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, 7 June 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 A R J Boggis	Dr J T Canning	Mr J Clarke
	Dr G Daynes	Dr L Dobson	Dr T Gjertsen
	Dr J Harley	Dr M Hazarika	Dr A Holmes
	Dr I A Lone	Dr K Machender	Dr T Nadah
	Dr A Ramaswamy	Dr R Roberts	Dr N T Rowell
	Dr R S Sagoo	Dr M Speight	Dr J R Thornham
	Dr R J Wheeler	Dr S White	Dr C Wilson

In attendance: Mrs C A Knifton : Office Manager, LMC
Dr M E Patrick : Registrar with Dr Beeby's practice

05/06/1 APOLOGIES

Apologies for absence had been received from Dr K Ellenger, Dr A Gash, Dr C Harikumar, Dr T Sangowawa and Prof Van Zwanenberg.

05/06/2 MINUTES OF THE MEETINGS HELD ON 12 APRIL 2005

These had been circulated to members. In the minutes of the Annual Open Meeting there was an inaccuracy on Page 3 under "Superannuation on Appraisals". MPCT is not paying superannuation contributions to appraisers carrying out appraisals. Subject to this correction, the minutes for both the Annual Open Meeting and LMC meeting were **AGREED** as a correct record and duly signed by the Chairman.

05/06/3 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

05/06/3.1 Superannuation on Appraisals (LMC Annual Open Meeting : 12 April 2005)

MPCT had already been contacted regarding the employer's contributions for appraisers.

It was pointed out that as all earnings were now superannuable GPs were, in effect, working for 14% less if PCTs refused to pay the 14% employer's contribution.

Members from Langbaurgh and Hartlepool confirmed that as far as they were aware no superannuation was being paid to appraisers. North Tees members had received an email from Terry Bearpark confirming that 14% employer's superannuation would be paid.

It was **AGREED** that the Secretary should contact the remaining PCTs to ascertain whether or not they were paying employer's contributions to appraisers. *Post meeting note*: Terry Bearpark confirmed that NTPCT were paying 14% employer's contribution to appraisers.

It was queried whether there was a list of "specialist" work GPs were undertaking for PCTs, in which case those GPs should be contacted by the LMC and informed about the superannuation payment.

05/06/3.2 IUCD Fitting – Response from MPCT, GP Clinical Governance Lead
Ref Min 05/04/18***)***

"I am in the process of determining eligibility and accreditation of GPs providing minor surgery and IUCD and Implanon insertion services to patients, and I am enclosing a draft proposed guidelines to be discussed at the PCT in the next couple of weeks. I found the comments on IUCD fitting attached to your letter very helpful and would welcome your comments."

The draft guidelines had been circulated to members. Dr Lone emphasised that these related to MPCT only and he did not know what other PCTs were doing. Deborah Beere was insisting on the minimum requirement of a person fitting 12 coils a year. As MPCT presently only have two GPs fitting more than 12 coils per year, it may be that in future there are no GPs qualified to fit coils. Deborah Beere had been informed her department would be called upon to provide the service.

If PCTs used an above-practice service, there would have to be an arrangement covering holidays and sickness to enable the service to be available at all times. It was noted that the standard of 12 coils a year was based on a good practice point of professional consensus of an interested group, and was not research based. If GPs adhered to the recommendations, in the next 2-3 years there may be no GPs skilled to undertake the work. There were no local accredited training courses for GPs, and registrars also required training.

It was **AGREED** that the Secretary would:

- write to MPCT supporting their proposed guidelines but voicing concern over the requirement to perform the insertion of 12 coils a year, as this was based on professional consensus rather than hard evidence;
- contact the other PCTs to ascertain what their proposals were.

05/06/4 CONFERENCE OF LOCAL MEDICAL COMMITTEES : 16/17 June 2005

The full Conference Agenda was tabled, although an extract had previously been circulated.

It was **AGREED** to add a rider to Motion 137, as follows:

Existing Motion 137
That conference regrets that the DDRB has yet again failed to recognise and remunerate the work of GP trainers and course organisers, and

(i) believes that this will have significant consequences upon recruitment and retention of such clinicians
(ii) instructs the GPC to press for a substantial increase in remuneration for these doctors next year
(iii) urges the health departments to make speedy progress in taking forward discussions on remuneration for trainers
(iv) if there is no satisfactory package of remuneration and resource in 2006 calls for the BMA to ballot trainers on a withdrawal of their services
(v) asks the GPC to facilitate the formation of an Association of Trainers.

Rider to Motion 137
(vi) whole heartedly supports the concerns of the Association of Course Organisers, as expressed at its recent Annual Conference, that neither the opportunity for the majority of F2 doctors to have exposure to general practice nor the re-alignment of GP training to be increasingly practice-based will be possible without that recognition and remuneration.

05/06/5 PMS UPLIFT 2005 / 2006
All PCTs contacted – no response received from HPCT & LPCT

Response from Middlesbrough PCT (Martin Phillips)
"I write regarding your letter dated 6 April 2005 with reference to the above. I am aware that certain payments including locum allowances covering sickness, maternity, paternity, adoption and prolonged study leave to PMS practices have increased in line with the same items in the GMS Statement of Financial Entitlements, and I can confirm that this uplift will be applied.

The uplift for PMS practitioners seniority is now within their practice baseline and each practice has been informed of the amount that their baseline has been increased by, seniority has given in line with GMS practitioners.

You will be aware that the weighted uplift of 1.1% including PA/Dispensing and it would seem reasonable to incorporate these into PMS baselines in 2005/6.

All PMS contracts within MPCT have a provision in para 298 "*where applicable payments made to contractors will be on an equivalent basis to the SFE provisions shall be subject to the appropriate supplementary provisions contained in Part 6 of the SFE*".

If I can be of any further help, please do not hesitate to contact me."

