Cleveland Local Medical Committee

Chairman: Dr D Donovan
Vice Chairman: Dr I Bonavia
Secretary: Dr J T Canning
Medical Director/Asst Secretary: Dr J-A Birch
Development Manager: Ms J Foster
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Minutes and report of the meeting of the Cleveland LMC Limited commencing at 7.00 p.m. on Tuesday, 6 November 2012 at Norton Education Centre, Norton, Stockton on Tees TS20 1PR.

Present:

Dr D Donovan (Chairman)	Dr W J Beeby	Dr M Betterton
Dr J-A Birch	Dr A Boggis	Dr I Bonavia
Dr J T Canning	Mrs V Counter	Dr H El-Sherif
Dr K Ellenger	Dr I Guy	Mrs C Hurst
Dr E K Mansoor	Dr R McMahon	Dr T Nadah
Dr R Roberts	Dr N Rowell	Dr O Sangowawa
Dr S Selvan	Dr M Speight	Dr D White
Dr C Wilson		

In attendance: Ms J Foster : Development Manager
Mrs C A Knifton : Office Manager

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The Chairman welcomed Mrs Catherine Hurst to her first meeting as Practice Manager representative for south of Tees

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12/11/1 APOLOGIES

Apologies had been received from Dr S Byrne, Dr G Chawla, Mr S Doyle, Dr R Gossow, Dr J Hameed, Dr M Hazarika, Dr M Hulyer, Dr H Lamprecht, Dr N Miller and Dr H Murray.

12/11/2 MINUTES OF THE MEETING HELD ON 11 September 2012

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

12/11/3 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

12/11/3.1 OOH Complaints – Update from Dr Edward Summers, NDUC Head of Clinical Services (Tees) Ref Minute 19/09/3.2

"Thank you very much for your email of the 9 October regarding the LMC concerns over the numbers of OOH patients being referred to A&E and/or 999 when their own doctor believes that a visit may have been more appropriate, which led to your request for an outline of the NDUC policy for giving such advice and/or referrals.

The first point of contact for the public when they request assistance from NDUC is with our trained call handlers and in order to rapidly identify high risk clinical symptoms we have developed guidelines (Urgency Criteria) for our call handlers, a copy of which I attach.

If the first response of the call handler is not to arrange a 999 ambulance, the patient's details are passed into the telephone triage pool. Throughout all of our processes OOH we operate to comply with National Quality Requirements which are regularly reported to the Commissioners and are open to CQC scrutiny.

I'm sure the LMC will agree that within any urgent care system there will inevitably be discrepancies between clinician's views about what might constitute an emergency and an appropriate response to an urgent call. I venture to suggest that it is also more likely that greater differences of opinion will exist between practitioners who work in hours and those who regularly undertake shifts OOH – this will inevitably occur for a variety of reasons and the decisions for a clinician to allocate an emergency response to any particular call will, in addition, partly rest upon how risk averse an individual practitioner might be – this in turn is influenced by knowledge (both clinical & local), training, skills (especially communication), previous experience (both good & bad), personality & confidence.

There are differences between in & OOH work which were helpfully highlighted by The Colin-Thome report and I summarise:

- unfamiliar patients often without benefit of any clinical record
- initial assessment often being completed on the phone
- colleagues who may not be well-known to one another
- unfamiliar surroundings/equipment
- higher proportion of vulnerable patients
- urgent and often more complex care needs

At NDUC we have acted robustly to ensure that the risk associated with OOH work have been minimised by making certain that the vast majority of our GPs are registered on local PCT MPLs (we use no Agency GPs and have no 'flying doctors'), all have experience of OOH work and we have a very thorough interview process to ensure that the GPs who provide medical services OOH meet our high standards. We undertake regular assessments of OOH GPs work by rigorously assessing telephone triage and we are also introducing similarly robust face to face assessments. I would add that we use every opportunity to identify learning points from untoward incidents so that we may share these in regular communications with OOH clinicians. I enclose the last couple of large bulletins – since Easter we have concentrated upon disseminating smaller chunks of information for our clinicians to inwardly digest. All of this information is included in the regularly updated tome of Clinician's Guidelines and is also available on the NDUC intranet which can be accessed by all of our clinicians as soon as they log on. In addition we hold educational evenings OOH to amongst other things, update clinical knowledge, local pathways & triage training. We are fortunate to have an effective GP Registrar Clinical Supervision process OOH and year on year a percentage of local GPRs apply to work for NDUC which helps to maintain a high quality service.

