CLEVELAND LOCAL MEDICAL COMMITTEE

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Minutes and report of the meeting of the Cleveland Local Medical Committee commencing at 7.32 p.m. on Tuesday, 12 September 2006 in the Committee Room, Poole House, Nunthorpe, Middlesbrough.

Present:	Dr I A Lone (Chairman)	Dr W J Beeby	Dr J-A Birch
	Dr S Burrows	Dr J T Canning	Dr K Ellenger
	Dr A Gash	Dr T A Gjertsen	Dr K Machender
	Dr R McMahon	Dr T Nadah	Dr J R Nicholas
	Dr J P O'Donoghue	Dr A Ramaswamy	Dr N T Rowell
	Dr N Siddiqui	Dr M Speight	Dr J R Thornham
	Dr S White	Dr C Wilson	

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

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Dr Lone explained to Members that the Chairman was on holiday and, as Vice Chairman, he was Chairing the meeting in her absence.

Dr Lone, on behalf of Members, welcomed Dr Siddiqui to the meeting as a newly appointed Hartlepool representative.

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06/09/1 APOLOGIES

Apologies had been received from Dr A R J Boggis, Mr J Clarke, Dr G Daynes, Dr D Donovan, Dr M Hazarika, Dr A Holmes, Dr D Obih, Dr R Roberts and Dr T Sangowawa.

06/09/2 MINUTES OF THE MEETING HELD ON 18 July 2006

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

06/09/3 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

06/09/3.1 Hartlepool Borough Council's Scrutiny Committee investigation:
"Access to GP Services" : Ref Minute 06/04/15.3 : 06/07/3.1

In their Final Report, (Page 28 Para 19.2n) Hartlepool Borough Council requested that the LMC be asked to consider the findings of the PPI Forum Report "Having trouble getting in touch with your doctor?".

HPCT were nominated after the White Paper to become part of the national procurement regime; the PCT have been involved in discussions with the centre and are no longer included in the scheme. Although GP recruitment was improving in Hartlepool, it was difficult to know how many sessions a week each GP worked, so GP numbers may appear satisfactory but are deceiving as many GPs are not full time. It was felt that patients were choosing not to move to those doctors with low lists, and the photograph in the Report showing patients queuing outside a practice was not indicative of what was actually happening in Hartlepool. It was also not known why the queue had formed, although it was first thing in the morning and the surgery had not yet opened; patients could have been queuing to see the phlebotomist, a doctor, a nurse or make an appointment . It was reported that HPCT was not consulted on the document until it had been published.

It was **AGREED** that the Secretary would reply accordingly to Hartlepool Borough Council.

06/09/3.2 Primary Care Development Schemes (formerly "Golden Hello Scheme")
Ref Minute 06/04/4.3 – PCDS allocations notified to SHA's by DoH

The LMC had reminded the four Heads of Primary Care at local PCTs that the funding is to be used for PCDS only.

Hartlepool PCT total allocation	£35,637
North Tees PCT total allocation	£54,746
Middlesbrough PCT total allocation	£74,702
Langbaurgh PCT total allocation	£37,809

The Scheme was ring fenced for three years and it was **AGREED** that the Secretary would write to PCTs asking how much had been spent in the first year and on what, together with what plans they had for its future use.

06/09/3.3 Primecare: Protocol for transfer of responsibility at 0800 hours
Ref Minute 06/07/6

Dr Lone explained that the matter had been raised by a GP who had a call transferred back to him at 8.00 a.m. when the patient had rung Primecare at 6.52 a.m. resulting in the GP having to call an emergency ambulance. The GP subsequently took the matter up with Primecare and was sent a copy of their "Transfer of Responsibility Protocol".

Dr Lone assured GPs that calls were triaged and those thought to be urgent were dealt with. A Primecare doctor works up to one hour after 8.00 a.m. to cover any remaining urgent calls; very little is passed back to practices.