Response from North Tees PCT (Liz Hegarty)
"Thank you for your letter dated 6 April, regarding the above. In NTPCT we are implementing the following:

- Doctors Retainer Scheme – Uplift as GMS
- Prolonged Study Leave – Uplift as GMS
- Seniority – PMS will be treated as GMS
- Baselines – Global sum uplifted by 25p from £54.47 to £54.72. This is not an inflation uplift but related to additional superannuation on new income. PMS practices will also receive an additional 25p per weighted patient for 05/06.
- Other payments equivalent to SFE payments

- Locum sickness / maternity	Agree PMS treatment same as GMS
- Dispensing fees	Currently rolled up within PMS baselines, but will take out and add 6.37% uplift as per GMS.
- Enhanced services	DES, NES and LES increased by 3.225% for GMS and PMS
- Quality and outcomes	PMS treated same as GMS other than the 109 points deduction
- Premises	GMS rent, rates, etc, are reimbursed at full costs. PMS rent and rates have either been taken out and reimbursed at cost, or where in baselines still, uplifted by 5.1%.

I hope this is helpful and answers your query. We will be writing out to our PMS practices in the near future to explain the uplifts."

Dr Canning informed members that there is no uplift for GMS via the global sum, it is largely through seniority and quality payments. For PMS practices, PCTs have received 1.1%.

In answer to a query concerning what salary increase practices were expected to give their staff as of 1 April 2005, it was noted that the NHS figure was typically 3.225%, though this had been complicated by Agenda for Change and practices using this as an opportunity to incentivise staff.

05/06/6 REPORT FROM GPC

GPC meeting
The General Practitioners Committee (GPC) met on 21 April and 20 May 2005.

Report on main negotiating issues

PGEA payments
A recent County Court judgement found in favour of a GP claiming payment due in 2004/05 in arrears for Postgraduate Educational Allowance (PGEA) undertaken in 2003/2004. The claimant was able to demonstrate to the court that he had undertaken the necessary period of education in the year before the introduction of the 1990 contract, was therefore paid in arrears for this allowance throughout the duration of the old contract, and was due a further full year's payment in the first year of the new contract. Following this judgement, the question has arisen of whether it sets a precedent for all GPs.

This whole matter hinges on whether PGEA was paid annually in arrears or in advance. The General Practitioners Committee's (GPC's) legal advice is that the ruling cannot be applied generically to all GPs because;

- It would only apply to those who could present evidence themselves (as did the claimant in this judgement) that they had been paid annually in arrears.

- It is evident that some doctors were paid in advance.

- It would not apply to Personal Medical Services (PMS) GPs, who have different arrangements, and is not likely to apply to new GPs post-1990/91

It is important to note that the judgement ruling on this case is only relevant to this one particular case. It therefore does not set a precedent for all General Medical Services (GMS) GPs who have worked under both old and new contracts to claim this money.

However, what it does do is indicate that any other GP in the same situation as the claimant in this case may be successful in a challenge. The GPC's current advice is therefore that only those who can provide evidence (in the form of their practice accounts, for example) that they had been paid annually in arrears might have a case.

The Department of Health do not believe that the circumstances of the case reflect those of the generality of GPs, and so do not expect any other cases.

IT update

Service level agreement

The final version of this document has been received this week, and the final stages of negotiations are taking place. This is the document which will ensure that the transfer of ownership of IT systems and equipment from the practices to the Primary Care Trusts (PCTs) takes place in accordance within nationally approved guidelines, whilst service levels are maintained or improved.

GP2GP

Members of GPC were able to meet representatives and see demonstrations of the GP2GP message transfer systems from EMIS and In Practice Systems. Chris Leary and Dr John Williams from the GP2GP transfer project team were also present. The guests demonstrated homogeneous transfers (from one system PC, to a separate PC running the same system) and also heterogeneous transfer, from system A to system B. Unfortunately, the Torex demonstrators were unable to attend at the last minute, but hope to demonstrate their work at a later date.

The committee debated on how GP2GP transfer should work. There were various options for discussion, including whether the electronic record should be 'locked' 48 hours after the patient registered at a new practice. This would mean that no further additions or edits could be made at the original practice. Alternatively, the original practice could hold on to the electronic record, in an 'open' state, able to make alterations and editions, until it was forwarded to the new practice at the same time as the paper record. Benefits of this would include the ability to add results from pathology etc. before forwarding the record.

The committee had a comprehensive debate about the issues, the majority thought that it was in the best interest of patients to forward electronic records as swiftly as possible to the new practice and therefore the GP2GP team will be advised that the electronic records should be sent as soon as the patient registers at a new practice.

Small practices

Following the recent publicity about the government's negative stance on small practices, the GPC chairman immediately contacted the Health Minister to raise concerns about the reports. John Hutton gave assurances that it was not the government's intention to abolish small or solo practices, and that the press reports had been misleading.

Motions on this issue had been received from two Local Medical Committees (LMCs), and the committee reaffirmed its support for small practices.

Alternative provider medical services (APMS)
Guidance on APMS will be published towards the end of May, following the general election. We are also awaiting final guidance from the NHS Employers to Primary Care Trusts (PCTs) in England, on which the GPC has been consulted, regarding APMS contracts; this will inform our own guidance.

Self sickness certification
The GPC debated and supported the following policy statement from the BMA's Occupational Health Committee:

"The present system requiring a doctor to certify absence beyond the first seven days is a problem for all concerned and serves no-one well as shown by a wealth of evidence. The BMA proposes that the government moves to a system of full self certification with arrangements for random audit as with the present tax system."

The GPC will be working with the BMA's Occupational Health Committee, in conjunction with other crafts, to discuss this issue with the Department for Work and Pensions (DWP) after the general election. This will be undertaken in the context of the DWP's ongoing pilot projects using nurses, and other health professionals, to certify sickness. This is in addition to the pilot scheme for alternatives to certification in general practice being run by the Working in Partnership in Primary Care programme¸ as part of the demand management initiatives established following commitments given in the new GMS contract.

Independent nurse and pharmacist prescribing
The committee discussed two consultations from the Medicines and Healthcare Products Regulatory Agency (MHRA) on independent nurse and pharmacist prescribing. Both consultations presented a broad range of options. These ranged from continuing with the situation as it currently exists, limited nurse prescribing and no pharmacy prescribing, to opening up the whole British National Formulary (BNF) to nurse and pharmacist prescribers. The committee recognised that there were real possibilities for nurse and pharmacist prescribing and they could contribute to a reduction in GP workload. However, any changes to the current situation needed to include adequate funding for training and mentoring, clear guidelines on where legal responsibility lay, show a clear evidence base of benefits and recognise the potential influence of pharmaceutical reps. Overall the committee was in favour of continuing with extended formulary nurse prescribing and enlarging the drugs that could be prescribed based on skill, and the committee supported the introduction of pharmacist prescribing along lines similar to that of current independent nurse prescribing.

