CLEVELAND LOCAL MEDICAL COMMITTEE

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Minutes and report of the meeting of the Cleveland Local Medical Committee commencing at 7.30 p.m. on Tuesday, 13 September 2005 in the Committee Room, Poole House, Nunthorpe, Middlesbrough.

Present:	Dr J P O'Donoghue (Chairman)	Dr K P Bhandary	Dr A R J Boggis
	Dr J T Canning	Mr J Clarke	Dr G Daynes
	Dr L Dobson	Dr K Ellenger	Dr A Gash
	Dr M Hazarika	Dr A Holmes	Dr I A Lone
	Dr K Machender	Dr T Nadah	Dr J R Nicholas
	Dr R F Roberts	Dr R S Sagoo	Dr M Speight
	Dr R J Wheeler	Dr S White	Dr C Wilson

In attendance: Mrs C A Knifton : Office Manager, LMC
Mr S Smith : Programme Director, SHA, Teesdale House

05/09/1 **Update from Mr S Smith, Programme Director for SHA NPfIT Programme**
Ref Minute 05/06/11

The Chairman welcomed Mr Smith to the meeting and invited him to speak about the NPfIT Programme.

Mr Smith explained that the National Programme for IT had experienced a number of difficulties in delivering the service and was behind where it had been anticipated at this stage . County Durham &Tees Valley was part of the North East Cluster whose service provider was Accenture who were obliged to provide two systems for GPs to replace current practice systems. One is iSOFT's (formerly Torex) Synergy Enterprise System, and the other is The Phoenix Partnership's (TPP) SystmOne, which broadly provide similar functionality to the systems currently operating in practices. The software and database will be located centrally elsewhere and not in the practice. In time this will enable a more efficient and robust set up, and the ability to share information between practices, across the healthcare sectors, and with other healthcare trusts via the data 'spine'.

Currently, the first phase of implementation of the Phoenix system was underway, although a little behind schedule. The first wave will involve approximately 15 practices going live in the very near future, with 3 already being on-line in County Durham and some Middlesbrough practices likely to go live in the next few weeks, followed by a second wave of 6-10 practices in the latter half of this year/early next year. After that the plan is for roughly 15 practices to go on line during each quarter with

every practice in Tees Valley being on line by the end of 2008.

Child health was expected to go live in Middlesbrough and Langbaurgh imminently, followed by north of the river soon afterwards. There was no deployment in community as yet but plans were being formulated for a team to support deployment of the system to various groups of community nurses and therapists, depending on what PCT priorities were. Software for child health and community was basically the Phoenix system.

His team had no confirmed demand for the Torex Synergy system because the provider was experiencing problems with bringing the system up to standard in certain areas e.g. scanning.

Demand to go on to the new system has been, to date, mainly from practices who currently used a system they were not happy with, or which required replacing for whatever reason. Practices currently using Emis or Torex may take time to change systems in view of perceived disruption with the changeover. The wider choice of systems announced by the Department of Health (in addition to the two LSP offerings) earlier this year is unlikely to be available until the end of 2006 at the earliest. In the meantime, deals such as that currently being offered by Torex need to be fully explored as they may not be as attractive as it at first appears.

One of the key drivers for change is to be more efficient in terms of management and support capacity which hopefully will result in improved practice support and IT support people working on the programme.

Questions were then invited.

How do systems link into QMAS software? Supposed to be able to link in straight away without converting any of the existing consultations or set-ups, but he wasn't certain so would check and find out.

What are you going to about the prisons? They are part of the NPfIT Programme and the Phoenix system was planned to be made available. Emis systems have been installed fairly recently in prisons within CDTV.

How do OOH providers link into this? OOH provision is part of the contract but not part of this current phase of the contract. It may be in Phase 2 or 3. Phoenix already being used to support OOH in other areas (not as part of the LSP contract) but they are a small company and it is proving difficult for them to provide everything.

What progress is being made on safeguarding confidential information; who is going to be able to access what and where? Inevitably there is something of a compromise between the benefits offered by access to shared information and restriction of access to safeguard privacy. Any unauthorised access will be reported and raised with the patient. Patient has right to say which part of their records they want to be seen by whom. Not yet clear what consequences will be if patient does not want to have their information available for sharing. There is no dilution of the commitment to allow patients to have choice about who sees their record.

Dr Canning commented that queries had been received at the LMC about patients saying they did not want their records keeping on the computer, which for paperlight practices made it extremely difficult. This was resolved following discussions between the Practice Manager, doctor and patient when the patient agreed to have their records on the computer. However, this may change if patients learn that their records are being kept off site. Mr Smith agreed there were some genuine concerns about information being kept off site. A staff leaflet campaign would shortly commence followed by a public leaflet campaign to explain the new service.

Should any doctor or practice manager have any queries they would like to raise with Mr Smith, it was **AGREED** they should email the LMC office on (christine.knifton@tees-shs.nhs.uk) and they would be passed to Mr Smith for a response.

Mr Smith thanked members for their time and offered to re-visit at a later date to answer any concerns they may have on confidentiality or any other subject. He then left the meeting.

05/09/2 APOLOGIES

Apologies for absence had been received from Dr W J Beeby, Dr T A Gjertsen, Dr A Ramaswamy, Dr N T Rowell, Dr T Sangowawa, Dr A J Smith, Dr J R Thornham and Prof T van Zwanenberg.

05/09/3 MINUTES OF THE MEETINGS HELD ON 7 June 2005

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

05/09/4 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

05/09/4.1 Request to give presentation to LMC members on Expert Patients Programme
Ref Minute 04/04/12 : 05/06/11.1

It was **AGREED** that the information handout received from the Expert Patients Programme was sufficient and there was no need for the representative to attend an LMC meeting to give a presentation.

05/09/4.2 Funding for practice based commissioning meetings
Ref Minutes 05/06/21.3 & 05/07/3.2

Response from Ali Wilson, Hartlepool PCT
"Whilst HPCT fully supports the development of Practice Based Commissioning, there has so far been very limited interest in using this approach by our GPs during 2005/6.

We have discussed the implications of the approach at our PEC, Primary Care Development Sub-Committee and GP Council, and have not had necessity to required GP attendance at meetings outwith these for a.

However, Practice Based Commissioning will be one of the areas covered in a practice Time-Out Event planned for Thursday, 28 July, when the PCT will be funding Primecare cover to allow all GPs and Practice Managers to attend. I trust this provides you with the information you require at this stage."