NDUC is organising a Teesside Urgent Clinical Care Network and you will be receiving the first invitation to attend these meetings today (I will attach a Draft Terms of Reference and I intend for the Agenda for the meetings to encompass avoidable/inappropriate admissions) – the inaugural meeting will be on 15 November and I look forward to seeing you if you can make it. In the next two months I am also planning to establish regular meetings with Tees A&E Clinical Directors that will be known as CREAM (Clinical Review, Evaluation and Assessment Meetings) to hopefully iron out difficulties with referrals.

It leaves me to highlight (with the greatest of respect to my GP colleagues on the LMC) that there are existing mechanisms available to GPs and hospital doctors which serve to investigate and respond to any specific instances of concern relating to the management of a patient during the OOH period and we receive very little feedback. I would welcome the GP who raised his/her disquiet to the LMC to please contact me so I can personally scrutinise the details of the OOH assessment. Indeed all GPs are invited to forward NDUC details of adverse incidents which might include what are deemed to be inappropriate admissions or referrals to A&E. Please send anonymised details (perhaps consider including patient's age & initials) to either clincialfeedback@nduc.nhs.uk or governance@nduc.nhs.uk – we would however require the call number in order for us to properly confirm and identify the case.

Please let me know if there is any other information you require."

RECEIVED.

The Chairman reminded GPs to contact NDUC if they felt inappropriate admissions or referrals were being made by OOH doctors, with the LMC office receiving an anonymised version of the email without patient identifiable information so that we are aware of how often this was happening. In communications with NDUC it should be made clear that a copy was being sent to the LMC office.

12/11/4 PRACTICE MANAGER REP FOR SOUTH OF THE RIVER

Mr Stephen Doyle, Practice Manager rep for south of the river, has submitted his resignation from the Board. A letter of thanks would be sent to Mr Doyle on behalf of the Committee.

Mrs Catherine Hurst will be taking his place as a co-opted non-voting member effective from 6 November 2012.

NOTED.

12/11/5 GP CONTRACT 2013-14

The only information available at the moment was the letter from Laurence Buckman, GPC Chairman, which had been distributed to all GPs in England on 25 October. The government was offering a 1.5% contractual uplift to encourage further negotiations to take place which would be swallowed up by a staff pay rise of 1%, changes to QOF which could result in an average practice losing a significant sum next year, and from 2014 there is an intention to apply a national funding formula to equalise funding for patients which would result in those practices with MPIG losing large amounts of funding, as will PMS practices. Government will be holding a consultation to which the LMC shall be responding and GPs were also encouraged to respond. Once the LMC had more details the information would be circulated to all GPs with the probability of an open meeting being called.

Practices were warned, again, not to take on any extra work without funding, or the guarantee of continued funding. Practices must look at what it costs to do a particular job and the manpower / resources involved.

Recruitment was perceived as a future problem in the Tees area with GPs nearing retirement age and many seeing huge amounts of their money going into the pension scheme without any benefit as it will all go in tax. In the North East of England the VTS Scheme is looking to recruit extra registrars into the Tees Valley Scheme.

Cleveland LMC was carrying out a survey on the proposals for a contract imposition and thus far GP responses had showed a lack of positiveness with the changes. Once the anonymised findings had been analysed they would be circulated.

The Secretary emphasised that the LMC and LMC members must not encourage colleagues to disengage from CCG activity as this would be considered illicit industrial action and, therefore, place the LMC and LMC Committee Members at risk of serious financial and other consequences up to and including sequestration.

Practices were encouraged to contact the LMC office when they receive requests to carry out additional work without funding so that the LMC can advise on the work and if required make enquiries on their behalf.

Comments to take to the GPC meeting next week related to money and the effort involved to earn that money, with the possibility that many GPs may do more work outside the practice for a greater reward. Students had the additional burden of repaying student loans.

NOTED.

12/11/6 111 SERVICE – Update

The 111 service would be rolled out across Tees as from 1 April 2013 via a triage pathway. NHS Direct would no longer be functioning. NHS Direct used trained nurses, whereas 111 would be manned by call handlers. Patients will be offered advice over the phone on self medication / a centre visit / sent an ambulance. The only direct triage to service would be for OOH GP contacts. A member reported that in one of the areas already operating 111, pre-111 only 5 emergency ambulances had been requested in a month, and post-111 85 emergency ambulances had been requested in one month. From a survey previously carried out by a GP, only 20% of acute admissions to JCUH went via the practice with the remainder being via A&E or OOH.

