CLEVELAND LOCAL MEDICAL COMMITTEE

Dr J T Canning MB, ChB, MRCGP
Secretary
Tel: 01642 304052
Fax: 01642 320023
Email: *christine.knifton@tees-shs.nhs.uk*

Grey Towers Court
Stokesley Road
Nunthorpe
Middlesbrough TS7 0PN

Minutes and report of the meeting of the Cleveland Local Medical Committee commencing at 7.30 p.m. on Tuesday, 25 January 2005 in the Committee Room, Poole House, Nunthorpe, Middlesbrough.

Present:	Dr I A Lone (Chairman)	Dr K P Bhandary	Dr A R J Boggis
	Dr J T Canning	Mr J Clarke	Dr G Daynes
	Dr K Ellenger	Dr T A Gjertsen	Dr M Hazarika
	Dr A Holmes	Dr K Machender	Dr J Nicholas
	Dr N T Rowell	Dr R S Sagoo	Dr T Sangowawa
	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
Professor T Van Zwanenberg : GP Adviser, SHA
Dr E Summers : Local Medical Director, Primecare *(first item only)*

Dr Lone thanked members for attending and welcomed Dr Krysha Ellenger (Thornaby/Yarm/ Eaglescliffe), Dr Tony Boggis (Middlesbrough), Dr Tom Gjertsen (Redcar/Saltburn/Marske), and Dr Mike Speight (East Cleveland) to their first meeting as newly appointed members.

05/01/01 PRIMECARE, CLEVELAND
Ref Minute 04/11/11

Dr Lone welcomed Dr Edward Summers, the Local Medical Director of Primecare for the past year, to the meeting and invited him to speak about his role at Primecare and to answer any questions members may put to him afterwards.

Dr Summers introduced himself as a Redcar GP for 16 years, who whilst a GP, had always worked for the OOH service in his area, initially Cleveland Deputising, then Cleveland Healthcall and now Primecare. He explained that as doctors had opted out of providing OOH under the new contract, Primecare would very much like the support of the LMC to encourage GPs to do occasional OOH sessions with the aim of providing first class care for patients. Currently Primecare needed to hire agency staff and European doctors, mostly German, who are registered with, and employed by, an agency in Cambridge, and were on the Cambridge Performers List. Such doctors had to have medical defence organisation cover and a GMC approved certificate to practice before working in this country. Concern was expressed that it would not be long before the GMC no longer had any powers over European doctors and it will be left to their own native country to govern them.

Middlesbrough PCT had concerns about the linguistic capabilities of the European doctors and were currently in discussion with Primecare. Dr Canning felt sure PCTs could impose conditions concerning linguistic skills upon doctors when they were applying to be included on a Performers List and queried whether these concerns had been notified to Cambridge PCT. He **AGREED** to write to MPCT with suggestions on how they can pursue this issue, and liaise with his counterpart in Cambridge. Dr Lone pointed out that MPCT had imposed appropriate conditions on the Spanish doctors recruited to Middlesbrough.

A question was asked concerning what language should be used in this country, as a local doctor had an occasion when a Spanish doctor had written a report in Spanish, which no-one in the practice could understand. Dr Summers asked for a copy of the document to be sent to him for investigation.

Concerns were also voiced with the experience of European doctors, especially Germans, in prescribing opioid and opiate drugs or dealing with young children as they tend not to do this in their own country. Again, Cambridge PCT could have looked into the doctors experience and imposed conditions prior to their inclusion on the Performers List. Dr Summers said diamorphine is not available in Germany and the German GPs are also unfamiliar with syringe drivers. The terminally ill patient appears to be managed largely by secondary care in Germany.

It was suggested that if any doctor had concerns about European doctors, MPCT should be notified and would take the matter up with Cambridge PCT. MPCT could also be notified of any concerns about any doctor working for Primecare, and would investigate issues raised.

Dr Summers informed the Committee that Primecare were monitoring the complaints against German doctors (in addition to UK doctors). Primecare were at times experiencing difficulties in obtaining responses to complaints from non-UK doctors. Dr Summers explained that if no response is obtained after three letters of request then the clinician will be reported to the GMC and the patient's PCT for further action. Dr Summers informed the LMC that a Clinician Alert Register was used by Primecare which is checked prior to engaging Duty Doctors in an effort to reduce clinical risk.

