CLEVELAND LOCAL MEDICAL COMMITTEE

Dr J T Canning MB, ChB, MRCGP **Grey Towers Court**
Secretary **Stokesley Road**
Tel: 01642 304052 **Nunthorpe**
Fax: 01642 320023 **Middlesbrough TS7 0PN**
Email: *christine.knifton@tees-shs.nhs.uk*

Minutes and report of the meeting of the Cleveland Local Medical Committee commencing at 8.45 p.m. on Tuesday, 12 April 2005, in the Committee Room, Poole House, Nunthorpe, Middlesbrough.

Present:

Dr J P O'Donoghue (Chairman)	Dr W J Beeby	Dr K P Bhandary
Dr A R J Boggis	Dr J T Canning	Dr G Daynes
Dr K Ellenger	Dr T Gjertsen	Dr A Holmes
Dr I A Lone	Dr K Machender	Dr J Nicholas
Dr A Ramaswamy	Dr N Rowell	Dr M Speight
Dr J R Thornham	Dr R J Wheeler	Dr S White
Dr C Wilson		

In attendance: Mrs C A Knifton : Office Manager, LMC
Dr W S M Orr : GP in Yarm

05/4/1 APOLOGIES

Apologies for absence had been received from Mr J Clarke, Dr L Dobson, Dr A Gash, Dr C Harikumar, Dr T Nadah, Dr R Roberts, Dr T Sangowawa, Dr A Smith and Prof T Van Zwanenberg.

05/4/2 MINUTES OF THE MEETING HELD ON 25 January 2005

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

05/4/3 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

05/4/3.1 Monitored dosage schemes (Nomad and similar systems)
Ref Minutes 04/04/7 : 04/06/3.4 : 04/07/3.2 : 04/11/3.1

Update received from Head of Medicines Management, Langbaurgh PCT
"I have just written out to all practices recently and wish to update you with my recommendations. As you will no doubt be aware, the new pharmacy contract comes into

being in April 2005. Included in the Essential Services funded within the contract is the provision of support to all patients covered by the Disablement Discrimination Act. This will include help with medication which will, in essence, mean the provision of MDS where appropriate, free of charge. We estimate that patients covered by the DDA will account for approximately 90% of those already receiving this facility.

As this service is funded by the contract, I have written out to practices advising that the current practice of providing 7 day scripts should cease from 1 April 2005 and I have cited the recommendations of the LMC in support. I wondered if the LMC could support this stance with their own advice to prescribers? I have also made pharmacists aware that it will be illegal to charge for such services under the DDA.

Of the remaining 10% of patients not covered by the Act no-one will be offered any support service without an assessment which will be provided by LPCT prescribing support staff.

My aim over the next months is to bring the MDS service in check and to re-assess users of the scheme as I am aware that with proper assessment probably only 50% of referrals actually merit an MDS whilst the other 50% benefit from a combination of medication review, ordinary tops (i.e. non-child resistant), large print labels and reminder charts."

RECEIVED.

05/4/3.2 An up to date breakdown of enhanced service funding with, if possible, details of the spend to date
Ref Minute: 05/01/5.2 – Updates requested from all PCTs

Given the time constraints, Dr Canning explained that he would not be going into detail for individual PCTs, but that discussions were ongoing with PCTs concerning what is within the floor. The floors were being met, it was just that some things within the floor were questionable.

05/4/3.3 The NHS Pension Scheme – Death in Service update
Ref Minute 05/01/09

The advice received was that death in service for employees is funded by the PCT not by the practice, the PCT being perceived as the employer.

NOTED.

05/4/3.4 TENYAS proposals for management of category 'C' calls (Minor/Non-Serious 999 calls) : Response from TENYAS Category C Project Manager
Ref Minute: 05/01/10

"We too accept that our screening of calls should not increase the workload in general practice. Our aim in providing triage is to relieve pressure on the primary and secondary care system by treating patients on scene where possible. If a patient should need the services of their GP we would ask the patient to contact their surgery for an appropriate appointment.

Where a patient accesses the 999 service for a second time, all consideration will be given to their needs and at any point during their call we are able to despatch an emergency response.

Policies and procedures are currently being drawn up to manage these issues. We hope that this information satisfies your concerns."

RECEIVED.

05/4/3.5 Intrapartum care: 5-10 day baby care : Response from NTPCT
Ref Minute 05/01/12

"It was most helpful for you to draw our attention to this and after discussion at our Developing Primary & Community Services Committee last week it was decided to write to all GPs in the NTPCT area and recommend that these checks are no longer necessary and we will ensure that the baby books are changed accordingly."

RECEIVED.

05/4/3.6 Conciliation Services
Ref Minute 05/01/13

Hartlepool PCT – Carol Johnson & Ali Wilson
"Should the PCT require access to conciliation services, we would of course ensure such advice be independent and impartial. We would also, however, encourage the GP to seek robust advice of their own.

We can offer (and have offered) conciliation services, if both parties are agreeable via UNITE which is an independent mediation / conciliation service based in Middlesbrough. We have some written details if required."

Langbaurgh PCT – Marilyn MacLean
"I would like to reassure the LMC that LPCT would continue to provide a rigorous conciliation service. I am pleased to see that the LMC will continue to make available independent medical advice."

Middlesbrough PCT – Colin McLeod
"Middlesbrough PCT is already in discussion with a local conciliation service which we would hope to make accessible to all contractor professions as well as our own services. This cannot however be an open ended commitment as the costs of such a service could obviously spiral out of control. I anticipate that we will be in a position to offer a service to practitioners on a shared cost basis in the near future."

North Tees PCT – Liz Hegarty
"I note your comments relating to the provision of conciliation services by both Tees Shared Services and its predecessors. So far as I can ascertain the provision of qualified conciliation services ceased some years ago locally. It would appear that when Mrs Jean Stewart ceased to provide a conciliation service, to which Tees Health subscribed, the service was no longer funded. During the years of Shared Services Mrs Carole Johncey acted in the role of conciliator with the assistance of a professional adviser or clinical governance lead from outside the area. (Carole has kindly provided this information to the PCT's Complaints Manager.)

As you will be aware the new complaints regulations were issued for consultation in the early part of 2004 and they place great importance on the use of conciliation/mediation services when considering the local resolution of the process. I understand that a working group of

Complaints Leads was established through the auspices of the Tees Valley & Cleveland SHA and its accompanying SHA in Northumbria to seek out suitable provision of conciliation and mediation services. So far the group has looked at a number of possibilities and I believe that most of the Trusts locally have a preferred option of obtaining suitable training which will be offered to a group of interested individuals to provide us with a 'pool' of qualified conciliators. This PCT is, of course, committed to continue to work towards improving standards in complaints handling and would wish to be involved in any positive developments.

