# CLEVELAND LOCAL MEDICAL COMMITTEE

**Dr J T Canning MB, ChB, MRCGP**
**Secretary**
**Tel: 01642 304052**
**Fax: 01642 320023**
Email: *christine.knifton@tees-shs.nhs.uk*

**Grey Towers Court**
**Stokesley Road**
**Nunthorpe**
**Middlesbrough TS7 0PN**

Minutes and report of the meeting of the Cleveland Local Medical Committee commencing at 7.32 p.m. on Tuesday, 1 November 2005 in the Committee Room, Poole House, Nunthorpe, Middlesbrough.

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| **Present**: | Dr J P O'Donoghue (Chairman) | Dr W J Beeby | Dr A R J Boggis |
| | Dr J T Canning | Dr G Daynes | Dr L Dobson |
| | Dr K Ellenger | Dr T A Gjertsen | Dr M Hazarika |
| | Dr A Holmes | Dr I A Lone | Dr K Machender |
| | Dr T Nadah | Dr J Nicholas | Dr A Ramaswamy |
| | Dr R Roberts | Dr T Sangowawa | Dr M Speight |
| | Dr J R Thornham | Dr C Wilson | |

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

**05/11/1 APOLOGIES**

Apologies for absence had been received from Mr J Clarke, Dr C Harikumar, Dr J Harley and Dr S White.

**05/11/2 MINUTES OF THE MEETINGS HELD ON 13 September 2005**

**Funding for practice based commissioning meetings : Correction to response from John Chadwick, Langbaurgh PCT**
Ref Minutes 05/06/21.3 & 05/07/3.2 & 05/09/4.2

The minutes show that "5 out of 16 practices" are actively involved in PCLC. This should be changed to "15 out of 16 practices".

Subject to the suggested amendment, the minutes were **AGREED** as a correct record and duly signed by the Chairman.

**05/11/3 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS**

**05/11/3.1 Superannuation for Appraisers**
Ref Minutes: 05/06/3.1 : 05/07/3.1

The Secretary reported that:

- North Tees are paying an uplift of 14% to cover superannuation payments;
- Langbaurgh PCT indicated that they will uplift payments by 14% to compensate for the employer's contribution;
- Hartlepool PCT stated they have received no additional funding to increase payments and "assumes that all payments made to GPs are considered to be inclusive of superannuation";
- Middlesbrough PCT are not willing to pay the additional contributions.

It was **NOTED** that the non-payment by Hartlepool and Middlesbrough PCTs of the 14% uplift to cover for superannuation means that appraisers have, in effect, taken a 14% pay cut.

## 05/11/4 RESIGNATION OF SHA REPRESENTATIVE ON LMC

Prof Tim van Zwanenberg has resigned from the LMC with effect from 1 October as he no longer works for the SHA. He is not being replaced at the SHA.

The resignation was **NOTED**.

It was commented that the present two SHAs have appointed a substantive management team jointly between the two Authorities to create North East England SHA. The posts of Chief Executive and Finance Director were understood to have gone to Tyneside employees.

## 05/11/5 ACUTE SERVICES REVIEW – OVERVIEW AND SCRUTINY OF THE PROPOSALS (Joint Scrutiny Committee)

Dr Canning explained that he had been approached by the Joint Scrutiny Committee consisting of councillors from Middlesbrough, Stockton, Hartlepool, Redcar & Cleveland, Durham and North York Councils, inviting representatives from the LMC to provide their views at a meeting originally arranged for Tuesday, 15 November but subsequently changed to 10.00 a.m. on Thursday, 17 November at Middlesbrough Town Hall. The changed date meant that Dr Canning would be unable to attend because of a prior commitment, and no LMC member was available to attend in his place. In the meantime, the LMC had canvassed all GPs for their views on the proposed changes as outlined in the Acute Services Review, and anonymised comments which had been received were tabled. The comments were mainly from North Tees GPs reflecting concerns about patients being expected to move to Hartlepool to obtain treatment for certain specialties. Should patients choose to attend Middlesbrough instead of Hartlepool, this may cause problems.

Dr Thornham gave details of a meeting between Stockton Council and GPs whereby GPs understood the reasons necessitating the changes, but felt that the evidence had not been shared satisfactorily, and that whatever happened, the consultants and hospital staff should be working in an environment suitable for them. Concern had been expressed about the North Tees midwifery suite which may be under-utilised with people choosing to go to Middlesbrough rather than Hartlepool. At another

consultation meeting in Stockton attended by about 200 people, there was great concern voiced at the proposal to move the maternity and breast units to Hartlepool, whilst paediatricians were against paediatrics moving to Hartlepool.