Vaccine supply problems
The prescribing subcommittee met recently and Richard Tiner, Medical Director of the Association of the British Pharmaceutical Industry (ABPI), joined the subcommittee to discuss a number of issues related to the supply and withdrawal of drugs over the last year. The subcommittee expressed concern about problems with vaccines, where supplies are given to practices with a very limited use by date. A representative of the Department of Health (DH) was also present at the meeting.

- Members **AGREED** that supplies of MMR were tight but otherwise everything fine. Supplies of MMR were having to come from Germany.

Maintaining high professional standards in the modern NHS
The Department of Health GP bulletin (March 2005) included an article on new disciplinary procedures for doctors, 'Maintaining High Professional Standards in the modern NHS'. This guidance is not applicable to GPs, unless they are employed by Primary Care Organisations (PCOs) to perform services other than primary services.

New legislation
The 2005-06 Statement of Financial Entitlements, Directed Enhanced Services (DES) directions and Personal Medical Services (PMS) payments directions, as agreed between the GPC and the Department of Health came into force on 1 April 2005. The amendments that have been made are minor and non-contentious.

A series of amendments to the General Medical Services (GMS) contract and PMS agreements regulations have also been agreed. Primary Care Organisations (PCOs) will be expected to incorporate these amendments into GMS and PMS contracts by 14 April 2005 or as soon as possible thereafter. They are set out in the National Health Service (Primary Medical Services) Miscellaneous Amendments Regulations 2005. The variation notice to the standard GMS contract has also been issued.

Pending further discussions between the Health Departments in Scotland, Wales and Northern Ireland and their respective GPCs, it is expected that these documents will be amended in a similar way in these countries. We are awaiting final confirmation of these changes.

SFE – quality payments
Since publication of the Statement of Financial Entitlements (SFE) a drafting error has been found regarding the 60% methodology for the 2005-06 quality aspiration payments. The SFE currently states it is 60% of the 2004-05 achievement payment (defined as total achievement in 2004-05 minus aspiration payments in 2004-05), when the agreed policy is 60% of total achievement in 2004-05. The Department of Health has confirmed this is an error and an amendment will be made. The Department has also confirmed that Quality and Outcomes Framework Management and Analysis System (QMAS) makes the correct calculation, so the error in the SFE should not result in practices receiving incorrect aspiration payments in 2005-06.

It was noted in the GPC meeting that some PCOs had been arguing that the original £75 per point continued to apply for aspiration payments in 2004-05 and that the increase to £77.50 to incorporate superannuation funding applied only to the achievement payment in 2004-05 and not to total payments. This is of course erroneous. The increase to £77.50 per point for the average practice in 2004-05 applies to all quality payments.

Childhood immunisations
As you know, the issue of the calculation of immunisation targets for the under twos was drawn to our attention. The problem raised was that the number of qualifying immunisations in the new Statement of Financial Entitlements has gone from four (DTPolio, HiB, Pertussis, MMR) to two (new pentavalent vaccine and MMR). This means that, if all the immunisations were equally taken up, this would be fine but, because they are not - with MMR uptake often being significantly lower – and because MMR now counts for a greater proportion of the payment, it will make it more difficult to meet the higher target.

Our policy to compensate for any adverse impact of this change is to continue to push, throughout the contract review, for the introduction of 'informed dissent' to count for childhood immunisations and MMR in particular. A vaccination and immunisation sub-group of plenary has been set up to discuss all vaccination and immunisation issues within nGMS and this issue will be taken forward through this group.

Dispensing
We were informed fairly recently by NHS Employers that they had been given a mandate from the Government to review the current situation with regard to dispensing doctors, now that the new Pharmacy contract had been accepted and implemented. In response to this mandate, the negotiators, plus Russell Walshaw (Chairman of the Rural Practice Subcommittee) and Malcolm Ward (Chairman of the Dispensing Doctors Association), have held an initial internal scoping meeting to look at the various options available to us. We have confirmed that the actual negotiations will take place via a plenary sub-group on which both Malcolm and Russell will sit.

Pensions updates
The NHS Pensions Agency for England and Wales published its technical newsletter, concerning changes resulting from the GP contract, on 22 March. The existing GP locum web page has been revised to take account of the fact that GP locums can now pension NHS out-of-hours work and the new out-of-hours web page is now on the Pension Agency's website homepage. In addition, the latest Pensions Agency technical newsletter, detailing the main changes to the NHS (Pension Scheme and Injury Benefits) Amendment Regulations 2005 has also been published. These regulations came into force on 5 April 2005 and are effective from 1 April 2004.

The Pensions Agency has also published the documentation regarding the assessment of GP pensionable earnings and the GPC has issued its own introductory guidance. There are a number of outstanding queries about this process, which is very complex, and these are still under consideration between the parties.

The Government's plans to alter the NHS Pension Scheme, along with those of many other public sector workers, have been suspended pending a review. It is not clear precisely what this will mean or how we will give evidence to it, especially as the proposals for the NHS scheme were still at the consultation stage unlike proposals for other public sector schemes which were much further advanced. Nevertheless, we and the BMA Pensions Department will continue to watch this area very closely.

Code of practice on confidentiality and disclosure of information
Since the last meeting, the final version of the revised Code of Practice has been agreed with the Department of Health.

Although we are still not completely happy with the final version, it does go someway further than it had previously with regard to assurances that disclosure of patient information is conducted within the parameters of the Data Protection Act and that information should only be disclosed when certain conditions are met. Now that the Code of Practice is public we will be producing further guidance for LMCs setting out under what circumstances records might be disclosed, which can then be used to inform patients. This will be done in conjunction with the BMA Ethics Department.

- It was **AGREED** that the Secretary would send guidance out to Practice Managers letting them know what they could and could not divulge to third parties when asked for information. Specific examples were: the Addictive Behaviour Service requesting a full list of medication for a mutual patient, or information requested on patients referred via the optician for cataract procedures – this was not appropriate without the written consent of the patient; PCTs asking practices for information – if not included within practice's contract, and time is being spent obtaining the requisite information, then the practice should be recompensed.