06/09/3.4 Trusts circulating information to GPs
Ref Minute 06/07/9

Dr Canning, as requested at the previous meeting, had checked with the National Patient Safety Agency to see what they had on their database, but nothing was available. He had also spoken with Chris Willis in her capacity as Chief Executive Designate of NTPCT / Acting Chief Executive of HPCT, to ask whether an intranet was something which should be supported by PCTs once they had been established. She thought there may be some merit in dealing with information circulation on a four PCT-wide basis, and that this may be the opportunity of having information on a properly maintained intranet which is kept updated. Dr Canning intended to pursue this proposal and asked GPs to keep him informed of examples of duplicate/trivial/ irrelevant information being distributed to practices.

06/09/3.5 Employers superannuation contribution on trainers grant
Ref Minute 06/02/8 : 06/07/15.1

Letter received from Newcastle University, Postgraduate Institute for Medicine & Dentistry
"I have been waiting for a response from colleagues at the DoH to clarify if superannuation on trainer grants had been raised or considered. Quoting from a finance colleague at the DoH via email:

The advice I have been given is that in the case of payments such as the trainers' grant that fall outside the GMS contract but which are now pensionable, the practice/GP bears the cost. Increasing the range of payments now allowable for pension purposes is a huge benefit for GPs in terms of their lifetime incomes, even if it makes them slightly cash poorer now. However, this is an issue that keeps cropping up and those responsible for this policy area are considering taking the matter to the GPC to get final clarification/resolution of the issue."

The LMC subsequently wrote to the GPC concerning the statement from the Postgraduate Institute, requesting the matter be taken forward and received the following response:

Letter from Senior Policy Executive, General Practitioners Committee, BMA, London
"We agree that the uplift to the trainers grant over recent years has not taken into account the increased costs arising from the transfer of responsibility from the Treasury to the DoH relating to 7% of employers' superannuation contributions. The GPC has written to the DoH about this problem on a number of occasions and is keen to see it resolved; we have yet to receive a response.

I have drawn the relevant colleague's attention to the correspondence between Cleveland LMC and Newcastle University (enclosed with your letter), highlighting the extract from the DoH email included in Mal Glass' letter of 1 August 2006. We will continue to pursue this issue centrally and will keep LMCs informed of any developments accordingly."

There is currently a survey on the workload of Trainers being undertaken, which has been sent to a random selection of Trainers, asking that at least one of the partners in the Training practice also take part in the survey.

A letter had been received from a Middlesbrough Trainer expressing disappointment at the level of training grant paid for vocational training and also F2 doctors, with the suggestion that there may be a shortage of Trainers if funding was not rectified.

Dr Canning had been informed about problems with F2 doctors not wishing to take up general practice because of the significant reduction in remuneration. A member said this problem was not exclusive to general practice, with other specialties only paying basic salary resulting in as much as a 40% drop in salary. The amount of teaching and supervision required by an F2 is significantly more than a Registrar, partly because F2 doctors rotate three times a year, and Cleveland had only coped with a shortage of F2 supervisors by incorporating the Northallerton Scheme into theirs.

06/09/4 REPORT BY THE CHIEF MEDICAL OFFICER "GOOD DOCTORS, SAFER PATIENTS"
Ref Minute 06/07/14.1

Cleveland LMC, with the support of the BMA South Tees and Hartlepool Divisions, (there did not appear to be an active North Tees BMA Division) had organised a meeting to take place on Tuesday, 3 October 2006, 6.30 – 9.00 p.m. at The Sporting Lodge (formerly The Post House) which was open to all GPs, Registrars, and hospital doctors to enable them to express their views on the document. The most important changes were around:

- Removing the elected members from the GMC
- Serious professional misconduct to be judged on the balance of probabilities rather than beyond reasonable doubt
- Removing undergraduate education from the GMC and giving it to PMETB
- New arrangements for revalidation

It was **AGREED** that it would be more appropriate to discuss the document at the meeting on 3 October.