Dr Canning **AGREED** to :

- write to the Joint Scrutiny Committee to try and obtain a meeting on a different date;
- draft comments based on those already received and circulate to members so that a consensus view was put to the Joint Scrutiny Committee

**05/11/6 CHOOSE & BOOK**

Dr Canning explained that a Middlesbrough practice has been told by MARS (nothing in writing) that patients will not be given a hospital appointment as quickly as practices using Choose & Book, with written referrals being seen as "partial bookings".

A long discussion ensued on the workings of Choose & Book:

- once service is loaded onto the 'Desk Top' of the computer, it should take 10/15 seconds to get through; what takes the time is getting on to the service initially and this should be done at the beginning of the day;
- booking an appointment should not take more than a few seconds;
- it was the time it takes to counsel the patient on "choice" which takes the time;
- the issues of confidentiality, security and people accessing records were raised. Dr Nicholas said that you will only be able to access information about referrals which have originated within your own practice, you will not be able to see referrals made by other practices. Similarly, at the hospital end, hospital staff will be able to see referrals made into that hospital, but not referrals made into any other hospital;
- ST have intimated that once their target quota on referrals has been reached, they will cease taking any more referrals;
- "choose and book" is only available in five specialties;
- PCTs will not be commissioning a service which cannot offer appointments within 13 weeks;
- North Tees GPs disadvantaged because, at this point in time, they do not have access to tertiary services;
- one PCT has intimated that if practices do not use "choose and book" they will eventually stop taking paper referrals; it was felt the LMC should have an opinion because you cannot continue to use a dual system, however, the software must be capable of performing the functions required of it
- GPs were aggrieved they were being pushed into taking up the new technology;
- those GPs not using the system until the technology was performing satisfactorily should not have their patients disadvantaged;
- it is the "choice" agenda which has to be in place this year, not the "choose and book" agenda;
- PCTs should recognise that some of the changes they want GPs to implement are somewhat more complex than they appear to be.

It was **AGREED:**

- that patients should not be disadvantaged if practices do not use "choose and book" referrals and that there needs to be a level playing field.
- practices should not be disadvantaged if they prefer to wait until the software has had all the 'glitches' eradicated.
- practices wishing to be involved in the scheme should be fully supported in both financial and IT resources.

**05/11/7 GP TRAINERS CONTINUING PROFESSIONAL DEVELOPMENT PAYMENT**

It was **NOTED** that the £750 CPD payment was now coming via the Deaneries.

**05/11/8 MEDICAL REPORTS FOR CHILDREN NOT ATTENDING EDUCATION**

Dr Canning explained that an arrangement had been made between NTPCT and the Education Department of Stockton Borough Council, for an approach to be made to GPs in cases where children were frequently absent from school because of illness. No consideration had been given to resourcing these requests.

**Response from Louise Johnson, North Tees PCT**
"With reference to recent correspondence, the PCT and the Children's Trust are proposing involving school nurses more in the cases of children who are not attending school, for medical reasons. It is hoped that this will remove the need for Attendance Officers (previously known as Educational Social Workers) to contact GPs for written medical reports.

The school nurse allocated to a particular case will review the child health records and will liaise with all healthcare professionals who have been involved in the child's care, in a similar way to a health visitor or district nurse.

It is proposed that this will be piloted for a 6-month period and I will be grateful for your comments on the proposal and/or any feedback from your members, once the pilot is underway.

Mark Telford is the PCT Locality Team Leader, based at Tower House, who will be overseeing the pilot should you need any further details."

Three important issues were:

- Consent or a decision to waive the need for consent in the interest of the child – is required either from the appropriate parent or the child if they were of an age when able to give informed consent (i.e. from about the age of 12).
- Payment – it was felt this should be made via the Collaborative Arrangements invoice (precedents already set with payments for Disabled Badges forms from Local Councils, and payment for Purple Forms from Social Services).

- Concern - over School Nurse being allowed access to patient records; there should be an agreed standard letter asking if there are any recurrent illnesses which facilitate the child being away from school, to which doctors can answer Yes / No.

**05/11/9 PRIMARY CARE DEVELOPMENT SCHEME**
*(formerly known as GP Golden Hello Scheme)*

The SHA are having a half day workshop on the morning of Friday, 4 November, to explore how best to use the allocation from the DoH. All PCTs and LMCs have been invited and Dr Canning would be attending. The discussion paper for the event was tabled and debate ensued with comments being received.