Freedom of Information Act
We are finalising guidance for practices and Local Medical Committees (LMCs) on how to handle requests for information under this Act and will be releasing it very soon. It will deal with the range of queries we have been receiving over recent months as well as drawing on correspondence from the GPC list server.

Primary care development scheme
The golden hello scheme in England ended on 31 March 2005. The golden hello scheme was additional money provided by the English Department of Health and it was not in our gift to hold onto it. Indeed, the GPC criticised it from the beginning and campaigned for its abolition when it was announced. It was always made clear to the GPC that the scheme was time-limited and would be reviewed and replaced in due course.

A new primary care development scheme was due to come into effect on 1 April 2005 in England. Unfortunately, we are unable to provide detailed information on this scheme at present as we are currently awaiting the final framework for the new scheme from the Department of Health, which we understand has been delayed pending the final allocations to Strategic Health Authorities (SHAs). The Department has recently written to apologise for the delay. We have prepared guidance for LMCs on this which will be sent out once the new scheme is announced.

Complaints procedures and investigations
The Complaints Sub-Group of Plenary met, for the second time, on 9 March 2005 to discuss changes to the complaints procedure in light on the Shipman Inquiry's Fifth Report. These meetings continue to be constructive and we have been told that many of our initial concerns with the proposed recommendations and associated changes to the complaints procedures have been taken on board. It is anticipated that there will be formal consultation on the new regulations in June and that these will come into effect in October when the Social Care Regulations also come into force.

Negotiators' report for the GPC meeting – 19 May 2005
Since the last GPC meeting in April 2005 there has been one informal joint meeting with NHS Employers and the Departments of Health in the immediate aftermath of the appointment of new ministers. The parties are making progress on identifying the main issues, in addition to the QOF and formula reviews, for discussion as part of the contract review and, from the next formal negotiating meeting, will be beginning to ascertain the areas of common interest as well as those which will be more difficult to resolve.

QOF, formula and dispensing reviews
The QOF and formula review processes have been continuing despite the hiatus in negotiations on other areas. The QOF review is still at the stage of receiving evidence submitted for changes to the QOF, the deadline for which is 30 May 2005. Once this deadline has passed the expert panel will begin its review. The formula review is at the stage of commissioning the major pieces of work to analyse the evidence to be reported back to the review group. One of the priorities for the contract review is dispensing policy and funding, and the plenary sub-group is due to begin its work in June in order to make progress on dispensing issues as soon as possible.

SFE amendments
Since the 2005 SFE came into force on 1 April 2005, two issues have been raised where it seemed that the SFE did not reflect our understanding of the agreed policy/payment mechanisms. We raised these concerns with the Department of Health, which agreed that certain adjustments needed to be made to the SFE to clarify these issues. The draft amendments to the SFE have now been agreed and will be issued in due course.

(a) Aspiration payments:
As reported at GPC last month, a drafting error had been found regarding the 60% methodology for the 2005-06 quality aspiration payments. The SFE currently states it is 60% of the 2004-05 achievement payment (defined as total achievement in 2004-05 minus aspiration payments in 2004-05), when the agreed policy is 60% of total achievement in 2004-05, uprated to 2005-06 prices. The new wording proposed in the SFE (Amendment) Directions 2005 resolves this issue.

(b) Timing of childhood immunisation target payments:
This issue concerns the timing of the DES payments for childhood vaccinations and immunisations. We were aware that, historically, different methods and systems for payment had been used in different parts of the country. However, due to the varying interpretations of the wording in the 2004-05 SFE, which were transferred into the new SFE, it was not clear which method should be used. The wording appeared to indicate that payments should be made 'in quarter' – ie at the end of the quarter for which the work related, when in fact the situation should have been clear that the payment was made at the end of the following quarter as was the system under the SFA. We consulted the DH and the Exeter payment system and they confirmed that the payment system should not and has not changed as a result of the new contract, but that the system had not been sufficiently clearly described in the SFE, hence leading quite reasonably to a misinterpretation of the timing of the payments.

Amendments to the SFE, including a table clearly setting out the timings underpinning the payment process added to paragraph 8.10, have now been agreed.

During the coming year we will have our first opportunity to negotiate significant changes as part of the contract review to apply from April 2006, and so we have added this item to the work programme for the joint negotiations. We agree that it is certainly a desirable aim to try to achieve these payments as soon as practically possible for practices. The fact that the SFE previously indicated that an earlier payment, within quarter, could be made, and the fact that some PCOs and LMCs had agreed to implement this, indicates that this should be the next natural step forward in terms of payment for childhood vaccinations and immunisations. In our response to the Department of Health, in agreeing to the amendments to the SFE, we forewarned them that this would be something we would be wishing to discuss as part our future negotiations on other outstanding issues around childhood immunisations.

Pensions
We are aware that, since the Pensions Agency published the documentation on the assessment of GPs' pensionable earnings, a number of queries have been raised, mostly from accountants but also GPs, on a number of similar issues, particularly the impact on handling practices' accounts and the tax implications. These issues are very specialised in nature and we do not believe we are in a position to provide our own advice at this stage. We are, however, currently holding discussions with a specialised firm of accountants about producing some FAQs in response to those queries. We therefore hope to be able offer some further guidance to practices shortly.

The allocation formula and normalisation
The GPC has expressed serious concerns about the process of normalisation that is applied at each stage of the allocation formula. Normalisation involves scaling back the results of applying the formula to practice lists so that they always total the national registered population. If this was not done, the aggregated weighted practice lists would differ from the total population.

Two particular problems have arisen. First, an error in the Exeter software has led to the normalisation index being recalculated every quarter, when it should have remained constant through the year. This has resulted in overpayments to some practices, and underpayments to others. The GPC has been urgently pressing for clarification and rectification of this error by

the Department of Health but there have been considerable delays and several proposed meetings have been cancelled due the apparent inability of the Department to gather together all the necessary figures.

The GPC has obtained legal advice on what measures an underpaid practice can take and has been advised that it would need, at least, to be able to estimate a minimum figure, repayment of which it could then claim from the PCO. If the payment was not forthcoming, it could invoke the dispute resolution procedures. However, the problem with this approach is that it would be extremely difficult for the practice to estimate the extent of underpayment in the first place.

