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, 1 May 2007 in the Committee Room, Poole House, Nunthorpe, Middlesbrough.

Present:	Dr R Roberts (Chairman)	Dr J-A Birch	Dr A Boggis
	Dr S Burrows	Dr J T Canning	Dr K Ellenger
	Dr T Gjertsen	Dr A Holmes	Dr R McMahon
	Dr T Nadah	Dr J Nicholas	Dr D Obih
	Dr J O'Donoghue	Dr A Ramaswamy	Dr T Sangowawa
	Dr N Siddiqui	Dr M Speight	Dr J R Thornham
	Dr R Wheeler	Dr S White	Dr C Wilson

In attendance: Mrs C A Knifton : LMC Manager
Mr I McFarlane : LMC/PCT Liaison Officer

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The Chairman introduced members to Ian McFarlane, the newly appointed LMC/PCT Liaison Officer, who was welcomed to the meeting.

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07/05/1 APOLOGIES

Apologies had been received from Dr W J Beeby, Mr J Clarke, Dr G Daynes, Dr D Donovan, Dr A Gash, Dr C Harikumar, Dr I A Lone and Dr N Rowell.

07/05/2 MINUTES OF THE MEETING HELD ON 20 March 2007

Dr Holmes commented that in Minute 07/03/3.6, it had been mentioned that the Tithebarn practice "had not been successful" and asked that the Minutes reflect that whilst the practice had not attracted as many patients as were anticipated (with currently 1000+ patients) the practice felt they had been successful in the variety and quality of services they offered.

Apart from this addition, the Minutes were **AGREED** as a correct record and duly signed by the Chairman.

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

07/05/3.1 Draft Tees Commissioning SLA : Provision of ICT services to primary care
Ref Min 07/03/3.2.1

The document had been produced by Peter Jacques following meetings with the LMC Secretary and still contained the clause about not moving pieces of equipment around in the surgery. Peter had explained that this was outside the control of the PCT as it was part of the policy Dell put in place when providing the equipment, probably in an attempt to stop old and new equipment being put together resulting in the computer not working. It was suggested that if the movement of equipment was documented, this would be acceptable and work could continue uninterrupted in the surgery and alleviate an IT call-out request being logged.

The service time was listed at 9.00 a.m. – 5.00 p.m. yet doctors work 8.00 a.m. – 6.00 p.m. It was felt that some provision had to be made for those periods outside of the service time to take into account emergency call-outs from surgeries.

As a way forward, it was **AGREED** that there should be provision in the document for:

- Call-outs from surgeries to be made outside of the 9.00 a.m. – 5.00 p.m. core times
- Ability to move equipment around surgeries without the need for an IT call-out
- A review to take place in, say, 3 months time.

07/05/3.2 HPCT consultation for the procurement of primary medical services – Update
Ref Minutes 06/12/11.3 & 07/03/3.6

Very little movement to report. HPCT's involvement in the "Fairness in Primary Care Procurement" concerning the tendering process had been published in local adverts/media and was available on the DH website, with a deadline of 25 April for expressions of interest to be received. Three public consultations had commenced, with the first, held on 30 April, not being particularly well attended. The LMC office was monitoring the situation and providing support to Hartlepool practices.

07/05/3.3 Prescribing at the secondary/primary care interface
Update: How is it working?
Ref Minutes: 07/01/5.1 : 07/02/5.2 : 07/03/3.1 : 07/03/3.1.1 : 07/03/3.1.2 : 07/03/3.1.3

Following a lengthy discussion, it was ascertained:

- Forms were being used by hospital staff to 'interpret' Regulations as to what drugs should/can be prescribed
- Hospital staff prescribing amber/red drugs without shared protocol being in place (and hence no funding to take account of extra workload/responsibility and

increased drugs bill). Particular problem with out of area hospitals. Newcastle (transplant patients) will prescribe if GP refuses to take on the responsibility
- Patients being informed there is no reason why GP cannot take on prescribing and patient arriving at surgery expecting to receive prescription
- Forms still being used instead of typed letters (caused by shortage of typists)
- Forms are to be reprinted to eliminate ambiguity with wording

It was felt that, at the moment, there was no need for a "yellow card" system to be instigated in order to flag up concerns about hospital prescribing, but this may change when new drugs came into the system.