It remains to be seen what emphasis is placed on conciliation/mediation within the proposed amendments to the local resolution stage of the complaints regulations.

From the above I am sure you will agree that far from having disappeared with the advent of PCT monitored complaints procedures there had, in fact, been no formal conciliation available in this area for some years. The PCT's Complaints Manager continues to liaise with practices and complainants in North Tees whenever she is requested to do so.

I am grateful for your offer to continue to make available independent medical advice and perhaps this might be an opportune time for you to have a brief chat with our Complaints Manager, Mrs Pat Burridge about how we might continue to access this service. We have had occasion to obtain independent medical advice from practitioners outside of the area when dealing with requests for Independent Review Panels over the past year and have successfully accessed this through other PCTs.

I hope that this will reassure you and your colleagues that we have a very positive approach to dealing with complaints within North Tees PCT and that we are more than willing to continue to work together to provide a service which will give a positive outcome to both those who are making a complaint and those who are being complained against. If you would like to discuss the matter further please do not hesitate to contact me."

It was **AGREED** that this matter should remain dormant until after the complaints process had been reviewed in the light of the Shipman Inquiry.

05/4/3.7 GPs undertaking Jury Service (appropriate reimbursement)
Ref Minute 05/01/18

Langbaurgh PCT – Marilyn MacLean
"The situation was discussed at the Tees Contractor Services meeting on 15 March 2005 and I have been requested to respond on behalf of all the PCTs. Unfortunately we all feel that we are unable to support your request, as this would have further implications for the PCT in respect of other independent contractors. It was suggested that it might be more appropriate for the LMC to lobby nationally on this issue. I am sorry we cannot give you a more positive response."

North Tees PCT
No individual response received – see LPCT's response above.

Middlesbrough PCT
No individual response received – see LPCT's response above.

Hartlepool PCT – Ali Wilson
"As you know, HPCT has a responsibility to use its limited resources (public funds) efficiently and ensure value for money at all times. We do not consider that the reimbursement of locums in this case to be appropriate although we would of course support

the practice in identifying suitable locum cover if necessary, which may be through the provision of a PCT employed GP (for which the practice is recharged). Clearly, we too have a responsibility as an employer to manage the burden of cost should any of our employees including SGPs be required to undertake jury services – with no access to additional NHS funding."

Dr Canning explained that the subject of GPs undertaking jury service was being discussed nationally. Legislation was not going to be changed to allow GPs automatic exemption as had happened pre-1 April 2005. At the moment GPs were receiving sympathetic treatment from the courts in relation to undertaking jury service at a more convenient time for the GP. It was hoped this continued and some funding or insurance could be sorted out.

05/4/3.8 Opening hours for pharmacies
Ref Minute 05/01/22.1

North Tees PCT – Liz Hegarty
"The new pharmacy contract is being implemented from April 2005, this will bring with it many changes and opportunities for community pharmacy. There will be a contractual obligation for community pharmacies to open a minimum of 40 hours per week, although many pharmacies are currently providing pharmaceutical services for more than this at the moment. In preparation for the new pharmacy contract North Tees PCT is undertaking a pharmaceutical needs assessment to consider the whole provision of pharmaceutical services PCT wide.

Your concern regarding opening hours will be considered together with all other relevant factors, although it makes sense for pharmacies located in close proximity to surgeries to align themselves to the surgery opening times. However, this should not be at the expense of weekend opening, where necessary, during which the pharmacy provides essential pharmaceutical services.

We are fortunate in North Tees to have three pharmacies that open late every weekday to 8.00 p.m., plus Saturday and Sunday which already provide pharmaceutical services after the core GP day. We do not anticipate that these pharmacy contractors will amend their hours in light of the new contract, but will need to await the results of the needs assessment before we can provide a definite answer.

We are committed to providing appropriate pharmaceutical provision PCT wide to meet the needs of the patients. I will keep you up-to-date with developments."

Middlesbrough PCT – Colin McLeod
"We will be discussing this matter with the pharmacists as part of our work to implement the new pharmacy contract. It is interesting to note that community pharmacists are not of the view that their opening hours [as commercial enterprises] should necessarily be determined by changes to the GP contract. They would have obviously preferred GP practices to remain open on Saturdays. Our priority is of course to ensure patients have access to services to meet their needs and this will be the focus of our future discussions with all contractor professions."

Hartlepool PCT – Carol Johnson
"You note that Hartlepool does not currently have a problem during core GP hours, however, we are aware that implementation of the new Pharmacy Contract may change this.

Our prescribing team will be contacting all pharmacies to ascertain their intended working hours and we will inform you of the outcome."

Langbaurgh PCT – Jon Chadwick
"I would like to reassure the LMC that LPCT is committed to continue to provide pharmaceutical services during core hours."

RECEIVED.

05/4/4 GPC ANNUAL REPORT

Executive Summary sent to all GPs. Full report available at http://www.bma.org.uk/ap.nsf/Content/gpcannualreport2005

RECEIVED.

05/4/5 REPORT FROM ANNUAL OPEN MEETING

Already discussed under Annual Open Meeting *(minutes attached).*

05/4/6 ANNUAL CONFERENCE OF REPRESENTATIVES OF LMCs

05/4/6.1 Motions to Conference

Motions discussed were:

1) That this conference believes that, in the interest of fairness and equity, Schedule 1 of the Freedom of Information Act must be amended to place all providers of primary medical services under the same obligations.
2) That the current central vaccine distribution system does not provide a safe level of health protection for the community. At least until a consistently reliable system is provided practices should be free to make their own arrangements with reimbursement from the PPA.
3) That conference supports the principles of Agenda for Change
   (i) But asserts that pressure for practices to introduce it must be resisted
   (ii) Requires full funding for its introduction
4) That conference recognises that the new contract is "high trust" but notes that a random 5% of practices are subjected to in-depth QOF investigations. Conference therefore calls on the TSC to carry out in-depth investigations of 5% of PCTs use of enhanced services funding.
5) That the age range for the Cervical Screening Indicator CS1 must be revised to reflect revised national screening policy.
6) That if no satisfactory settlement of collaborative arrangements is forthcoming in the 2006 DDRB report this conference instructs the BMA to withdraw from this element of the DDRB and enable local negotiations by supporting joint working by LMCs and LNCs.
7) That this conference notes that the DDRB are "dismayed at the Department of Health's position" on collaborative arrangements and that they "urge the Department of Health to get discussions underway". This conference demands that:
   (i) Urgent action is taken to define the fees for collaborative arrangements and the method of payment

(ii) Every endeavour is used to negotiate appropriate fees for work done under collaborative arrangements
(iii) Should there not be a satisfactory package of remuneration and resources in the DDRB's 2006 report the BMA should withdraw from this aspect of the DDRB and continue direct negotiations between local authorities, Trusts and LMCs and LNCs.