The second problem relates to the fact that weighted practice lists are normalised to PCO level for three quarters of the year, but then readjusted to national level for the first quarter of each new financial year. What this effectively means is that for three quarters of the year, if all practices in a PCO experienced identical growth, no practice would receive any additional funding for that growth. This happens because normalisation adjusts the growth in a practice's weighted populations relative to growth in the other practices in the PCO area for those three quarters. When, in the first quarter of the subsequent year, the normalisation is made to national level, this lack of financial recognition should be corrected, because overall growth in the national registered population brings additional funding.

However, there have been reports of significant and inexplicable falls in global sums in some areas in April 2005 despite growing practice list sizes. Although, in theory, this could simply reflect the correct operation of the formula, or list-cleaning exercises, the extent of the fluctuations has led to concerns that they could be a result of misapplication of the normalisation process.

The GPC will continue to press for urgent correction of the software problems, and will also press for the Department to fully investigate any other problems that could be arising from the application of normalisation to PCO level for the last three quarters of the year. If the latter problem turns out to be a consequence of the process itself, rather than misapplication, we will wish to address this as part of the formula review.

IT Update

Registration for Connecting for Health (nee NPfIT) has commenced in some areas. Registration creates an electronic identity for each individual on the central NHS user register. Registration will enable practices to use programmes such as Choose and Book, GP2GP transfer and the Electronic Transfer of Prescriptions (ETP). Registration does not oblige practices to use Choose and Book. The registration process involves completing a form to allocate roles to staff, which will determine the level of data staff can access e.g. receptionists will be unable to access full clinical details. The burden on practices in completing the form is being raised with Connecting for Health.

Registration is not the same as "expressing an intent to use Choose and Book". Practices do not need to register in order to express an intent to implement Choose & Book, which could be verbal, on paper or by e-mail.

The committee expressed concerns about the Choose and Book process and requested clarification on the allocation of the £95 million capital funding. Issues relating to Choose and Book will be raised at a meeting with the Department of Health on 3 June 2005.

The Government's plans for a central care record are receiving greater public scrutiny. Patients are beginning to ask about this as awareness grows. Some patients are asking that their records do not go onto "NHS computers" or the "spine". How should GPs respond?

– The GP's paramount responsibility is to the patient.

- Except in certain specific circumstances patients have absolute control over who has access to their record.
- GPs have a duty to maintain a record and this can be on paper or computer.
- There are potential disadvantages, even dangers in having multiple record systems; some patients on one and others on another.
- Most GPs now use computer records and these are a vital tool for the GP, patient and practice.
- At the moment GP systems are not connected to the spine and it is both GPC and BMA policy that patient data should not go onto the spine until concerns about privacy and confidentiality have been answered.
- The electronic transfer of GP records (GP2GP) will soon be a reality and, although the records will transit over the spine, no data will be retained by (or leak onto) the spine during the exchange.

Patients should therefore be reassured that data collected locally on GP controlled systems, even though these are "NHS computers" is best, safe and essential for their care. Data collected in this manner will not go onto the "spine". Data will only go to outside agencies with the patient's express consent and that only relevant data will be shared. Patients should be encouraged to allow GPs to continue to build locally held and controlled electronic records.

- A member asked if practices were obliged to do Choose & Book if they were doing Practice Based Commissioning. The response was that practices have to demonstrate an interest but do not have to do Choose & Book if it is not resourced.
- There was concern, with NPfIT, that the designation of authority allocated to a member of staff may allow them to make an appointment but not to produce a prescription. Reassurance was given that access was on an individual basis not a blanket job title basis.

The GPC Review Task Group and proposals for change

The GPC approved the final report by the Representation subcommittee documenting the work done and decisions made in light of the GPC Review Task Group Report. This report is available on the BMA website and on request from the LMC Office

Postgraduate Medical Education and Training Board (PMETB)

The GPC has concerns about the arrangements and ongoing uncertainties regarding the transition of the Joint Committee on Postgraduate Training for General Practice (JCPTGP) to the Postgraduate Medical Education and Training Board (PMETB). The committee is particularly concerned about the PMETB proposals to introduce a new fee scale for certification. The suggested fees are quite disheartening and could discourage doctors from becoming GPs. This issue will be widely raised to ascertain how potential GPs will be compensated for these significant additional costs. We have written to the PMETB expressing our disquiet and have requested that the PMETB delays the introduction of these charges until the issues are clarified.

BMA and ABI reach agreement on fees for GP reports

The BMA Professional Fees Committee and the Association of British Insurers have agreed a fee increase for GP reports and medical examinations undertaken for life assurance and income protection purposes. From 1 July 2005 the new fee for a GP report will be £70.50. Medical examinations will be £77.50 and the fee for a supplementary report, at the time of the original request or later, will be £18.00. Increases are linked directly to pay increases for

GPs and there is a clause allowing for adjustment in the fees for 2007/08 and 2008/09. BMA Professional Fees Committee Chairman, Peter Holden, has said that is important doctors produce reports in the format required, rather than reproducing a patient's health record.

Criminal Record Bureau checks for all NHS staff
On 13 October 2004, John Hutton announced the government's intentions to introduce Criminal Record Bureau (CRB) checks for all NHS staff. This would include receptionists, cleaners etc as well staff who have direct contact with patients. It is **not** a legal requirement for all NHS recruits to undergo CRB checks at present. If there are steps to introduce such legislation, the financial implications to practices will be raised by the GPC. Further information about CRB checks is available on the BMA website in the September 2004 edition of the Sessional GPs Bulletin.

- Concern was expressed over the possibility of CRB checks for all members of practice staff regarding the cost implication and length of validity.

National Conference for GPs to Be: General Practice: Your Choice? Your Future? Thursday/Friday, 7/8 July 2005 : Thistle Bristol Hotel, Broad Street, Bristol
We would ask all GPC members and LMCs to continue to help promote this year's National Conference for GPs to Be. Booking forms are now available from the BMA's Conference Unit. Further information and on-line booking can be found at: www.bma.org.uk/gpstobe05

05/06/7 SPECIAL PMS PRACTICES/PRACTICE BASED COMMISSIONING
Letter received from a local GP

"I have recently received notification of the localities for Practice Based Commissioning and on looking at the practice populations as at 01/01/05 I notice some great anomalies which I think deserve explanation and action from the PCT. In particular the Trinity Practice, with its population of 310 patients, and the Galvani Practice with just 52 patients, would appear to be a gross misuse of public funds. I wondered if the PCT could be approached on behalf of the LMC to justify this situation. The PCT must be persuaded to come up with an alternative way of using these practices to reduce the burden which everybody else is bearing. I would appreciate the opportunity for a full and frank discussion on this at the next LMC meeting."