06/09/05 PCT RE-CONFIGURATION
Ref Minutes 06/02/3.4 : 06/04/4.1 : 06/06/3.4

At present Mr Colin McLeod has been appointed as CEO of the reconfigured Middlesbrough PCT, and is Acting CEO of Langbaurgh PCT. Mrs Chris Willis is CEO of North Tees PCT, pending assessment under the "Fitness for Purpose" exercise and Acting CEO for Hartlepool PCT.

The Secretary had arranged with both CEOs for the provision of a brief status report for the meeting, but this had not been received.

The Committee discussed the possible management configuration for the four PCTs. There appears to be significant pressure from above on the local PCTs. There will be four PCTs each with a Board, but a suggestion of 2 PECs. It was noted that the role, function and responsibilities of PECs was subject to a review announced the previous Friday.

Issues to be addressed include:

- how will the necessary management savings be made? Management savings can be spread over a three year period;
- a proposal for a management team north of the river and a management team south of the river with a Chief Executive for each of the management teams;
- the proposal that there should be a Tees-wide commissioning team;
- PECs in re-configured PCTs (Middlesbrough/Langbaurgh,) have to be reconstituted, but in non-reconfigured PCTs (Hartlepool/North Tees) PECs can stay as they are until the review is completed;
- membership of the PECs will be by selection not election, and nominations will be by application;
- delay and the risk that there would be a loss of the opportunity to recruit the best management staff, therefore, it was vital a decision be reached quickly. It is presumed nothing will be in place until end-November.

Members noted that there had been minimal discussion between GPs and PCTs, but that the system established will need to work efficiently to achieve delivery of effective healthcare.

In conclusion, the Committee **NOTED**:

- The strong desire of a large majority of GPs in Langbaurgh PCT to have a PEC in the new Redcar & Cleveland PCT;
- That whatever the outcome of PCT reconfiguration, GPs must be in control of the local PBC groupings.

06/09/6 LMC LEVY PAYMENT
Ref Minute 06/07/4

A draft budget had been submitted to members and was discussed at length. Levies reported on the UK LMC ListServer varied from 35p – 45p, and it was **AGREED** that forthwith the levy be increased to 35p per patient.

Dr Canning informed members that he had been in discussions with HM Customs & Excise concerning the £25,000 which had been paid 'on account' to stop interest charges accruing on past NICs and Tax payments; an early resolution is anticipated.

It was **NOTED** that the LMC/PCT Liaison Officer had left on 14 July and the Chairman and Secretary were discussing what job description and process should be recommended to the Board concerning re-appointment. It was hoped to issue documentation prior to the next LMC meeting.

06/09/7 PRACTICE BASED COMMISSIONING - Updates
Ref Minutes 06/06/4 & 06/02/8.3

- ***Carl Parker, PEC Chair, HPCT***

As you are aware in Hartlepool we have a single group covering the whole of the town. Attendance at meetings is variable but there is a consistent core group and no practice that is actively not engaging. The commissioning intention plan for C1 of the DES has been developed and currently am awaiting for practices to sign and return this - which I expect all

to do. Areas we are looking at include dermatology, gynaecology, ENT, A+E and prescribing.

As of 8 September 15 of the 16 Hartlepool practices have signed SLAs for the PBC DES and the final practice has indicated they will be doing so by next week.

There are various approaches we are trying including education for GPs, development of community based services and medication swaps to more cost efficient alternatives. There is a general concern among practices not to destabilize local secondary care services and we are trying to get as much clinical input into development from secondary care as possible e.g. work with Richard Harrison to develop a community SpR to integrate into a respiratory assessment team.

If there are any specifics you'd like to know let me know.

- ***Rodger Thornham, PEC Chair, NTPCT***

NTPCT has agreed an incremental approach to practice based commissioning, with the aim of developing practice and clinical involvement in commissioning with the ultimate objective of improving patient care.