8) That conference requires urgent action on mental health act examinations to:
   (i) Ensure that, except in an emergency, GPs are given adequate notice to make appropriate arrangements
   (ii) Provide remuneration compatible with the time taken, responsibility involved
   (iii) Ensure fees relate to comparable work under the new contract.
9) That this conference notes that the DDRB, in its latest report, urges the Health Departments to make speedy progress in taking forward discussions on the remuneration for trainers and demands that:
   (i) The GPC uses every endeavour to engage in negotiations
   (ii) Should there not be a satisfactory package of remuneration and resources in the DDRBs 2006 report the BMA should ballot trainers on a withdrawal of their services.
10) That, in order to retain the GP workforce, doctors in need of remedial professional development should be eligible for adequate resources to facilitate their full integration into the workforce.
11) That this conference is dismayed at the failure to produce the English SLA for general practice IT and calls on the GPC to ensure either it is promulgated within one month, or full details of the areas of contention are published.
12) That this conference believes that whilst directed and national enhanced services have served their purpose by allowing GPs to say "no" to un-resourced work they have proved to be over bureaucratic for practices, LMCs and PCTs and should be integrated into carefully defined essential services as an enhancement of the global sum.
13) That this conference requires clear and detailed parameters for access to primary medical services for:
   (i) Overseas visitors
   (ii) Patients in hospital, whether private or NHS.
14) That conference urges further work to be undertaken to enable practices to recoup costs involved in supplying information under:
   (i) The freedom of information act
   (ii) The data protection act.

It was **AGREED** that members should submit suggested re-wording for (9) by Thursday, 14 April, and that the motions then be submitted.

Post-meeting note: No members suggested alternative wording. The wording was, however, clarified to read:

That this conference notes that the DDRB, in its latest report, urges the Health Departments to make speedy progress in taking forward discussions on the remuneration for trainers and demands that:
   (i) The GPC uses every endeavour to engage in negotiations;
   (ii) If there is no satisfactory package of remuneration and resources for trainers in the DDRB's 2006 report, the BMA should ballot trainers on a withdrawal of their services.

05/4/6.2 Honorarium and expenses payments for representatives at Conference

The Secretary explained that last year attendees received £326.19 per day (tax to be deducted) or the actual cost of an external locum, if greater, for the duration of the conference; and £30 out of pocket allowance per day (tax to be deducted) with the expectation that they make a significant donation to the GP charity "The Cameron Fund" at the annual dinner. Members believed that this did not reflect the current cost of providing a day's cover, and:

It was **AGREED** that conference attendees receive £400 per day and £50 out of pocket allowance.

05/04/6.2.1 Tax and NICs payments from LMCs to part-time committee members

Dr Canning informed members that the LMC office had just been advised that members would not be expected to pay PAYE on any money received from the LMC if they paid it into the partnership and left it in the partnership. The LMC will still be required to pay the employer's NICs on any payments to members. If members did not pay their money into the practice, tax would have to be deducted under PAYE. Members will be required to give an assurance that the payments were going into the partnership.

05/4/6.3 BMA document "A vote to improve health"

A copy of the March document had been sent to all LMC members. A GPC version (April 2005) was now available on the BMA website which contained reference to adequate funding for trainers, and recommends the role of holistic general practice.

05/4/7 PRIMARY CARE FUTURES

05/4/7.1 Article from The Times : 28 March 2005 "Super-surgery plan signals end for the family doctor"

Members commented that there were very few single handed doctors left in the LMC area.

05/4/7.2 PowerPoint presentation by Jo Whithead, to Early Adopters Workshop, Novotel West, Hammersmith : 10 March 2005)

Members had been sent an abstract of the presentation and discussion: *"Jo looked at the vision for primary care to deliver more care in more accessible venues by more providers. Jo looked at how primary care may change to be more flexible so that "GP plus services" could offer more specialist services such as diagnostics, out patient services and follow up care. The opening up of Choice for patients in primary care services presented a challenge. Primary care services offered by independent*

sector, voluntary services or groups of alternative primary care providers were an option. Patient populations were asking for more flexibility. The discussion that followed looked at the opportunities and threats this vision offered. There was some heated debate about how PCTs could develop strategic commissioning plans with practices and localities to reconcile these issues."

It was **AGREED** that Dr Canning would formulate motions for conference concerning:

- the support of holistic general practice; and
- opposition to the fragmentation of services (super surgeries)

Post meeting note: The following motions were submitted:

That This conference asserts in the strongest possible terms the commitment of British General Practitioners to holistic, list-based, patient-oriented, general practice.

That This conference strongly opposes any policy which gives financial or other incentives to "super surgeries" over more traditional models of service.

05/4/8 CHANGES TO THE CONTRACT FOR 2005/2006

05/4/8.1 Statement of financial entitlements

A new SFE was published annually. Dr Canning recommended that the edition be downloaded and only held locally in an electronic format as it was quite lengthy. (Available at www.dh.gov.uk/assetRoot/04/10/75/17/04107517.pdf.

05/4/8.2 Regulations

Regulations had been amended but much of the detail was about electronic transfer of prescribing and what happens if single handed doctors died and how they are protected.

05/4/8.3 QOF

Discussed earlier in the Open Meeting.

05/4/9 PRACTICE BASED COMMISSIONING

Discussed earlier in the Open Meeting.

05/4/10 LPCT CONSULTATION DOCUMENT re INTEGRATED HEALTH & SOCIAL CARE FACILITY

A copy of the document had already been circulated to Langbaurgh GP members. No comments had been received and LPCT would be notified accordingly.

05/4/11 LETTER FROM DR A RAMASWAMY, CHAIRMAN OF STOCKTON SMALL PRACTICES ASSOCIATION re SHIPMAN INQUIRY REPORT

"The Recent Council meeting of our Small Practices Association decided to send copies of Chapter Thirteen of the above Inquiry to the LMC, PCT and MPs. I have no doubt our LMC is supportive of single handed practices and small practices, unlike the reports I have heard from other LMCs around the country. SPA strives to support, educate and involve GPs practising alone and GPs in smaller practices, and I would urge GPs in our area who would like to make use of our services to get in touch with me (Dr A Ramaswamy). Our website is www.smallpractices.org.uk."

Dr Ramaswamy explained that the number of single handed practices was on the decline and there was concern that there was no longer a right of appeal to decide whether, when a SHP vacancy arose, that practice remained as single handed, was amalgamated into a larger practice, became an APMS practice or came under PCTMS arrangements.