The subject of death certification for expected deaths OOH and whether the Coroner should be notified, was raised. Dr Summers, together with Dr Canning representing the LMC, and Val Hall representing MPCT, had already had one meeting with Mr Sheffield (Coroner), and other representatives, with a further meeting scheduled for Thursday. Dr Summers said more deaths will be occurring OOH because of GPs reduced working hours under the new contract, and bank holidays. The Coroner had wished Primecare to notify, to the uniformed police out of hours, all deaths whether expected or unexpected, which Dr Summers had opposed, and this matter had been discussed at that initial meeting.

Ultimately Duty Doctors will need prior information from local GPs as to whether they anticipate the need for Coroner involvement when a patient dies. This should, therefore, be made clear by GPs in either Palliative Care notes at the patient's house or by informing Primecare when a patient becomes very ill and is not expected to survive the illness. It will become necessary for Duty Doctors to know in advance whether or

not the patient's GP is willing and able to issue a death certificate for their terminally ill patients. Without this information there will be a much greater likelihood of the Duty Doctor informing the Coroner of a patient's demise. This is a situation which we need to avoid as much as possible.

Dr Canning gave two areas of concern for the Coroner:

(1) Single handed doctors on leave when a patient died. It was easier in a group practice for a colleague to have seen the patient prior to death.
(2) Instances when bodies have gone to an undertakers without a death certificate having been issued by the doctor.

It was important to make death as dignified as possible when it was an expected death.

A doctor queried if it had to be a GP who pronounced life extinct. Dr Canning said a doctor's duty is to issue a death certificate if that doctor had treated the patient in the last illness. Although only the Registrar has a statutory duty to refer deaths to HM Coroner, doctors should do this when indicated to reduce distress to families of a delayed registration.

Dr Summers was thanked for his attendance at the meeting and left at 8.00 p.m.

05/01/2 APOLOGIES

Apologies for absence had been received from Dr W J Beeby, Dr L Dobson, Dr A Gash, Dr J Harley, Dr J O'Donoghue, Dr A Ramaswamy, Dr R Roberts and Dr A Smith.

05/01/3 MINUTES OF THE MEETING HELD ON 2 NOVEMBER 2004

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

05/01/4 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

05/01/4.1 Proposals for Change - The Way Forward from GPC
Ref Minute 04/11/6

Dr Canning reported that the paper had been discussed at the November GPC meeting where it had been decided:

- Not to split the role of Chairman of the GPC Negotiating Team and Chairman of the GPC.
- Negotiators move towards a 3-year tenure subject to continuing membership of GPC
- GPC to establish a reference group to advise on current contract implementation and any future contract negotiation
- A GPC communications strategy should be developed in conjunction with the newly appointed BMA Communications Director to take five recommendations forward.

05/01/4.2 PMS Agreements
Ref Minute 04/09/4.3 : 04/11/3.4 – Responses received from all PCTs

Responses received showed PCTs were taking PMS agreements forward.

05/01/4.3 Agenda for Change – All PCTs asked to update LMC
Ref Minute 04/11/8 : Responses receive from all PCTs

All PCTs stated Agenda for Change in relation to practice staff was nothing to do with them, and recognised there were potential financial implications for practices for which there was no additional funding.

05/01/4.4 Payment to Locum & Salaried Appraisees – All PCTs asked to update LMC
Ref Minute 04/11/21.1 : Responses received from all PCTs

- **Hartlepool** – All appraisals funded from one budget. Would not expect any GP to fund appraisal from personal income and currently fund the time for sessional GPs.
- **North Tees** – Fund locums at same rate as other doctors, salaried GPs are expected to use their protected time for appraisal,.
- **Middlesbrough** – Will pay the agreed amount to all appraisees whether they are locum, salaried, PMS or GMS
- **Langbaurgh** – Checking their Performers List for locums working in their area, do not differentiate payment between part time and full time GPs, GMS practices payment is in their baseline.