NOTED.

12/11/7 VIRTUAL WARD, SOUTH TEES – Update
Also known as Predictive Risk/Transforming Community Services

This is not a scheme to which the LMC is opposed as the merits of it can be seen, however, the scheme needs adequate resourcing. A LES at £1 per patient has now been produced (the LMC having been told in August that this was not possible) but it is a procedural LES and does not cover any of the clinical elements that may be required. Practices must look at what needs to be done and make a decision on that basis knowing that there is no further funding once the 6-month scheme has finished. The LES encompasses auditing the scheme and it purely to inform commissioning decisions; it does not mean the scheme will remain within practices, it may go to an outside organisation. It is a practice's choice as to whether or not they participate in the LES – there is not an obligation so to do – and practices will <u>still have</u> access to existing community services irrespective of whether or not they choose to sign up to the LES. The LMC had drawn up a list, agreed with the PCT, of 12 points covering the work involved with the LES. The list would be distributed to South Tees GPs imminently.

One of the key issues was patient consent because the letter currently being sent to patients had assumed their consent for referral into the scheme and data to be shared with the community matron. After discussions with the local Caldicott Guardian it was agreed the letter going to patients would be changed so that if the patient did not respond, the practice will use its discretion to decide to refer / not refer into the scheme ensuring that considerations were made in accordance with individual patients rather than a blanket policy being imposed.

Practices should look at the LES and make a decision as to whether or not it is right and an enhancement in services for their patients and practical to implement in their practice within the resource offered, or to continue to use community services and the community matron as they have done in the past.

The LMC was thanked for their efforts. It was pointed out that when the CCG had first muted the scheme, instead of collaborating with the LMC over its concerns, it had proceeded with the

scheme anyway. Data collection in Eston had now been suspended pending revisions being made to the scheme. It is anticipated the scheme will re-commence in Eston on 19 November and on 1 December for Middlesbrough and Langbaurgh.

Practices were reminded that CCGs represent GPs as commissioning decisions-makers, whereas the LMC represents GPs as providers. Practices can always approach the LMC when they disagree with CCG decision-making. GPs on CCGs only represent GPs with regard to commissioning, not as providers.

It was emphasised that practices must have an up to date signed working Practice Agreement with minutes of practice meetings attached itemising exactly which GP / group of GPs / majority of GPs will be responsible for decision-making / signing documents / agreeing to participate in schemes on behalf of the practice. That documented minute is binding should any adverse repercussions arise later.

NOTED.

12/11/8 DEMENTIA SCREENING, SOUTH TEES – Update
Response from Rachel McMahon, ST CCG Mental Health Lead

"The scheme is part of the nationally mandated CQUIN scheme. This is not a CCG designed idea and we had no control over it being placed in the contract with the acute trust. We are trying to work with the trust to ensure sensible implementation, with minimal impact onto general practice. The specific target is:

"90% of all patients aged 75 and above admitted as emergency inpatients who are asked the dementia case finding question within 72 hours of admission or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia"

1) What was the outcome/details of the pilot and can you share the results/analysis that says this is of benefit and should be rolled out

The pilots have been taking place almost entirely within the trust and looking at the most effective ways of implementing the project, rather than whether this is of benefit. The impact on general practice is unpiloted, but the likely number of referrals to practices have come from the pilots.

From the first time the pilot was done on ward 37, 3 out of 12 patients (25%) had an AMTS of less than 8. The second time we looked at the data, 13 out of 40 patients assessed (32%), had an AMTS of less than 8. If we take an average of the two, approx. 29% of patients would end up being referred. There are around 720 patients that stay 3 days or more. The caveat to this might be that ward 37 & 34 may have proportionally more dementia patients because of the potential for fragility fractures and falls associated admissions with this cohort of patients. That aside, if we extrapolate the 29% to the 720 patients 75 years and over that stay more than 2 days, the Trust could potentially be referring over 200 patients a month across the Trust. Across the Middlesbrough, Redcar and Cleveland and Hambleton and Richmondshire areas, there are around 70 individual GP practices, which means that on average we would be referring 2 – 3 patients a month to each GP practice.

2) what is the evidence that testing elderly patients at a time when they are acutely unwell is appropriate

I am not aware that there is any evidence to support this. It is not felt to be the most appropriate method by any of the local clinicians.