Dr Canning commented that even in a large practice there may, in the future, be only one single handed practitioner with the remainder of the partners being salaried doctors. There had to be one full time partner in any practice.

Dr Canning **AGREED** to draft an appropriate motion for conference.

Post meeting note: The following motion was submitted:

That This conference supports the principle of sole contractors being able to provide primary medical services and urges the GPC to seek formal mechanisms for:

(i) Consultation, involving the LMC, on the management of sole provider vacancies;

(ii) Appeals against PCO decisions on management of sole provider vacancies;

(iii) The appointment of replacement contractors which includes LMC representation;

(iv) Appeals to an independent body by short listed candidates failing to be appointed to sole provider vacancies.

05/4/12 REPORT FROM GPC MEETINGS

Enhanced Services

Discussions have continued in plenary following a number of reports that have been received about Primary Care Organisation (PCO) enhanced services under spends in 2004-05. The negotiators have been constantly striving to ensure that this money is not lost to enhanced services and used to pay off deficits elsewhere in PCOs' budgets. An agreement on this issue has now been reached with the Department of Health, subject to some final drafting amendments. This agreement is that for 2004-05 only, where Primary Care Trusts (PCTs) do not achieve the level of expenditure to meet the enhanced services floor (ESF) in 2004-05 they should discuss the position with their Local Medical Council (LMC). The aims of

discussion will be to obtain LMC agreement that under expenditure against the ESF will be rolled over into enhanced services budgets in 2005/06 and made good in 2005-06. Where agreement is not reached either party may refer the matter to the Implementation Coordination Group (ICG), for consideration of the issue. This agreement will be for one year only and the money rolled over will be available in addition to the ESF already agreed for 2005-06.

Enhanced Services Floor

The draft of the letter from the NHS Director of Finance and Investment to Primary Care Trust (PCT) finance directors detailing the agreement reached with the Department of Health in England and with NHS Employers on handling enhanced services underspends in 2004-05 was agreed at plenary. This letter has now been issued and is available on the Department of Health website - go there now

The agreement is that for 2004-05 only, where PCTs do not achieve the level of expenditure to meet the enhanced services floor (ESF) in 2004-05 they should discuss the position with their LMC. The aims of the discussion will be to obtain local medical committee (LMC) agreement that under-expenditure against the ESF will be rolled over into enhanced services budgets for 2005-06 and made good in 2005-06. Great vigilance will be necessary to ensure that PCTs do not again underspend in future years or divert enhanced services monies into other budgets. Where agreement is not reached either party may refer the matter to the Implementation Coordination Group (ICG), for consideration of the issue. PCTs will have until the end of April 2005 to agree with LMCs how the carried forward sums will be invested in 2005-06. This agreement will be for one year only and the money rolled over will be available in addition to the ESF already agreed for 2005-06.

QOF and the Freedom of Information Act (FOIA)

Following the Department of Health's consultation with a limited number of stakeholders, including the GPC in November and December 2004, a draft policy paper on the publication of Quality and Outcomes Framework data has been considered in plenary. Given that there is little alternative to making such information public, the paper was promising in that it laid out quite sensibly what information should be published by PCTs, what explanations would be required and the role the new Health and Social Care Information Centre may be able to play to reduce the bureaucratic impact on PCTs and practices. In Scotland, Northern Ireland and Wales, it is likely that the same principles will apply but the guidance will be adapted to suit local circumstances.

QOF Visits, Confidentiality and Data Protection

The confusion generated by this issue and the delays in getting substantive advice to PCOs, LMCs and practices is unfortunate. This is in part due to the complexity of these matters and the wish to get clear legal advice but also, on the GPC's part, due to the need to involve practices in the minimal amount of additional work or risk in dealing with these matters.

Discussions on the revised Code of Practice on Confidentiality and Disclosure of Information continued between the GPC and Department of Health lawyers during February. Despite best efforts and the Department insisting that the GPC's comments have been taken on board, the latest version is still, in our view, not an accurate reflection of the present position.

One key concern is that it is still very weak on the contractor's right to refuse to disclose where the contractor believes there may be a breach of the Data Protection Act (DPA). The effect of the Department's latest version of the Code of Practice is to suggest that the DPA has become irrelevant to practices when it comes to disclosure of information to Primary Care Organisations (PCOs), simply because Counsel has advised that an exemption may apply in one set of circumstances – the QOF visits. There is the chance that the Department will go ahead and publish this Code of Practice anyway, especially if agreement cannot be reached. However, if this is the case, the GPC will be publishing its own guidance, in

response to the Department of Health guidance, to ensure that practices understand the issues – and have an easier, clearer, document to which to refer.

Premium-rate Phone Lines

A ministerial announcement, banning the use of all premium and certain national rate numbers by all NHS bodies has been made. The reasoning behind this ministerial policy decision is to protect patients from higher-cost calls. There are a number of GP practices, which have entered into contracts with certain commercial telephone companies that will be affected by this decision. Some practices entered into these contracts with the encouragement of their PCO. The GPC's aim is to ensure that practices are not financially disadvantaged as a result of this policy.

Choose and Book

There is no contractual requirement for General Medical Services (GMS) practices to participate in Choose and Book, and this also applies for Personal Medical Services (PMS) practices, subject to any clauses concerning participating in new initiatives in their contracts. Practices should not take on any work that they are not contracted to do, are not happy to do or for which they do not feel they are being properly resourced.

The main concerns the GPC has been impressing upon the Department of Health are the lack of clear information on the programme, the implications for workload, and concerns about patient confidentiality, together with a belief that the Government's version of Choose and Book is not the best way to offer patients appropriate choices about their treatment. In an attempt to address some of these concerns, new 'incentivisation' money was announced by the Secretary of State last month, but it is not clear how much of this money will reach practices, especially as the GPC was not consulted on this matter.

Normalisation

The Department of Health has confirmed that, through a fault in the Exeter payment system, a new normalisation factor each quarter was being calculated and applied, rather than applying the factor calculated at the beginning of the year, throughout the year. Appropriate software changes to the Exeter payment system have been agreed and, in areas where payments were made mid-month, payments in quarter 4 were briefly delayed, in order to correct this.

Although quarter 1 payments will have been correct, payments for quarters 2 and 3 will be incorrect. Therefore, practices with increasing populations have been underpaid for this period, and those with decreasing populations have been overpaid. The Department of Health and 'Exeter' are running tests on possible solutions to correct this problem. The GPC will be meeting the Department of Health to discuss potential solutions to deal with the over and under payments in early March. This problem is limited to England and Wales, and is not an issue in Scotland and Northern Ireland.