Response from Jon Chadwick, Langbaurgh PCT
"As you know we have 5 out of 16 practices actively involved in PCLC and working in 5 commissioning groups. In the run-up to going live on 1 April 2005 we funded clinical time at £5,700 (£5,000 + 14%) pro rata for 3 months. We also paid practices £500 per practice as a lump sum to recognise the time spent by Practice Managers in the development of PCLC.

Each practice has a nominated clinical lead. Their responsibilities are to:

- meet, on a regular basis, with the other leads in their commissioning group;
- liaise with colleagues in their own practices;
- meet as a clinical leads group with PCT managers and the Executive Chairman on a monthly basis. The purpose of this meeting is for the clinical leads to feed back and receive information.

Clinical leads are paid for their clinical input and ideas and have no responsibility for administration. We are paying £5,700 per annum per lead in 2005/6.

The PCT are providing admin support through existing staff and 2 new systems analyst posts. In addition there have, and will be in the future, meetings with Practice Managers as a group and the PCT pays £35 per meeting.

The PCT has allocated approximately £90,000 in 2005/6 for PCLC. This has not been top sliced from practices' commissioning budgets.

We continue to have enthusiasm (of varying degrees) from our practices and are very optimistic about the future of PCLC in our PCT."

Response from Colin McLeod, Middlesbrough PCT
"I can confirm the following:

- Funding set aside to support implementation of PBC is £50,000 per each of the 3 forums in 2005/6
- The funding is protected to support clinical time and no funding has been set aside specifically for practice manager or staff time
- GPs will be reimbursed for their contribution to discussions through the Practice Based Locality meetings at the standard rate approved by the PCT. This currently stands at a rate of £45 per hour up to a maximum of £90 per meeting. This cost will be a first call on the funding outlined in the first bullet point
- Additional payments will be made to practices for leading on agreed pieces of work that contribute to the commissioning agenda. Once the remuneration has been agreed it will be for the practices to determine how this funding is used to

reimburse the time of practice managers or practice staff who contribute to the work. This should be made clear when the initial proposal is approved

- Agreement has been reached with the localities to appoint dedicated staff, employed by the PCT to support their work. This is however now under review pending discussions on the future configuration of PCTs

I hope this demonstrates the significant support we are giving practices in the Middlesbrough PCT area whilst at the same time demonstrating the efficient and effective use of resources."

Response from Liz Hegarty, North Tees PCT
"To date we have been developing our approach to practice led commissioning and have been using existing for a such as Time Out! And Practice Clinical Governance Leads meetings, for which back-fill is paid. A proposal on how to implement practice led commissioning and support practices is being involved will be considered by our PEC and Board in September. This will involve a remuneration package. I will be happy to share this paper with you in due course. I hope this answers some of your concerns."

NOTED.

05/09/4.3 Sick Doctors Trust (based in Farnham, Surrey)
Ref Minutes 05/06/17 : 02/09/11 : 03/09/13.5 : 05/07/3.6
Response from Dr I Joiner : Trustee

"I have received your generous cheque of £1,000 and will send it to the Treasurer of the SDT. Would you please convey the thanks of the chairman and Trustees of the SDT to your members. We have had a small response from other LMCs, less than 10% of the total, so far. Once again, thank you very much."

NOTED.

05/09/4.4 Mental Health Promotion
Ref Minutes 05/06/18 : 05/07/3.7

The Calypso CD-ROM on self help for mental health patients can be obtained from:

Media Innovations Limited
3 Gemini Business Park
Sheepscar Way, Leeds LS7 3JB Tel: 0113 262 1600

NOTED.

05/09/4.5 Hazardous Waste - Update
Ref Minutes 05/06/15 & 05/07/3.8

Although it had originally been thought that LPCT would be reimbursing practices for registering with the Environment Agency in accordance with the new Hazardous Waste Regulations, it transpired that they had decided not to block register their health

centres and would not be refunding the registration fee. Middlesbrough and Hartlepool PCTs also refused to reimburse the registration fee despite the LMC's best efforts. Only North Tees PCT were reimbursing practices.

NOTED.

05/09/4.6 Specialist PMS and new practices in Middlesbrough (Galvani Practice)
Ref Minute 05/06/7 : 05/07/3.9

Response from Colin McLeod, Middlesbrough PCT
Just a quick note to confirm that the PCT will (over the summer) be undertaking a review of the Galvani practice with regard to investment, service plan, etc. I will ensure you receive a copy of the report as soon as it is available."

It was **NOTED** that a paper had gone to MPCT PEC and a committee had been set up to look at the Galvani practice. QOF money had been withheld from the practice because they had adequate funding.

05/09/4.7 Choose & Book
Ref Minute 05/07/10.1

The Secretary advised members that despite remarks being accurately minuted, Colin McLeod had disagreed with the statement "*Choose & Book is supposed to offer patients more choice but in MPCT referral letters are being intercepted and the patient offered cheaper treatment*", and had made the following comments:

"I have a number of concerns about this minute:

1. The word 'but' in the minute implies that we are not offering patients more choice
2. The word 'intercepted' implies that we are preventing referrals from taking the route expressed by the referrer
3. The word 'cheaper' has serious connotations regarding the actions taken in Middlesbrough re patient care

To put the record straight:

1. Middlesbrough PCT has the best record of all PCTs in Tees and Durham re offering patients choice. The MARS service provides a first class choice service to patients, offering local advice with a high degree of knowledge of which services are available, waiting times, transport support etc etc. Many of the choices offered to patients maintain the link with the original consultant thus further reassuring patients of the quality of care they will receive. We are now being approached by other PCTs to offer the same service to their patients
2. We do not 'intercept' referral letters. All GPs [and more recently optometrists] refer patients to MARS by agreement. If any GP wishes to refer patients direct to providers then they can do so. Indeed if all GPs wish to implement choice at the point of referral then they are also free to do so
3. We do not [and never will] offer patients a service based on cost. The majority of patients offered choice are provided services either in the independent sector or elsewhere in the NHS and in both circumstances it costs the PCT significantly more than the service provided at JCUH. We do this to ensure that patients wait less long for treatment irrespective of the cost recognizing that independent sector providers [or asking other NHS providers to hold local outpatient clinics in Middlesbrough] will incur additional costs on the PCT."

The comments were **NOTED**.

A Middlesbrough GP said that he had recently had several letters triaged inappropriately. One GP had taken to writing on his letters "I want this patient to be seen by a consultant" and therefore triage cannot take place. Another problem had arisen between "registered GP" on the first sheet of the computer records and "referring GP" on the second sheet of the computer records. The computer picks up "registered GP" and the letter gets sent to that person instead of the doctor who has requested the referral.