All practices are involved in the Commissioning Forum, which has been meeting every two months, and all have agreed to sign up to a "memorandum of understanding" to work together in PBC. The PCT has appointed some "Practice Managers with Special Interest" (in PBC) and they are working with PCT managers to develop a commissioning framework. The Commissioning Forum has appointed a "Steering Group" which has its first meeting on 31 August. The Forum has identified a number of areas where it feels commissioning will have a rapid impact on quality of services; these are in Lab Medicine, Physiotherapy, X-ray and Mental Health. It has also started to look at working with the PCT Commissioning team to develop alternative pathways for ENT, Dermatology and pain management.

Practice have received their nominal budget statement and will be discussing this as they develop their commissioning plans.

If you need any further information please let me know.

- ***Henry Waters, Middlesbrough PCT***

In Middlesbrough PCT, all the practices have signed up and have agreed to work together as a single group for the purposes of the overall budget, for strategic planning purposes and to facilitate equity of the use of future resources across the practices in the PCT. Such an approach automatically encourages everyone to work together and to learn from each other as well as avoiding some of the pitfalls of smaller budgets.

A PBC executive committee has been formed with two GPs from each of the three locality groups in Middlesbrough and Eston. Dr Danny Donovan is the chairman of the group. Each executive GP member will meet with a small cluster of local practices on a regular basis to monitor progress.

All practices submitted PBC plans and these have been aggregated to a composite plan with emphasis on common themes. Several work groups will be formed to focus on service developments in different clinical areas. The executive committee will co-ordinate this work.

The Eston practice cluster with Dr Dilip Acquilla as their PBC executive committee member will be in Redcar and Cleveland PCT from 1st October 2006. However, most service developments are likely to affect patients in both Middlesbrough and Eston, so we would suggest that Dr Acquilla continues to work alongside his colleagues on the Middlesbrough PBC executive committee.

- ***John Doherty, Executive Chairman, LPCT***

LPCT have 15 out of 16 practices who have submitted commissioning plans for 2006/2007. All the plans have been examined by the PBC sub-group and we have an Implementation Group responsible for delivering on an action plan over the next 12 months. The 16th practice has expressed a wish to engage in PBC and discussions are taking place with them. At the moment we have three commissioning groups in the LPCT area.

I understand from Colin McLeod that all 6 practices in the Eston "corridor" have submitted plans to MPCT. Those plans will require Redcar & Cleveland PCT's approval. My expectation is that the 6 practices will work as a commissioning group.

At Colin's suggestion, I am enclosing the Project Plan for management of transition of Eston "corridor" into Redcar & Cleveland PCT.

It was pointed out that SHA's plan seemed to point to PCTs doing the commissioning and it was felt GPs should be cautious of this arrangement, however, the Secretary reminded the Committee that this was the nature of PBC.

Members were concerned that there was a danger that PBC may become too orientated to PCTs concerns and financially driven, rather than patient orientated and, therefore, it may be worthwhile for PBC groups to have links to Patient Forums in order to keep them fully informed of events.

06/09/8 FUNDING GENERAL PRACTICE

Ref Minutes 06/06/3.5 & 06/04/5

The updated figures (excluding the 107 QOF figures) for all four PCTs were discussed. Other than in Middlesbrough it was noted that there was a significant difference between PMS and GMS funding.

It was **AGREED** that the information be circulated across the whole of the area with names attached. The "averages" would be removed as they were not statistically valid.

06/09/9 VERIFICATION OF DEATH BY REGISTERED NURSES & EMERGENCY CARE PRACTITIONERS : POLICY & PROCEDURE – REVIEW PROCESS

Ref Minute 05/06/14

A policy on the verification of death by registered nurses and emergency care practitioners was been produced by MPCT in 2005, on behalf of the Out of Hours commissioners, in conjunction with the LMC and HM Coroner. The policy authorises registered nurses and emergency care practitioners to verify a patient's death and to arrange/direct relatives to arrange for the removal of the deceased body to the funeral directors or seek the involvement of HM Coroner. The policy also provides guidance as to the process of the verification of death. A GP does not have to see the body after death. The policy was being reviewed and comments from the LMC had been sought.

It was commented that there were still cases of paramedics phoning doctors to verify the fact of death.