Dr Canning **AGREED** he would report the outcome of the workshop to the next LMC meeting.

**05/11/10 FRAGMENTATION OF THE PRIMARY HEALTHCARE TEAM**

The LMC had received a letter from a Middlesbrough practice which expressed grave concern and dissatisfaction with the current district nursing services no longer being attached to practices. Patients were complaining that they did not know which district nurse was going to visit or when they were going to visit.

It transpired that this was not a problem confined to Middlesbrough, and after discussion, it as **AGREED** that Practice Based Commissioning was going to be the key to providing a good community nursing service in the future.

**05/11/11 LMC ANNUAL CONFERENCE 2006**
Thursday/Friday, 15/16 June 2005 : Logan Hall, London

Nominations are sought for 3 representatives. Dr Canning is already attending in his capacity as Chairman of Conference.

It was **AGREED** that the Chairman, Vice Chairman and Dr Beeby be nominated, with any name changes being notified to the GPC once local elections had taken place for the new 2006 – 2009 CLMC.

**05/11/12 UPDATE ON LMC/PCT LIAISON OFFICER VACANCY**
Ref Minutes : 05/01/25 : 05/07/9 : 05/09/21.1

Four candidates had been shortlisted and interviewed by Dr O'Donoghue and Dr Judy Gilley (external adviser). One candidate had been shortlisted and would attend a final interview with Dr Canning on Thursday.

**05/11/13 PUBLIC CONSULTATION MEETINGS ON MERGER**
**Co Durham & Darlington Priority Services NHS Trust & TNEY NHS Trust :** Ref Minutes: 05/06/21.5 : 05/07/12.2 : 05/09/16

"Public meetings have been planned by Co Durham & Darlington Priority Services NHS Trust and TNEY NHS Trust as part of their formal consultation on a proposal to merge. Local meetings are:

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|---|---|---|
| Thursday, 13 September | Stockton Central Library | 6.00 p.m. |
| Friday, 16 September | Redcar Adult Education Development Centre, Redcar | 10.30 a.m. |
| Wednesday, 21 September | Middlesbrough Teaching & Learning Centre | 10.30 a.m. |
| Tuesday, 27 September | Stockton Central Library | 10.30 a.m. |
| Tuesday, 18 October | Hartlepool Historic quay | 2.00 p.m. |
| Thursday, 27 October | Middlesbrough Teaching & Learning Centre | 6.00 p.m. |

Following two months of informal consultation with service users, carers, staff and partner organisations, the Trusts have agreed to formally consult on coming together to form a new Trust to provide all existing mental health, learning disability and addictive behaviour services across County Durham, the Tees Valley and North East Yorkshire from 1 April 2006.

The formal consultation period began on 15 August and will run until 14 November 2005. Both Trusts are keen to gather the views of as many local individuals and organisations as possible.

As well as holding public meetings, representatives of the Trusts would be happy to meet with you or to attend a meeting to discuss the proposal. Please contact Caroline Parnell, Project Manager (01642 516461) who will be happy to make the necessary arrangements."

**NOTED.**

**05/11/14 REPORT FROM GPC**

**GMS contract review negotiations**
Discussions on the GMS contract review have been progressing over the past month. There are, however, still a number of major areas that need to be agreed that will affect the whole contract package. Therefore, at this stage it is not possible to give full details of the exact nature of the deal that is being negotiated, mainly because providing partial information could be potentially misleading The next plenary meeting is due to take place on 3 November and we hope to be in a position to provide further information shortly afterwards.

**Normalisation**
Following the Department of Health's continuing difficulties in sorting out the mechanism for correcting the over and underpayments that were made to practices' global sums due to errors in the Exeter software which led to faults in the quarterly calculation of the normalisation index 2004-05, the GPC wrote to the Department expressing severe dissatisfaction and frustration with the process. The Department has stated in response that it

fully understands GPs' frustration, apologises for the delays and reports that it is currently working to ensure that the calculations are 100% correct before publication.

**Childhood Immunisations**
The GPC has discussed the issue of the change in the calculation of immunisation targets for the under twos. The problem is that the number of qualifying immunisations in the 2005 onwards SFE (section 8 – childhood immunisation scheme refers) has gone from four (DTPolio, HiB, Pertussis, MMR) to two (new pentavalent vaccine and MMR).