Whilst some of these issues can be addressed as part of Practice Based Commissioning, the Secretary **AGREED** to take them forward with Middlesbrough PCT.

05/09/4.8 Addictive Behaviours Service (Alcohol), Stockton
Ref Minute 05/07/10.2

Letter sent to all North Tees GPs and Practice Managers by NT PCT PEC Chair
"Given the recent letter from Tees and North East Yorkshire NHS Trust regarding the withdrawal of their provision of alcohol treatment services, I am writing to update you on action being taken by the PCT to ensure that services return to normal at the earliest opportunity and that patients continue to receive the care and support they need.

Work has been ongoing to develop models of service across a range of substance misuse problems, with the aim of providing a more primary care focused service.

The new model (being considered) will be PCT-led and will include outreach to practices, as well as opportunities for an expansion of enhanced services (subject to discussion with the LMC). It is proposed that developments will be funded from existing resources, currently invested in the TNEY contract, as well as new funding attached to the *Choosing Health* White Paper.

Meanwhile, the PCT is working with TNEY to explore options for an interim service until new arrangements can be put in place. The PCT is also putting together alcohol brief intervention training and has sent out emails to practices requesting for interest. (So far, 7 practices have expressed interest.)

I am meeting with other PEC Clinical Leads, TNEY representatives and the Directors of Public Health, Service Development and Primary Care & Healthcare Governance on 29 July to update on the current position and agree next steps.

In the meantime, I would be grateful if you could keep me informed of your concerns and would also welcome your ideas for how we develop the new services. I will write to you again following next week's meeting."

NOTED.

05/09/5 COMMISSIONING A PATIENT-LED NHS

The Committee had received, with the Agenda, a paper from the Secretary giving details of the proposals outlined in a letter from Nigel Crisp to the NHS. The Secretary explained that, since the preparation of that paper, John Bacon from the Department of Health had written to all SHA Chief Executives, on 26 August, the main points of the letter being:

- this was an opportunity for local health economies to design the structures that they needed for the future;
- there was no template for the size or for exact correlation with local government boundaries;
- if they chose to stay with small PCTs, they would need to show how powerful commissioning can be delivered;
- if they took the "large PCT" approach, he wanted to see how they were proposing to maintain close integration to local authorities and provide support to practices;
- changes to PCT service provision did not need to be complete until December 2008; PCTs will want to wait for the White Paper, Your Health, Your Care, Your Say, before forming a firm view on how services should be provided in the future. Possible PCT re-structuring in the light of Commissioning of Patient-led NHS.

As a result of the letters, the Secretary had met with the Chief Executives of LPCT, MPCT, the Acting Chief Executive of HPCT, David Flory the Chief Executive for the SHA, and had spoken on the telephone with Chris Willis from NTPCT.

The position the LMC had taken in these discussions was :

- That function is more important than form
- Services should be provided at the most appropriate level
- Unless there is a single PCT there should be greater use of Shared Services to concentrate knowledge and expertise
- Opportunities for shared services include professional development, training, implementation of performance procedures for list management and associated policies.
- Whatever structure emerges a local focus for GPs and practices is essential
- Proper GP representation at local and PCT level

It was now known that there was support for a single PCT for Tees Valley which may or may not include Darlington, and a single PCT for Durham which may or may not include Darlington. It was up to Darlington PCT and local stakeholders to decide whether they feel Tees Valley or Durham is more appropriate for them.

In discussion, members raised the following points:

- By the end of the year (2005/6) all PCTs have to have an actual balanced budget (no rotating of money) and none will be bailed out by those who have surpluses.
- From now until 1 April 2006 all work has to stop; no decisions can be made; no appointments can be filled
- LIFT has been suspended (Redcar & Cleveland Local Authority not involved in LIFT)

- By the end of 2007/8 the whole of the NHS should be within 3% of its target level of funding.
- PCTs as they currently stand will disappear on 1 April 2006.
- PCTs stop being providers at March 2008.
- Although there will be only one PCT with its Board and PEC, it was felt there would be four smaller boards without PECs for the four PCT areas, with four localities responsible for the commissioning.

Dr Canning pointed out that each PCT can recognise the LMC which can recognise one or more PCTs. If the Tees PCT consists of the four current PCTs nothing will change. If Darlington decides to join the Tees PCT then CLMC will have to expand. There is also the option, previously rejected, of a merger with Durham LMC and become one LMC. The two SHAs are going to merge to become one region again.

It was felt that practice based commissioning was best for the survival of GPs otherwise the PCT will be offering too many contracts for services leading to fragmentation. There was also concern over services becoming privatised. Patients like continuity, stability and the holistic approach provided by GPs.

GPsWSIs were discussed. If employed by the PCT now, who would employ them in the future? Would that employer provide indemnity cover for them? If not, this will result in higher premiums with MDOs in the future Would GPsWSIs want to provide these services within their own practice? It is profitable at the moment because the indemnity is being paid.

When a referral is made, is the patient being made aware that they are seeing the consultant, SHO, nurse practitioner etc? Where does a GP stand when a patient expects to see a consultant and is seen by someone else?

The Committee **RESOLVED** to write and formally advise the PCTs and SHA of the Committee's stand with regard to re-organisation.

05/09/6 LMC ELECTIONS 2006

The Secretary explained that the current LMC was elected for 2003 – 2006. An election must take place in time for a new committee to take office from 1 April 2006. Whilst there are discussions taking place on PCT configuration it seems unlikely at the present that any reconfiguration will breach the present LMC external boundary.

The election arrangements are governed by Paragraph 2 of the Constitution.

2.1	Constituencies	The Committee may if it wishes divide the area into a number of Constituencies for administrative and electoral purposes. If it does so it shall use its best endeavours to ensure, across each Constituency, the fair and equitable representation of each class of Represented Member
2.2	Term of Office	Elected Members shall hold office for a term of three years.
2.3	Frequency	The election of the Committee shall take place in the

same month in every Third year and Elected Members shall commence their term of office on the next following 1 April

2.4 Method

Voting shall be by postal ballot of those represented Members whose names appear in Registers A, B and C on 1 January in each year that an election takes place and the persons whose names are so included on such Registers are referred to as "the electors"

The Returning Officer shall send written notice of the election to each elector and such notice shall be sent so as to be delivered to the elector not less than 28 clear days before the date of the election

Each notice shall

- state the date of the election
- the number of vacancies so as to ensure the fair and equitable representation respectively of practitioners on Registers A, B and C
- state the date by which nominations must be submitted to the Returning Officer
- set out the nomination provisions, as set out below, and
- enclose a nomination form

Each candidate shall be nominated by at least two electors and each nomination form must be accompanied by a statement in writing that he is prepared to accept office.