Dr Canning was in the process of establishing contact with the new Ambulance Trust, who were keen to have general practice input, and he **AGREED** to discuss the document with them.

06/09/10 PROPOSED GPC REGIONAL CONSTITUENCIES

In order to bring the GPC electoral constituencies and conference regions into line with the new SHA and PCT boundaries, and giving consideration to the number of GPs in each PCT area, new constituency boundaries had been produced for consideration and discussion. There had been a reduction of three constituency areas (South Central, West Midlands & Scotland) but did not affect the Northern & Yorkshire Region which covered Durham/Sunderland/Cleveland, where Dr Beeby was currently the elected member.

NOTED.

06/09/11 ASSIGNMENTS TO AND REMOVALS FROM A CONTRACTOR'S LIST : Annual Report from Tees Contractor Services 1.4.05 – 31.3.06

The report had already been sent to practices by Tees Shared Services. Hartlepool continues to have the highest number of individuals assigned per contractor, and also the highest number of removals per contractor.

Dr Canning emphasised that it was important, when a patient was removed from the List, to give the patient a reason and keep a record. Also when a patient applied to join a List practices must not discriminate when considering accepting/rejecting the application. To prevent allegations of inappropriate or discriminatory decisions, all practices should have a set of criteria against which all applications are considered, and are obliged to keep a record of the reason for an application being rejected.

06/09/12 AMBULANCE BOOKING

At present practices are expected to arrange ambulance transport for patients, and the Ambulance Trust expect practices to "vet" whether or not patients require transport by ambulance. This is very time consuming for practice staff and is not part of essential services, nor a commissioned enhanced service. Members were also concerned at the variability of criteria between practices and the risk that a refusal to arrange transport will bring adverse publicity to a practice. In some areas, (Hambledon and Richmondshire for example) patients contact the Ambulance Trust directly to arrange transport, and this suggestion was put to members for consideration.

After considerable discussion, the proposal was accepted, and it was **AGREED** that the Secretary would:

- Contact the Ambulance Trust to inform them of the proposal;
- Draft a letter and send it to practices to enable them to notify the Ambulance Trust that with effect from a given date patients will be contacting ambulance service directly to arrange their own transport (practices do not have to withdraw from providing this service to patients);

- Draft a letter and send it to practices for them to give to patients stating that from a given date patient will need to ring a given number in order to contact the Ambulance Trust to arrange transport.

06/09/13 TERTIARY REFERRALS

A letter had been received from a Middlesbrough doctor citing a delayed chest x-ray result which took a month to arrive at the practice which required the patient to be urgently referred to the chest clinic. In the past, the x-ray result would have resulted in a CT scan being organised by radiology.

It was **AGREED** that this matter should be passed to the PBC Group.

06/09/14 COMMISSIONING OF CARE

- JCUH being initially unable to see a patient within 14-day rule and referring patient to another venue 30 miles away (Dermatology Department); patient eventually offered a cancellation appointment by JCUH;
- JCUH initially refusing to see a Hartlepool patient (Orthopaedic Department) "*due to the increasing number of referrals received and our current waiting time, we are unable to offer patients outside our immediate area unless they are of a tertiary nature*"; patient eventually offered an outpatient appointment by JCUH.

It was **AGREED** that these matters should be passed to the PBC Groups.

In considering the above items, the Committee **AGREED** that the role of the LMC in disputes about commissioning was when no local resolution could be achieved at local level or there were contractual issues to be addressed.

06/09/15 HOSPITAL TRUSTS : Notification of hospital appointments; Old addresses being used; Lack of interdepartmental referrals

06/09/15.1 ***North Tees & Hartlepool NHS Trust: (one item queried)***

- ***Giving appropriate notice to patients about their appointment dates***

"I have had feedback on this from our Head of Medical Records who also runs the booking system for us, Mrs Jan Atkinson. She tells me that any "urgent" appointments are already telephoned out to patients. The booking clerks make two separate attempts at different times of the day to contact each patient and only if they fail to get through to them personally is a letter then sent. At that stage, in the same letter we explain that we have tried to phone them without success and invite the patient to contact us to re-arrange the appointment if it is not convenient for them. I wonder if these may be the patients you are highlighting?

