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, 19 July 2005 in the Committee Room, Poole House, Nunthorpe, Middlesbrough.

Present:	Dr J P O'Donoghue (Chairman)	Dr W J Beeby	Dr K P Bhandary
	Dr J T Canning	Dr G Daynes	Dr L Dobson
	Dr K Ellenger	Dr A Gash	Dr T A Gjertsen
	Dr I A Lone	Dr K Machender	Dr A Ramaswamy
	Dr R Roberts	Dr A J Smith	Dr M Speight
	Dr J R Thornham	Dr C Wilson	

In attendance: Mrs C A Knifton : Office Manager, LMC

05/07/1 APOLOGIES

Apologies for absence had been received from Mr J Clarke, Dr J Harley, Dr M Hazarika, Dr A Holmes, Dr T Nadah, Dr N T Rowell, Dr T Sangowawa and Prof T Van Zwanenberg.

05/07/2 MINUTES OF THE MEETINGS HELD ON 7 June 2005

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

05/07/3 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

05/07/3.1 Superannuation on Appraisals
Ref Minute 05/06/3.1 – No response received from HPCT, NTPCT, MPCT

Response from Stephen Childs, LPCT
"Thank you for your letter dated 10 June. I can confirm that it is our intention to uplift the payment we make to appraisers to reflect the fact that it is now superannuable (14% employer's contributions)."

Dr Canning advised members that questions were now being asked about the whole of the Collaborative Arrangement fees which should be increased by 14% to pay for superannuation.

MPCT have used LMC rates to pay their GPs for attending certain meetings.

It was **AGREED** that the LMC would open negotiations with PCTs in an attempt to obtain appropriate remuneration for GPs attending PCT instigated meetings.

05/07/3.2 Funding for Practice Based Commissioning meetings
Ref Minute 05/06/21.3 - No response received from NTPCT, MPCT, LPCT

Response from Ali Wilson, HPCT
"Whilst HPCT fully supports the development of Practice Based Commissioning, there has so far been very limited interest in using this approach by our GPs during 2005/6.

We have discussed the implications of the approach at our PEC, Primary Care Development Sub-Committee and GP Council, and have not had necessity to required GP attendance at meetings outwith these for a.

However, Practice Based Commissioning will be one of the areas covered in a practice Time-Out Event planned for Thursday, 28 July, when the PCT will be funding Primecare cover to allow all GPs and Practice Managers to attend.

I trust this provides you with the information you require at this stage."

NOTED.

05/07/3.3 IUCD Fitting
Ref Minutes 05/04/14 & 05/06/3.2
All PCTs contacted. No response from MPCT, LPCT

Response from HPCT – Richard Haggerty
"Regarding our policy on performers who carry out enhanced services. Any practice who provided this service prior to the new contract were allowed to continue to do this under an enhanced service if they wished. We are now in the process of validation of competence and suitability of premises.

We are collecting information around number of procedures carried out by each GP in relation to the enhanced services they provide (see attached letter). We have recently carried out a decontamination audit which looks at activity levels, equipment used and suitability of premises. Also, we are about to start a baseline audit of suitability of premises to provide these services.

The intention is to collect a baseline and from this determine action plans to help practices achieve the standards. We are looking at current guidance to determine what these standards should be e.g. a minimum of 12 coil insertions per year. However we welcome any guidance you may have."

Response from NTPCT - Liz Hegarty
"Thank you for your letter regarding the PCT's policies for performers employed by providers to carry out enhanced services, particularly contraceptive implants, coil fitting and minor surgery.

The latter two are NES and DES and performers are subject to the criteria outlined in those specifications, namely that practitioners undertaking these procedures should have undertaken appropriate training and continual professional development.

For IUCD's it is recommended that practitioners meet the requirements set down by the Faculty of Family Planning and Reproductive Health Care (FFPRHC) for the letter of competence in intrauterine techniques.

The minor surgery specification details that the practitioner has the necessary skills and experience to carry out the contracted procedures. Practitioners should demonstrate a continuing sustained level of activity, conduct regular audits, be appraised on what they do, and take part in necessary supporting educational activities.

