline budget – there is no new money available. Any implementation of the new C&B DES will have to show clear measurable benefits for MPCT otherwise the funding will be better used elsewhere.

4. You may not want to offer Choice but a national PR campaign is planned and some patients are going to be asking what options are available to them when informed they need a secondary care referral. Locally the majority of patients may not want Choice but some will and you need to be able to respond to those patients. Just ignoring patient Choice will not make it go away!

5. Yes a DES is now available to provide practices with additional resources to support C&B and Choice. However 50% of the C&B DES will be payable on the results of a patient survey – so unless the practice is actively offering Choice then patients are unlikely to recall this at the time they complete the retrospective survey. Other national surveys have already shown that patients going through the current Choice process cannot recall the offer of Choice.

6. Several GP colleagues have commented that GPs have offered Choice for years – and have made the final decision with the patient. Manual Choice can be seen as an extension of that previous informal approach – except now there are services formally commissioned at all the main local NHS and IS providers that GP colleagues can refer patient into. All these organisations are subject to strict governance arrangements under auspices of the Health Care Commission. While that is no absolute guarantee of an individual patient's safety there should be no need for GPs to have any generalised concerns about clinical safety if any patient opts to attend a provider other then JCUH.

I would be grateful if practices would continue to return the letters outlining if they will be offering Choice from January 2006. Should any practice have concerns about providing a positive response in this letter I would be pleased to discuss it further with them to provide whatever reassurances they require."

It was **AGREED** that the Secretary would pursue the statement "a DES is now available" with Middlesbrough PCT.

The Secretary was unsure what was happening in the four areas about referral management centres and whether referrals were being moved to the dissatisfaction of GPs.

Hartlepool – no-representative present.

Langbaurgh – Some patients being referred to Northallerton which is too far for them to go for management of complications and as a result they are starting to book appointments at surgeries. Information had been received from LPCT showing patients could be referred to nine hospitals but did not contain any background information on their performance, waiting times, complication rates, etc. North Tees was on list of approved hospitals. Sunderland was not on the list as yet.

In response to a query, the Secretary reported that he understood free choice for patients commences December 2006.

North Tees – Members reported that referrals for musculoskeletal and dermatology were sent via a referral management arrangement.

General issues - It was commented that the current Choose & Book software was neither user friendly nor fit for purpose, though it was understood that work was currently being carried out to correct the faults and a new version should be ready in the Spring. This version would allow hospitals to re-direct patients to other clinics if

they have been put into the wrong clinic, without passing referral back to the GP. Nurse practitioners can also make referrals using Choose & Book but some consultants refuse to see these patients and bounce the referral back to the surgery. It was felt that the problem was "scope" in that the system can cope with someone else's referral but they can block it at the other end.

The Secretary explained that he understood guidance was currently being written nationally by the GPC on referral management centres. In response to a question of how to manage a "bounced" referral, the Secretary informed members that if the patient still needed to be referred and the referral is appropriate, responsibility to commission the service rests with the PCT and it should be referred to a medical person at the PCT (Medical Director, Director of Public Health, Chairman of PEC) to take some responsibility for the PCT's commissioning responsibility. Only North Tees PCT had a medically qualified Director of Public Health.

There were also problems with the MARS system in Middlesbrough and concerns over patients being referred to the correct clinic.

The Secretary **AGREED** to make it very clear to PCTs that GPs did not accept the responsibility of patients ending up being referred to the wrong clinic, or being seen by a nurse specialist as opposed to the consultant.

06/01/4.5 Essential Services Floors – Allocation of funds to general practice
Ref Minute 05/11/4

It was **NOTED** that all PCTs had been contacted in November and, under the FOI Act, (20 day response period), asked for current details of funding. To date neither Hartlepool nor Langbaurgh PCT had furnished that information under the 20 day rule.