3) Can you assure that any tests carried out at this, what we consider to be, inappropriate time will be accepted for further action (if considered necessary) rather than retesting being required at a more appropriate time when the patient is not acutely unwell

The information being passed into primary care by the acute trust is only a 10 point mental state score. For an accurate cognitive assessment to be completed, reassessment over time will be essential. Whether this

is the clinical responsibility of general practice, the acute trust, or the mental health trust is unclear at this time, and is a pathway that the CCG will be looking to develop as a priority.

4) If a pilot has been running and analysed why is the notice so short as the CCG must have been aware that this was intended for roll out and would be able to discuss this with practices in advance

At the September meeting, we were informed that the trust needed to complete 3 months of "screening" before the end of the financial year to meet their targets. There were some ongoing issues with implementation/piloting, and we were led to understand that the most likely start date would be late autumn. The CCG were only made aware of the start date of 8th October on 4th October. The start date was non-negotiable.

5) Once the information is passed to GPs surely they have a duty to act on it, therefore the process for actioning this is not at the 'discretion of the practice' as the letter suggests. How do you reconcile professional duty with your proposal

We agree that GPs have a professional duty to action all relevant clinical information. We are referring to the process by which GPs choose to action this information. The letter coming from the acute trust will suggest that the 10 point mental state score should be repeated, and a referral to memory services should be undertaken if the score remains abnormal. This may be a process that practices wish to follow. Equally, it may be that this is not clinically appropriate because the patient is already known to memory services (prior to admission, or after having been referred during the acute episode of care), is known to have a dementia diagnosis and has no current need for specialist input, refuses a referral to memory services, or has more pressing physical health issues (eg is terminally ill) that makes a referral inappropriate. The practice would also theoretically have the option to pass responsibility back to the acute trust to follow-up, or to automatically generate a referral themselves to the memory clinic for further assessment.

If the practice chooses to follow-up the information themselves, they may wish to actively recall patients, or to tackle this opportunistically.

We would hope that practices would want to follow-up any new concerns about cognitive impairment, as awareness of cognitive problems will allow the practice to make adjustments to the long-term holistic care of that individual, and ultimately improve overall quality of care. A formal dementia diagnosis will also improve QOF prevalence and the associated payments.

6) If a practice chooses not to 'action' the information provided in the screening and later face a complaint by a patient, will the CCG stand by and support the practice in any resultant action and make it clear the GP is not at fault as they are following CCG instructions

It is not the intention of the CCG to encourage practices not to action this information at all. The letter is informing practices of a change in the way the acute trust is working and giving them an opportunity to consider how they wish to respond.

7) If the patient is still an in-patient is it not the duty of the Trust to action any results/put in place required care

We have expressed the clear belief that this is the case. The trust do not feel that they have a robust system in place to re-screen patients prior to discharge, or to inform GPs of the outcome of this "screen" at the time of discharge. The trust will action concerns about cognitive function where they feel it is directly linked to the current episode of care. We will continue to work with them to try to encourage a culture shift in the longer-term.

8) If the CCG envisage that this 'may generate a bulge in referrals to the memory clinic' are you not actually saying you expect practices to action the results or acknowledging that they will have a duty to

Increased awareness of cognitive problems is likely to result in an increase in referrals, whether these are generated by primary or secondary care. We will be working closely with TEWV to monitor and manage the impact on memory clinic capacity resulting from this initiative through our scheduled contract meetings.

9) If the CCG has been 'working with the mental health trust to increase capacity to meet the anticipated demand' then has this been organised, what is the increased capacity, how is this accessed etc and if the CCG has been able to give the Trust notice to do this why have you not been able to notify practices sooner

The increase in dementia services has been commissioned outside of the CQUIN target as part of the overall CCG strategy. This has taken place over a number of years in recognition of the need to try to improve diagnostic rates.

In addition, this financial year we are investing £1.25m across Tees to enhance the mental health liaison services to the acute hospitals which will allow for rapid access to support for people with mental health problems including dementia in the acute hospital setting. This scheme which we expect to be operational early in 2013 will allow for people with dementia to be signposted to appropriate specialist support, including memory clinics following detection through screening. To complement this we are investing circa £700,000 across Tees to further enhance the Older People Mental Health CMHT service to enable them to provide treatment to people in their place of care (home or care home setting) with the aim of reducing hospital admissions."