After a long discussion, it was **AGREED** that the Secretary should:

- write formally to MPCT (Chairman or Chief Executive, and the PEC Chairman) voicing concern over the value for money of the projects, in particular the level of service provided for the funding, and seeking the PCTs evaluation of them. The matter will be discussed at the next meeting in July; and
- contact the remaining PCTs who may be looking at similar specialist PCTMS projects.

05/06/8 STANDARDISATION OF PROCEDURE TO MINIMISE DELAYS HAPPENING DUE TO THE LACK OF BLOOD RESULTS
(Letter sent to all GP by Mrs A Russell, Lead Nurse, Division of Radiology, JCUH)

Response from Mrs Ingrid Walker, Divisional Manager, Radiology Dept, JCUH
"In light of the feedback received with regards to our proposal on the above procedure, we are in the process of arranging a meeting with PCT leads for consultation. During this consultation we hope to find a way so that both financial and patient care issues can be resolved satisfactorily. We will keep you informed of any progress."

Dr Canning reported that he had written to all four PCTs and NT PCT had informed him that this is covered by their Treatment Room LES "which included a modest increase in activity without requiring additional resources". When contacted earlier, Mrs Russell, the Lead Nurse, had said that it was felt this would result in about 20 requests a week area-wide.

NOTED.

05/06/9 ANNUAL REPORT ON CLMC REGULATIONS SUB-COMMITTEE ACTIVITIES

Dr Canning reported that CLMC Regulations Sub-Committee had considered one case during the period 1 April 2004 – 31 March 2005 which involved advising a PCT on the procedure to be undertaken relating to a doctor with possible health related problems. A medical examination was undertaken with a report to the Regulations Sub-Committee, who accepted the findings of the independent medical examiner and made an appropriate recommendation to the PCT.

RECEIVED.

05/06/10 PRIMARY CARE RESOURCE & DEVELOPMENT CENTRE FINANCIAL POSITION
Ref Mins 01/11/9 – 01/12/3.4 - 02/03/10.1

The Secretary advised members that the PCRDC was in the process of being disbanded and the finances clarified. It would appear that there is £39,383.42 remaining in the PCRDC bank account. On the premise of their imminent bankruptcy, the LMC and the other users of the PCRDC were asked to make two additional payments, (over and above rent already paid to THA for the office space and utilities), to cover PCRDC staff salaries. The payments made to PCRDC from CLMC amounted to £2,763.60. He sought advice from the Committee as to what they felt should happen to the payment made by the LMC together with the amount of money standing in the PCRDC bank account.

Drs Canning, Thornham, Holmes and Boggis expressed an interest as they are still Trustees of the PCRDC, together with Prof Oswald.

Dr Thornham explained that since the closure of the PCRDC, income had continued to accrue. The Trustees were now trying to decide what to do with the remaining monies. Returning the money to the organisations who had funded it in the first instance (the four PCTs plus the additional payments made by CLMC, CVTS, MAAG) was against the obligations of the Charity. The aim of the Charity was to stimulate educational development in Teesside, perhaps in the form of bursaries.

It was **AGREED** that the Trustees should produce a framework of proposals as to what bursaries they wanted to support, short term and long term. The proposals should be distributed within the primary care service on Teesside, and should be open and explicit with both GPs and other members of primary care being able to apply.

05/06/11 REQUESTS FOR LMC TIME

05/06/11.1 Expert Patients Programme

Ref Min No: 04/04/12

A further request has been received from Mr Stephen Wilkinson, Regional Programme Manager of the Expert Patients Programme, to attend an LMC meeting to give a short presentation and video about the programme.

05/06/11.2 NPfIT

A request has been received from Mr Stephen Smith, Programme Director for the County Durham & Tees Valley NPfIT Programme, to attend an LMC meeting to update members on NPfIT.

It was **AGREED** that the Secretary would write to both parties asking for a submission on two sides of A4 to be made to the LMC to allow for further consideration at the July LMC meeting, with a view to an invitation to attend the September LMC meeting.

05/06/12 SIGNATORIES ON CLMC CHEQUES

The Chairman, Secretary and Office Manager's signatures are registered with NatWest to enable them to sign cheques. The Office Manager can sign cheques up to £100, with anything over £100 requiring a second signature. To cover for holidays and meetings resulting in the Chairman and Secretary being unavailable at the same time, it is recommended that the Vice Chairman's signature also be registered with NatWest.

The proposal was **AGREED**.

05/06/13 DEATH CERTIFICATION – CREMATION FORMS

The Secretary advised members that he had discussed the question of the revised Form C - Confirmatory Medical Certificate (usually referred to as Part 2) with Dr Ian Holtby, Senior Medical Referee, Teesside Crematorium. It had been agreed that :

- Doctors should complete at least one of questions 5 – 8 in the affirmative, however, if the communication with the person concerned has been by telephone, a note to this effect will not cause problems.

- If for any reason it is not possible to complete Parts 5 – 8 in the affirmative, an alternative may, in exceptional circumstances, be a different method of confirming the information in Form B (Part 1) such as an inspection of the medical records of the deceased.

After discussion the proposals were **AGREED**.

05/06/14 VERIFICATION OF DEATH BY REGISTERED NURSES & EMERGENCY CARE PRACTITIONERS : TRUST POLICY

A policy on the verification of death by registered nurses and emergency care practitioners has been produced by MPCT, on behalf of the Out of Hours commissioners, in conjunction with the LMC and HM Coroner. The policy authorises registered nurses and emergency care practitioners to verify a patient's death and to arrange/direct relatives to arrange for the removal of the deceased body to the funeral directors or seek the involvement of HM Coroner. The policy also provides guidance as to the process of the verification of death. A GP does not have to see the body after death.