The fitting of contraceptive implants is a LES and again, practitioners need to have undertaken appropriate training and maintenance of skills. The suggested training is either the FFPRHC or the RCN guidance of insertion or removal of sub-dermal implants.

I hope this addresses your query, but if you require any further information, please let me know."

NOTED.

05/07/3.4 Request for LMC Time : NPfIT (Now renamed "NHS Connecting for Health")
Ref Minute 05/06/11

Response from Mr S Smith, Programme Director for SHA NPfIT Programme
"Thank you for your letter of 10 June regarding the 19 July meeting of the Cleveland LMC Board regarding my offer to attend a meeting of the LMC Board to discuss the National Programme for IT.

My initial contact followed the announcements about the widening of the choice of systems for use in practices, rather than being confined to the two systems offered by our Local Service Provider (LSP). I thought that you and your colleagues would be interested to discuss the implications for local plans for IT systems.

To put this in context it would probably be useful to give an overview of our plans for deploying NPfIT services across County Durham & Tees Valley, to summarise current status, and highlight some of the experience to date. I am happy to be guided as to what you and your colleagues would find most useful as individual GPs and as representatives of the profession.

Perhaps more important than a presentation as described above would be the opportunity for an open discussion covering the questions and concerns that you and your colleagues may have. I may not always be able to give the answers people would like to hear, but I can undertake to be frank. If I don't have the information available, I will be able to chase things down later and feed back through the most appropriate method.

If any of this sounds as though it would be useful and interesting, please let me know. I am happy to put the emphasis on whichever area you prefer. If you would like to focus on particular areas, please let me know.

Incidentally I have been invited to attend Durham LMC on Tuesday 5 July. This may give me some additional thoughts on what GPs are most interested in and I will discuss with you any such emerging thoughts."

The SHA IT team were due to give a demonstration next week at a Guisborough practice using the Phoenix system. (Isoft and EMIS were other providers available).

It was **AGREED** that Mr Smith be invited to attend the next LMC meeting on 13 September and allocated 30 minutes at the beginning of the meeting.

05/07/3.5 Mumps Vaccinations
Ref Minute 05/06/21.4

Response from Dr Ian Holtby
"I refer to your letter of 10th June concerning the above. We did receive some information on this from the HPA on behalf of the Department of Health, which I have forwarded to our local PCTs and which I shall now forward to yourself. I shall also summarise this information for inclusion in our next newsletter to all GPs.

To answer the points you raise:

- All those aged between 15 – 24 should receive two doses of MMR if they have not already done so. Those over 24 are not being sought out for vaccination unless they are rubella susceptible women of child bearing age. The above also applies to health care workers.
- PCTs will be carrying out catch up campaigns of year 10 children at school by the autumn term, and will be considering similar campaigns of students in years 11 – 13. Others in this age group (15 – 23 inclusive) may be offered vaccination when attending their family practitioners surgery for whatever reason (the catch up campaign in November 1994 only covered measles and rubella and not mumps).
- Antibody responses to the mumps component of MMR vaccine are too slow for effective prophylaxis after exposure to this infection and would therefore be unlikely to confer much benefit on contacts of cases. Best to try and ensure immunity prior to exposure.

The primary immunisation programme will, of course, continue to be a priority in terms of preventing these infections from taking place. Hope this is of some assistance."

Because Farillon have been unable to provide adequate supplies of the vaccine resulting in a shortage, the problem of using unlicensed vaccines was discussed. It was recommended that doctors did not use unlicensed vaccines. The DoH has inferred that using unlicensed vaccines was no different to any other unlicensed medication, in that any repercussions were the GPs responsibility.

A problem in North Tees was that Middlesbrough Public Health Department was sending patients back to their doctor, with a letter requesting the patient be given the MMR vaccine – despite the fact that the surgery could not obtain sufficient vaccine for priority patients.

At LPCT, the public health department had been trying to vaccinate people about to leave secondary school but because of the shortage of vaccine they have not been able to do this. They intend going into Sixth Form Colleges in September. Those

students not going to college are being asked to go into the college to be vaccinated, and practices will be advised of those who still require to be vaccinated.

There is also the problem of the polio vaccine only being available on a named patient basis.

