Cleveland Local Medical Committee

Chairman: Dr D Donovan
Vice Chairman: Dr K Jaiswal
Secretary: Dr J T Canning
Medical Director/Asst Secretary: Dr J-A Birch
Development Manager: Ms J Foster
Office Manager: Ms C A Knifton

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Minutes and report of the meeting of the Cleveland Local Medical Committee commencing at 7.02 p.m. on Tuesday, 11 January 2011 at Norton Education Centre, Norton, Stockton on Tees.

Present:

Dr D Donovan (Chairman)	Dr W J Beeby	Dr J-A Birch
Dr I Bonavia	Dr S Burrows	Dr J T Canning
Dr G Chawla	Dr G Daynes	Mr S Doyle
Dr K Ellenger	Dr A Gash	Dr J Hameed
Dr M Hazarika	Dr M Hulyer	Dr I A Lone
Dr R McMahon	Dr R Mudalagiri	Dr H Murray
Dr T Nadah	Dr M Pritchard	Dr R Roberts
Dr S Singh	Dr C Wilson	Mr G Wynn

In attendance:
Mr S Childs : Interim Chief Executive, NHS Tees (first item only)
Mr T Merritt : BMA Lawyer
Ms J Foster : Development Manager
Ms C A Knifton : Office Manager

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The Chairman welcomed everyone to the first meeting to be held north of the river. Dr Rushi Mudalagiri, the new VTS representative, and Dr Girish Chawla, the new representative for Redcar & Cleveland were welcomed to the Board. Dr Nikhil Jaiswal, the new Hartlepool representative, was unable to attend.

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11/1/1 INTRODUCTORY TALK FROM Mr STEPHEN CHILDS, INTERIM CHIEF EXECUTIVE, NHS TEES

Mr Childs thanked members for the invitation to attend. He explained he was currently covering for the duration of the Chief Executive's sickness absence until end February and would assist in any way possible following that date.

Key points of his talk were:

- Operating Framework for 2011/12: Affects all GPs and commissioning, and the Command Paper which is the response to the consultation on the White Paper "Liberating the NHS". Legislation was due to go before Parliament in the summer. Composition of GP consortia can be flexible rather than fixed and expand/contract or dissolve/merge as consortia feel fit as long as NHS Commissioning Board is satisfied arrangements are workable. Government does not consider it viable for consortium to be made up of practices drawn from multiple areas. All holders of primary medical contracts will have a duty to be part of a consortium and the consortium can employ staff/buy in services/collaborate with local authorities for their services. There needs to be a lead role for clinicians within the consortium, especially where the Accountable Officer is not a GP. Consortium are not required to have a Board or lay participation, but must hold an AGM / make commissioning plans public / produce an annual report. Consortia will be

required to work closely with their Local Authority Health and Wellbeing Boards (on co-production of the Joint Strategic Needs Analysis and the Health and Wellbeing Strategy as well as accounting to the Board for the planning and delivery of commissioning intentions). The duty to promote collaboration between GPs and local authorities will be the responsibility of the NHS Commissioning Board through the Health & Wellbeing Board.

- Financial accountability: NHS Commissioning Board will establish a risk pool on behalf of the consortium.
- Commissioning primary care: There will be a duty on GP commissioners to support the NHS Commissioning Board in continuously improving primary care services; Commissioning Board can delegate some of its responsibilities for GP performance down to GP consortia.
- Maternity services: to be commissioned by GPs (previously proposed to be the NHS Commissioning Board).
- Consortia: Commissioning Board will establish GP consortia from April 2012 with notification of budgets from autumn 2012. Responsibility for consortia will not commence until 2013. Expectation that majority of consortia will be established by April 2012 or shortly thereafter.
- Consolidation of PCTs: There will be a consolidation of PCTs into clusters (north east PCTs have already done this). Perhaps further consolidation of the PCT Boards within clusters (currently four Boards on Tees).
- Clear priority for PCTs to support development of GP Commissioners and possible assignment of staff to GP consortia, according to what functions and responsibilities each consortium decides to deliver itself.
- Funding: 2011/12 development fund of £2 per patient for consortia to resource their development.
- QIPP: QIPP planning and delivery to be disaggregated to consortia.
- Finance: Better settlement than envisaged with a 2.4-2.7% uplift across the four local PCTs.
- PCT running costs: In the £25-£35 per head range by 2014/15
- Developing GP consortia: PCT wants to continue to work as closely as possible with CLMC; PCT see their role as being supportive and collaborative and not imposing on practices/GPs to deliver consortia. PCT wants to facilitate and move at pace that is comfortable with emerging consortia; will respect views of GPs as to configuration/size that is right for them. PCT has concern over pace of developing consortia and does not want any of them to be left behind. Langbaurgh has become a Pathfinder and a lot can be learnt from them as they take on responsibilities. It is possible that at least two more local consortia will wish to become Pathfinders by April 2011.
- Key risks: Time GPs have to devote to consortia. Meeting to QIPP targets. Risk of PCTs losing further staff over coming months whilst still being required to cover workload.
- SHA: SHA's will cease to exist from 1 April 2012, a year earlier than PCTs.