If all the immunisations were taken up equally this would not present a problem, but with MMR uptake often being significantly lower, this impacts seriously on practices' ability to reach the higher target. We have been collecting information about the level of impact that the change from a 25% to a 50% weighting for MMR vaccinations is having.

We had already agreed with the Department of Health that this issue would be revisited during the 2005-06 negotiations as part of the overall vaccinations and immunisations review and this will continue to happen. In the meantime, the GPC chairman has written to the CMO expressing serious concerns about the problem.

**Premises Underspends**
The GPC wrote to the Department of Health back in July expressing concern at reports of some PCTs not spending their share of the £108 million allocated for 2004-06 on primary care premises capital developments. We have received a response to this letter which reaffirms our understanding that the £108m has been allocated to PCTs in a way that prohibits it being used for anything other than qualifying capital developments.

The letter also seeks to give reassurance by stating that the Department of Health is closely monitoring the use of these monies to ensure that they are not lost or spent elsewhere and that SHA colleagues will be reminded that the £108m can only be spent on private sector capital grants/premises improvements. However, where there are concerns about PCTs not spending these allocated monies properly, then the Implementation Coordination Group (ICG) will investigate further. Please send any information to your local liaison officer.

A member asked if Dr Canning was able to obtain details of local PCT premises underspends, and Dr Canning **AGREED** to make enquiries.

**DDRB evidence**
The GPC has this week, as part of the wider BMA evidence, submitted its evidence to the Doctors and Dentists' Review Body (DDRB). It has not submitted any evidence relating to GP principals due to the current ongoing negotiations. In the event of the parties being unable to reach agreement on the contract negotiations there would be an opportunity to submit evidence at a later stage, or as part of the oral evidence.

**Practice Based Commissioning Guidance**
The Department of Health had been planning to provide more detail on PBC management support to PCTs and general practice in October. We have been informed that following feedback from the NHS, the Department of Health has now decided to provide more comprehensive information to support implementation. The plan is to get this out as soon as possible, and they hope it will be in November/December.

The GPC would also like to stress that, if adequate funding is not available locally for preparatory management costs, practices should not feel obliged to enter into PBC agreements regardless. The GPC is seeking to agree separate funding for this purpose and those who feel they would be financially disadvantaged by moving forward now should wait for further details. The GPC also recommends that if practices are considering signing PBC agreements with their PCTs now, they should add a clause stating that if later national

negotiations result in a more favourable rate than the one agreed locally, that the local contract should be amended accordingly.

London-wide LMCs have produced a series of helpful briefing notes on Commissioning a patient-led NHS, which include an issue on practice based commissioning.

**Enhanced services floors**
The GPC has been made aware of instances of some PCTs not spending up to their enhanced services floors and using underspends for other purposes and is exploring the legality of this.

It was always the intention that the floor was the absolute minimum that should be spent on enhanced services each year. This is also the opinion of the Department of Health who signed up to this principle when agreeing to the virement of enhanced floor services money from 2004/05 – 2005/06.

**Your Health, Your Care, Your Say : Improving Community Health and Care Services – White Paper consultation**
The committee received copies of near final drafts of the 'Your Doctor' campaign leaflet and poster, part of the GPC's strategy on the White Paper. This campaign material will be sent to practices and LMCs across England, and aims to draw patients' and the wider public's attention to what is positive about current general practice and to encourage patients to express support. In addition to this campaign, BMA media and parliamentary activity is ongoing and the GPC will be making a detailed submission in response to the consultation process in due course. A representative of the GPC is also taking part in one of the five policy taskforces established by the Department of Health to support policy development for the White Paper. Other members of the policy taskforces include individuals from the Royal College of General Practitioners, the King's Fund, the Healthcare Commission, the National Association of Primary Care and NHS Alliance. Once the White Paper is published, the committee will further consider the most effective way to respond to the Government's new proposals.

Members discussed the four main themes that had emerged from the public consultation events thus far and were likely to have an impact on GPs: self-care (i.e. health 'MOTs'); extended surgery opening hours; dual registration and access. There was strong feeling that only evidence-based initiatives should be supported and that initiatives that would exacerbate or create health inequalities should be opposed. In addition, the provision of care should continue to be needs-led, rather than led by demand. The mechanisms already exist within general practice to embrace new initiatives and the Department of Health should take into account the limitations presented by current practice infrastructures and national IT systems. Issues of capacity were also raised and there was recognition that for the majority of GP practices, in order to offer new services (or extend opening hours), there would be the inevitable trade-off with existing services.