It was **AGREED** that the LMC would discuss with people concerned to make sure there is an appropriate use of an inadequate supply of vaccine.

05/07/3.6 Sick Doctors Trust (based in Farnham, Surrey)
Ref Minutes 05/06/17 : 02/09/11 : 03/09/13.5
Response from Dr I Joiner : Trustee

"Thank you for your letter concerning the Sick Doctors Trust. I can assure you that the service is in no way confined to the South. Since 1995 we have arranged for the treatment of some 400 doctors in a unit particularly run for health professionals. They have come from Cumberland, Scotland, Northern Ireland, Wales, Sheffield, London, Devon, Cornwall, Isle of Wight, Durham and Northumberland, to name but a few. I think that this indicates the widespread coverage that we have.

We have already circulated all PCTs who, as you are ware, are stretched for funds and have not been of direct financial assistance to us. However, some have paid by means of out of area payments for the treatment of some individual doctors. The money that we raise is to pay for the administration of the Trust to keep the level of awareness of addiction in the profession as high as we possibly can and to produce hard evidence that it is worth treating medical practitioners so that they can return to work. Of the 400 treated preliminary studies show that 86% are sober or clean after 3 years and of this figure 96% return to work.

Hospital based colleagues often have their treatment paid for by hospital Trusts.

You are quite correct about the number of LMCs lack of support. In the main they do not recognise addiction or substance abuse as a problem in the profession. It may be that appraisal will change their minds. We have noticed an increase in doctors being referred to us, we think possibly as a result of appraisal. It is worthy of note that historically we have approximately 45 doctors per year admitted because of substance abuse and this is 10% of the predicted incidence. We know that some doctors are treated privately but as to the precise figures we are unsure. Some doctors die before they get into treatment or we receive them with advanced liver disease when it is often too late to assist. There is still a culture of covering up ones colleague but in so doing it always delays the onset of appropriate treatment.

I can assure members of the LMC that none of the money is used to treat doctors. The appeal was made so that we may still function, run a National Helpline, raise awareness of the problem, e.g. manning a stand at the Joint LMC meeting of the BMA (cost £2,000). Advertising in the BMJ at commercial rates with a 10% reduction because we are a registered charity. All the work is carried out on a voluntary basis so part of the money is used to pay out of pocket expenses and to carry out training in intervention.

I hope that I have covered all the doubts raised by your members."

Dr Dobson stressed that he felt it was a worthwhile cause, run purely voluntarily. He had written to the four local PCTs regarding financing treatment out of the area for

addicted doctors. Only MPCT and LPCT had responded, and they were happy to support financing such treatment.

It was **AGREED** that the LMC would donate £1,000 to Sick Doctors Trust.

05/07/3.7 Mental Health Promotion
Ref Minute 05/06/18

The minutes of the Suicide Prevention Group (discussed at the last LMC meeting) had implied that GPs were unwilling to refer patients for cognitive behavioural therapy (CBT). Dr Gash explained that she had been on holiday when the meeting had taken place at Venture House and had been shocked when she read the minutes, because they should have stated that the reason GPs prescribed SSRIs was because they could not gain access to CBT. More care would be taken when checking the draft minutes in future.

There was the possibility of CBT becoming more available, through training, following a possible alliance between Durham Trust and TNEY in April 2006 as some of Dr Gash's colleagues north of the river had expertise in teaching CBT. There was pressure from all sides to make CBT treatment more available.

There are self help materials which can be given to patients. Calypso CD-ROMs are available for patients to work through in order to help themselves. Details will be obtained and circulated on where to source the information.

It was **AGREED** that CBT training be re-addressed post-April 2006.

05/07/3.8 Hazardous Waste
Ref Minute 05/06/15

New regulations had become effective on 16 July 2005 which required that each practice had to register with the Environment Agency, including all individual practices based in Health Centres. It was recommended that practices paid the Environment Agency and reclaimed the cost from their PCT. NTPCT are paying practices. LPCT are now paying practices. MPCT had rejected claims so far. It is not known what is happening within HPCT.

It was **AGREED** that the LMC pursue registration reimbursement with PCTs.

In other parts of the country, some PCTs had bulk registered all their practices with the Environment Agency and reimbursement was the norm.