Normalisation: Update March

As has been reported previously, through a fault in the Exeter payment system, a new normalisation factor each quarter was being calculated and applied, rather than applying the factor calculated at the beginning of the year, throughout the year. Appropriate software changes to the Exeter payment system were made to correct this for quarter four payments. However, payments for quarters 2 and 3 are still incorrect. Therefore, practices with increasing populations have been underpaid for this period, and those with decreasing populations have been overpaid. The Department of Health and 'Exeter' have been running tests on possible solutions to correct this problem. Unfortunately, the work on this by the relevant IT experts has been delayed and the proposed software developments are not yet ready for us to be able to discuss possible solutions to the problem of over- and under-payments with the Department of Health. We have been promised that the information should

be available for discussion in mid-April. We are very anxious to resolve this problem but cannot agree to payment changes being made without consideration of their effects on practices. This problem is limited to England and Wales, and is not an issue in Scotland and Northern Ireland.

Community matrons

The committee considered the Department of Health's guidance for developing the role of community matrons 'Supporting People with Long Term Conditions: Liberating the talents of nurses who care for people with long term conditions' published 1 February 2005. The document can be accessed on the DoH website www.dh.gov.uk/assetRoot/04/10/24/98/04102498.pdf

Members felt the document lacked important detail on funding, medico-legal implications such as where responsibility for the patients would ultimately lie, workforce and recruitment issues, and the need for competencies in note-taking and IT. The committee agreed that there appeared to be much cross-over in the work already carried out by GPs in chronic disease management, but felt that if the community matron model enhanced the care provided to this patient group and supported GPs in this work then the model was a positive step. However, the views of the committee were unchanged and members maintained that the community matron would need to be integrated into the practice team for the model to work effectively.

IT update

Choose and Book

The GPC have met with representatives of the Department of Health to discuss Choose and Book. We have also sent to the National Program for IT a 'ten point plan', listing changes which we believe are needed to make Choose and Book more useable.

GP2GP

The testing of the electronic transfer of GP patient records between different GP clinical systems is currently underway. Clinicians have been engaged in this process, particularly in the quality assurance work. Hopefully the GPC will receive a demonstration of *GP2GP* at its April meeting.

Service Level Agreement

The Service Level Agreement (SLA) detailing the service that PCTs must provide to practices is still pending. The Joint GP IT Committee have sent further comments to the National Programme for IT and is still awaiting a response. A liability statement detailing who is responsible for replacing equipment, for example in the event of theft or damage, is close to being finalised and will be attached as an appendix to the SLA. This is an 'England only' agreement, however, it is expected to be adapted for use in Wales and Northern Ireland. Scotland already has an agreement in place.

Quality and Outcomes Framework Management and Analysis System (QMAS)

The majority of practices (97%) are sending in their reports, with only a small proportion reporting difficulties in submitting reports. The Co-Chairman of the Joint GP IT Committee (JGPITC) wished to congratulate this success on the work of the National Programme for IT on the successful roll out of this project.

Patient Confidentiality

The Committee considered a letter to the Chairman of the BMA, James Johnson, and a letter from the Patient Liaison Group Co-Chair, Barbara Wood, regarding the issue of patient confidentiality. It was agreed by the GPC that it would be beneficial to discuss this issue in as open a forum as possible, and that appropriate arrangements should be made to bring these proposals about.

Accreditation of Future Systems

Under the new GMS contract, the JGPITC is responsible for ensuring that future systems are fit for the purpose. Representatives from the Joint GP IT Committee are meeting with the National Programme for IT to discuss the practicalities of the accreditation process in the first week of March.

IT Update: March

ETP

The Joint GP IT Committee welcomed a presentation from representatives from the Electronic Transmission of Prescriptions (ETP) team at their recent meeting. The ETP team is working with a group of GPs, including representatives from the GPC, who will provide advice and guidance and review the impact of the ETP service on working practices within surgeries.

Centrally held Data

Representatives of the Joint GP IT Committee have visited Bletchley Data Centre. This is where decrypted data will be held centrally for National Programme for IT initiatives such as Choose and Book and the NHS Care Record. It was therefore important for the GPC to see the physical protections that exist around this information. Those visiting were reassured that the data centre has adequate physical access controls and more than adequate support resilience. Representatives did not visit the mirror centre but accept that the protections there are equivalent. Representatives from the Joint GP IT Committee have also been invited to Choose and Book pilot sites to view the systems and speak to the GPs who have been involved with the pilots. The GPC is planning a further meeting with the Department of Health to discuss policy issues surrounding Choose and Book. The GPC has given the Department of Health a list of suggested changes that would make the process more acceptable to GPs.

Microsoft Licences

There were reports at the Joint GP IT Committee that practices and PCTs are still not aware of the English NHS Licensing arrangements for Microsoft products. NHS organisation in England (including GP practices) are covered by the national licence and are therefore entitled to free access to Microsoft products - Word, Access, Excel, Outlook, Powerpoint and FrontPage. Practices should contact their PCT if they wish to take up this offer.

Promoting general practice

The proximity of the general election provides an unrivalled opportunity for the BMA/GPC/LMCs to promote the value and importance of NHS general practice to the public and politicians. More information on how to engage the public and local political candidates will follow shortly.

Reducing the bureaucratic burdens of sharing information

Further to our work with the Cabinet Office on reducing bureaucracy on GPs, the Cabinet Office Public Sector Team in partnership with the Department of Health is undertaking a project to reduce the bureaucratic burdens associated with sharing data between health and social care. A key element of this project is a questionnaire to identify bureaucratic burdens and possible changes to processes and paperwork that will reduce or remove burdens. The questionnaire can be found at the Cabinet Office website http://www.cabinetoffice.gov.uk/regulation/pst/projects/mad/data.asp. We would be grateful if LMCs would inform local practices about the questionnaire and encourage them to complete the form.

Postgraduate Education Allowance (PGEA)

Further to the case won against Islington PCT claiming a full year's PGEA following the start of the new contract, we have now looked at the details of this particular legal ruling to check

its relevance to all GPs and to see if this could set a precedent or whether this is ruling is specific to this particular doctor.

The whole crux of this matter hinges upon whether PGEA was paid annually in arrears or advance. Following legal advice and internal discussions, it has been agreed that the ruling cannot be applied generically to all GPs because:

1. it would not apply to Personal Medical Services (PMS) GPs who have different arrangements and is not likely to apply to new GPs post 1990-91, but more importantly,
2. it would only apply to those who could present evidence themselves that they had been paid annually in arrears, and
3. we know of other GPs who can provide evidence that they had not been paid annually in arrears.

