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
Office Manager: Ms C A Knifton

LMC office email: christine.knifton@tees.nhs.uk

Second Floor
320 Linthorpe Road
Middlesbrough
TS1 3QY

Tel: 01642 737744
Fax: 01642 737745

Brief note of the Annual Open Meeting of the Cleveland Local Medical Committee commencing at 7.02 p.m. on Tuesday, 20 March 2012 at Norton Education Centre, Norton, Stockton on Tees TS20 1PR.

Present:

Dr D Donovan (Chairman)	Dr W J Beeby	Dr J-A Birch
Dr I Bonavia	Dr J T Canning	Dr G Daynes
Dr D Donovan	Dr K Ellenger	Dr R J Gossow
Dr J Hameed	Dr M Hazarika	Dr R McMahon
Dr H Murray	Dr T Nadah	Dr R Roberts
Dr N T Rowell	Dr O Sangowawa	Dr P Singh
Dr M Speight	Dr S White	Dr C Wilson

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

ANNUAL OPEN MEETING

The Chairman formally opened the meeting and welcomed Dr Ranjita Chaudhury, Dr John Saxton, Dr Patrick McGowan, Dr Debs White and Dr Sameer Dave to the meeting.

The Secretary explained that there seemed to be three main topics of concern in the current medico-political climate, namely: NHS reforms / GP pensions / GP pay and falling profits. These topics would be taken forward to LMC Conference

There was concern that the government spin on GP pensions meant the public was not aware that the GP pension fund was in deficit whereas the teachers' pension scheme was not. GPs paid not only employee contributions but also employer contributions to the scheme. The increase in contributions would take pension employer contributions up to 14.9% which was far higher than contributions in other pension schemes. GPs paid 24% to pension schemes and should expect a fair return on their investment. BMA leaders should be encouraged to get these points across to the public.

It was pointed out that even the best projections of a private pension scheme would not do as well as the NHS pension scheme at this point in time. Private pension schemes usually did not provide a widow's pension or death in service benefits of a certain nature.

Industrial action could result in losing favour with the public – goodwill between individual doctors and their own patients was good but, on the whole, doctors were not popular with the public at large. Perhaps withdrawing from CCGs and C&B (which the government would notice but would not impact on patient care) would be more effective than restricting / withdrawing services from patients. Industrial action is complex for general practice and time is being taken to ensure that it is correct, with all implications understood. If doctors take strike action, their work cannot be back-filled by another doctor.

Younger GPs did not want to work until they were 68, and retiring earlier would incur a substantial reduction in pension entitlement. GPs may choose to leave early because of taxation when hitting the annual allowance, a forecast loss in the forthcoming budget of losing the higher rate tax relief on pension contributions (post meeting note – this did not occur) and increased employee contributions.

Recruiting GPs was becoming a problem. Locally there were fewer applicants than training posts. More young doctors were choosing to enter secondary care rather than primary care and it was felt this was because of the uncertainty in primary care as opposed to perceived stability within secondary care. There were also some areas of the country where people would choose not to work.

There was a national proposal to extend GP training to 4 years with Registrars doing an extra "probationary" year (6 months in general practice and 6 months elsewhere). Practices would not receive a training grant for their employment and it may create a second tier of doctors which practices come to rely upon. Extended training was to be applauded but must be properly considered and resourced. In the current financial situation, it was felt this was not the right time to do something which will cost a lot of money.

It was **AGREED** that a motion on length of GP training and appropriate funding should be put to Conference, together with a motion with regards to concerns on funding being held by for undergraduate teaching in general practice by the Local Education Training Board.

Other suggested motions to conference were:

- That this conference which represents all GPs in the UK and mindful of recent events over the Health and Social Care Bill, re-asserts the position of the Conference and the GPC as the only representative bodies for NHS General Practitioners in the UK.

- That this conference believes that GPs should not be asked to provide reports to patients claiming DLA or AA and demands that Q19 and the associated notes on form DLA1 are redrafted to make it clear that reports should not be sought from a GP prior to making a claim.

- That this conference condemns the misuse of the Data protection Act by insurance companies and demands that the Information Commissioner takes appropriate action.

It was **AGREED** that the Secretary would produce a standard letter for practices in relation to inappropriate requests from patients for DLA and other benefit reports. Practices were asked to fax the LMC copies of letters threatening to subpoena them when they refused to provide the reports. Doctors are obliged to complete IB 113. DS 1500s are also required under the contract. When completing forms for DWP benefits doctors are advised not to give an opinion in the report, merely state the facts.

Doctors are receiving an increased number of requests for reports from a variety of different agencies i.e. housing associations, councils, universities, etc wanting medical reports on patients without any willingness to pay for the report.

The BMA website gives advice on fees for reports that can only be completed by a person in possession of the records, together with advice on calculating fees more generally. The only times a report has to be completed without charging a fee are listed in the Regulations. Reports need only be produced without initial guarantee of funding arrangements for the fee if it is in the public interest, i.e. child protection, shotguns, etc. A report does not have to be produced for suicide audits, research trials, etc as this is outside NHS Regulations. A patient cannot complain to the PCT / NEPCSA / Ombudsman because a doctor has refused to do a report if that report is not an NHS matter. GMC would not expect a doctor to produce a report without a fee. The practice, as a whole, should decide whether or not to provide reports without asking for payment.

The Secretary **AGREED** to draw up a letter and some explanatory guidelines for practices, listing what reports have to be produced.

The meeting was adjourned at 7.50 p.m. and non-Committee GPs were invited to remain for the Committee Meeting which followed the Open Meeting, although none took up the offer.