The Committee were informed that a meeting would shortly be arranged between the LMC (who oversaw the clinical waste contract on behalf of practices) and PCTs, to discuss the clinical waste contract which was due for renewal on 1 January 2006 and had a 2-month termination clause. There was concern that a move to PCT-based arrangements may be less advantageous.

05/07/3.9 Specialist PMS and new practices in Middlesbrough
Ref Minute 05/06/7

No formal response had been received from MPCT. However, at a recent meeting with the PCT Chairman and Chief Executive, the LMC Chairman and Secretary had been told MPCT were looking seriously at how the Galvani practice was functioning with a view to re-assessing how the practice provides the service.

Following a query over what would happen to the funding for this PMS practice if the small number of patients were de-registered, Dr Canning said the funding would remain in MPCT and a small amount would go to the practices where those patients then registered. There was no route for the funds to go back into GMS unless Section 28Y was used.

05/07/4 HPCT DRAFT STRATEGY FOR THE DEVELOPMENT OF PRIMARY CARE AND THE MODERNISATION OF HEALTH SERVICES

The document had already been circulated to Hartlepool GPs by the PCT. Two comments from GPs had been received at the LMC office and these were tabled. The PCT were looking at a range of services currently provided within secondary care that could be appropriately managed in primary care, incorporating nursing and social services, from three bases throughout Hartlepool. Services provided would cover health advice, improved access to non-urgent minor ailment advice, diagnostic procedures including, for example, ECG and spirometry, minor surgical procedures such as removal of lumps and bumps, injection of joints, vasectomy, and family planning procedures. Referrals will be made centrally and allocated to the appropriate department. The PCT were anticipating that the status of the hospital would change within the foreseeable future and were moving services out into the community in anticipation of the change.

The proposals may be linked to changes in GP services but had not been discussed fully with GPs as only two had attended a meeting. There was to be a time-out event later in July in order for all GPs to attend, with cover provided by Primecare.

05/07/5 LMC ACCOUNTS for 2004/2005

The accounts were tabled and showed a healthy balance, which would enable the LMC to remain solvent once a Liaison Officer had been appointed. A break in taking the levy from practices can be arranged when appropriate. MPCT had advised the LMC of a large increase in rent and service charge for the offices used at Grey Towers Court, which would take additional funding.

It was pointed out that there was no longer any need for members to put LMC cheques through their practice accounts in relation to attending meetings, because all cheques now had Tax and NICs deducted before being issued, and were accompanied with a payslip.

05/07/6 REPORT FROM GPC

The GPC had not met since the last LMC meeting in June. Items still requiring finalising included problems of list sizes and normalisation (which has been a problem for some practices locally) and continuing negotiations on envelope funding for 2006.

05/07/7 REPORTS FROM MEETINGS

05/07/7.1 Tuesday, 5 July 2005 : Meeting with LMC Chairman and Secretary & MPCT Chairman, Chief Executive and PEC Chairman

05/07/7.2 Tuesday, 5 July 2005 : Meeting with LMC Secretary & LPCT Chief Executive and Executive Chairman

Among other items, configuration was discussed at both meetings in the light of a DH document expected on PCT configuration and function.

05/07/8 REPORTS FROM REPRESENTATIVES

05/07/8.1 Report from LMC Conference : 16/17 June 2005
Conference Chairman: Dr J T Canning
Attendees: Dr J P O'Donoghue – Dr W J Beeby – Dr A Ramaswamy

Dr Canning was congratulated on his chairing of the Conference. It was felt that the Conference had gone well and that debates had been accurately reported in the medical press. Concerns had been voiced at the government wanting super surgeries and their attitude towards smaller surgeries. What the government wants to include in QOF caused concern. The new electronic voting system with each member having a key pad had worked quickly and effectively. Overall, it was felt to have been a positive conference, with the future being viewed with caution.

05/07/9 APPOINTMENT OF LIAISON OFFICER
Ref Minute 05/01/25

Dr Canning explained that he had approached Dr Judy Gilley for advice on the Job Description and appointment of an Officer, because she could look at the position from the outside, and had previous experience of recruiting such staff. She had produced a draft Job Description and time frame for recruitment. The post was perceived as a full time job. Copies of the Job Description and key skills/competency requirements were tabled and members were asked to let the LMC office have any comments by the end of July.