05/01/4.5 Amendment to LMC meeting dates for 2005
Ref Minute 04/11/23.4

It was **AGREED** that the March and April dates be amended to :

01 March
12 April (Open Meeting)

05/01/5 NEW CONTRACT – All PCTs asked to update LMC, responses tabled.

05/01/5.1 How PCTs have allocated the former Treasury contribution (7%) of employer's superannuation to PMS practices

- **Hartlepool** – Weighted list size as per GMS
- **North Tees** – Weighted increase
- **Middlesbrough** – Matching GMS calculations
- **Langbaurgh** – Actual amount payable transferred (presume 2003/4 rate)

05/01/5.2 An up to date breakdown of enhanced service funding with, if possible, details of the spend to date

- **Hartlepool** – Floor needs clarification. OOH should not be an enhanced service
- **North Tees** – Current status not stated. Floors are being met. When figures are obtained they will need to be clarified.
- **Middlesbrough** – It is not clear what proportion of baseline funding is being allocated to enhanced and essential services. Was there an opportunity to bid for services?
- **Langbaurgh** – Floors are being met, nurse triage is being disputed.

Dr Canning emphasised that it was important to get the baseline floor correct now so that future budgets were correct.

It was **AGREED** that an update be brought to the next LMC meeting on 1 March.

05/01/6 QUALITY & OUTCOMES FRAMEWORK

05/01/6.1 Indicator DM8

A query had arisen in North Tees that DM8 (retinopathy screening) should not be claimed by practices unless patients had undergone retinal photography. The issue had been resolved in the absence of a camera-based screening service for North Tees, with patients undergoing appropriate methods of screening available being considered as having been screen for QOF purposes.

Apparently there was a problem in Hartlepool with the PCT being asked for guidance but as yet this has not been provided to Hartlepool practices.

In South Tees if patients DNA, they cannot make another appointment until the next year.

The Committee were informed by a member that the specifications for diabetic screening include the code for the recommendation to the patient to attend retinal screening, therefore crediting the practice with the criterion being met.

05/01/6.2 5% random fraud counter check for QOF visits

All PCTs have agreed that practices cannot be considered fraudulent until they have made a claim, and claims will not start to be submitted until after 31 March 2005.

Those practices chosen at random to make up the 5% fraud counter check will not be used in successive years. The LMC should be involved in the selection process, along with other members of the PCT, to keep the process acceptable to practices. Depending on the number of the practices in a PCT, there will be a minimum of two practices chosen per year. There were no national standards concerning what should be checked on these visits. Dr Nicholas felt that it should be possible to produce and analyse data on the system to check for suspicious patterns i.e. everyone in a certain category seen on the same day.

05/01/6.3 Other QOF issues

A query was raised as to the compatibility of computer hardware for QMAS; it was essential that PCTs were made aware if the system was not running properly and that PCTs refuse to pay the supplier until the problem was resolved.

Some practices had reported that the CD ROM used to ensure confidentiality during QOF visits did not work and this was thought to be because the systems were not powerful enough to run the program. Dr Canning **AGREED** to report to the Committee on the latest legal advice on confidentiality available.

There was a rumour circulating that there was not sufficient funding to pay practices at the end of the year, and Dr Canning emphasised that doctors had a legal contract which obliges PCTs to pay and the NHS have promised to find the money.

05/01/7 SICKNOTES FROM NORTH TEES & HARTLEPOOL NHS TRUST

Following a number of requests from former hospital patients for sicknotes, a Hartlepool practice has requested, under the Freedom of Information Act, copies of Trust documents outlining their sickness certification procedures.

NOTED. The outcome was awaited, with interest.

05/01/08 FREEDOM OF INFORMATION ACT

Guidance on the Act has been circulated to practices.

All PCTs had received a request under the Freedom of Information Act, from a consultancy in Kent, asking for practices proportional payments and points. Glasgow PCT had received a request for the PACT data for practices by net ingredient, cost, who prescribed, who dispensed them, and other criteria. If PCTs had this information they were obliged to divulge it, but if they had to request any information from practices, it was up to the enquirer to contact individual practices requesting this information, not the PCT.