Following a brief Q & A session, Mr Childs was thanked for his presentation, and he offered to attend further LMC meetings if needed. Mr Childs then left the meeting.

NOTED.

11/1/2 PRESENTATION BY TIM MERRITT, BMA LAWYER: INCORPORATION (Limited Company status for the LMC)

Mr Merritt gave a comprehensive PowerPoint presentation on limited company status for the LMC (attached). Limited company status would limit the liability of members and officers, depending on the limited company status sought, and could allow the LMC to bid for contracts/charge for services/recommend certain companies to practices resulting in a small referral fee to the LMC once the contract had been set up.

After much discussion on the merits of limited by shares/limited by guarantee, is was felt that limited by guarantee status would be easier to work with administratively, and most appropriate considering the current intentions/aims of the LMC. There would be two entities: Cleveland LMC as it is now, and Cleveland LMC Limited with a different letterhead and

separate set of accounts for clear audit purposes. Statutory enquiries from the PCT/PCO would be dealt with by Cleveland LMC, all other enquiries would be dealt with by Cleveland LMC Limited. At all meetings, Cleveland LMC would commence proceedings and conduct all Cleveland LMC work. This meeting would then close and the Chairman of Cleveland LMC Limited would officially open the Limited Company meeting to discuss further business. It is vital that there is a clear definition between the work of the two organisations.

It was important to have a full and comprehensive Articles of Association (filed with Companies House) covering any and all issues that may arise because you are not under any obligation to fulfil everything in the Articles of Association.

Members were asked to think about limited company status and send any queries / questions / concerns / ideas to the LMC office and the matter would be discussed again at the next LMC meeting on 1 March when a decision would be reached.

11/1/3 APOLOGIES

Apologies had been received from Dr M Betterton, Dr A Bonavia, Dr S Byrne, Dr K Jaiswal, Dr N Jaiswal, Dr V Nanda, Dr O Sangowawa, Dr M Speight and Dr S White.

RECEIVED.

11/1/4 MINUTES OF THE MEETING HELD ON 2 November 2010

These had been circulated to Members and subject to the query shown in Minute 11/1/5.1 (below), were **AGREED** as a correct record and duly signed by the Chairman.

11/1/5 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

11/1/5.1 Minute 10/11/3.1 – A query has been raised over *A random audit of 100 admissions at JCUH concluded that 75% of them had not been admitted by their GP and were inappropriate admissions by OOH, Darzi practices and A&E*.

Clarification from Dr Lone was sought, who said: "I informed the meeting that our practice had audited 100 consecutive discharges from JCUH and this showed that only 25% of patients had been admitted by GPs from the practice. 75% of patients had been admitted either by Darzi practices, the Out of Hours Service or via the A & E Department. As I did not have access to the records of patients who had not been admitted by the GPs it was difficult to ascertain whether they were appropriate or inappropriate admissions. Twenty four of the twenty five patients admitted by the GPs were deemed to be appropriate."

RECEIVED.

11/1/6 WHITE PAPER UPDATE

Langbaurgh is one of the first national Pathfinders and the LMC Development Manager will be the Returning Officer for their elections for a Chairman and two Directors.

Middlesbrough are having steering group meetings at which both the LMC Asst Secretary and Development Manager are facilitating; group wishes to become a Pathfinder.

Hartlepool and Stockton are a little further behind but the LMC Asst Secretary and Development Manager are willing to facilitate, if asked.

Eston have decided to apply for Pathfinder status.

The LMC has organised a steering group to enable consortia reps / PCT reps / LMC Asst Secretary / LMC Development Manager to facilitate consortia development across Tees. Martin Phillips is the PCT Director responsible for consortia commissioning and the LMC is working closely with him.

Julie Birch, in her role as a Guisborough GP, is currently the Tees lead GP on the SHA Regional Advisory Group for commissioning which meets every two weeks. The group is organising regional meetings to help develop consortia and are looking at how PCTs can help with development and training needs and any other assistance. The group is for information and feedback purposes only and will not impose anything on consortia.