05/07/10 SUPPLEMENTARY AGENDA

05/07/10.1 Choose & Book

A couple of Langbaurgh practices had contacted the LMC because LPCT were insisting they commence Choose & Book, (particularly if the practice is involved in Practice Based Commissioning) with no funding for practice staff involved in the process, there was also the issue about the length of time it would take a GP to go through the process with a patient. Practices were, however, being asked to bid for new IT equipment and minor premises changes. LPCT were inferring that if Choose & Book was not used, practices would be compromising patient care. The LMC had been approached for advice.

Dr Canning said, and this relates to all PCTs, that there was a requirement for practices to express an interest in Choose & Book to be involved in PBC, though this did not necessarily mean this was going to be commenced until resourced and fit for purpose. There is no contractual obligation to commence Choose & Book. The contract requires doctors to refer patients as appropriate to services available under the NHS Act; this can be done using any appropriate method. Practices get IT equipment whether or not they are involved in Choose & Book, broken and faulty equipment should be replaced. You should also have workstations which function adequately and not be using outdated equipment. If PCTs do not/will not replace IT equipment you can invoke a dispute with the PCT. Unfortunately, as yet, the service level agreement was still not available.

If a practice uses Choose & Book, the doctor can send the patient to another member of staff elsewhere in the building, to complete the screen details and explain things to the patient. In this case, the practice should be resourced for that member of staff having been taken away from their usual job.

It was noted that NT GPs only have Choose & Book for cataracts. When department was unable to contact the patient, the referral was returned to the surgery. Dr Canning said there should be a responsibility on the person to whom the patient was referred, to write to the patient stating they had been unsuccessful in contacting them and they were being referred back to the GP, this would ensure reasonable means had been taken to inform the patient of the action taken.

Choose & Book is supposed to offer patients more choice but in MPCT referral letters are being intercepted and the patient offered cheaper treatment.

It was **AGREED** this item would be included in the next LMC Newsletter.

05/07/10.2 Addictive Behaviours Service (Alcohol), Stockton

Extracts from email sent by NT GP requesting the LMC's comments and advice

"Is the LMC aware of what has been going on with ABS in Stockton? I think there are implications for the whole of Teesside but I have only experienced local problems. Does the LMC have any comment or advice?

Last month, Simon Beaumont (TNEY Manager) wrote to GPs asking that we make no further referrals to ABS. They had a long waiting list and due to pressure on the service needed to

ease some pressure. In the letter this was declared as a temporary arrangement and they would instruct us at a later date when we could refer. Speaking to several people, including Simon Beaumont, this is clearly part of a wider commissioning dispute and there are clear indications that this is not a temporary measure to relieve pressure. It seems to be a withdrawal from alcohol services by TNEY. Their contract runs until March 2006. From then the PCT could commission elsewhere.

From my practice's point of view, we have a big problem with alcohol abuse among patients. For the last 6 months we have had one session a week from a support worker, providing brief interventions for our patients and support for the clinicians. This was a massive improvement on the previous service based at Yarm Lane, Stockton. This 'opened a door' to some of our patients who have always refused to attend Yarm Lane or whose poor compliance had resulted in discharge from the service. This support worker has chosen to leave the service in anticipation of the organisational review. ABS are unwilling/unable to replace them.

I have had communication with Toks Sangowawa, Rodger Thornham & Mike Orr by email. They are aware of the situation but have been unable to offer any advice on alternative care pathways for patients with alcohol problems. The PCT do plan to discuss this was at a PEC-Net meeting on 21 July. Most of the patients affected have chronic problems and will rely on their GP to provide support in these circumstances. However, a small number have escalating problems and I see no intervention is available until acute admission to a medical unit. I have one patient in this situation at the moment.

I am appalled that a service can be withdrawn in this manner and disappointed by such a low key response by NT PCT. This stinks of commissioning tactics and is done with significant disregard for patients with alcohol problems, clinicians working with patients with alcohol problems, and employees working within the service. I understand that this may be a cathartic process which may ultimately result in an overall improvement in the service. However, I do not accept this point of view and believe the interim period could be very difficult."