The GPC negotiators will be considering these and other issues relating to the White Paper review further as part of their strategy discussions.

***Freedom of Information Update***
The Department of Constitutional Affairs (DCA) published the first edition of its Information Rights Journal on 22 September 2005. This is available at www.dca.gov.uk/foi/irj.htm In addition, the DCA has commissioned Northumbria University to run a range of courses on Freedom of Information from next September. The Health and Social Care Information Centre, which has replaced the NHS Information Agency, may also prove to be a valuable resource for the profession.

There are currently problems with the applicability of the Data Protection Act to deceased patients, meaning that their records may be disclosable in England under the Freedom of

Information Act. The DCA is working with the Information Commissioner (IC) to investigate ways in which exemptions in the Freedom of Information Act may be used to prevent disclosure of deceased patients' records. It is hoped that guidelines will be produced in the near future. We also expect DCA guidance on disclosure logs and IC guidance on refusal notices to be published soon.

Publication schemes will need to be reaccredited by the IC in 2007. Submissions from GPs will be accepted from June until October 2007. It is thought that the IC is likely to be more prescriptive about the content of publication schemes during this second round.

**GPs' duty to refer**

Concern has been raised about PCTs who are insisting they want to see a percentage reduction in referrals to secondary care. In particular, there were serious worries that GPs in some areas thought they needed to comply with this. It was pointed out that GPs should be reminded that they had a professional and ethical duty to refer their patients as they believed was clinically necessary. GPs should not compromise their clinical duties to meet PCT financial initiatives.

**Flu vaccines – can they be provided to those outside the DES?**

Every year there are queries about the issue of providing flu vaccines privately or to patients who request it.

It is clear under the flu DES what it is the NHS is prepared to provide - flu vaccination for the over 65s and at risk groups. GPs get their flu vaccines for this through central suppliers, they claim a PA fee for each vaccination given and a DES payment. The Joint Committee for Vaccinations and Immunisations will be involved in determining the number who could be at risk and ensuring that the relevant amount of vaccines are ordered to cover those groups. Therefore companies like Farillon should have enough stocks available for the over 65s and at risk groups.

GPs always have clinical discretion to vaccinate outside this ie: if there is a patient who continually had flu the previous year, spent weeks off work etc who the GP may think could benefit from having a flu vaccine. Under such circumstances, it may be worthwhile providing it through an NHS prescription and then administering it, as it will not then affect the vaccines supplied and bought specifically for the at risk groups and over 65's.

GPs can certainly advise patients that they may be able to get the vaccination privately and there may be a reciprocal arrangement with other practices in the area where they vaccinate each others patients privately. GPs cannot of course charge their own registered patients for either providing a private prescription or administering a flu vaccine privately.

We would also not advise giving a private prescription to vaccinate free of charge. There are times when GPs give private prescriptions to non exempt patients because the cost of a drug is actually lower than the prescription charge. If this happens we always advise the GP also gives an NHS prescription which they are entitled to under the NHS. The patient then makes the choice.

**Avian Flu**

During the GPC meeting the Chairman, Hamish Meldrum, informed the committee he had spoken with the CMO regarding the Department of Health's response to an avian flu pandemic. GP practices should have received information for patients on Wednesday and should be receiving more information in the coming weeks. The Chairman, expects to speak to the CMO again on this matter in due course. The committee raised a number of issues they would like clarified including: will a state of emergency be declared which allows GPs to better deal with the task in hand when it is unlikely regular services can continue.

**GP trainers' pay**
The DDRB's 34th report recommended that a separate payment of £750 should be made to all GP trainers in recognition of their CPD costs. We are pleased to report that the Health Department has now said that this payment will be made to all GP trainers this year. This follows letters to the Health Department about the delay in the payment and more recently a letter to Lord Warner, Health Minister, expressing our anger and dismay at news that the payment might not be forthcoming at all.

We are currently awaiting confirmation from the Health Department on when and how GP trainers will receive the £750.

**PMETB CCT delays**
The Postgraduate Medical Education Training Board (PMETB) took over the issuing of certificates of completion of training (CCTs) on 1 October 2005. The procedure for the awarding of a CCT by the Joint Committee of General Practice Training (JCPTGP) used to take a maximum of 10 working days. However, the PMETB has said that it will take three weeks to award a certificate. We have also heard of some GP registrars who submitted their application to the JCPTGP prior to 30 September and have not yet received a certificate. This is unacceptable and is obviously of grave concern to the GPC. It means that GPs who have passed summative assessment and are therefore fully qualified will not be able to have their name included on a PCO's medical performers list in a timely manner and therefore are unable to start their career posts. Unlike junior doctor specialist registrars, a CCT is needed in order to practise independently as a GP. The GPC and the RCGP have written jointly to the PMETB about this and the need for a far speedier process. The next step will be to raise this with the Health Minister, Lord Warner.