It is important to note that the judgment ruling on this case is only relevant to this one particular case. Therefore, this does not set a precedent for all doctors to claim this money; however what is does do is indicate that any other GP in the same situation may be successful in a challenge. The GPC's current advice is that only those who can provide evidence that they had been paid in arrears might have a case.

We are currently undertaking investigations to find out what further information we can about what happened in the past, to see if there is anything further we can do and are working on some guidance that will assist individual GPs, and LMCs, in assessing whether they may have a case and the best way to take this forward.

Doctors' and Dentists' Review Body (DDRB)

Following the publication of the DDRB's report in 2004 there was a groundswell of opinion in the profession questioning the role and effectiveness of the DDRB as an independent process for recommending changes to the profession's remuneration levels. This was crystallised into an ARM resolution passed in 2004 calling for the BMA to consider withdrawing from the DDRB process, which BMA Council and BRPAD have been discussing this session. The recent publication of the 2005 report has returned this issue to the political centre stage. At the BMA Council meeting on 9 March 2005, it was agreed that the BMA should not withdraw from the DDRB process at this time.

The GPC also considered the arguments for and against the DDRB process, especially when compared to direct negotiations with NHS Employers and the Department of Health. Although it was recognised that there had been a disappointing lack of progress in some important areas, the GPC felt the DDRB has had a beneficial impact on GPs remuneration, both in terms of overall earnings of the medical profession and specific awards in recent history for GMS GPs, and has provided and will continue to provide the best opportunity for the long-term protection of incomes.

To understand the issues and the arguments involved, it is helpful to appreciate the historical information in context. GPC negotiator Peter Holden has produced a paper, written in February 1996 and revised in March 2005, 'The Doctors' and Dentists' Review Body: An Historical Preview with a GP perspective', a full copy of which is available electronically from the GPC secretariat (email: info.gpc@bma.org.uk). The GPC will feed its views into the BMA's continuing deliberations and will produce a briefing paper, that will highlight the main issues and set out the GPC's position, to inform discussions at this year's ARM and LMC Conference.

Revalidation

The committee discussed the Chief Medical Officer, Sir Liam Donaldson's 'Call for ideas – Clinical Performance and Medical Regulation: Chief Medical Officer's review following the

Shipman Inquiry reports', - go there now. In addition to feeding into the BMA-wide response, it was agreed that the GPC would provide a separate response which would be based on committee debate and then further considered by the negotiators, and the educational and professional development subcommittee. The deadline for the response is 11 April 2005.

The committee felt the GPC response should emphasise the purpose of appraisal and revalidation, and highlight that, although the same evidence may feed into both, appraisal is predominantly an educational and supportive process and is therefore distinct from revalidation. Fitness to practise is about performance, rather than competence and knowledge, and the development of a no-blame culture would enhance patient safety. The committee discussed that professionalism should not only be limited to doctors, but should also apply to other professions. The committee felt it vital the response stress that any arrangement put in place should not introduce an onerous workload, as this would pose a threat to general practice recruitment and retention. It should also be made clear that an extensive system of re-training and revalidation would need adequate resources. Members re-emphasised the importance of joint working with the Royal College of General Practitioners on these and other matters.

Salaried GPs and practice letterheads

There have been a number of enquiries regarding practice letter heads and whether or not salaried GPs can be included in any letter heading.

Under The Business Names Act 1985 a business is required to include all the names of its partners on the letter heading if they are not included in the Business Name. All those partners carry joint liability in relation to their business.

Practices are able to include the names of other members of staff (eg salaried GPs) on their letter head. However, it is important that they put a qualifier by their name (eg salaried GP, staff GP) so as to distinguish them clearly from the partners. Failure to do so could leave these doctors/staff members open to carrying joint liability with the partners.

Election and tenure of the GPC chairman and negotiators

The GPC discussed the election and tenure of the GPC chairman and negotiators. This continued the discussion and work on reforming the GPC's structure in relation to the Proposals for Change paper and the GPC Review Task Group report.

The committee voted to elect the chairman of GPC for a period of three years rather than continue with the annual election process. The committee also voted that the overall tenure of the chairman should not exceed two three year terms of office (ie: six years in total as chairman).

The committee had already decided to extend the tenure of the negotiators to three years, again moving away from an annual election process. After discussion it was decided that there should be no cap placed on the overall length of time a negotiator could be in post.

It was felt that this would allow both the chairman and negotiators to plan their commitments in relation to their practices and LMC work and provide the necessary continuity and experience.

NOTED and RECEIVED.

05/4/13 REPORTS FROM MEETINGS

There were no reports from meetings.

05/4/14 REPORTS FROM REPRESENTATIVES

There were no reports from representatives.

05/4/15 ANNUAL REVIEW OF LMC MILEAGE & ATTENDANCE ALLOWANCE

Attendance Allowance is currently £41.30 (less tax) per hour
Inland Revenue mileage rate remains at 40p per mile for 2005/2006

Dr Canning explained that in previous years, rates had increased in line with DDRB increases for general medical services; the DDRB no longer sets such increases and there is, therefore, no appropriate figure. The nearest objective indicator of average GP pay increases is the dynamising factor, however, final figures are known only retrospectively.

The interim dynamising factor for 2005/2006 is 7.3%.
The Inland Revenue mileage rate remains at 40p per mile for 2005/2006.

It was **AGREED** that:

- attendance allowances increase in line with the interim dynamising factor of 7.3%, and that a similar approach is taken in future years, subject to adjustments required to replace the interim dynamising factor with the actual figure; and
- the mileage rate remains at 40p per mile.

05/4/16 CHILDHOOD VACCINATION & MMR

Practices were having problems obtaining childhood vaccinations.

Particular difficulties were associated in obtaining MMR following a directive from Public Health that everyone in the "at risk" age group be vaccinated; there was also the question of funding to undertake this work LPCT had agreed to pay GPs an items-of-service fee. North Tees were paying their GPs. Dr Canning had a meeting with MPCT on Wednesday. Hartlepool were not paying.

Dr Canning explained the vaccine shortage had already been raised centrally.

It was **AGREED** that:

- The shortages should also be pursued locally with Public Health; and.
- GPs should receive an item-of-service fee for additional work in all areas.

05/4/17 ASSESSMENT OF GP PENSIONABLE EARNINGS

Documents received from accountants were proving difficult to understand.