The Secretary **AGREED** to pursue further with the two PCTs concerned.
(Post meeting note: Information received from HPCT on Tuesday evening after office had closed)

06/01/4.6 Terms and conditions of employment of doctors by practices/PCTs
Ref Minute 05/09/12

Response from Jill Harrison, Head of Primary Care, NTPCT
"NTPCT employs three salaried GPs at present, two of whom are working their notice, and their contract terms and conditions are the same or better than those set out in the Model Terms and Conditions of Service. There are no GMS practices within NTPCT that employ salaried GPs at this time."

Response from Carol Johnson, Assistant Director of Primary Care, HPCT
"We can confirm that our own PCT employed staff are employed under minimum conditions and would encourage the GMS practices to follow this guidance. Unfortunately we are not in a position to insist that their terms and conditions of service are aligned with the NHS employment recommendations but would work closely with the LMC to this end."

Response from Marilyn MacLean, Head of Primary Care, LPCT
"Doctors employed by LPCT are employed under terms and conditions which are the same as those included in "Model Terms and Conditions of Service for a Salaried GP Employed by a Primary Care Trust". As far as I am aware, none of our GMS practices are employing doctors."

Response from Martin Phillips, Head of Primary Care, MPCT
"I am not aware that any salaried GP with MPCT is employed under conditions less than that prescribed by national agreement. However, I will look into the matter. If you are aware of any instances, I should be pleased to be advised further.

RECEIVED.

06/01/4.7 Premises Underspends
Ref Minute 05/11/14

Response from Neil Nicholson, Director of Finance, NTPCT
Within Durham & Tees Valley the Primary Care Premises Board meets to determine the allocation of premises funding. Administration of the Board is undertaken by MPCT on behalf of all PCTs in the patch. My understanding is that, whilst there may be some slippage in year, all funds are committed recurrently. You may wish to validate this with MPCT."

Response from Glen Quinn, Finance Manager, MPCT
"I am pleased to confirm that MPCT will be investing specific allocations relating to premises development in the refurbishment or replacement of sub standard facilities. There will, of course, be slippage on these investments given phasing and build times.

You will, of course, be aware of the exemplary track record of MPCT (and the former PCG) in the development of primary care facilities including:

- The refurbishment of Cleveland Health Centre
- New premises for Dr Palczynski and Dr Lakeman
- One Life – new premises for Dr Basson
- North Ormesby Health Village – new premises for five GP practices
- Fulcrum Medical Centre
- Martonside Medical Centre
- The planned Eston Health Village providing new facilities for four GP practices
- Refurbished premises at Thorntree for Dr Basson & Partners
- Refurbished premises for Dr Sykes"

Response from Ian Reeve, Director of Finance, LPCT
"The scheme subject to a risk of underspending this year is the extension of Dr Clements practice at East Cleveland Hospital (total cost £300,000). It has been a very difficult scheme to commission, starting off as a reconfiguration within the hospital and changing to an extension and changing again due to ground conditions to adding a new floor. It is difficult to say how much will slip from this year into next year at this stage. However, I can assure you that all the funds (and perhaps a little more) will be spent on this scheme when it is complete. There may be some small underspends on

other schemes but the Premises Board are looking to re-allocate resources to other schemes in order to use up all resources this year.”

Response from Karen Gater, Director of Finance & Performance Management, HPCT
“I can confirm that the premises allocation for HPCT is fully committed for this financial year. The allocations are discussed by a central Primary Care Premises Board chaired by Martin Phillips, Head of Primary Care of MPCT.”

RECEIVED.

06/01/5 CONSULTATIONS

06/01/5.1 New Primary Care Trust Arrangements in County Durham & Tees Valley

Initial consultation last year resulted in a recommendation to the DoH for 4 PCTs in the North East, one in Tees, one in Durham, and two in Tyne & Wear. The DoH has decided upon further consultation (deadline 22 March) and is putting forward two options:

- 6 PCTs for Tees Valley, one for each of the districts together with Darlington and Durham
- 2 PCTs, one for Darlington & County Durham, one for Cleveland area.

David Flory and Rosemary Grainger from SHA have offered to try and attend the LMC’s February meeting to give a presentation, if invited.