Dr Thornham agreed that TNEY had ceased to provide the service, which left NT GPs with no support for alcohol abuse victims. There had been no consultation with NTPCT prior to TNEY ending the service. There is to be a PECNet meeting shortly when this problem will be discussed. PCT looking to pull funding, which had been provided for this service, from TNEY. Something like £40/50,000 for substance misuse and £40,000 for practice abuse where worker visited practices.

It was **AGREED** that:

- The LMC would write to the PCT expressing its deep concern
- The item be included in the next Newsletter

05/07/10.3 Request by Stockton Learning Disability Service for a practice to undertake examination of patient

Response to LMC from Dr R Banerjee, Consultant Psychiatrist, (Learning Disabilities)

"Thank you for your letter. I have recently joined the Stockton Learning Disabilities Service and have initiated a screening programme for individuals with Down's Syndrome who are over the age of 35 years. As you will know there is a higher incidence of physical, psychological and cognitive problems in this patient group, and, given the severe learning

disability and communication difficulties, treatable medical conditions are often unrecognised.

Under my supervision my SHO, Dr Archibald, has seen a number of individuals with Down's Syndrome in the last few weeks and written to their GPs with requests for routine examinations and tests. Neither he nor I were aware that they could not be done under the current contract between GPs and the PCT. I apologise for inconvenience caused."

NOTED and **RECEIVED**.

05/07/11 ANY OTHER NOTIFIED BUSINESS

05/07/11.1 Acute Services Review – Hartlepool & Teesside (Prepared by Professor Sir Ara Darzi's Report

Dr Thornham advised members that Professor Sir Ara Darzi had presented the Acute Services Review to the SHA, PCTs, Hospital Trusts, key stakeholders, MPs, and Local Councillors. There will not be a new hospital north of the river; there will not be a single Trust on Teesside; there will not be any major re-organisation in management services anywhere.

Hartlepool will continue to provide a doctor-led accident and emergency service and acute medicine. It will host a new Centre of Excellence in Women's & Children's Services, including consultant-led maternity, paediatric services, gynaecology, and breast surgery. It should increase its inpatient elective surgery portfolio, in particular orthopaedics. Major trauma and emergency surgery OOH should move to North Tees.

North Tees should become the main centre north of the Tees for emergency surgery, including trauma, with expanded intensive care facilities. It should continue to provide a full accident and emergency service and acute medicine. It should develop as a centre for major complex surgery, including hosting a new North Tees Complex Surgical Centre, providing upper gastro-intestinal cancer services for the whole Teesside area. Vascular surgery should be developed at North Tees as part of a clinical network with the JCUH. An endo-luminal vascular service should also be developed at North Tees serving the whole Teesside area. A 24-hour midwife-led maternity unit should be developed. Consultant-led maternity, high-risk obstetrics and paediatric services should be centralised at Hartlepool.

James Cook should retain its full range of district general hospital-type services and its range of tertiary and supra-regional services. The proposed move of upper gastro-intestinal cancer services to North Tees should free-up a modest amount of capacity. Work should also be intensified to improve integration with, and make full use of, capacity at the Friarage Hospital, for example, in orthopaedics and ophthalmology, to reduce capacity pressures on James Cook.

The Friarage strategy is underway. Work should focus on securing the future of A & E services, maternity and acute medicine. It will be hard to justify major trauma and emergency surgery OOHs remaining at the Friarage for the longer term. Greater use of the Friarage to relieve capacity pressures at James Cook should help provide the volume of business needed to secure key services at James Cook, for example, anaesthetics.

From the Hartlepool point of view, this will depend on more investment in primary care.

None of the proposals came with any funding, however, SHA Acting Chief Executive, David Flory, (Ken Jarrold retires August 2005), said it was their responsibility to make it happen.

Dr Thornham expressed regret at North Tees losing paediatrics, and the loss of consultant-led maternity services, which may mean a lot of patients drifting towards JCUH.