The GPC already has some examples of doctors who have experienced a delay and/or are still waiting for their CCT. We would also welcome any further evidence from LMCs, including the date on which the original application to the JCPTGP or the PMETB was made.

**PMETB and summative assessment for Article 11 doctors**
The PMETB previously agreed that doctors who apply for a CCT under the equivalent experience route of training (Article 11) would have to undergo summative assessment, in the same way as GP registrars who apply for a CCT under the prescribed experience route of training (Article 5). However, we have now heard that the PMETB has reversed this decision and so Article 11 doctors are not now required to undertake summative assessment. The GPC is concerned that this raises questions of quality assurance, and we will be raising this further.

**Payments to GPs undertaking work on PMETB's behalf**
Following a letter from the GPC, the PMETB has agreed that it is crucial for GPs to be able to participate in the PMETB's work and that it will make sure the arrangements are there to encourage that. The PMETB chairman will be recommending to the next Board meeting that it undertakes a review of its policy on payment for various kinds of work that stakeholders undertake on PMETB's behalf and the assistance that they give on committees, etc. The PMETB is making arrangements for GPs on visiting panels to be reimbursed locum costs by deaneries.

**NSPCC/EduCare Programme**
GPs and their support staff are to be targeted as part of the NSPCC's biggest ever child protection training exercise. GP surgeries will have been receiving free copies of EduCare, a child protection awareness distance learning programme. This is part of a much wider campaign to mobilise people to act to end child abuse. It is about recognising the possible signs of abuse and ensuring GPs and their staff know how to act if they have concerns about a child. The programme is available as a PDF document and is on the BMA website at www.bma.org.uk/ap.nsf/Content/NSPCC2005.

**Royal Medical Benevolent Fund**
Details of the Royal Medical Benevolent Fund Christmas appeal are available from your LMC office.

**NOTED.**

## 05/11/15 CERTIFICATION FOR GP REGISTRARS: TRANSITIONAL ARRANGEMENTS FOLLOWING HANDOVER FROM THE JOINT COMMITTEE OF POSTGRADUATE TRAINING IN GENERAL PRACTICE (JCPTGP) TO THE POSTGRADUATE MEDICAL EDUCATION AND TRAINING BOARD (PMETB)
**Guidance note from GPC**

This short guidance note has been produced in response to a large volume of queries received by the BMA and GPC from doctors waiting for certification following the handover from the JCPTGP to the PMETB on 30 September 2005. It deals solely with the transitional arrangements for those doctors who submitted their applications for certification before the handover date.

**Definitions**
The Certificate of Completion of Training (CCT) relates to the application that GP registrars will make under Article 10 or the 'prescribed experience'/Article 5 route of training.

The Statement of Eligibility for Registration (SER) relates to the application GP registrars will make under Article 11 or the 'equivalent experience' route of training.

**Fees**
We understand that doctors who submitted a complete application for a CCT to the JCPTGP by the 30 September 2005 will be exempted from fees. The completion of this process is being managed by the PMETB.

Doctors who submitted requests for an assessment of a partially completed CCT – i.e. who want guidance about further training, but who are not yet ready for a certificate – are exempt from the RCGP registration fee of £350 for this assessment. However, they will need to register and pay when they next apply to the college for an evaluation of their experience. These doctors will also need to apply to the PMETB and pay their application fee when they are nearing the end of their training programme and are ready for a certificate.

The situation is less clear for doctors who submitted either complete applications for an SER or requests for an assessment of a partially completed SER.

**Location of applications**
*Certificate of Completion of Training (CCT)/Article 5/10*
Where training is complete, those CCT applications that were received by the JCPTGP by 30 September, but were not finished/processed by this date, have been passed to the PMETB. [Detail on the PMETB's procedures for processing these applications is not available.]

Where training is incomplete and the trainee is not ready for a certificate, those CCT applications that were received by the JCPTGP by 30 September have been retained by the RCGP. These ongoing CCT applications continue to be processed in more or less the same way as was the case under the JCPTGP. If paperwork is not in order, it will be sent back to the applicant for amendment. Once the paperwork is in order, the file will be assessed and a detailed letter will be sent to the applicant telling them how much of their training has been

accepted and what further training they need to do to be eligible for a CCT. The evaluation process will normally take up to 10 working days, though at present and during the transitional period, this may take about a week longer than usual.