07/05/3.4 Choose & Book – Update

Ref Minutes: 07/01/4.1 : 07/01/4.2 : 07/01/4.3 : 07/03/3.5 : 07/03/10.2

Ian McFarlane had taken this up on behalf of the LMC following Colin McLeod's letter of 12 April to Middlesbrough GPs which stated "*the LMC has been consulted on the proposal for the LES and this has been welcomed in principle*". It was emphasised that the LMC had been consulted, at a meeting on 11 April, but had not "welcomed" the proposal and continued to have reservations about the scheme, and this had been conveyed to both Chief Executives, in writing, on18 April. The LES applied Tees-wide. Because of the lateness of the LES notification to practices, PCTs would change the proposal so that achievement of the May target would automatically generate a payment for April. There was no information available on any national plans to fund continued C&B.

Dr Nicholas had attended a meeting organised by StHA/C&B users in PCTs/hospitals, where there had been the suggestion of StHA/health communities moving towards electronic-only referrals, with StHA being keen to move this forward. No definite decisions have been taken but it is possible that manual referrals would have to be directed to hospitals via the PCT. The PCT would vet suitability for electronic referral using a non-clinical proforma attached to the referral. It is accepted that manual referrals will continue to be required for a small minority of referrals.

Dr Canning pointed out that under the NHS Act GPs had a duty to refer patients to the appropriate service; if a PCT referred a patient to someone which the GP felt was inappropriate, then the GP had to take action. If patients are referred to hospitals outside of the area it will have a significant effect on payments by results. Not all clinics are available on C&B and not all have named consultants for named referrals. In some areas GPs were being told not to refer to a named consultant – what happened to patient choice which seems to have evolved into hospital/time/date but not choice of consultant?

Dr Canning reminded members that he had attended a meeting with StHA/DH on 27 February where the concept of turning off manual referrals had been discussed. A DH spokesperson had said that the DH could not be seen to support a move towards rejection of paper referrals.

Problems with software were the main reasons for GPs not wanting to use C&B. Poor software resulted in computers crashing, and secretaries taking long periods of time to make appointments online.

07/05/3.5 Enhanced Services – Update
Ref Minutes 06/01/8 : 06/04/4.5

PCTs awaiting formation of Tees-wide Commissioning Group before implementing changes to enhanced services. MPCT/HPCT/NTPCT provide funding for a "basket" of services. R&CPCT do not provide such a "basket". Eston practices, recently transferred from MPCT to R&CPCT, should anticipate discussions to re-negotiate enhanced services to bring them in line with other practices in R&CPCT.

A Middlesbrough GP said his practice had not been paid last year for the "basket" and may not have been paid for two years. Another Middlesbrough GP said his practice had withdrawn from the "basket" a short while ago but had re-commenced once MPCT had provided funding.

An Eston GP said they were still receiving electronic updates from MPCT but had heard nothing from R&CPCT as yet. Having transferred PCTs, Eston practices now had access to Stead Hospital which had GP beds. A Redcar practice looked after the patients which meant Eston GPs did not have to work outside of their practice area.

07/05/4 LOCAL IM&T PLAN FOR TEES LOCAL HEALTH COMMUNITIES
The NHS in England: The Operating Framework for 2007/08 – 2011

The aspiration of the document is that by 2011 all practices would have moved to a single converged system, with TPP being the preferred software at present. Hartlepool/North Tees were scheduled to be finalised by 2010; Middlesbrough by 2009; Redcar & Cleveland not specified.

Considerable debate ensued on the contents of Page 10 concerning GP practices. The feeling was that practices were not being given a choice on change, with the document stating that "a migration path towards a single converged solution is planned by 2011", without any consultation having taken place except in Redcar & Cleveland.