If the number of nominated candidates qualified for election in each category where there are vacancies does not exceed the number of vacancies the Returning Officer shall declare those candidates to be elected In other cases a vote shall be taken

Any voting shall be conducted by single transferable vote.

The Returning Officer shall prepare voting papers which shall contain a list of the candidates for whom the elector may vote together with an indication that voting shall be by single transferable vote. The voting paper shall also specify the date of the election by which the voting paper must be returned to him. A voting paper shall be invalid if it is not signed and/or if the elector has marked preferences incompatible with single transferable voting.

The Returning Officer may also disallow a voting paper if it does not comply with this Constitution or if it causes uncertainty as to the candidates for whom the elector desires to record his vote, save that the Returning Officer may in his absolute discretion treat a voting paper so marked as valid for the purpose of any vote other than that in connection with which the uncertainty arises

Voting papers received by the Returning Officer after

	the election date are invalid The Returning Officer, after examining the voting papers and determining the validity of the votes, shall count the votes properly recorded and shall prepare a return for the candidates according to the single transferable voting system. If the votes received by any two or more candidates are equal and the addition of one vote to any one such candidate would enable that candidate to be declared elected the Returning Officer shall decide by lot which of the said candidate shall take the highest place Any question as to the validity of nomination or voting paper or otherwise in connection with an election shall be determined by the Returning Officer in his absolute discretion At the conclusion of the election the Returning Officer shall immediately give notice in writing of the result to all candidates
2.5 Saving Provisions	No election shall be invalid by reason of any mis-description or non compliance with the provisions of this scheme or by reason of any miscount or of the non-delivery, loss or miscarriage in the course of post of any document required or authorised by this Constitution to be despatched by post if the Returning Officer is satisfied that the election was conducted substantially in accordance with the provisions of this Constitution

It was **AGREED** that:

(a) Current constituencies remain as:

- Billingham
- East Cleveland
- Eston
- Hartlepool
- Middlesbrough
- Redcar/Saltburn/Marske
- Stockton/Norton/Stillington
- Thornaby/Yarm/Eaglescliffe

(b) Mrs C A Knifton be appointed as the Returning Officer.

(c) The election timetable be adopted as:

Action	**2005/6**
Seek members for Register B	Letter sent to all non-contractor performers 1st week September
Appoint Returning Officer	13 September
Adopt election timetable	13 September
Determine constituencies	01 November

Obtain list of doctors as at 1 January	03 January
Confirmation of constituency representation	17 January
Nomination forms out [Election Notice] 1st class post	20 January
Nomination forms returned by 9.00 a.m.	21 February
Ballot papers out 1st class post	24 February
Election Day. Ballot closes 9.00 a.m.	20 March
Letters to candidates	24 March
First meeting : 7.30 p.m. : Poole House	04 April

It was **NOTED** that if Darlington were to join the CLMC area, the elections may have to be deferred.

CLMC represents all doctors on the Performers List, irrespective of whether they were principals, assistants, salaried GPs, locums or registrars. 139 letters had been sent out by Shared Services on behalf of CLMC to all those GPs on the Performers List who were not principals. CLMC do not have access to these names and addresses because of the Data Protection Act. Only when the forms are returned to CLMC are names and addresses known, together with the constituency they perform the majority of their duties in, and they can then be contacted to take part in the ballot.

05/09/7 REPORT FROM GPC News 1 : July 2005

GP2GP Transfer – Attached documents

The testing of GP2GP transfer has identified an issue which GPs can assist with *prior* to the system being implemented. Whilst the "core" record in most GP systems is very compact, attachments are generally much bigger by comparison. As more and more practices are utilising document management systems, the number of attachments is growing. Attached records will be transferred with GP2GP but they have the potential to swamp the system. The practice of one of the Joint Chairmen of the Joint GP IT Committee has 89,000 attached documents; practices need to ensure that attached documents are as compact as possible.

In particular, Microsoft Word processed documents have the potential to be very large, especially if they incorporate images in the header or background. Some embedded images can make the file size 100 times bigger than the text-only version and the implications are self-evident.

We would like to advise practices to consider *removing any embedded images* in any word processor generated letters they attach as their *core* clinical records. If at all possible, attached word processed documents should be *text-only*. This would *not* apply to word processed documents that were *not* attached or appended to the *clinical system records*.

The Clinical Development of the NHS Care Record Report

The GPC considered the recently published Connecting for Health document *The Clinical Development of the NHS Care Record Report*. It can be accessed at the following link:
www.connectingforhealth.nhs.uk/crdb/docs/scrrdocument.doc

The Joint GP IT Committee has already submitted its response and this will be available on the GPC website in due course.

A key part of the consultation document is the *NHS Care Record Guarantee* which can be found in the appendix. This will be an 'evolving' document, ie it will be continuously updated, following consultation with the profession.

The Committee remains concerned at the lack of public knowledge about NHS Care Record (NCRS), especially its implications for the confidentiality of information. However, the development of the NCRS will be incremental and the Joint GP IT Committee will be fully involved in future developments.

Modernising Medical Careers
The BMA is concerned that F2 junior doctors will be discouraged from undertaking a training period in general practice. This is because they may only receive their basic junior doctor salary, and not a supplement, during their time in general practice, which would mean a pay drop. The GPC will be liaising with the BMA's junior doctors committee (JDC) on the need for these F2 doctors to receive a pay supplement during their GP training component to ensure that they do not suffer a pay detriment.

GP educators' pay
We are pleased to report that the Department of Health has confirmed that the GP educator pay scale in England will be uplifted by 3% with effect from 1 April 2005. We will continue to work to ensure that the pay level is appropriate for these doctors.

Partnership Agreements
The GPC has dealt with some difficult and acrimonious partnership split cases recently, mainly due to the fact that there was not a partnership agreement in place. Unless a partnership agreement is in place, a 'partnership at will' will operate and the partners will be governed by provisions of the Partnership Act 1890. This could result in:

- the loss of the practice NHS contract, with no obligation on the PCT to award a new contract to the remaining partners;
- the forced sale of partnership assets including the premises;
- significant legal costs;
- the inability to exclude one of the partners without a lengthy dispute resolution process or a court case.