It may also be a problem if a clinic is unexpectedly cancelled for sickness. These patients occasionally get shorter notice than is usual in an attempt to get them seen as near to the original appointments possible, but again they are always telephoned where possible.

I wonder if you could give me any specific examples to investigate where there have been problems that would help us to identify if there is any additional unidentified problem we need to tackle. I appreciate the feedback and would be very keen to investigate further if you think it is a significant issue."

RECEIVED.

06/09/15.2 ***South Tees Hospitals NHS Trust: (three items queried)***

- ***Giving appropriate notice to patients about their appointment dates***

"Currently we are operating three appointment systems in our appointment areas. These are Partial Booking, Indirect Booking and Direct Booking.

For the Partial Booking system, we are required to invite patients to contact our offices to book their appointments. We try to allow 3 weeks notice between inviting the patient to ring in, and agreeing an appointment date. Referrals that are prioritised as urgent may, however, be booked at short notice. Where an appointment date is being organised within one week, staff do already make every attempt to contact the patient by phone, however, it is often difficult to speak to many patients during the day. Unfortunately, we do not have staff working in the evenings to do this work outside of normal hours. Once we have made two attempts, at varying times during the day to speak to the patient by phone, we enclose an information slip in the appointment letter explaining that we have made a couple of attempts to contact the patient but have gone ahead and made the appointment. All appointments being booked within one week are sent out in the first class post. These same processes also apply when we have to cancel clinics at short notice.

With Indirect and Direct Booking, the patients ring us and an appointment date is arranged over the phone for them. Most patients will not be seen under a week, however, if an appointment within one week was available usually due to another patient cancelling their appointment date, it will be offered to the patient.

One of the problems we do come across very often is incorrect or no patient phone numbers being given on the referral letters. This makes the job of finding the correct number very difficult. It would also be extremely helpful if the practices could explain to patients who withhold their numbers or who are ex-directory, that it is sensible to allow the Hospital to be given access to their number so we can get in touch with patients quickly and especially if a clinic has to be cancelled at short notice.

Many patients also now have mobile telephone numbers but it is very rare that we are provided with those when the referral letter is received. If the practices could obtain and provide the mobile numbers to us in the referral letter, this would be another way of helping us to get in touch with patients if their appointments have to be arranged at short notice."

- ***Old address information for patients being retained***

"When a new referral letter is received, the information contained is checked against the Patient Administration System. I can confirm that any changes of demographics are updated at that stage. All subsequent appointment letters will then automatically be directed to the latest information that has been recorded. As each patient attends a clinic or admission, appropriate reception or ward based staff check the demographic details with the patient and again update the PAS system as necessary. Very often patients write to us or phone us to notify us of their new address details and again the PAS system is updated.

If a patient moves address between appointments or after referral to the Hospital and fails to notify to Hospital of a change of address then their original demographic detail will remain until such time as we are notified of the change. Unfortunately if they fail to attend the clinic, they will be recorded as a DNA patient and it is generally only after the GP surgery receives a letter notifying about the DNA that new address details come to light. It is not possible to telephone the GP surgeries for every patient who fails to attend to check out address details."

- ***Lack of interdepartmental referrals***

"This has arisen as a consequence of PCT pressure to limit internal referrals to an absolute minimum and it has been agreed with all the PEC Chairs that patients who have a condition unrelated to their original referral will be referred back to their GP, who then has a CHOICE as to where that person is referred. I have had 1:1 meetings with all the PEC

Chairs and there is an agreement about which patients can be referred internally and this largely relates to the urgency with which they need to be seen and whether the referral would normally be part of the patient care pathway. Clearly, when this is the case, patients will be referred internally. However, with PCT pressure to reduce internal referrals, I think you are simply going to see more of this from now on. I am a little surprised that you are not aware that the Trust is under a significant amount of pressure not to refer patients internally. Someone with an ENT problem was sent to the Medical Admissions Unit by a GP, and I think this is almost certainly part of the problem."