*Statement of Eligibility for Registration (SER)/Article 11*
Where training is complete, those SER applications that were received by the JCPTGP by 30 September, but were not finished/processed by this date, have been passed to the PMETB. [Detail on the PMETB's procedures for processing these applications is not available.]

Where training is incomplete and the trainee is not ready for a certificate, those SER applications that were received by the JCPTGP by 30 September, but were not finished/processed by this date, have been passed on to PMETB. [Detail on the PMETB's procedures for processing these applications is not available.] It should be noted that the process for evaluation of partially completed SER applications in the future is still being agreed. However, the RCGP is happy to offer informal advice on this by telephone, email or letter.

All applications to the JCPTGP which had been assessed in the past and have reached a conclusion have been kept in the RCGP offices.

**Advice for GP registrars affected**
A doctor must be included on a PCO's Performers List to be able to practise independently as a general practitioner and holding a valid CCT or SER (or their former equivalents) is a prerequisite to this. Therefore, doctors who have finished their final training post and are waiting to receive their certificate in order to take up a position in general practice may wish to consider taking up a locum hospital post in the interim period. We realise of course that this is by no means a solution to the current problems and doctors affected might also wish to contact their local deanery for further guidance and support.

The GPC is aware that many doctors are experiencing a long delay in receiving their certificates and recognises the very serious implications of this situation. This is a cause of great concern for both the BMA/GPC and the RCGP and this issue has been raised with the PMETB as a matter of urgency. We have been gathering examples of individual problems to be able to illustrate the gravity of the situation and we would welcome receiving further such evidence from LMCs accordingly.

**NOTED.**

## 05/11/16 REPORTS FROM MEETINGS

### 05/11/16.1 LMC/MPCT Liaison Meeting, 1 November 2005

Dr O'Donoghue and Dr Canning had met with MPCT's Chief Executive, Chairman and PEC Chairman that lunchtime. There was nothing substantive to report because of the situation surrounding re-organisation.

### 05/11/16.2 Regional LMC Meeting, Thursday, 13 October 2005 Newcastle Marriott Hotel, High Gosforth Park, Newcastle.

Dr O'Donoghue had attended this meeting, where Richard Vautrey had updated members on current issues:

- there would be very little money in the pot other than for enhanced services;

- changes in the payments for immunisation and the local weighting. Formerly MMR contributed to only 25% and the Triples made up 75% so most practices achieved higher payments. MMR now contributes to 50% which has adversely affected many practices; many practices in the south have lost their top payment. Practices should be aware of this in case vaccine payments have changed.

The Secretary explained that there was an implicit logic to the process as the target now related to two immunisations (Combined Polio / Triple / HiB, and MMR) rather than four (Polio, Triple, HiB and MMR) in the past.

## 05/11/17 REPORTS FROM REPRESENTATIVES

There were no reports from representatives.

## 05/11/18 SUPPLEMENTARY AGENDA

### 05/11/18.1 PCT configuration / Commissioning a Patient-led NHS

Dr Canning recapped on proposals for a single Tees PCT, together with a Durham and Darlington PCT with North of Tyne and South of Tyne, which had been put forward to the DoH. The Scrutiny Committee of the DoH would assess these and other plans received from elsewhere in England against the criteria in the initial paper proposing the changes. Some areas are proposing PCTs be allowed to remain as quite small. The timescale seems to be slipping, with the result of consultations not out until the end of February 2006. By the time Statutory Instruments have been prepared and laid before Parliament, it may be that formal change will be delayed until later in 2006 and not in place for 1 April 2006. Budgets are fixed to existing PCTs until 2008.

A letter had been received from LPCT supporting a strong co-terminous sub-PCT locality, which was felt to be in the best interests of their patients, primary care providers and staff.

The LMC will want to discuss as part of the formal consultation what localities should be, with either a PCT-down approach or practice-up approach.

### 05/11/18.2 Insulin Initiation

Dr Canning explained that following queries from practices as to whether or not commencement of insulin should be an enhanced service (as it is in a number of other areas) he wrote to the four PCT Heads of Primary Care requesting they consider a suitable LES arrangement for GPs initiating insulin in their patients. They were asked to respond in time for the November LMC meeting.