Whatever the outcome, there must be strong local functioning and collaboration between the four current PCT areas with the resultant structure being workable for a reasonable length of time, and a Chief Executive who is willing to work with localities and the LMC. Local Authorities are also being reviewed and we may end up with Local Authorities which are not co-terminus with the new PCT structure. It was also felt that Local Authorities would not be fit for purpose with populations of less than 300,000.

It was **AGREED** that the Secretary would circulate GPs (in bullet form) asking for their views on the proposed options, with a deadline for comments being received prior to the LMC meeting on 28 February.

06/01/5.2 New Strategic Health Authority Arrangements in North East England

Members felt that the decision for a single SHA for the North East had already effectively been made and there was little point in commenting on the consultation document (deadline for responses being 22 March) The new SHA would require a new Chief Executive and there was concern that it may become Newcastle central and efforts should be made to ensure this did not happen.

The Secretary informed members that he had written to the other five LMCs in the northern region with the response from the northern group that they did not see any reason for change, except some closer liaison within the new SHA area.

06/01/5.3 Configuration of NHS Ambulance Trusts in England

The deadline for responses on the consultation document was also 22 March. Members felt that the last time there had been a re-organisation of the ambulance service, Cleveland had lost out on quality of service and it was essential to preserve and increase standards.

06/01/5.4 PMETB fees

The final response to the consultation document was tabled, having been prepared in the light of comments received from members. This was **RECEIVED.**

The Secretary informed members that on 1 April 2006 a GP register was being established by the General Medical Council; inclusion in the register will be a requirement to work in general practice except in training posts. For a GP on the Performers List, inclusion was automatic and free of charge; those GPs not currently in practice will need to apply to be included in the register. Although there will be publicity for this, GPs may wish to draw affected colleagues attention to the register.

06/01/6 REVIEW OF NEW CONTRACT

All GPs had received a letter dated 19 December 2005 from Hamish Meldrum, Chairman of the GPC, itemising the current state of progress on the GMS contract review following negotiations with NHS Employers. Additional investment in the contract has been agreed, mainly in the form of directed enhanced services. Changes have been made in the Quality & Outcomes Framework, Directed Enhanced Services, Dispensing Doctors Review, Access, Maternity, Childhood Vaccinations & Immunisation, Normalisation, Contractor Population Index, and Pensions.

Concerning maternity payments, it was **NOTED** that an agreement had been reached between CLMC/PCTs in April 2004 that doctors on maternity leave should be paid the maximum payment.

06/01/7 LMC ELECTIONS 2006
Ref Minute 05/09/6

06.01/07.1 Constituency representation : Distribution of GPs by PCT and area

The Secretary explained that specific data on allocating doctors between constituencies, providers/performers, and performers, was no longer available. The total number of GPs per area is :

Hartlepool	66	37 providers : 29 performers
Langbaurgh	80	54 providers : 26 performers
Middlesbrough	152	103 providers : 49 performers
North Tees	141	103 providers : 38 performers
TOTAL	439	

After discussion it was **AGREED** that representation would be:

Hartlepool PCT area	4	No sub-divisions
Langbaurgh PCT area	5	with a minimum of 1 from each of: Redcar/Saltburn/Marske Brotton/Loftus/Guisborough
Middlesbrough PCT area	10	with a minimum of 1 from each of: Middlesbrough Eston
North Tees PCT area	9	with a minimum of 1 from each of: Stockton/Norton/Stillington Billingham Thornaby/Yarm/Eaglescliffe
TOTAL	28	Representatives

If there is an election in any of the PCT constituencies, all GPs in that area will be eligible to vote, and when the votes are counted at least one person will be elected from each of the sub-divisions of those constituencies.

In CLMC's Constitution all GPs are equal. After the election, if there is a disproportionate ratio of members by contractual arrangement, the LMC is able to co-opt GPs to represent a particular interest to see it reflects the make-up of GPs locally.

06.01/07.2 Retirement of Chairman

Dr O'Donoghue gave notice that he would be retiring as the LMC Chairman in April. Nominations were invited from members and members were asked to advise the LMC office if they were interested in applying for the post.