RECEIVED.

06/09/16 LETTER FROM A PRACTICE CONCERNING A COMMUNICATION RECEIVED FROM TEESSIDE HOSPICE CARE FOUNDATION, LINTHORPE re Tobacco control policy at Teesside Hospice Care Foundation

"From 1 July 2006 Teesside Hospice Care Foundation, alongside NHS colleagues, will prohibit smoking both within the hospice and all grounds.

I would be most grateful if you would ensure patients, families, and carers, are made aware of the new THCF regulation so people can decide if admission to the in-patient unit and referral for day care, etc, would be appropriate for their needs."

After discussion, it was **AGREED** that the LMC should not become involved with the hospice and that the practice should raise the issue with their local PPI Forum.

06/09/17 REPORTS FROM REPRESENTATIVES

There were no reports from representatives.

06/09/18 REPORTS FROM MEETINGS

06/09/18.1 Meeting with Dr Peter Heywood, Consultant in Public Health, MPCT : Thursday, 7 September 2006 @ LMC office

The meeting had been about emergency planning relating to flu and pandemic flu. Dr Heywood was looking for a group of 3-4 doctors representing different types of practices to help him look at the issues in general practice, to meet him at a convenient time and then communicate by email thereafter.

Dr R McMahon, Dr R Ramaswamy and Dr J-A Birch kindly volunteered to meet Dr Heywood.

06/09/19 SUPPLEMENTARY AGENDA

06/09/19.1 Rheumatology Services at University Hospital of North Tees
Letter from Mr Ian Dalton, CE, NT&H NHS Trust to Secretary, Durham LMC regarding vacancy within Rheumatology Services

"Dr John Harvie was employed in 2001 to ensure a consultant-led service was provided across both Hartlepool and north Tees Hospital sites. It was subsequently agreed that a second rheumatologist be appointed to work with Dr Harvie, again, across both sites.

Since Dr Harvie's departure in February 2006 we have continued to see all new patients within the required waiting time i.e. under 13 weeks, with patients requiring review seen by the rheumatology team of medical and nursing staff. Although we are in the process of recruiting to this vacant (Trust-wide) second post, we are aware of the national shortage of doctors in this specialty. However, we are confident that the service we are providing meets the demands placed upon it and I can confirm that there are no changes in the shared care arrangement regarding monitoring and actioning abnormal blood results for patients on disease modifying drugs.

I hope this has reassured you and your colleagues, but please do not hesitate to contact me if you require further clarification."

Members felt that the service was chaotic with nurses trying to keep the unit running. GPs were unhappy with the service being provided and felt it was not being given priority. They felt it was something Commissioners should be getting involved with and it affected a lot of elderly patients. Dr Thornham said the Practice Based Commissioning Forum for North Tees was meeting the following day and the matter would be raised then.

06/09/19.2 Urological Services – Regional spinal Cord Injury Centre, JCUH

Letter from Professor C G Greenough, Consultant Orthopaedic Surgeon, JCUH to Chief Executives and PEC Chairmen at PCTs

"You will of course be aware that one of the recommendations of the Darzi Report was the establishment of a specialised surgical service at the University Hospital of North Tees. At the present time Urology is one of the services being considered to be re-located from James Cook to North Tees.

You may not be aware, however, that this would have a major detrimental affect on those of your patients who are spinal cord injured. All spinal cord injured patients in your area are treated by the Regional Centre at James Cook.

The Golden Jubilee Regional Spinal Cord Injury Centre is at present the flagship of the Regional Spinal Cord Injury Centres in the U.K in terms of the completeness of services available to our patients. Spinal cord injury is a very complex management problem and I enclose an outline of the service and a description of the pivotal importance of urological service to these patients.

We at the Centre are extremely concerned about the detrimental effects that would ensue should urological services leave the James Cook site. I would ask you to consider the matter and if you feel it appropriate to consider making representation to the strategic health authority in the interest of your patients. You might also considering communicating with Angela Lamb, Director of Acute Services at the University Hospital of North Tees, who is leading a group evaluating the possible move of urological services.