It was **AGREED** that the reservations expressed be taken up with whomever needs to be notified.

07/05/5 CD & FLOPPY DISK TRANSFER OF PATIENT NOTES

The LMC Secretary had met with Chris Webb of NTPCT some time ago and she had suggested developing an interim solution until GP 2 GP arrives. TPP practices have discovered that when a patient transfers from one practice to another, the system can produce up to 300-500 pages of records. Contractor Services work with Lloyd George envelopes and this is a huge problem for them in terms of storage. Does the incoming practice want information on a CD/floppy or a printed version? There is also the issue of storing deceased patients records on computers. TPP can send data to the PCT electronically and the PCT can print it and send it to incoming the practice if they want a paper version.

Dr Nicholas explained that he had first noticed the problem when his practice moved to TPP, saw the amount of pages that could be produced when printing records off, and wondered how incoming practices would cope with that amount of paper. A printout had been developed which was similar to an insurance printout and was supplemented by a full extract of everything electronically as a "Word document" with document attachments, which had the advantage for the incoming practice that they can attach this document into the patient's record as standard documents rather than scanning them in, so it could be loaded on to any PC and viewed and searched as a text document. He envisaged an update summary with full details over xxx years with the remainder of the information being contained on the CD, and if the incoming practice required a full paper copy they would contact the outgoing practice and request this, so the onus was still on the outgoing practice to originate the paper copy. Regulations would need to be looked at to see what is/is not acceptable.

Concern was expressed at:

- software compatibility between practices in relation to, for example, ECG readings.
- the need to look at the whole of the record when answering the question "are the records complete" in which case you will have to look at the text files to see if there are any apparent gaps
- prison services were moving to SystemOne but it will be a different SystemOne from general practice so there will be an issue about patient records for people leaving/entering prison; it would be nice to receive a summary from the prison.

Whatever was finally instigated had to be compatible with systems in other localities should the patient move out of the area.

It was **AGREED** that it would be helpful to have sight of the protocol produced by Dr Nicholas. *(Post meeting note: Protocol received at the LMC office.)*

07/05/6 REPORTS FROM REPRESENTATIVES

No reports had been received from representatives.

07/05/7 REPORTS FROM MEETINGS

07/05/7.1 Report from LMC/NT & HPCT Meeting : 11 April 2007

The main items discussed had been reorganisation/commissioning appointments, Hartlepool APMS, the Primary Care Development Scheme, PEC arrangements, Choose & Book, and the Access DES (LES being considered).

Dr Thornham (PEC Chair) reported that the person appointed as Director of Commissioning for Teesside had moved to North Tees & Hartlepool NHS Trust to oversee plans for the new hospital so the commissioning post was still vacant and alternative solutions were being sought.

05/05/7.2 Joint GPC/LMC Secretaries Meeting : 19 April 2007

A copy of the Report had been emailed to all LMC Members on 27 April and was discussed. GPs were in a very difficult position because patients perceive them as being overpaid and are not sympathetic to the zero pay increase. Patients are not aware that GP earnings have been made from reaching targets set by government and by doing work outside of the NHS. Superannuation figures cannot be obtained in order to ascertain what is the average income comparable to other people working in the NHS.

07/05/8 SUPPLEMENTARY AGENDA

07/05/8.1 NEAS: GP Urgent Requests for an Ambulance : Effective 1 May 2007

NEAS had written to all GPs on 19 April explaining that as from 1 May 2007 the DH had introduced a new national standard for ambulance services across the country and they would be measured on their performance in dealing with urgent calls from GPs and their staff. It will be necessary for the ambulance controller to ask some key questions to establish the right level of response, some of the responses being defined by national guidelines. When a member of staff requests an ambulance, NEAS had produced a form in order to obtain the information that will be needed as they develop the system; the form may ultimately be in electronic format but was currently in paper format.

Because of the criteria involved with "emergency responses" of 8 and 19 minutes, together with "urgent responses" of one hour blocks, or a deferred admission whilst waiting for a bed, it was felt that for a patient in imminent risk of death it was quicker to dial 999, or get patient to dial 999.