NOTED.

05/06/15 HAZARDOUS WASTE
Change in Regulations effective on 16 July 2005

Regulations governing hazardous waste will change on 16 July 2005. Any practices producing over 200 kg of hazardous waste per annum (which includes clinical waste), encompassing but not restricted to discarded fluorescent tubes, single use cameras, sphygs, thermometers, some discarded electrical equipment including TVs, fridges and computer monitors, will have to be registered with the Environment Agency and keep a note of everything that goes into waste bags. There is talk about 4-5 different kinds of waste bags and perhaps 3 different kinds of sharps bins. There is the threat of a £20,000 fine or 6 months imprisonment for failing to keep accurate hazardous waste records. The fee for registration varies from £18 – 28 per practice, depending on whether it is done on-line or by letter, and lasts 12 months.

Dr Canning said that the fee for registration with the Environment Agency is the responsibility of the PCT, continuing from the Red Book or PMS arrangements to reimburse practices for the cost of trade refuse.

It was **AGREED** that the Secretary would send out some information to practices.

05/06/16 BMA NORTH EAST ENGLAND REGIONAL COUNCIL
Letter from Mr D Carter, IRO, BMA Leeds

"I am writing to invite your LMC to nominate two delegates to attend the newly formed BMA North East England Regional Council. The next meeting of the Regional Council will take place in September 2005, by which time it is hoped that all the representatives from throughout the region will be in place. The September meeting will take place in Newcastle but future meetings will be rotated around the region."

It was **AGREED** that Dr I A Lone and Dr J P O'Donoghue, who had attended previous meetings, would be nominated.

05/06/17 SICK DOCTORS TRUST (based in Farnham, Surrey)
Ref Mins 02/09/11 & 03/09/13.5

"I am appealing for funds to support the continued running of the Sick Doctors Trust (SDT). The aims of the SDT are to assess, arrange treatment, follow-up, introduction to support groups and re-employment of the recovering doctor. We also assist the families of those doctors who are addicted to chemical substances and offer support groups for them through the British Doctors & Dentists Group. In many instances we arrange for financial assistance through the various medical charities.

Although recognised by the Government and the GMC, we receive no official funding. The Officers of the SDT are all volunteers and endeavour to work at the highest professional level in relation to our clients.

We often encounter difficulties with funding for treatment and we are trying to build up a fund so that we may assist doctors who need to be treated. Formerly we had very little difficulty in obtaining funds through out of area payments. Since the concept of the PCTs inadequate financing has made it very difficult to raise the required funds for treatment.

As a result of appraisal, more cases of substance abuse are being uncovered, particularly in the younger doctor. We have assisted in excess of 400 doctors in the past 8 years, but this is less than 50% of the predicted annual incidence of new cases. We are assisted by the BMA and 5 LMCs in Britain. Please donate part of your voluntary levy to help those less fortunate colleagues. If you wish to make a donation please send your cheque to Dr R Brown (Treasurer), Sick Doctors Trust, 36 Wick Crescent, Bristol BS4 4HG."

The Secretary informed members that CLMC had donated £1,000 in September 2002 with the proviso that a further donation would depend on what other LMCs had donated. In September 2003 it had been agreed that, because only £4,428.88 had been donated by LMCs for 2003, no further donation would be authorised.

The majority of members felt that SDT was well outside of the Tees area and doctors already had the services of GP Health available to them which was funded by the four PCTs, as well as House Concern which is available to all GPs in the Northern Deanery. Durham GPs had access to GP Choices in their area. The comment was made that SDT should have looked at the funding aspect prior to setting up the organisation and expecting LMCs to support it. It was paramount for GPs to be looked after locally

Dr Dobson, who founded GP Health, felt very strongly that SDT should be supported in order to aid GPs suffering from substance abuse, as GPs suffering this affliction often did not normally want to be treated locally.

A member cited an example where a local GP had initiated treatment out of the area and his PCT willingly paid 50% of the cost. Dr Dobson said it was up to GP Health to decide whether or not to fund out of the area treatment.

After a long discussion it was **AGREED** that the Secretary would :

- Obtain more information from the Sick Doctors Trust in relation to where the treatment took place, was it mainly local GPs who were receiving treatment, were hospital doctors being treated; and
- Approach PCTs to ascertain their views on funding and using out of the area treatment for GPs.

05/06/18 MENTAL HEALTH PROMOTION

Extract from the Minutes of the South Locality Suicide Prevention Group meeting held on 12 April 2005

Mental Health Promotion

"Tina (Walker) stated an update of the Mental Health Promotion Implementation Plan is needed. Activities have slowed down at present. Kay (Stephenson) reported that the end of year report for Middlesbrough MIND showed that 330 individuals had engaged in structured courses dealing with mental health issues. 650 residents had been involved in health promotion in the past year. National MIND Week is from 14 – 21 May and the focus is on "Stress". There is an established health network in Middlesbrough so considerable support is available from other agencies.

Research on the prescription of SSRIs for mild to moderate depression has shown that cognitive behavioural therapy is the preferred first line of treatment rather than drugs. However, it is difficult to engage GPs in this therapy. Kay stated that therapy courses are available through MIND for service users.

Action:
SM/KS to undertake a piece of work with the PR Department on how to take this issue forward.
AG: It was also suggested that Dr Gash take this issue to the LMC."

Dr Canning explained that due to unforeseen circumstances, Dr Gash had been unable to attend the LMC meeting to speak on the subject. Members felt that they were being castigated in the minutes. It was felt that CPNs and others were more appropriate to provide this service than GPs, and that GPs did not refer because there was no provision for the service.

It was **AGREED** that the Secretary would write to the South Locality Suicide Prevention Group expressing these views.

05/05/19 REPORTS FROM MEETINGS

There were no reports from meetings.

05/06/20 REPORTS FROM REPRESENTATIVES

There were no reports from representatives.

05/06/21 SUPPLEMENTARY AGENDA

05/06/21.1 LPCT CONSULTATION DOCUMENT: RELOCATION OF SKELTON HEALTH CENTRE

No comments were received. The document was **NOTED**.

05/06/21.2 ADDITIONAL REFERRAL INFORMATION BEING REQUESTED BY TNEY (Stockton North Locality)

There seemed to be a growing tendency for referrals to be returned to practices requesting additional details on patients, and stating what should be included in the referral request.