The GPC urges practices to ensure that they have a written partnership agreement in place and to check that it is up to date and includes all partners. Further guidance on partnership agreements is available at:
www.bma.org.uk/ap.nsf/Content/PartnershipAgreements0504

Jury Service
Representatives of the GPC, senior hospital doctors and junior doctors committees recently attended a meeting with the Department of Constitutional Affairs to discuss doctors' concerns about the implications of jury service on service delivery and practice organisation. The meeting was constructive and, as a result, the BMA is to draft guidance for those doctors who would like deferment or excusal from jury service. We anticipate that the guidance will be available in the autumn. In the

meantime, LMCs may wish to advise constituents seeking their advice that any application for excusal or deferment should be accompanied by detailed reasons, including the implications for service delivery of the absence of the doctor summoned; this explanation may be continued on a separate sheet of paper where there is insufficient space on the jury summons response form. Further advice may be sought from Rachel Merrett (rmerrett@bma.org.uk)

Negotiators' Report for the GPC Meeting – 21 JULY 2005

MMR
An issue has arisen about the supply of imported MMR vaccines from the US that are not licensed for use in the UK. Despite the Department of Health's assurance that the vaccine is identical to the MMR-II routinely supplied by Sanofi Pastuer MSD, which is licensed in the UK, it has so far not agreed to the GPC's request for general indemnity.

A letter from David Salisbury, Principal Medical Officer, says "i*n relation to the liability of individual GPs, the general position is that doctors prescribe or administer unlicensed specials to their patients on their own direct responsibility*". The GPC advises GPs and LMCs not to use this vaccine until the position is clarified satisfactorily. In the meantime, we have written again to the Department to reiterate our concerns and restate our position. We will keep LMCs informed of any progress.

Premises survey
The GPC is undertaking a comprehensive, one-off survey to gather information about the state of GP practice premises and the position of GP finances with relation to their premises. This is primarily to help build a case for increased revenue and capital funding for premises to enable GPs to provide a wider range of services under the new contract, to engage in practice-based commissioning and to help deliver funded shift of work from secondary to primary care. We will be seeking information not only on the physical condition of premises, but also views on what GPs would do with improved premises. It is requested that as many practices as possible complete the survey, which will be made available shortly.

IT issues: NHS Care Records Service - The negotiating team met Mike Pringle and Gillian Braunold on 6 July in their capacity as national clinical leads for NPfIT, for a briefing and presentation on the care records service. This gave an opportunity to ask questions and air concerns, mainly around the sharing of health information that the system allows. We have submitted detailed comments to a living document on the latest proposals and will have the opportunity to comment on future versions too.

Registrars conference
Dr Hamish Meldrum attended the national conference for GPs to be in Bristol two weeks ago and gave a talk on the future of general practice to about 150 delegates. Other speakers there were Mayur Lakhani and Roger Neighbour. There were also eight parallel, break-out sessions on offer including one lead by Richard Vautrey on the nGMS contract, one by Beth McCarron-Nash on flexible careers within general practice, one by David Wrigley on becoming a partner and one by Rebecca Viney on appraisal, revalidation and CPD.

Feedback from those who attended this year reaffirmed that the national conference provides an invaluable learning and networking opportunity for GPs in training, or those doctors merely considering a career in general practice, and we hope that it will continue to be a success in future years.

VAT allowance on dispensed drugs
Following consultation with DDA representatives, the GPC has recently agreed to an amendment to paragraph 18.3 of the SFE relating to the VAT allowance paid on dispensed drugs. An error in the transcription of this provision from the SFA to the SFE led to the SFE stating that the allowance is calculated on the basic price before rather than after deduction of the discount. This meant that in 04/05 there was a considerable overpayment of the VAT allowance to dispensing doctors, which the Department of Health has agreed not to claw back. We are satisfied that this was a genuine transcription error and have agreed to an amendment to the SFE for 05/06 to correct it with immediate effect and to avoid further overpayment.

GPs working in community hospitals
The GPC community hospitals working group has produced new guidance on GPs working in community hospitals, which will be available next month. Discussions with the NHS employers organisation and Department of Health on national negotiating rights for this work have not made as much progress as we had hoped, given the DDRB's recommendation that the various parties seek a joint solution. We are however planning to raise this issue again at a higher level.

RECEIVED.

05/09/8 ENHANCED SERVICES

05/09/8.1 Influenza Immunisation 2005

The Secretary explained that he had written to the four PCT Heads of Primary Care concerning the Chief Medical Officer's letter of 25 July which identified two further groups for immunisation against influenza this year (those people with chronic liver disease, and those who are the main carer for an elderly and disabled person whose welfare may be at risk if the carer falls ill). PCTs were sent a draft LES.

Response from Marilyn MacLean, Langbaurgh PCT
"Thank you for your letter regarding the changes to the influenza campaign which were advised by the Chief Medical Officer in his letter dated 25 July. LPCT has amended the current enhanced service to include these groups and this will be taken to our Executive Committee in September for ratification and support of the changes."

Response from Martin Phillips, Middlesbrough PCT
"Middlesbrough PCT are today forwarding out to practices an addendum to the Directed Enhanced Service for Flu Immunisation to include the two new additional 'at risk' groups."

Response from North Tees PCT
Although no formal response had been received, NTPCT had approved the addition of the two groups to the current enhanced service for flu immunisation.

Response from Hartlepool PCT
No response had been received.

Discussion centred on the definition of a carer who would quality for a flu vaccination. It was felt that a carer was someone who, if they became ill, could no longer look after the elderly/disabled person resulting in that person going into hospital.

NT PCT GPs have been told that if the community nursing service administers the flu vaccine to patients in care homes, the housebound not known to the district nurse, or within a practice based clinic, the practice will be charged at £3.50 per vaccine. If the flu vaccine is given to patients on their core caseload, no charge will be made. MPCT and LPCT already do this. It was not known if HPCT charged practices.

05/09/8.2 Phlebotomy

Members discussed the report produced by the GPC Enhanced Services Subgroup in July 2005.

By definition, the provision of a phlebotomy service is neither an essential nor additional service and it is the view of the Enhanced services subgroup that the duty of a GP ends at organising for the test to be carried out and later dealing with the result. [Essential and additional services are set out in part 5, paragraph 15 and schedule 2, paragraphs 1-8, respectively, of the NHS GMS Contracts Regulations 2004.] It follows therefore that phlebotomy is not covered by the global sum (or MPIG) and so practices should not be expected to undertake this work without adequate, additional funding. The source of this funding may be via a Trust-funded service, provided within practices, or as part of a local enhanced service (LES) agreement. [Where it can be clearly demonstrated that a PCT has provided recurrent, ring-fenced monies specifically for in-house phlebotomy provision in the past, and this was both agreed by the LMC and continues to be paid and uplifted in addition to global sum/MPIG payments, it may not be reasonable to negotiate a LES as this could be considered a double payment. However, this will only apply to a small minority of practices.]*

The subgroup acknowledges that arrangements do vary across the UK, including within PCO areas. We are also aware that some LMCs do not consider entering negotiations with PCOs on a local enhanced service for phlebotomy to be a high priority, given long-established routes of access to or alternative provision of this service locally.