05/07/12 RECEIVE ITEMS

05/07/12.1 Medical List

Applications:

Effective Date	Name	Partnership	Practice Area
06/06/05	Dr L Smith	Dr Clements & Partners	LPCT
Joined as partner			
01/11/05	Dr T Baxter	Dr Boyd & Partner	LPCT
Dr Baxter returning to practice on reduced commitment following early retirement.			
01/05/05	Dr P F Morral	Dr Waters & Partners	MPCT
Formerly a Salaried GP at the practice			

Resignations:

Effective Date	Name	Partnership	Practice Area
03/06/05	Dr L Smith	Dr Glasby & Partners	LPCT
Resigned. Salaried GP			
18/09/05	Dr T de Burca	Dr Neoh & Partners	NTPCT
Resigned			
01/07/05	Dr P K Chatterjee	Dr Lone & Partners	MPCT
Resigned			
30/06/05	Dr O F Adedapo	Dr Nath & Partners	MPCT
Resigned			
03/10/05	Dr C Moll	Dr Robson & Partner	MPCT
Resigned			

30/09/05 Dr T W Baxter Dr Baxter & Partner LPCT
Early retirement. To return to practice on 1/11/05

RECEIVED.

05/07/12.2 Potential Organisational Change for Local Mental Health and Learning Disability Services
(Co Durham and Darlington Priority Services NHS Trust & TNEY NHS Trust)

"On 12 May 2005, we wrote to you to explain that Co Durham & Darlington Priority Services NHS Trust and Tees & North East Yorkshire NHS Trust have been prompted to consider options for organisational change.

This week the Boards of both Trusts agreed to carry out informal discussions with key stakeholders, including service users, carers, staff and partner organisations, about a range of options including whether we should continue as two separate organisations or come together as a single organisation. The result of these discussions will influence the development of proposals on which we will formally consult later this year.

As well as approving the informal discussions, the two Boards also approved the creation of a Project Board to develop a robust process to effectively involve and consult all stakeholders.

Both Co Durham & Tees Valley SHA, and North East Yorkshire & Northern Lincolnshire SHA, support the move to consider options for organisational change.

In considering the options for the future of local mental health and learning disability services, both trusts need to consider the impact any proposed changes would have on a number of factors. These include having the critical mass to ensure their ability to:

- Recruit and retain the highly skilled staff needed to provide local specialist services, and to provide those staff with a full range of career development opportunities;
- Provide locally based integrated services for local people, including the development of new specialist services to prevent people travelling outside the area;
- Play an active part in influencing national and local decision makers to maintain a positive profile and a high priority for the future development of mental health and learning disability services;
- Further development partnership arrangements with service users, carers, advocates, and the general public in each locality to ensure their involvement and influence in local service development and delivery, strengthening the accountability of services to local people.

If you would like more information or to arrange a meeting with us to discuss any issue in relation to the options for change, please contact Caroline Parnell, Project Manager on 01642 516461."

RECEIVED.

05/07/12.3 Report the receipt of:

GPC News M11 : Conference News for 16/17 June 2005
Sunderland LMC minutes of meeting held on 15 February 2005
Sunderland LMC minutes of meeting held on 22 March 2005
Sunderland LMC minutes of meeting held on 19 April 2005

RECEIVED.

05/07/12.4 Date and time of next meeting

Tuesday, 13 September 2005, at 7.30 p.m. in the Committee Room, Poole House, Stokesley Road.

RECEIVED.

ITEM FOR DISCUSSION "BELOW THE LINE"

05/07/13 Payments to Committee Officers
Ref Minute 05/06/22.2 – Report from Remuneration Sub-Committee

Dr Lone informed the Committee that because of diary commitments, the Remuneration Sub-Committee had been unable to meet to discuss proposals formally. They hoped to meet before the next LMC meeting on 13 September. In the meantime, they had **AGREED** that the Chairman and Secretary be paid for the first quarter of the year at the old rate.

Dr Holmes would be on holiday for the next three weeks, and it was suggested that a deputy be sought. Dr Ramaswamy was **NOMINATED** and it was hoped a meeting of the three members could take place in the very near future to finalise proposals.

There being no further business to discuss, the meeting closed at 9.00 p.m.

Date: ***Chairman:***