05/4/18 NES INTRA-UTERINE CONTRACEPTIVE DEVICE FITTINGS – ACCREDITATION & TRAINING REQUIREMENTS FOR DOCTORS WISHING TO PROVIDE THIS SERVICE

There is now a requirement that doctors must insert a minimum of 12 coils per annum in order to obtain a letter of competence. Deborah Beere said this requirement was based on evidence, but she may be prepared to reduce this figure from 12 to 10 per annum. Even so, because of the reduced number of people using the coil, many doctors will have/have had to withdraw from providing the service, resulting in a shortage of skilled doctors, unless they attend local training sessions to keep up their expertise. It was noted that coil fitting training for GP registrars would no longer be funded as it is an enhanced service, and this would result in even less doctors being competent to fit coils. Far less coils were being inserted now because of the misconception that they caused ectopic pregnancies. The Faculty say there are fewer expelled coils.

Dr Canning **AGREED** to:

- obtain a copy of the evidence that was used to determine the number of coils required to be fitted to remain competent; and
- look at the contractual guidance wording relating to those who have been trained being deemed to continue to provide the service.

05/4/19 LETTER FROM HPCT re PROPOSED BRANCH SURGERY CLOSURE

"Drs Omer & Thakur have approached HPCT for permission to close their branch surgery at 151 Annandale Crescent, Hartlepool, which has resulted in a formal consultation process being arranged. It is expected that this consultation process will commence on 1 April 2005 until 30 June 2005.

As part of the process, a consultation document has been produced by HPCT and we are seeking the views of many organisations, as well as patients of the practice and members of the public. Comments on the proposed closure of the branch surgery will be sought from the following organisations:

- Cleveland LMC
- Contractor Services, NHS Poole House
- Public Health portfolio
- Health & Social Care Scrutiny Committee
- Lloyds Pharmacy, Surgery Lane, Hartlepool

The proposal has already been discussed with neighbouring GP practices with two out of the four surrounding GP practices agreeing to patient re-assignment should the need arise. We would welcome your thoughts/comments during the consultation period."

NOTED. No comments received.

05/4/20 SUPPLEMENTARY AGENDA

05.04/20.1 PGEA Claims

Dr Canning explained that the old FHSA had paid the first PGEA payment in advance of end of the quarter June 1990. If doctors had documentary evidence that they had not been paid in advance when they were already on the List, they may be able to make a claim for payment. If a GP was on the list at 1.04.1990 they received PGEA if they had been in receipt of previous allowances. It appeared that the doctor in London had won his case because he had been able to produce documentation whereas the PCT could not.

The arrangements in place in the former Cleveland FHSA were that GPs received the first payment at the end of the first quarter of 1990-91 and that payments were continuous, subject only to the attendance criteria.

05/4/21 ANY OTHER NOTIFIED BUSINESS

There was no other notified business.

05/4/22 RECEIVE ITEMS

05/4/22.1 Medical List

Resignations:

Effective Date	**Name**	**Partnership**	**PCT Area**
31.01.05	Dr T Rijken	Dr Basson & Partners	MPCT
Resignation – Salaried GP.			
27.10.04	Dr N Siddiqui	Tithebarn Medical Centre	NTPCT
Resigned – Salaried GP			
31.03.05	Dr B K Lal	Dr Bentley & Partners	LPCT
Retirement			
31.05.05	Dr A Lakin	Dr Marshall & Partners	MPCT
Retirement			
31.03.05	Dr M D Speight	Marske Medical Centre	LPCT
Resignation. Salaried GP.			

Applications:

Effective Date	Name	Partnership	PCT Area
01.02.05 *Salaried GP*	Dr J Schmidt	Tithebarn Medical Centre	NTPCT
01.03.05	Dr M C Peverley	Drs Hazle & Peverley	HPCT
01.06.05 *Rejoining following retirement*	Dr B K Lal	Dr Bentley & Partners	LPCT
01.04.05 *Currently salaried GP, becoming a partner*	Dr A Garcia Ferrer	Dr Beeby & Partner	MPCT
14.03.05 *Salaried GP*	Dr V Nanda	Dr Khair & Partners	MPCT
01.04.05 *Salaried GP. Partner wef 1.10.05.*	Dr M D Speight	Dr Glasby & Partners	LPCT

RECEIVED.

05/4/22.2 Report from GPC meetings

Formula and Quality and Outcomes Framework (QOF) Review Groups

Further meetings of these groups have taken place.. A workplan for the formula review has now been developed with a large measure of agreement between the parties about what needs to be done and by whom. Technical members of the group are now in the process of preparing the research specifications for the various aspects of work identified in the plan. The main policy issue currently under discussion is the impact on the Minimum Practice Income Guarantee (MPIG) of any changes to the formula and again progress is being made at a technical level to jointly identify and clarify the policy and political issues that arise.

The QOF review group is currently at the stage of considering the appointment of the independent QOF expert review panel – a fully independent panel of experts with the relevant knowledge and expertise in developing quality indicators and assessing and researching evidence.

The group has also recommended changes to the Mental Health Indicator 5, which have now been agreed in plenary, as follows:

- that the therapeutic range for serum lithium levels be changed to 0.4 – 1.0 mmol/l
- that the upper achievement threshold for this indicator be increased to 90%
- that these changes are introduced from April 2005.

For 2004-05, it is still the case that, where practices have agreed a locally valid range with their PCOs, they will receive all the appropriate QOF points. This is because the Quality and Outcomes Framework Management and Analysis System (QMAS) has the ability for practices to raise issues about their final achievement on any particular indicator with the PCO. The PCO can then agree that the practice has met the achievement within the local range before the practice agrees to the final sign off.

Premises Rent Increases

The GPC has raised with the Department of Health and NHS Employers the concerns about reports received from PCOs that, from next year, rent increases for practices will not be automatically funded, and the further rumours circulating that PCOs will not continue to review rents automatically every three years. However the GPC believe that there is an unequivocal statement (para 42) in the NHS (General Medical Service - Premises Costs) (England) Directions 2004 which does not allow for this. Final confirmation from the Department is awaited.

Locum GPs undertaking PEC work

It appeared that the Department of Health had been taking the view that, while all other GPs could superannuate regular PCO Executive Committee work under the NHS Pension Scheme, freelance/locum GPs were unable to superannuate this work even though these GPs could superannuate all other NHS work. Further to written correspondence and discussions in plenary this anomaly has been resolved in favour of the freelance/locum GPs. It has been confirmed that locums can pension any additional Board or Advisory work in accordance with the amended scheme regulations. The only condition is that the doctor is actively engaged in the provision of medical services, which they have to be if they are a GP member of the Board, and is a member of the NHS Pension Scheme.

Interim Dynamising Factor

The interim pensions dynamising factor for 2005-06 has been agreed. An estimated factor of 12.0% has been confirmed and, at a 90% confidence level, the interim dynamising factor will be 7.3%. This means that the total dynamising factor estimated for 2003-06 is potentially over 30% which is in line with initial predictions. The GPC will be updating the 'focus on dynamising factor' guidance shortly to reflect these figures.