RECEIVED.

The Chairman thanked Dr McMahon for her comprehensive response.

It was not known how good the quality of the data would be from hospital wards and it was not known what patients would be told by the hospital. The target was to collect data for three consecutive months. Although this was a national initiative it was not known why it was not running in North Tees.

NOTED.

12/11/9 LOCAL AREA TEAMS (LAT)
Letter from Cameron Ward, Director for Durham, Darlington & Tees LAT

"As the newly appointed director for Durham, Darlington and Tees Local Area Team (LAT) I would like to outline our role within the new NHS landscape, to introduce our senior team and to clarify arrangements for the transfer of responsibilities.

The NHS Commissioning Board (NHS CB) is the body nationally accountable for the outcomes achieved by the NHS and which also provides leadership for the new NHS commissioning system.

The NHS CB was established in June 2011 and began shadow running in October 2011. It will become fully operational on 1 April 2013 and will be legally responsible for NHS commissioning system.

The NHS CB is responsible for £80bn budget and will allocate £60bn directly to clinical commissioning groups. It directly commissions a range of services including primary care and specialised services and has a key role in improving broader public health outcomes. It has now established Local Area Teams (LATs) who are the local offices of the NHS Commissioning Board. They will have a number of core functions around direct commissioning, the development and assurance of clinical commissioning groups (CCGs), emergency planning, resilience and response, quality and safety, partnerships and service reconfiguration and system oversight.

NHS North of England is the regional presence of the NHS Commissioning Board across the north and will provide strategic leadership, including coordination and oversight of Local Area Teams. It will work with CCGs and partners across the north to ensure we have a strong and innovative commissioning system that improves outcomes for patients.

LATs are focused on local geographies, service patterns and relationships to achieve what the NHS CB believe to be a sustainable solution that will establish the local presence of the NHS CB.

All LATs will have the same core functions around:

- Direct commissioning
- CCG development and assurance
- Emergency planning, resilience and response
- Quality and safety
- Partnerships
- Configuration and system oversight.

There are 27 LATs across England and they will be accountable for the direct commissioning responsibilities for GP services, dental services, pharmacy and certain aspects of optical services, specialised commissioning, offender health commissioning and military health commissioning.

Ten LATs will lead on specialised commissioning across England with Cumbria, Northumberland, Tyne and Wear (CNTW) undertaking this on behalf of Durham, Darlington and Tees. The Durham, Darlington and Tees LAT will undertake primary care and offender health commissioning on behalf of CNTW. Military health is being led by the LAT in North Yorkshire and Humber.

The Durham, Darlington and Tees LAT will be based in Darlington. Existing NHS estate is being considered as the office location and it is hoped to confirm temporary accommodation in the next few weeks.

LATs have started to make appointments to their director posts in their structures and I am pleased to let you know of the following director appointments for Durham, Darlington and Tees:

- Dr Mike Guy, previously a GP in Northumberland, who is currently medical director of NHS North of Tyne and NHS County Durham and Darlington has been appointed medical director.
- Bev Reilly, currently Board Nurse, Quality and Safety, NHS Tees, has been appointed director of nursing.
- Audrey Pickstock, who is currently acting director of finance for NHS Tees, has been appointed as finance director.
- Caroline Thurlbeck, currently Strategic Head for Performance at NHS North East, has been appointed as the director of operations and delivery.
- Sue Metcalfe, who is currently Deputy Chief Executive/Director of Localities, NHS North Yorkshire and York, has been appointed as director of commissioning.

The LAT is currently in discussion with NHS County Durham and Darlington and NHS Tees on a phased transfer of responsibilities from the PCTs to the LAT. A Transitional Management Group, consisting of the Chief Executives and directors from NHS County Durham and Darlington and NHS Tees with the Directors from the LAT, has been established to oversee the transition from PCT business to LAT.

This transfer will be concluded by 31 December 2012 whereupon the LAT Director will become the accountable officer for the PCTs. The PCTs themselves will retain formal accountability until 31 March 2103 with the establishment of new health organisations. Business will continue as per current arrangements and with your present contacts until you are advised of any changes.

Induction meetings with stakeholders are currently being arranged for the new members of the LAT to begin to discuss the roles of the LAT and the expectations from people on the contribution the LAT can make to support the improvement of health, reduction in health inequalities and the improvement in healthcare experiences for the people of County Durham, Darlington and Tees."