Two GPs, one from North Tees and one from Middlesbrough, cited incidents concerning delayed ambulances/no beds in A&E, which had resulted in Significant Event Reports.

It was **AGREED** there was no requirement for a presentation to be made to LMC members by NEAS.

07/05/8.2 VAT on medical services - Update
Ref Minute 07/01/12.3
(Update sent to all GPs/Practice Managers on 1 May 2007)

VAT came into force on 1 May 2007 for medical services which do not have a health benefit or prevention benefit for the patient. The LMC would like to be made aware of any problems practices undergo concerning VAT.

- Most insurance medicals are exempt from VAT
- Cremation certificates are exempt from VAT under death rules

Practices should keep a record of work undertaken by VAT liability. If partners do not pool their VAT liable income they must take appropriate advice on aggregation of fees for VAT registration.

It was **RECOMMENDED** that practices take advice from their accountants and document the advice for future reference.

07/05/8.3 £750 CPD (Continuing Professional Development) payment - Update
Ref Minute 06/12/11.5

It would appear that this payment has not been made to trainers by the deaneries. Nationally, only Kent appear to have made the payment. The GPC and COGPED met this week when this was discussed. If a trainer felt so aggrieved at not receiving payment, they are entitled to proceed through the Small Claims Court, although against whom the case should be taken is less clear.

07/05/8.4 Warfarin – Update
Ref Minute: 06/12/11.4

MPCT have agreed to pay £100 for each patient initiated on warfarin, however, the other PCTs have not accepted that payment is required. It is clear that initiation of warfarin is an enhanced service and practices should consider how to manage cases according to the resources available to them.

07/05/8.5 DoH Referral Management Centres in England: Scoping Study & Stakeholder Analysis

CRG Research Ltd in partnership with Cardiff University have been commissioned by the Department of Health to conduct the above research - and as part of this work have invited the LMC Secretary to participate in a short telephone interview (approx 20 - 30 minutes) and/or nominate a GP colleague who the LMC believe has an interest in this area.

The topics/questions to be explored will include:

- experiences of RMCs to date
- any examples of where concerns have been raised
- the effect RMCs are having/might have on the relationship between clinicians
- the effect RMCs are having/might have on the relationship between management and clinicians
- what solutions might there be/could there be to a health service which has limited means to manage demand.

All interviews will be confidential and reported anonymously.

No nominations were received to take part in the survey and it was **AGREED** that the LMC Secretary should proceed with the interview.

07/05/9 ANY OTHER NOTIFIED BUSINESS

07/05/9.1 Meeting between Dari Taylor (Labour MP for Stockton South) and constituent GPs

Dari Taylor was keen to meet local GPs to discuss primary care services in her constituency. BMA had approach the LMC in order to ascertain the names of interested GPs who had patients in Stockton South. The meeting would take place in the constituency on either a Friday morning or afternoon.

Dr G Daynes, Dr J Nicholas, and Dr K Ellenger expressed their interest and it was **AGREED** BMA London would be so informed. The BMA Parliamentary Unit will provide a brief for attendees.

07/05/10 RECEIVE ITEMS

07/05/10.1 Medical List

Applications:

Effective Date	**Name**	**Partnership**	**Practice Area**
1.04.07 *Partner*.	Dr M J Kayser	Dr Blakey & Partners	MPCT
25.04.07 *Partner*.	Dr K Shanmugam	Dr Hobkirk & Partners	R&C PCT
11.04.07 *Salaried GP*.	Dr E K Mansoor	Dr Brash & Partners	HPCT

RECEIVED.

07/05/10.2 Report the receipt of:

Sunderland LMC's minutes of meeting held on 27 February 2007
GPC News M8– Friday, 20 April 2007 (*available at www.bma.org.uk*)

RECEIVED.

07/05/10.3 Date and time of next meeting

Tuesday, 5 June 2007, at 7.30 p.m. in the Committee Room, Poole House, Stokesley Road.

RECEIVED.

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

Date: ***Chairman:***