NHS Pensions Review

The consultation period on the NHS Pensions Review is currently in operation. The potential changes are being presented throughout the BMA and the consultation is being led by the BMA Pensions Department. GPs are encouraged to read the information available on the Pensions Review, to send their views to the Pensions Department and to complete the BMA survey on the key issues. The following motion was passed by the committee in relation to this discussion:

That the GPC believes the proposed changes to the NHS pension scheme for doctors:

- should not adversely affect current members of the scheme and allow them to maintain all of the current benefits, including retiring aged 60, if they so wish
- affect different branches of our profession in different ways and the GPC supports a robust BMA wide response to this consultation.

Pensions Salaried GPs

There is still some confusion about the current pension arrangements for salaried GPs, in terms of how they are regarded for NHS Pension Scheme purposes. Salaried GPs (PCO and practice-employed) are pensioned under the practitioner method (as per GP principals/providers) rather than under the officer method (as per hospital employees). In GMS and PMS, all salaried GPs will continue to be regarded as assistant practitioners for NHS Pension Scheme purposes and the relevant PCO will be their employer for NHS Pension Scheme and NHS Injury Benefit Scheme purposes. Therefore, contrary to the belief of some, salaried GPs will not automatically be pensioned under the final salary scheme. This is set out in the NHS Pensions Agency Technical Newsletter 5/2004, available on their website, under the library section, at www.nhspa.gov.uk - go there

The GPC guidance 'Pensions Questions and Answers', published in October 2004, further explains the current situation with regard to GP pensions - go there now.

Postgraduate Medical Education and Training Board (PMETB) – article 5 programmes

The committee discussed a joint paper from the Royal College of General Practitioners (RCGP) and Committee of General Practice Education Directors (COGPED) on "Specialist Training for General Practice". The paper will also be considered at the next JCPTGP meeting. Having already been discussed at RCGP Council, the RCGP were seeking the GPC's support of the recommendations the paper makes about the restructuring of GP training.

It will be important for the GPC to maintain an influence in these discussions as they could determine a move away from the constraints of current general practice training and help make it far more GP-oriented. Moreover it will give the GPC an opportunity to help shape any changes to article 5 which is being redefined (article 5 is the programme required to qualify an applicant for a Certificate of Completion of Training in general practice).

The paper was generally accepted and welcomed for its educational aims together with the fact that training would be far more learner focused including an emphasis on higher professional education after the completion of GP training. There was also the proposal that the whole training period could be spent in general practice rather than as now, to include a variety of hospital posts. However concerns were raised about the implications of reducing the service commitment of GP registrars (GPRs) in hospital posts as part of their training. Other concerns highlighted were that the personal mentor should be a GP; that any reference that work in out-of-hours for trainees would be a requirement in order to maintain salary levels should be removed; funding implications of the longer training in general practice needed to be recognised and addressed; that different parts of the UK may have different rates of progress which could have a destabilising effect and that the proposal of a UK-wide selection process for such training would require more detail. In addition, whilst there appeared to be consensus in that there were compelling reasons for there to be just the one employer for the GPR throughout the entire training period, it was recognised that further discussions would be necessary before a decision could be reached as to whether the contract should be held at practice or PCO level.

Comments from the GPC's discussion would be shared with the JCPTGP and RCGP. However if anyone would like to submit further comments could they please email to: abutton@bma.org.uk before Thursday 24 February 2005.

The Shipman Inquiry – Fifth report

The Committee discussed the report of a joint Statutes and Regulations Subcommittee and negotiators meeting on The Shipman Inquiry's Fifth Report - Safeguarding patients: Lessons from the Past - Proposals for the Future. In general the Committee approved of the conclusions reached by the Subcommittee and negotiators and there was consent that the Chairman and negotiators should work with the relevant personnel at the Department of Health and the Royal College of General Practitioners to ensure a proportionate response to Dame Janet's recommendations and a way forward that engaged the support of GP colleagues.

Health Professions Council Reference Forms

A number of LMCs have raised concerns about the reference forms issued by the Health Professions Council (HPC). When registering with the HPC, an individual has to have proof that they are of good health and are instructed to have an official form completed by a “registered medical practitioner.” Inevitably, patients are requesting that their GP completes the form.

Completion of HPC reference forms is not a GMS contractual obligation (PMS GPs are advised to check their contracts) and, therefore, a GP could charge a patient a professional

fee. When charging a fee, GPs should bear in mind the potential effect on the doctor/patient relationship.

Primary Care Development Scheme

The final version of the Framework for the Primary Care Development Scheme, which replaces the GP Golden Hello Scheme in England from 1 April, was signed off in plenary. Although this is no longer an SFE entitlement, the funding is directed at GPs and should not be lost in PCTs' general budgets. This funding should be used to improve GP recruitment and the GPC will be issuing separate guidance to ensure that GPs and LMCs can make the most of this scheme.

Medical reports for gyms and health clubs

As a result of the NHS campaign to encourage the general public to take more exercise, there have been a number of queries about GPs' obligations to provide medical reports to certify fitness to exercise and how to respond to requests for information from gyms and patients advised to see their GP before using the gym facilities.

In most cases the statement of patient's fitness from a GP is required for the liability insurance cover of the health club or gym. It is the BMA view that unless there is a direct clinical referral of the patient to the gym/health club as part of the patient's rehabilitation programme, then a charge is reasonable. This service is not covered under the new GMS contract and therefore the GP should be properly remunerated for the work which often involves the screening of the full patient medical record. The BMA is able to suggest fees for this work which can only be done by the patient's own GP or other attending doctor. The BMA suggested fee for this work is currently £11.50 for a straightforward certificate of fact and £19.50 - £41.50 for more complex certificates. Revised fees are due to be announced shortly. The GP does have the discretion to waive the fee after considering the implications to the doctor-patient relationship.

Where a gym or health club instructor is concerned about the health of one of its members, for example high blood pressure, it would be good practice for the gym to put details of the concern in writing to the GP. However, the gym should seek written consent from the patient before sharing this specific information.

RECEIVED.

05/4/22.3 Report the receipt of:

GPC News M7 : Friday, 18 February 2005 (www.bma.org.uk)
GPC News M8 : Friday, 18 March 2005 (www.bma.org.uk)
Sunderland LMC's minutes of meeting held on 21 December 2004
Royal Medical Benevolent fund Newsletter : Spring 2005

RECEIVED.

05/4/22.4 Date and time of next meeting

Tuesday, 7 June 2005, at 7.30 p.m. in the Committee Room, Poole House, Stokesley Road.

NOTED.

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

Date: **Chairman:**