06/01/8 LOCAL ENHANCED SERVICES (Extract of letter received from a GP)

"As part of our PMS objective we agreed to increase the skill mix within our practice and personally within the practice I trained our Nurse Practitioner to undertake such procedures as steroid injections for tennis elbow and to perform hormone implants and minor surgery such as removal of skin tags and cryotherapy. The PCT now say that as she has not been on a training course for joint injections she should no longer be allowed to do these within the practice, although we have checked with the Medical Defence Unions and they are quite happy for her to be trained as long as I am happy with her competency. I am a GP Trainer."

It was commented that there was nothing in the Contract which requires people to have certificates stating they are qualified in order for them to provide a service,

merely that a doctor must employ appropriately skilled people, and if a Trainer has trained a member of staff to perform a service, the conditions being applied by the PCT do not seem appropriate. Nurses in secondary care provide services when the patient has been referred to a specialist.

The Secretary **AGREED** to look at the appropriate regulations and take the matter up with the PCT.

06/01/9 PROBLEMS ACCESSING GUM CLINIC, MIDDLESBROUGH

Concerns had been notified to the LMC that the GUM Clinic at Middlesbrough were advising patients to contact their own GP for treatment as the waiting time was too long for Out Patients (6 weeks).

The problem covered all four PCT areas and the Secretary **AGREED** to take the matter up with PCTs, and nationally at the GPC.

06/01/10 FERTILITY TREATMENT PATHWAYS

GPs were concerned at being asked to assess patients' suitability as parents prior to receiving IVF treatment. In response to a recent consultation the GPC have indicated that GPs should not be advising on patients' suitability as parents prior to receiving this service. GPs do not normally have the appropriate information. At the moment, GPs are not contractually obliged to provide this information, however, this may lead to the patient not being offered the service. GPs are advised not to give information which cannot be substantiated and to give statement of fact only. GPs may also charge for this information.

06/01/11 GENERAL PRACTITIONERS AND FORENSIC MEDICAL EXAMINATIONS

The Secretary explained that he had, again, written to the Chief Constable concerning instances of patients being told by police to go to their doctor in order for their injuries to be documented. No specific details had been available at the time, and the Chief Superintendent of Cleveland Police has now asked to be appraised of specific details where patients are being told by police to go to their doctor for their injuries to be documented, so that they can addressed the problem directly.

The Secretary reminded GPs that as part of primary medical services they should not attempt a forensic examination such as documenting or measuring injuries, as this could result in being asked to give a statement to the police and perhaps having to encounter cross examination in a court of law. There is obviously a requirement to assess and treat, or refer a patient with medical needs, and record appropriate details in the medical record. Police requesting a Witness Statement can be charged a fee. A copy of the patient's records can be provided, with the patient's consent.

Doctors are asked to advise the LMC office, by email or fax, of instances when patients attend requesting injuries be recorded, having been told to do so by the police. Details required are:

- Practice computer number for the patient, **NOT** any identifiable information
- Date
- Police station involved

Any GP undertaking prison services should be provided with appropriate training.

06/01/12 COMMUNITY MATRONS

There was a pilot scheme in North Tees with nurses still in training, will be aligned with practices and work 9.00 a.m. – 5.00 p.m. Middlesbrough is looking to recruit six in the near future to manage chronic disease in the community.

It was **AGREED** that the Secretariat would write to all PCTs about community matrons.

06/01/13 REPORT FROM GPC

Nothing to report.

06/01/14 REPORTS FROM MEETINGS

06/01/14.1 Meeting between LMC Secretary and Wendy Balmain, SHA Policy Lead for Criminal Justice & Substance Mis-Use : Thursday, 3 November 2005 re MAPPA *(Multi Agency Public Protection Arrangements)* and GPs sharing information on sexual and violent patients

The Criminal Justice & Court Services Act 2000 required the police and probation services to establish MAPPA's with other agencies. Dr Canning felt that there seemed to be a lack of collaboration between health organisations, police and the probation service, concerning sharing information on sexual and violent patients. He had had a meeting with representatives in October 2004 but progress had been slow.