**Response from Langbaurgh PCT : Marilyn MacLean & Dr Richard Rigby**
"I would like to clarify the position from the perspective of LPCT. This issue has been discussed at the "Diabetes Task Group".

GPs within Langbaurgh are not being asked to provide this service, but rather that they are being encouraged and trained to do so in order to give continuity of care for the patients. If

GPs feel that they are unable to undertake the commencement of insulin for either clinical or fiscal reasons, then there is an above practice service available, the community diabetic service, which LPCT funds, into which GPs can refer. Input into the community diabetic service is provided by two GPs with a special interest and a diabetic specialist nurse.

I hope this clarifies the situation at least so far as LPCT is concerned, but if you have any further queries, then please do not hesitate to contact me."

**Response from Hartlepool PCT : Ali Wilson**
"Whilst HPCT, and indeed our Local Commissioning Group, are currently considering developing our diabetes care outside of hospital, we have not at this point asked GPs to initiate insulin.

Should we wish to commission additional diabetes services in primary care, we will provide the opportunity for GPs to take on additional work. If this is over and above standard contractual arrangements, we will be providing the appropriate reimbursement."

**Middlesbrough PCT** – No response received but insulin initiative was being encouraged via GPs, not as a local enhanced service.

**North Tees PCT** – No response received but North Tees representatives were not aware of this service happening in North Tees.

The Committee **AGREED** that initiating insulin was considered to be relatively time and skill intensive and should be rewarded. Doctors should be discouraged from undertaking this work without funding.

## 05/11/18.3 Changes to Clinical Waste Contract

Dr Canning explained that as from 16 July 2005, all practices had to register with the Environment Agency to cover themselves for the production of 200 kg of hazardous waste annually. The Environment Agency requires a consignment note to be completed each time a collection is made from a practice, and this will cost (at the moment) £10 per practice/per visit. PCTs have said they will only pay for what was in the original Red Book and nothing more.

The extract from the Red Book reads:

*"Where local authorities levy a separate charge for the collection of trade refuse from surgeries, this charge, or where suitable alternative arrangements exist, the charge made by a Health Authority or private contractor, whichever is the lowest, may be reimbursed, subject to the production of receipts."*

The £10 admin charge was associated with the collection of clinical waste and PCTs should be advised they are committed to reimbursing the fee. Had this charge been imposed when the Red Book had been valid, PCTs would have been obliged to reimburse practices. It was felt unreasonable for practices to make this payment, when they were unaware there was a charge to be levied once they had registered with the Environment Agency.

Dr Canning **AGREED** to :

- take the matter up with PCTs;
- to ascertain whether it was possible for practices to obtain a copy of the hazardous waste report which the clinical waste contractor provided to the Environment Agency on a quarterly basis.

**05/11/19 ANY OTHER NOTIFIED BUSINESS**

There was no other business notified.

**05/11/20 RECEIVE ITEMS**

**05/11/20.1 Medical List**

**Applications**:

| **Effective Date** | **Name** | **Partnership** | **PCT Area** |
|---|---|---|---|
| 01.10.05 | Dr Z Anam | Dr Juhasz & Partner | Hartlepool |
| 01.10.05 | Dr M D Speight | Dr Glasby & Partners | Langbaurgh |
| *Change in status from SGP to Partner* | | | |
| 08.08.05 | Dr D Wilson | Dr Joshi & Partners | Middlesbrough |
| *Salaried GP* | | | |
| 05.10.05 | Dr A S Hassan | Dr Douglass & Partners | North Tees |
| *Salaried GP* | | | |

**Resignations**:

| **Effective Date** | **Name** | **Partnership** | **PCT Area** |
|---|---|---|---|
| 31.12.05 | Dr A R Dawson | Dr Dawson & Partners | Hartlepool |
| *Retiring* | | | |

**RECEIVED.**

**05/11/20.2 Report the receipt of:**

GPC News M2 : Friday, 16 September 2005 (available on www.bma.org.uk)
GPC News M3 : Friday, 21 October 2005 (available on www.bma.org.uk)
Minutes of Co Durham LMC's meeting held on 6 September 2005
Minutes of Sunderland LMC's meeting held on 21 June 2005
Minutes of Sunderland LMC's meeting held on 19 July 2005

Minutes of Sunderland LMC's meeting held on 20 September 2005
Royal Medical Benevolent Fund Newsletter : Autumn 2005

**RECEIVED.**

**05/11/20.3 Date and time of next meeting**

Tuesday, 13 December 2005, 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 9.10 p.m.

***Date:*** ***Chairman:***