Dr Canning said that a GP was expected to refer as appropriate, and if a reasonable amount of information was provided for a referral and the referral was not acted upon, there was always the question of who was responsible if something went wrong. He emphasised that the responsibility would be with the mental health team not the GP. It appeared to be a Tees-wide problem that mental health seemed to regularly return referrals requesting additional information on the patient.

05/06/21.3 REIMBURSEMENT FOR ATTENDANCE AT GP COMMISSIONING GROUPS

Practices had received no notification regarding remuneration for GP and/or Practice Manager's time to attend GP Commissioning Group meetings. It was **AGREED** that the Secretary take this matter up with PCTs.

05/06/21.4 MUMPS VACCINATIONS

It was **AGREED** that the Secretary would contact Dr Ian Holtby to enquire about the possibility of staff being immunised against mumps (one practice had four staff off with mumps). What about a catch-up programme for the 15+ year olds? Was there a sufficient supply of vaccine?

05/06/21.5 POTENTIAL ORGANISATION CHANGE FOR LOCAL MENTAL HEALTH & LEARNING DISABILITY SERVICES TO BE CONSIDERED
(Co Durham and Darlington Priority Services NHS Trust & TNEY NHS Trust)

"The people of County Durham, Tees Valley and North East Yorkshire are currently served by our two specialist mental health and learning disability trusts. Over the years our two organisations have demonstrated our on-going commitment to providing the best possible mental health and learning disability services for the people we serve.

Thanks to the skills and commitment of staff in both organisations we have had considerable success in developing and introducing new services and facilities, in line with the National Services Frameworks and Valuing People, the White Paper on learning disabilities.

However, we feel that we must now consider how to continue that progress, and provide improved access to a greater range of specialist services that will make a real difference to the lives of all the local people we support. We wish to consider whether we should continue to develop as two separate organisations, or merge together as one.

Both trusts have been prompted to consider options for organisational change to meet a number of local and national challenges for mental health and learning disability services. These prompts include the:

- Findings of the recent review of specialist mental health and learning disability services across County Durham and the Tees Valley;
- Opportunities for specialist mental health and learning disability trusts to achieve Foundation Trust status;
- On-going efforts to maintain the high local and national profile of mental health and learning disability services to tackle the issue of stigma.

Our strategic health authorities recognise the appropriateness of discussing options, and support our decision to open up discussions about a merger.

We felt it was important for us to inform all our staff, service users, carers and colleagues in partner organisations, at the earliest opportunity of our intentions. At the May meetings of our Trust Boards we intend to discuss the process for exploring organisation change.

We appreciate that any potential change can cause concerns. So as we develop options for organisational change we will keep you fully informed, and hope that you will play an active part in consultation around any future proposals.

We remain totally committed to working in partnership to provide locally based, high quality integrated mental health and learning disability services for local people."

RECEIVED.

05/06/22 ANY OTHER NOTIFIED BUSINESS

05/06/22.1 QOF

Dr Dobson reported that, as a QOF assessor for LPCT, he had attended a regional QOF assessment review meeting in Newcastle. Next year assessments are going to look quite severely at exception reporting. Also, assessments will be looking at the

ownership of policies taken from websites, the relevance to practices, and whether practices are implementing those policies.

Dr Lone replied that MPCT did look at exception reporting which was very reasonable and it will be looked at again. With regard to taking policies from websites, policies were passed around but how will PCTs be able to ascertain if they are being adhered to?

05/06/22.2 Payments to Committee Officers

The Secretary and Chairman left the meeting in order for this item to be discussed. Dr Lone as Vice Chairman spoke on the matter. He explained that the Chairman and Secretary had been paid on a scale derived from the consultant scale determined by the DDRB. With the introduction of the new consultant contract and a variety of pay scales, it was not appropriate for consideration to be given to the method of remunerating the Officers of the Committee and it was proposed that a Remuneration Sub-Committee be established by the LMC to prepare a report for the July meeting.

This proposal was **AGREED** and Dr I A Lone, Dr W J Beeby and Dr A Holmes would meet to formulate suggestions to bring to the July LMC meeting.

05/06/23 RECEIVE ITEMS

05/05/23.1 Medical List

Applications:

Effective Date	**Name**	**Partnership**	**Practice Area**
01.05.05 *Partner*	Dr M N Khan	Dr Datta & Partners	NT PCT
04.04.05 *Salaried GP*	Dr I Garcia-Vega	Dr Bolt & Partners	H PCT
01.06.05 *Salaried GP*	Dr A W Cole	Dr Palczynski & Partners	M PCT
01.05.05 *Partner*	Dr B K Lal	Dr Bentley & Partner	L PCT
06.06.05 *Partner*	Dr L Smith	Dr Clements & Partners	LPCT

Resignations:

Effective Date	Name	Partnership	Practice Area
31.03.05	Dr C Parker	Dr Bolt & Partners	H PCT
HPCT Salaried GP			
28.02.05	Dr I Garcia-Vega	Dr Basson & Partners	M PCT
Resigned			
27.04.05	Dr Z Anam	Dr Brash & Partners	HPCT
Resigned. Will work 1 session for Dr Juhasz and 4.5 days at Peterlee practice			
31.05.05	Dr J Dyckhoff	Dr Palczynski & Partners	M PCT
Salaried GP			
03.06.05	Dr L Smith	Dr Glasby & Partners	LPCT
Resigned. Salaried GP.			

RECEIVED.

05/06/23.2 Report the receipt of:

Dales & Wolds LMC minutes of meeting held on 24 February 2005
Durham LMC minutes of meeting held on 5 April 2005
GPC News M9 : Friday, 22 April 2005 (available on www.bma.org.uk)
GPC News M10 : Friday, 20 May 2005 (available on www.bma.org.uk)
GPC Annual Report 2004 : Executive summary
LPCT Final Report on Consultation regarding Integrated Health & Social Care Facility

RECEIVED.

05/06/23.3 Date and time of next meeting

Tuesday, 19 July 2005, at 7.30 p.m. in the Committee Room, Poole House, Stokesley Road.

NOTED.

There being no further business to discuss, the meeting closed at 9.35 p.m.

Date: ***Chairman:***