The BMA/GPC were handling the consortia proposal in a "critical engagement" manner. No motions on consortia were discussed at the 2010 LMC Annual Conference or ARM because no information was available on which to base motions, so there was no policy or mandate in place from which the BMA/GPC could work, though it was assumed there may be a request for such a meeting to take place in order to reach a decision.

After discussion, it was **PROPOSED, SECONDED** and **RESOLVED** unanimously that the following resolution be sent to the BMA:

- That Cleveland LMC supports the GPC and BMA approach of critical engagement on the White Paper and does not wish to see a special meeting of Conference or the BMA's representative body at this time.

11/1/7 OUT OF HOURS UPDATE

The LMC Development Manager had been in negotiations with NDUC on behalf of all practices (excluding APMS practices who were presumed to cover from 8.00 a.m. – 8.00 p.m.) concerning cover for the 6.00 – 6.30 p.m. period. All GMS/PMS practices had agreed to the proposal and should shortly be receiving an interim letter followed by an agreement from NDUC. The Development Manager was **THANKED** for her efforts.

11/1/8 REFERRALS TO HOSPITAL WITHOUT FACE TO FACE GP CONTACT

The issue of the inappropriateness of referrals for admission/assessment without face to face contact has been raised in some areas. The contractual position is quite clear. Para 32 of the Standard GMS Contract, and a parallel requirement through the PMS Agreement regulations states:

> 32. Nothing in this clause or clause 31 *[which covers visiting]* prevents the Contractor from:
> 32.1. arranging for the referral of a patient without first seeing the patient, in a case where the medical condition of that patient makes that course of action appropriate; or
> 32.2. visiting the patient in circumstances where this paragraph does not place it under an obligation to do so.

During discussion, difficulty with hospital admissions without face to face patient contact was felt to be a Teeswide problem. The policy hospitals had adopted with regard to medical admissions was that between 2.00-10.00 p.m. you had to speak to a consultant via bed bureau, but before 2.00 p.m. and at weekends you could refer as normal. In some instances it had taken 35 minutes before being able to speak to a consultant. Practices has received no prior notice of the revised admissions process which had commenced on 10 January 2011.

The LMC was not represented on the subgroup of the Urgent Care Board that had devised this approach, but had been able to comment on the proposals and had insisted that good communication with practices was essential prior to implementation; this had not taken place. Hospitals were looking at reducing rates of admissions and lack of face to face GP/patient

contact was one of the ways they were doing this. The Development Manager would seek a meeting with PCT officials to take this matter forward.

There seemed to be a problem with the mental health crisis team who would not take a referral unless the doctor had seen the patient (and in some instances refused to talk to the GP once they knew no face to face contact had taken place), and were also wanting the GP to assess patient risk before admission. Dr Gash **AGREED** to take this matter up with TEWV and report back.

A constituent suggested that the LMC adopted and published a position statement on this, and a suggested form of words was debated. The word "privilege" in the sixth bullet point was felt inappropriate, and subject to amendment. GPs are reminded that admitting patients without face to face contact does not breach any conditions of service and GPs would receive the full backing of the LMC when so doing. Examples of any hospital refusals because of the lack of face to face contact to be notified to the LMC office.

The LMC unanimously **APPROVED** the following position statement:

- A GP, upon request, shall participate in a consultation by telephone with patient or appropriate carer.
- The GP shall decide whether or not a face to face consultation is required and if so where and with whom this shall be. This may include direct referral to a secondary care provider where circumstances are considered appropriate.
- The GP shall communicate appropriately with the secondary care provider including faxing summary details to the relevant department as appropriate.
- The GP is entitled to consider factors relating to the efficient running of the service as a whole in making such a decision although the clinical needs of the patient are the prime consideration.
- The primary care performer may wish, at his or her discretion, to discuss appropriate options with a secondary care colleague in advance of a final decision. However the expertise required in respect of such a referral lies with the primary care performer as does the legal duty, hence the views of the primary care performer must take precedence in the event of any dispute.
- Where referrals are considered to be 'inappropriate' by secondary care colleagues, then they shall initially contact the relevant GP for his/her observations. In the event of apparent persistent misuse of this arrangement, then the secondary care colleague shall have the matter considered through existing clinical governance pathways.
- Secondary care colleagues need to ensure there are proper referral pathways for urgent patients at all time and with the minimum of delay.
- Issues of quality patient care will override issues of cost on every occasion.

11/1/9 LIAISON WITH THE DVLA REGARDING FITNESS TO DRIVE
Correspondence from Sue Weatherhead, Medicines Management, MPCT

"As you may know one of the functions I have undertaken has been to support the Local Intelligence Network for Controlled Drugs. This Network was a requirement post the Shipman enquiries and brings together Accountable Officers from NHS and non-NHS health bodies, to review occurrences and share information. It is PCT led, following DoH guidance.