There are 700 spinal cord injured patients in the Region whose interest are at stake. We hope to be able to maintain the high quality of services which were achieved when the Centre moved from Hexham to the James Cook University Hospital.

Please do not hesitate to get in touch if there are any points you would wish to discuss."

Members felt Professor Greenough had a valid point but were reminded the recommendation came from the Darzi Report, which the Trusts had been left to sort out.

It was **AGREED** that the Secretary would express the Committee's view to the PCTs and Professor Greenough.

06/09/19.3 Referral Systems – Update
Ref Minute: 05/09/4.7 : 05/11/6 : 06/01/4.4

Hartlepool PCT - Carol Johnson, Assistant Director of Primary Care
"Once the correctly directed referral has been accepted, whether by the hospital or the primary care service, the responsibility will transfer to the new provider. Any newly provided service should have demonstrated robust governance arrangements to identify areas of accountability and the process to manage complaints and/or litigation."

Langbaurgh PCT – Neil Stevenson, Head of Acute Commissioning & Performance Manager
"I can confirm that in the circumstances, the PCT would carry the responsibility"

Middlesbrough PCT – Colin McLeod, Chief Executive
"MPCT is responsible for the actions of its employees while they are working within the set Policies and Procedures that govern any individual system of process within the PCT."

North Tees PCT – Elaine Wyllie, Head of Access & Choice
"I am happy to confirm that the PCT will accept its responsibilities on both counts in line with the relevant guidance."

RECEIVED.

06/09/20 ANY OTHER NOTIFIED BUSINESS

There was no other notified business.

06/09/21 RECEIVE ITEMS

06/09/21.1 Medical List

Applications:

Effective **Date**	**Name**	**Partnership**	Practice **Area**
01.10.2006 *Salaried GP.*	Dr E Hoida	Dr Inch & Partners	MPCT
07.08.2006 *Salaried GP.*	Dr L N Fazluddin	Dr Thornham & Partners	NTPCT
21.08.2006 *Salaried GP.*	Dr I A I Mashharawi	Dr Eaton & Partners	HPCT

01.10.2006 *Salaried GP.*	Dr S L Wilson	Dr Bolt & Partners	HPCT
01.09.2006 *Salaried GP.*	Dr A Carrasco	Dr Tahmassebi & Partners	LPCT
01.09.2006 *Partner.*	Dr M K Kesavalu	Dr Chappelow & Partners	MPCT
04.09.2006 *Salaried GP.*	Dr P Krishnamoorthy	Dr Geoghegan & Partners	NTCPT
01.09.2006 *Changing status from SGP to Partner.*	Dr V Nanda	Dr Khair & Partners	MPCT

Resignations:

Effective Date	**Name**	**Partnership**	**Practice Area**
15.09.2006 *Resignation. Salaried GP.*	Dr P L Greenaway	Dr Williams & Partners	LPCT
21.07.2006 *Resignation. Salaried GP.*	Dr D R Wilson	Dr Acquilla & Partners	MPCT
21.08.2006 *Resignation. Salaried GP.*	Dr M S N Norrie	Dr Acquilla & Partners	MPCT

RECEIVED.

06/09/21.2 Report from GPC

Summary of meeting held on 20 July 2006 emailed to all GPs and Practice Managers on 24 July 2006. The GPC next meet on 20 September 2006.

RECEIVED.

06/09/21.3 Report the receipt of:

GPC News M1 – Friday, 21 July 2006 (*available at www.bma.org.uk*)
Sunderland LMC's minutes of meeting held on 27 June 2006

RECEIVED.

06/09/21.4 Date and time of next meeting

Tuesday, 7 November 2006, at 7.30 p.m. in the Committee Room, Poole House, Stokesley Road.

RECEIVED.

There being no further business to discuss, the meeting closed at 9.30 p.m.

Date: ***Chairman:***