RECEIVED.

The LMC office was seeking a meeting with Cameron Ward as soon as diaries permit.

NOTED.

12/11/10 WYNYARD ROAD & WHITBY STREET SERVICE REVIEW, HARTLEPOOL
Communication from Wendy Stephens, Locality GP Contracts & Commissioning Manager, NEPCSA

"As you are aware NEPCSA, in conjunction with NHS Tees, is undertaking a service review of the Wynyard Road & Whitby Street practice. The scope of the review includes services provided by IntraHealth Ltd. via the Wynyard Road & Whitby Street practices, including:

- The registered patients (currently approximately 1,800);
- The unregistered patients receiving drug and alcohol specialist services at either Wynyard Road or Whitby Street site under the contract (currently approximately 800 patients);
- The violent patient service (currently approximately 15 patients).

The practice is managed by IntraHealth Limited, who holds an APMS contract for the service – this contract has an end date of 30 June 2013. As the contract is due to terminate on 30 June 2013, a decision needs to be made with regards to the future of this service - this end date has triggered the service review.

A review has been authorised by NHS Tees with a view to determine the future of the service. The service review is investigating the advantages and disadvantages of the existing service and will also look at the advantages and disadvantages of potential commissioning models of care so that the PCT can make an informed decision as to the future of the service.

The models for consideration are as follows:

- Decommission the GP practice & Alcohol Misuse Service at Wynyard Road, and the Violent Patient Scheme & Substance Misuse Service at Whitby Street.

- Extend the current contract for a specific period of time.

- Decommission the GP practice from Wynyard Road and the Violent Patient Service from Whitby Street, and commission a Specialist Substance Misuse and Alcohol Misuse Service only (location to be determined).

- Decommission the Substance Misuse and Alcohol Misuse Service and commission a General Practice with a Violent Patient Service.

- Disperse the patients who do not require Alcohol or Substance Misuse treatment from the practice at Wynyard Road amongst other practices in Hartlepool and commission one practice only for patients who require Alcohol or Substance Misuse Services or who are required to be placed with a Violent Patient Service – these patients will also receive their general medical care from this practice.

- Commission one practice to deliver Substance and Alcohol Misuse Services and a Violent Patient Service; as well as delivering general medical care to patients without any Alcohol or Substance Misuse issues (across one or two locations to be determined).

- Commission two separate practices:
    - one practice for patients who require Alcohol or Substance Misuse Services or who are required to be placed with a Violent Patient Service – these patients will also receive their general medical care from this practice
    - one practice for patients who do not require Alcohol or Substance Misuse treatment.

The service review is seeking the views of an extensive stakeholder group identified (but not limited to) as follows;

- Patients and carers
- The existing Practice staff
- Other GP practices within Hartlepool PCT area
- Local authority partners
- PCT personnel (public health, business intelligence, medicines management etc)
- Local MP
- Ward Councillors

- LINK groups
- Clinical Commissioning Consortia

We would be grateful for any comments the LMC has regarding the current service or any of the proposed models of care by 28th November 2012."

It was **AGREED** that all Hartlepool practices should be contacted for their views on the above proposals.

12/11/11 DATES OF LMC MEETINGS 2013

Norton Education Centre, Junction Road, Norton, Stockton on Tees TS20 1PR
7.00 p.m. prompt : Room E

22 January (changed from 8 January)
12 March – Open Meeting
7 May
9 July
10 September
12 November

RECEIVED.

12/11/12 REPORT FROM LMC REGULATIONS SUB-COMMITTEE

The Secretary **REPORTED** that no formal actions had been undertaken relating to the Regulations whereby the LMC manages performance of doctors and makes reports to the PCT. The LMC had been involved informally with doctors at meetings with the PCT and Shared Services, but had received no formal requests under the Regulations.

NOTED.

12/11/13 REPORTS FROM REPRESENTATIVES

No reports from representatives had been received.