At the Network's last meeting in December there was a discussion about advising patients in regard to fitness to drive and obligations on the part of GPs to inform the DVLA where the advice is not followed by the patient. In particular, there was some debate about the situation with chaotic drug users. The meeting wondered whether the LMC had developed any previous advice or a statement on this matter which the Network could disseminate? In so doing, the LMC would be appropriately acknowledged."

Members **RECEIVED** the item without making any recommendation as this was outside their remit. The matter will be mentioned at the GPC, and there is a Fitness to Drive Group at DVLA. The Secretary **AGREED** to respond accordingly to the PCT.

11/1/10 LMC COMMITTEE RESIGNATIONS / NEW MEMBERS

11/1/10.1 Dr Nikhil Jaiswal joins the LMC Board as a GP representative for Hartlepool following the resignation of Dr Don Obih effective on 1 January 2011. This still leaves one vacancy for the Hartlepool area which has been re-advertised.

NOTED.

11/1/11 REPORTS FROM REPRESENTATIVES

No reports have been received.

11/1/12 MEETINGS ATTENDED BY LMC SENIOR OFFICERS (since Executive Group meeting on 14.12.10)

15.12.10	GP commissioning update meeting with Martin Phillips, MPCT – Julie Birch / Janice Foster
15.12.10	Update meeting with Sue Greaves, LMC – John Canning / Janice Foster
15.12.10	NHS White Paper: Considering its implications, Middlesbrough Council Scrutiny Group – John Canning / Janice Foster
17.12.10	Fit for Work Pilot Strategy Group, Wynyard – Janice Foster
6.1.11	Middlesbrough GP Forum, MTLC – John Canning / Janice Foster

NOTED.

11/1/13 DATES FOR 2011 LMC BOARD MEETINGS

All meetings are held on a Tuesday evening, commencing at 7.00 p.m. at Norton Education Centre, Junction Road, Norton, Stockton on Tees TS20 1PR:

11 January
1 March
5 April – Open Meeting for all GPs
24 May
5 July
13 September
18 October
6 December

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11/1/14 ANY OTHER NOTIFIED BUSINESS

11/1/14.1 Sexual Health Contract with Assura

The Development Manager had emailed all GPs and Practice Managers asking for representatives to assist in negotiating three sub-contracts with Assura which would replace the LES's. Members present felt that Practice Managers would be more beneficial on the group when talking about funding. The BMA legal team would check the contract prior to acceptance.

NOTED.

11/1/15 RECEIVE ITEMS

11/1/15.1 Medical List

Applications:

Effective Date	Name	Partnership	Practice Area
1.1.11	Dr S Pradeep	Chadwick Practice	H PCT
Change in status from Salaried GP to Partner.			
31.12.10	Dr A A B El-Malak	Melrose Surgery	S PCT
Change in status from Salaried GP to Locum.			
1.3.11	Dr D R Moore	Zetland Medical Practice	R&C PCT
Salaried GP.			

Resignations:

Effective Date	Name	Partnership	Practice Area
31.3.11	Dr C Parkash	Chadwick Practice	H PCT
Resigned. Partner.			
24.1.11	Dr P J Inch	Coulby Medical Practice	M PCT
Resigned. Partner.			
31.3.11	Dr M J Kayser	The Linthorpe Surgery	M PCT
Resigned. Partner.			
21.1.11	Dr J M F Gilliat	The Garth Surgery	R&C PCT
Resigned. Partner.			
25.2.11	Dr D R Moore	The Green House Surgery	R&C PCT
Resigned. Salaried GP.			

RECEIVED.

11/1/15.2 Report the receipt of:

GPC News 5 – Friday, 17 December 2010 – available on www.bma.org.uk
Minutes of NE Regional LMC meeting held on 6.10.2010
Minutes of CLMC Executive Group meeting held on 14.12.2010 – available on CLMC website www.clevelandlmc.org.uk
BMA Sessional GPs Newsletter, Winter 2011 – available on http://www.bma.org.uk/representation/branch_committees/general_prac/sessionalgpsnewsjan11.jsp

RECEIVED.

11/1/15.3 Date and time of next meeting

Tuesday, 1 March 2011 : 7.00 p.m. : Norton Education Centre, Junction Road, Norton, Stockton on Tees TS20 1PR.

RECEIVED.

There being no further business to discuss, the meeting closed at 8.46 p.m.

Date: *Chairman:*