The GPC remains committed to working towards securing funding for all work that currently is not funded via the global sum/MPIG or enhanced services. The GMS contract enables practices to withdraw such services (giving a reasonable period of notice) and it is then the obligation of the PCO to commission alternative provision accordingly. However, the GPC also recognises that many practices still continue to undertake unfunded work out of good will.

An increasing number of LMCs and PCOs have agreed LES specifications for phlebotomy, which sets a benchmark for others to follow. It would be reasonable to use these agreements to facilitate local negotiation, bearing in mind that any discussions should take into account the specific, local and historical circumstances that apply.

**It should be noted that, in terms of their contractual obligations under GMS, there is no difference between a practice funded via the global sum and one funded via the MPIG.*

It was **AGREED** that the Secretary would pursue the provision of this service to practices with PCTs to ascertain their views.

05/09/9 ANNUAL QOF & CONTRACTOR REVIEW VISITS

The Secretary explained that he had written to the 4 PCT Chief Executives concerning annual QOF visits and annual contract review meetings asking for proposals on these visits. He pointed out that whilst the two visits are significantly different, the guidance does allow them to take place at the same time with the co-operation and approval of the contractor. He also offered to supply, in the absence of an agreed English model, PCTs with a pro forma, based on the Scottish model, which could be used for the annual review as anticipated in the Blue Book.

Response from Liz Hegarty, North Tees PCT
"I wish to confirm that we will be offering our contractors the opportunity to undertake the QOF visit and the annual contract review meeting at the same time. We have not seen the pro forma you refer to in your letter and would be interested in seeing this. Marie Clark will send you details of our proposals in a couple of weeks as at present we are revising our paperwork to ensure that the data being collected is in a form that can be mapped against the Healthcare Standards and used to support the annual health check, to save practices having to submit information more than once. As you may be aware the healthcare standards will apply to contractors in 2006/7 as well as PCTs and secondary care trusts."

Response from Richard Harrety, Hartlepool PCT
"The QOF visit will follow the same process as last years and I have enclosed a copy of the information that was sent to practices. Any feedback would be gratefully received. Included with this is a copy of a visiting schedule should you wish to attend any of the practice assessments.

Regarding annual contract review meetings, the intention is to carry out these visits separate from the QOF visits. My concern was that we allow a half day to carry out the visit and to include the annual contract meeting may impinge upon the assessment process. I was expecting to carry out these contract review visits in the New Year as I have agreed with the Practice Managers to schedule quarterly meetings with all practices to discuss current issues of which contract reviews would be included. However, if the practice wishes to add the contract review meeting on to the end of the QOF visit, I would be more than happy to include this, providing we can finalise the process in time. I am meeting with the Practice Managers Subcommittee on 13 September and will discuss this possibility. As mentioned in your letter, if you could supply me with a copy of the pro forma it would be most appreciated."

Response from Marilyn MacLean, Langbaurgh PCT
"Just a quick email prior to formally replying by letter. We are not planning to do contractor review visits at the same time but just looking at the QOF indicators and those indicators in the "Standards for Better Health" which link into the QOF. It would be appreciated if we could have a look at the pro forma mentioned."

Response from Martin Phillips, Middlesbrough PCT
No response had been received from Middlesbrough PCT.

It was commented that MPCT wanted to discuss more than QOF on their visits, and there was supposed to be an annual contract review too.

Some people have anxieties about the visits. The agenda has to be agreed between the PCT and the practice, and if the practice do not wish to discuss something, it cannot be discussed.

How much consistency could be expected on policies across the new PCT in relation to how GMS and PMS contracts are monitored and applied?

05/09/10 DATABASE ON PREVALENCE AND MANAGEMENT OF COMMON CHRONIC DISEASES (made up of results from QOF)

QOF data by PCT, SHA and GP practice level is available on the Health and Social Care Information Centre website www.ic.nhs.uk, also www.gpcontract.co.uk. In total, 8,486 practices took part in the QOF out of a possible 8,542.

It was commented that the database was being used as a quality marker for practices in a league table.

05/09/11 ASSIGNMENTS TO & REMOVALS FROM A CONTRACTOR'S LIST
Annual Report 2004/2005 issued by Tees Contractor Services to all practices

Upon receiving the LMC's copy of the document, the Secretary wrote to Tees Shared Services pointing out that on Page 2 they referred to the GMS/PMS Regulations, and in particular the need to warn the patient. This is not an absolute requirement as 20(3) and 20(4) do allow some leeway. Also he was interested in the assignments of violent/threatening behaviour/potentially violent patients, and asked if they were all to the nominated DES practices.

Response from Patient Registration & Claims Manager, Poole House
"In respect of your first comment I will ensure that the next report reflects that there is an exception to the rule only where exceptional circumstances apply.

Secondly, in the majority of cases patients who are removed with immediate effect are assigned to the Violent Patient Scheme. Dr Guy who has the highest number of patients on a VPS is consulted prior to the assignment. A meeting was held with Tina Pinkney, Practice Manager and the PCT some time ago and this arrangement was agreed with the PCT. She was concerned at the high numbers of patients being assigned and felt that some patients assigned to the scheme did not fit the criteria."

Dr Canning pointed out that there was relatively little knowledge of violence or threatened violence in practices because it is not reported to the police. In order for the violent patient to be put on the violent patient register with Shared Services, the police have to be informed over the phone of the date/time/name, but police do not

need to visit the doctor. Doctors are being put in a dangerous position when not warned that a patient is considered violent. There is a structure known as MAPPA (Multi Agency Public Protection Arrangements) managed by Lucia Saiger at the Probation Service, in conjunction with the police and local authority, and they were considering an arrangement whereby Shared Services and MAPPA kept each other informed about violent patients. Dr Gash said "Security Management Specialists" were very effective in the Trust.