A number of practices were not removing violent (or perceived to be violent), or sexually inappropriate patients from their List, and the Secretary hoped to be producing guidance shortly. Some reasons given for not removing patients were: we do not remove someone until we have had a partners meeting; we do not remove someone because we do not want police to pursue and prosecute (this is irrelevant you just have to inform police).

If you remove a violent patient via the normal channels, that person does not get put on the violent patients register, and can be allocated to another surgery instead of the specialist practice and the GP is not informed that the person is violent and should not be seen alone.

The Secretary was meeting the security specialists for North Tees PCT (Sharon Mee) and Langbaurgh/Hartlepool PCTs (Ian Ogilvie) in the coming week to discuss violent patients and sexually inappropriate patients. Despite reminders, no information had been forthcoming from Middlesbrough PCT

06/01/15 PRIMARY CARE DEVELOPMENT SCHEME
(formerly Golden Hello Scheme)

Dr Canning informed members that he had attended a Workshop at Seaham Hall on 4 November 2005, organised by the SHA where it had been agreed that funding would be allocated on the number of GPs per 100,000 population, and the proportion of GPs aged 55 and over. The money was for the current financial year 2005/2006, can be held over for next year, and cannot be used for anything else. It was essential the funding did not disappear into PCTs accounts.

This is not a "Golden Hello" it is about PCTs providing supportive structures in order to retain GPs in the middle and end of their careers (sabbaticals, training, next generation of PEC members, etc).

It was noted that Registrars would have to undertake 18 months training in practices which will be problematic because of a shortage of Trainers and training practices. More space in practices and Trainers were required as this had a direct bearing on recruitment.

06/01/16 REPORTS FROM REPRESENTATIVES

None had been received.

06/01/17 SUPPLEMENTARY AGENDA

06/01/17.1 Resignation received from Dr A Smith, representative for East Cleveland

Dr Smith's resignation was accepted, with regret, and the Office Manager was asked to thank Amanda for her support and efforts on behalf of the LMC.

06/01/17.2 Pandemic flu

It was known that Mike Grandey at Middlesbrough PCT wanted to talk to practices about the anticipated Pandemic Flu outbreak.

Langbaurgh had no Medical Director of Public Health but emails were being cascaded to practices.

Dr Toks Sangowawa the Director of Public Health at North Tees had developed a plan and could be asked to talk to members at the next LMC meeting.

The Secretary **AGREED** to obtain specific information from all PCTs on the issue.

06/01/17.3 Prescribing of methylphenidate (Ritalin)

One of the paediatricians at North Tees Hospital had retired and none of the other consultants were willing to take on any more patients so had written to NT GPs asking them to prescribe Ritalin without any shared care protocol being in place. No-one in child psychiatry would accept the referral so NTPCT arranged for a paediatrician to issue a script as an interim measure.

It was felt this should be regarded as a Significant Event and passed to the Clinical Governance Lead at NTPCT. This service should be in the form of an Enhanced Service to resource and reward the work and provide the necessary training which is required.

GPs were reminded that if they prescribe they are held responsible for the whole management of that patient. A shared-care arrangement needs to be put in writing and formalised and the service should not be shifted to primary care purely because of prescribing issues. The matter should go back to the hospital for them to sort out.

06/01/17.4 Community Pharmacy Medicines Review & Prescription Intervention Service *(Complaint from GP that pharmacist had reviewed a patient's medication, and medications altered or discontinued without consulting the patient's GP)*

Community pharmacists, as an enhanced service, have the ability if they are appropriately qualified, have been inspected, and have suitable premises, to carry out medicine reviews on patients. They are responsible, as a registered professional, to the Royal Pharmaceutical Society for their actions. If someone is felt not to be behaving in accordance with their professional registration you have a duty as a doctor to draw this to the attention of the PCT Clinical Governance Lead.

It was **AGREED** that this be discussed further at the next LMC meeting on 28 February.