12/11/14 MEETINGS ATTENDED BY LMC SENIOR OFFICERS (since LMC Board Meeting on 11.09.12)

13.09.12	Monthly catch-up meeting with NEPCSA @ LMC – Denise Jones / Wendy Stephens / Janice Foster
18.09.12	Pathology Report Meeting @ JCUH – John Canning
25.09.12	111 Clinical Engagement Event @ Wynyard Hall – Janice Foster
02.10.12	LETB Event @ Wetherby Racecourse – Janice Foster
03.10.12	NE Regional LMC Meeting @ Washington – Danny Donovan / Julie Birch / Janice Foster
04.10.12	Vaccs & Imms Group @ Redheugh House – Janice Foster
09.10.12	Bill Beeby @ Parkway Medical Centre re Rent – Janice Foster
11.10.12	Julie Birch @ LMC re Rent – Janice Foster
11.10.12	Tees Medicines Management Committee @ Riverside House – Julie Birch
23.10.12	Ian Ogilvie @ LMC office re Violent Patients – John Canning / Janice Foster

23.10.12	111 Engagement with Key Stakeholders @ Teesdale House – Jonathan Maloney / Alex Barlow / John Canning / Janice Foster
25.10.12	R&C Practice Managers Meeting @ Normanby – Janice Foster
30.10.12	Virtual Wards meeting @ Teesdale House – Janice Foster / Julie Birch / Karen Hawkins and others
01.11.12	Virtual Wards meeting @ Teesdale House – Janice Foster / Julie Stevens – Andrew Rowlands

RECEIVED.

12/11/15 ANY OTHER NOTIFIED BUSINESS

12/11/15.1 CQC

CQC will be seeking an annual registration fee from practices and a consultation was currently underway which was looking at what the charge may be. The fee will depend on a combination of the number of managed locations and list size – branch surgeries are not counted as managed locations. The annual fee is payable by the practice. Examples of fees being discussed are:

0 – 5,000	£550
5,001 – 10,000	£650
10,001 – 15,000	£750
More than 15,000	£850

The fee is tax allowable. Practices should not spend money buying "we will help you get through CQC" aids. All practices are encouraged to take part in the consultation at: http://www.cqc.org.uk/public/news/share-your-views-fees-registered-health-and-social-care-services-should-pay. The consultation closes on 21 December 2012.

NOTED.

12/11/16 RECEIVE ITEMS

12/11/16.1 Medical List

Applications:

Effective Date	Name	Partnership	Practice Area
1.10.12	Dr F Omer	West View Millennium Surgery	H PCT
Flexible Careers Scheme GP.			
1.10.12	Dr A J Thomas	Bankhouse Surgery	H PCT
Change in status from Returner to Partner.			
1.10.12	Dr N V Dharani	Queens Park Medical Centre	NT PCT
Change in status from Salaried GP to Partner.			
1.10.12	Dr C E Hodges	Queens Park Medical Centre	NT PCT
Partner.			

15.10.12	Dr S H Khan	Woodbridge Practice	NT PCT
Partner.			
1.08.12	Dr K Senior	The Linthorpe Surgery	M PCT
Change in status from Salaried GP to Partner.			
1.08.12	Dr A C Heywood	The Linthorpe Surgery	M PCT
Change in status from Salaried GP to Partner.			
29.10.12	Dr D A White	Coulby Medical Practice	M PCT
Partner.			
22.10.12	Dr H J Archibald	The Manor House Surgery	R&C PCT
Salaried GP.			

Resignations:

Effective Date	**Name**	**Partnership**	**Practice Area**
31.8.12	Dr C A Alhan	Hemlington NHS Medical Centre	M PCT
Resignation.	*Salaried GP. APMS practice.*		
31.8.12	Dr C A Alhan	Park End Medical Centre	M PCT
Resignation.	*Salaried GP. APMS practice.*		
31.8.12	Dr C A Alhan	Skelton Practice	RC PCT
Resignation.	*Salaried GP. APMS practice.*		
31.8.12	Dr R J Barker	Manor House Surgery	R&C PCT
Resignation.	*Salaried GP.*		

12/11/16.2 Notification of Change of Surname
Communication from Contractor Services, NEPCSA

"Dr C J Waddle of Queens Park Medical Centre, Farrer Street, Stockton is now practising under the name of Dr C J Lynch."

RECEIVED.

12/11/16.3 Rollout of Doctor First Telephone Appointment Service
Communication from Alison Hyde, Head of Communication & Engagement, NHS Tees

"As you will be aware, NHS Tees provides support to independent contractors, including GP practices, in enhancing the accessibility of their services and improving the patient experience. As part of this we are supporting some local GP practices in their implementation of the Doctor First telephone appointment service.

The Doctor First system means that every patient who telephones the surgery speaks directly to a doctor on the day that they call, who will agree with the patient whether an appointment / visit to the surgery is necessary or not.