All four PCTs have a service provider for violent patients, these are:

Hartlepool PCT – Secure Unit, Whitby Street (contact HPCT first)
North Tees PCT – Dr Olding, Lawson Street
Middlesbrough PCT – Dr Guy, Fulcrum Medical Practice, Acklam Road
Langbaurgh PCT – Stead Hospital (contact Dr Milner / Dr Islam directly)

05/09/12 TERMS & CONDITIONS OF EMPLOYMENT OF DOCTORS BY PRACTICES

The Secretary explained that a member has asked that the nature of contracts between practices and employed GPs is discussed. There was widespread ignorance about the model contract especially regarding maternity and sickness payments. Working in a PMS practice should not mean having terms of service less advantageous than those in GMS or a PCT, however, there is no contractual requirement to offer minimum terms and conditions of employment..

The contractual position is:

General Medical Services

358 The Contractor shall only offer employment to a general medical practitioner on terms and conditions which are no less favourable than those contained in the "Model terms and conditions of service for a salaried general practitioner employed by a GMS practice" published by the British Medical Association and the NHS Confederation as item 1.2 of the supplementary documents to the new GMS contract 2003 (this document is available on the Department of Health's website at:
http://www.dh.gov.uk/assetRoot/04/07/87/30/04078730.pdf
or a copy may be obtained by writing to the NHS Confederation, 1 Warwick Row, London SW1E 5ER).

Personal Medical Services

There is no requirement to meet any specified terms or conditions except those required by law.

Primary Care Trust Employed Doctors

Should be employed on Terms and Conditions no less advantageous than those in "Model Terms and Conditions of Service for a Salaried General Practitioner Employed by a Primary Care trust" published by the British Medical Association and the NHS Confederation, part of the supplementary documents to the new GMS contract 2003 (this document is available on the Department of Health's website at http://www.dh.gov.uk/assetRoot/04/07/87/32/04078732.pdf

It was **AGREED** that:

1. The Secretary would take this matter up with PCTs
2. Practices should ascertain that they are complying with the contractual requirements
3. Salaried doctors who believe that their Terms and Conditions are less than those required, should seek the advice of the Secretary.

05/09/13 PRIMARY : SECONDARY INTERFACE

05/09/13.1 Patients being sent to Northallerton for diagnostic investigations

The LMC had been advised by a Middlesbrough practice that one of their patients, although referred to JCUH for an abdominal ultrasound, had received an evening appointment at The Friarage for diagnostic investigations, without having access to personal transport.

No-one had encountered this situation and it was presumed this happened very rarely.

The Secretary **AGREED** to take the matter up on behalf of the practice to ensure that patients receive appropriate opportunities to choose their place of appointment.

05/09/13.2 Prescribing responsibility: Requests from hospital for GPs to prescribe or change medication

Dr B Chaudhury, Clinical Director for Medicine at North Tees & Hospitals NHS Trust has been asked to provide information on his department's policy of asking GPs to prescribe new or altered medication, following receipt of concerns from GPs who have either been asked to prescribe new medication or to amend doses without appropriate clinical information. Dr Chaudhury has been asked to respond in time for the LMC meeting but had been on holiday and unable to reply in time.

It transpired that:

- Hartlepool Hospital pharmacy did not stock expensive medication and GPs were asked to prescribe.
- A Hartlepool Cardiologist had sent a patient to his GP asking for a prescription in order to commence medication.
- Urology at North Tees had informed a practice that a drug was not available and asked the GP to prescribe it.
- No communication from North Tees Hospital to inform practice patient had not visited them meant practice had continued to prescribe as before.
- At JCUH a lack of letters and information about patient results meant practices were prescribing as before.

It was pointed out that doctors should refuse to prescribe drugs they were not familiar with or did not feel confident in prescribing.

Dr Roberts said her practice used a standard letter to inform the hospital they were not going to issue a prescription and kindly agreed to send a copy to the LMC office for distribution to members *(post meeting note – copies received).*

05/09/13.3 Patient Choice Centre requesting medication lists and medical history within 24 hours

The Secretary explained that the LMC had been advised by a North Tees practice that they are receiving letters from the Patient Choice Centre at Poole House following a referral from an optician for a patient requiring cataract treatment, requesting the patient's NHS number, medication list and medical history within the following 24 hours. If the information is not received, this is followed up by fax the next day.

It was felt that 24 hours was not an appropriate length of time for a response to be sent. It was **AGREED** that the Secretary would pursue.

05/09/13.4 Communication *back* to primary care
Letter from Mr J R Clarke, LMC Rep for JCUH Medical Staffs Committee

"I have always thought it important, and good professional manners to try and write directly back to the referring doctor after out patient appointments and I encourage junior staff to do this with varying success. This is becoming increasingly difficult because of the software programme called "Revive Booked Admissions" which usually gives two different names for the "Referring GP". Perhaps this is no longer an important issue but I wanted to bring it to your attention. I will bring two examples to the meeting as you may never see these letters."

Mr Clarke showed members the letters and it was **AGREED** that the Secretary would pursue.

05/09/14 PROPOSED DATES FOR LMC MEETINGS IN 2006:

Tuesday : 7.30 p.m. : Committee Room : Poole House
17 January 2006
28 February 2006
04 April 2006
06 June 2006
18 July 2006
12 September 2006
07 November 2006
12 December 2006

The dates were agreed and **RECEIVED**.

05/09/15 LMC SECRETARIES CONFERENCE : Thursday, 10 November 2005
BMA House, London (BMA will reimburse travelling and subsistence expenses)

Dr Canning was attending the Secretaries Conference in his capacity as Chairman of Conference. A nomination was sought from anyone interested in attending. No nomination was received.

05/09/16 FORMAL CONSULTATION ON MERGER : Co Durham & Darlington Priority Services NHS Trust & TNEY NHS Trust
Ref Minutes: 05/06/21.5 & 05/07/12.2

It was **NOTED** that TNEY had sent 100 copies of the document to each PCT for dissemination to practices for comment.

Concern was expressed that with a very large Trust it would be difficult to negotiate change. Dr Gash said that if the merger went ahead, they were aiming to equalise the service across the new Trust.

05/09/17 THE CAMERON FUND : Extract of letter from Dr R J Givans, Chairman

"I would be most grateful if you could circulate our appeal letter together with the model mandate to practices in your area.

May I take this opportunity of thanking your LMC and its representatives at the LMC Conference for the very generous donations to the conference dinner collection in aid of the Cameron Fund, which resulted in a record total for the Dinner Collection."

It was **AGREED** that the appeal letter and mandate be sent to practices by the LMC. Previously the LMC had made an annual donation, however the Secretary would speak to Shared Services to see if a donation could be made by individual practices, if this is what practices wanted.