06/01/18 ANY OTHER NOTIFIED BUSINESS

06/01/18.1 Election for the Regional Representative of the GPC

Dr Leslie Dobson had indicated he did not intend to stand for re-election. Members thanked him for representing this LMC and others in the northern region whilst he was a member of the GPC.

Dr Canning had been nominated and his nomination form submitted.

06/01/19 RECEIVE ITEMS

06/01/19.1 Medical List

Applications:

Effective Date	Name	Partnership	Practice Area
21.11.2005	Dr A Vilanova Ramos	Arrival Practice	NTPCT
Salaried GP.			
01.11.2005	Dr I Alvarez Perez	Dr Waters & Partners	MPCT
Salaried GP.			
03.01.2006	Dr P Singh	Dr O'Donoghue & Partners	NTPCT
Partner.			
03.01.2006	Dr J Donkin	Dr O'Donoghue & Partners	NTPCT
Partner – Currently on Darlington PCT Performers List.			
04.01.06	Dr N Val Jiminez	Dr Brash & Partner	HPCT
Salaried GP.			
01.05.2006	Dr M A Ayre	Dr Moody & Partners	HPCT
Returning part time.			
01.05.06	Dr N R Joshi	Dr Acquilla & Partners	MPCT
Returning to practice on reduced commitment.			
01.06.06	Dr P T McCarthy	Dr Nath & Partners	MPCT
Returning to practice.			

Resignations:

Effective Date	Name	Partnership	Practice Area
14.12.2005	Dr W Saltissi	Dr Dawson & Partners	HPCT
Resigned.			
16.12.2005	Dr A Ahmed	Dr Eaton & Partners	HPCT
Resigned. Salaried GP.			
31.12.2005	Dr P Singh	Dr Bolt & Partners	HPCT
Resigned. Salaried GP.			
31.12.2005	Dr Crofts-Barnes	Dr Bolt & Partners	HPCT
Resigned. Salaried GP.			

31.12.2005	Dr A R Dawson	Dr Dawson & Partners	HPCT

Retired.

31.12.2005	Dr P Williams	Arrival Practice	NTPCT

Resigned.

31.3.2006	Dr M A Ayre	Dr Moody & Partners	HPCT

Resigned. Returning part time on 1 May 2006.

31.3.2006	Dr H Leigh	Dr Murphy & Partners	MPCT

Retirement. Leaving Performers List.

31.03.06	Dr N R Joshi	Dr Acquilla & Partners	MPCT

Retirement. Returning to work on reduced commitment l.6.06.

30.04.06	Dr P T McCarthy	Dr Nath & Partners	MPCT

Retirement. Returning to practice l.6.06.

07.04.06	Dr K Machender	Dr Saha & Partner	LPCT

Retirement.

RECEIVED.

06/01/19.2 PROVISION OF SICKNOTES FOR PATIENTS ON DISCHARGE

Response from Mr Ian Dalton, Chief Executive, North Tees & Hartlepool NHS Trust

"The provision of sicknotes for patients on discharge is an issue in many hospitals and one I take seriously. Following receipt of your letter, I have asked every Clinical Director of bed owning Divisions that when patients are discharged a check will be made with the patient as to whether they require a sicknote or not. This issue will henceforth also be included at all Induction Programmes for future cohorts of junior doctors. It has also been included in the revised Trust Discharge Policy."

RECEIVED.

06/01/19.3 Report the receipt of:

GPC News M4 – Friday, 18 November 2005 (Available on www.bma.org.uk)
GPC News M5 – Friday, 16 December 2005 (Available on www.bma.org.uk)
Sunderland LMC's minutes of meeting held on Tuesday, 18 October 2005
Sunderland LMC's minutes of meeting held on Tuesday, 15 November 2005

RECEIVED.

06/01/19.4 Date and time of next meeting

Tuesday, 28 February 2006, at 7.30 p.m. in the Committee Room, Poole House, Stokesley Road.

RECEIVED.

There being no further business to discuss, the meeting closed at 9.15 p.m.

Date: ***Chairman:***