The aim is to reduce unnecessary visits to the surgery by patients who may be appropriately managed over the telephone – for example those patients requiring advice about self-care – and effectively prioritise those who do need an appointment so that patients with more urgent needs can be seen first. The system aims to be less frustrating and more equitable for patients, as they are prioritised based on clinical need and not a "first come first served" basis and enable doctors to work more efficiently by freeing up appointment time previously spent seeing patients who did not need to attend the surgery.

The Doctor First system is implemented by Productive Primary Care Limited. Further information is available on their website www.productiveprimarycare.co.uk.

The following GP practices will be implementing the Doctor First system in stages from late-November 2012 to early 2013:

- Coulby Medical Practice, Coulby Newham www.coulbynewham.gpsurgery.net
- Hillside Practice, Skelton www.hillsidepractice.co.uk
- McKenzie Group Practice, Hartlepool www.mckenziegrouppractice.co.uk
- Norton Medical Centre, Stockton on Tees www.nortonmedicalcentre.nhs.uk
- Tennant Street Medical Practice, Stockton on Tees www.tsmp.gpsurgery.net
- The Discovery Practice, Middlesbrough www.nhs.uk/services/gp/overview/defaultview.aspx?id=36120
- The Endeavour Practice, Middlesbrough www.endeavourpractice.co.uk
- Woodlands Surgery, Middlesbrough www.drmurphyandpartners.co.uk
- Zetland Medical Practice, Marske www.zetlandmedicalpractice.co.uk

Subject to successful rollout by these practices, and evaluation of the impact, the system may be adopted by other practices across NHS Tees.

Patients who are unable to use the system, for example, those patients who are deaf, whose first or preferred language is not English, or who have difficulty using a telephone, will be contacted directly by their practices so that an alternative arrangement may be put in place for them. An Equality Impact Analysis has been completed for the proposal, and will be published on www.tees.nhs.uk once finalised.

Evidence from implementation of the system by other GP practices outside of the NHS Tees area suggests that patients should benefit as follows:

- Improved access to the surgery by telephone
- Quicker, direct access to a GP to clinically assess symptoms
- More effective prioritisation of patients who need to be seen urgently by a doctor
- Less time spent in the surgery waiting area
- Fewer trips to the surgery needed

As part of implementing the system, each GP practice is committed to effectively communicating and engaging with their registered patients so that they understand the rationale behind the change and how they can benefit from it. This will include writing out to each of their patients and including a contact point for any patients with concerns.

Should you have any queries regarding this proposal, please contact Sarah Marsay, Engagement Manager, in the first instance, on sarah.marsay@tees.nhs.uk or telephone 01642 745047."

RECEIVED.

12/11/16.4 North Shore Health Academy, Stockton
Communication from Celia Weldon, Director of Corporate Affairs, NHS Stockton

"This letter is to confirm that, due to the forthcoming abolition of NHS Stockton on Tees, we have taken the decision to hand over our role as lead sponsor for North Shore Health Academy to the Northern Education Trust.

In June and July 2012 we gave parents and stakeholders the opportunity to comment on the proposed transfer of sponsorship.

Although we are no longer a formal sponsor of the North Shore Health Academy, we do, of course, have a continued interest in the health and wellbeing of young people across Stockton on Tees, and will continue to work with schools and colleagues across the borough, to encourage healthy lifestyles and healthy futures.

I trust you will join us in wishing staff, students, parents, governors, teachers and all those associated with the Academy all the best for the future."

RECEIVED.

12/11/16.5 Report the receipt of:

GPC Newsletter Issue 2 – Friday, 21 September 2012 – available on www.bma.org.uk
GPC Newsletter Issue 3 – Friday, 19 October 2012 – available on www.bma.org.uk
Royal Medical Benevolent Fund – Annual Review 2011-2012
Royal Medical Benevolent Fund – Autumn 2012 Newsletter
Sunderland LMC minutes of meeting held on 3 July 2012
Sunderland LMC minutes of meeting held on 18 September 2012
Minutes of NE Regional LMC meeting held on 4 July 2012
Durham & Darlington LMC minutes of meeting held on 12 June 2012
Durham & Darlington LMC minutes of meeting held on 3 July 2012
Durham & Darlington LMC minutes of meeting held on 3 September 2012

RECEIVED.

12/11/16.5 Date and time of next meeting

Tuesday, 22 January 2013 : 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 8.20 p.m.

Date: ..... Chairman: .....