05/09/18 BMA CONSULTANTS

"We are pleased to announce that the BMA has launched a new service designed specifically for Local Medical Committees. Historically, as you are aware, the BMA, through its General Practitioners Committee, has assisted LMCs in advising practices. The service, however, has been limited to the problems that practices face and there has been no service available for LMCs as independent businesses or legal entities in their own right. After communicating with many LMCs across the UK, it is clear that there is a demand for a BMA led service to assist LMCs with their day to day internal legal business needs, in particular, in relation to employment law, data protection and constitutional problems. BMA Consultants, operating under the umbrella of the BMA, has been formed to meet this demand, and has a range of legal/commercial experience in order to meet the needs of LMCs. We are aware that LMCs have, in the past, instructed local firms of solicitors where legal issues arise, and the costs of

doing so have been and continue to be high. We are now able to offer LMCs a choice at discounted rates.

You may opt to purchase our specifically designed package of five questions which entitles LMCs to communicate with us on a variety of legal issues. This will give LMCs the flexibility and control over the costs of legal advice without being charged the standard hourly rates of private firms. This package can be purchased for £200 + VAT and is valid for 12 months. In some cases, issues of a more complex nature may arise and an hourly rate may be more appropriate. For these cases, we are able to offer LMCs a special rate of £115 per hour + VAT."

It was **AGREED** that as the service had never been needed previously, the hourly rate would be used.

05/09/19 REPORTS FROM MEETINGS

No reports from meetings had been received.

05/09/20 REPORTS FROM REPRESENTATIVES

No reports from representatives had been received.

05/09/21 SUPPLEMENTARY AGENDA

05/09/21.1 Update on LMC/PCT Liaison Officer vacancy
Ref Minute 05/01/25 & 05/07/9

Dr Canning explained that the position was still relevant in the light of the proposed single PCT. The advert would be appearing in the Evening Gazette and Northern Echo this week and on the NHS Job website. Interviews were scheduled for Thursday, 13 October.

05/09/21.2 North East Unscheduled Care Project : Friday, 28 October 2005 9.30 a.m. – 3.30 p.m. : Shotton Hall, Old Shotton, Peterlee

The project had places for 3 attendees. Interested parties should contact Wilma Ayris, Project Manager, North East Unscheduled Care Project on 0191 270 5007. The closing date for applications is 30 September 2005.

05/09/22 ANY OTHER NOTIFIED BUSINESS

No other notified business had been received.

05/09/23 RECEIVE ITEMS

05/09/23.1 Medical List

Applications:

Effective Date	Name	Partnership	Practice Area
01.05.05	Dr Fernandez-Morral	Dr Waters & Partners	MPCT
Was PCT employed SGP. Wef 1.5.5 becoming practice employed SGP			
03.08.05	Dr M Alagarsamy	Dr Leigh & Partners	MPCT
08.08.05 *Salaried GP*	Dr A Ahmed	Dr Eaton & Partners	HPCT
19.09.05	Dr R T Lama	Dr Neoh & Partners	NTPCT
19.09.05 *Salaried GP*	Dr A Dhir	Dr Khair & Partners	MPCT
05.10.05 *Salaried GP*	Dr A S Hassan	Dr Douglass & Partners	NTPCT
5.9.2005 *Salaried GP*	Dr W H P Zijlmans	Marske Medical Centre	LPCT

Resignations:

Effective Date	Name	Partnership	Practice Area
31.10.05 *Retirement*	Dr J Bentley	Dr Bentley & Partners	LPCT
30.09.05 *Resignation*	Dr D R Moore	Dr Stocking & Partners	LPCT
07.10.05 *Salaried GP*	Dr A E Forrest	Dr Douglass & Partners	NT PCT
26.8.5	Dr K Singh	Dr Waters & Partners	MPCT
Resigned. Salaried GP.			
30.9.5 *Retiring.*	Dr J Datta	Dr Datta & Partners	NTPCT

RECEIVED.

05/09/23.2 Report the receipt of:

GPC News M1 : Friday, 22 July 2005 (www.bma.org.uk)
Royal Medical Benevolent fund Annual Review & Accounts 2004/5
Dales & Wolds Strategic LMC minutes of meeting held on 24 May 2005
Sick Doctors Trust : Annual Report 2004-2005 (copy available from LMC office)

RECEIVED.

05/09/23.3 Date and time of next meeting

Tuesday, 01 November 2005, at 7.30 p.m. in the Committee Room, Poole House, Stokesley Road.

RECEIVED.

ITEM FOR DISCUSSION "BELOW THE LINE"

05/09/24 Payments to Committee Officers
Ref Minute 05/06/22.2 : 05/07/13

Report from Remuneration Sub-Committee

Dr Lone invited the Chairman and Secretary to remain during the report to members.

The Remuneration Sub-Committee, consisting of Dr Lone, Dr Holmes, Dr Beeby and Dr Ramaswamy had met on 2 September. Dr Holmes explained the formula used to calculate future payments to the Officers could be used in subsequent years and the levels were set to reflect current GP principal earnings, and the expertise of the post holders.

The proposal was to use the basic consultant salary scale to recognise GP experience, and to recognise LMC experience by giving the equivalent of 0.3 year's clinical excellence points for each year served on the LMC, whether or not this was continuous service. The point at which the post holder starts on the basic consultant scale reflects the doctor's years as a GP, which is likely to be more than 5 years.

The Remuneration Sub-Committee had taken into account that an average salary was with QOF. If QOF disappeared the formula would have to be reviewed. It was important that if someone was taking time away from the practice and employing someone else in their place, the practice needed to be reimbursed. Payment should also be considered for the Vice Chairman. Payment should be backdated to 1 April 2005. Post holders should have a Contract of Employment.

Dr Canning commented that:

- he felt the LMC should have a Treasurer
- agreed it would be helpful to have some form of contract of employment. The GPC had produced job descriptions for the chairmen of the GPC and negotiators and were in the process of producing job descriptions for the chairmen of the various sub-committees and Dr Canning offered to bring the documents to a meeting, along with some suggestions as to how they would apply to the LMC
- there needed to be accountability
- the appointment of a Liaison Officer would change the job description of the Secretary.

Dr Lone thought a Treasurer was unnecessary as the accounts were audited annually by an accountant, and would prefer that there was an Assistant Secretary.

In the future there may be a need for some form of management board, etc to which the Officers are accountable for targets and appraisal.

RESOLVED to implement the report of the Remuneration Sub-Committee, in full.

There being no further business to discuss, the meeting closed at 9.50 p.m.

Date: ***Chairman:***