It was important that practices have a data destruction policy concerning length of time documents are kept i.e. you cannot give 10 years PACT data if you only have one year on file.

05/01/9 THE NHS PENSION SCHEME REVIEW CONSULTATION

The Summary of the document had been distributed to members. The full document (120+ pages) can be found by follow the links on:
www.nhsemployers.org/docs/full_consultation_doc.pdf
www.nhsemployers.org/docs/main_body_text.pdf
www.nhsemployers.org/docs/annexes.pdf

Some of the proposals included:

- Raising the retirement age from 60 to 65
- Removal of lump sum with accrual rate at 1/60th
- Career average re-valued earnings

There was a consultation period and anyone with comments to make should contact NHS Employers on www.nhsemployers.org. If anyone had views which they would like Dr Canning to take to the GPC, he would be happy to do that.

Dr Canning **AGREED** to pursue the question of death in service and who funds the first six months pension following death, as there was concern this may fall to the practice to fund.

05/01/10 TENY PROPOSALS FOR MANAGEMENT OF CATEGORY 'C' CALLS (Minor/Non-Serious 999 calls)

The document was discussed and Dr Canning **AGREED** to write to TENY requesting further clarification and pointing out concerns, particularly relating to passing calls to GPs and "re-rings".

05/01/11 LAPSED DOCTOR'S GMC REGISTRATION

Following the discovery that a doctor's GMC registration had inadvertently lapsed, an investigation took place involving the LMC and the appropriate PCT, the outcome of which involved a number of "lessons" learned. On behalf of the LMC, I agreed to take forward a number of these:

a) That all GPs be reminded of the importance of ensuring that their GMC registration, and from 2005 licence, is maintained.
b) That all GPs be advised of the advantage of using Direct Debit arrangements
c) That other local representative committees be informed of the position

NOTED and **RECEIVED.** Dr Canning **AGREED** to include GMC registration in a forthcoming newsletter to GPs.

05/01/12 GENERAL PRACTITIONERS AND INTRAPARTUM CARE

Dr Canning explained that since 1 April 2004 intrapartum care was specifically **excluded** from the maternity services part of the new contract unless a practice had an enhanced service. The lack of provision of this service has resulted in doctors being asked to prescribe pethidine for a home delivery, whilst not being responsible for the patient, and being asked to undertake 24 hour baby checks which are excluded from the contract as they are an enhanced service.

It was noted that North Tees is the only area doing 5-10 day baby checks and these checks are not part of the latest Hall recommendations and are considered unnecessary.

Dr Canning asked for the LMC to be informed of any intrapartum services or neonatal checks GPs were being asked to perform when a practice enhanced service agreement was not in place.

The PCT have to commission neonatal checks, and the LMC has notified hospital maternity departments and PCTs that intrapartum care and neonatal checks are no longer provided by GPs and that they must commission appropriate arrangements for patients.

It was **AGREED** that the LMC would take the matter up with North Tees PCT.

05/01/13 CONCERN OVER SUPPORT PROVIDED BY ICAS (INDEPENDENT COMPLAINTS & ADVOCACY SERVICE)

Following the disbanding of the Community Health Councils, assistance for patients with complaints is given by the Independent Complaints & Advocacy Service which covers the whole of the Teesside area. However, patients were being given incorrect advice by inexperienced ICAS staff, and ICAS were not adhering to response deadlines or notifying doctors when complaints had been dropped.

Dr Canning had talked to PCTs in the past about re-introducing a conciliation service to enable patients to be given an independent medical explanation of events in the hope of resolving the complaint. Dr Canning **AGREED** to pursue the question of instigating trained conciliators to assist with complaints. In the meantime, anyone with concerns about ICAS was asked to contact the LMC office.

05/01/14 SUPPORTING PEOPLE WITH LONG TERM CONDITIONS
An NHS and Social Care Model to support local innovation and integration

The document was discussed. It was based on community matrons co-ordinating care for people with long term conditions in an attempt to reduce the use of hospital beds by providing care in primary and community settings.

Points raised by members included:

- The care should not de-stabilise existing services but be aligned with practices.
- The role of the GP and community matron must be clearly defined so that everyone knows what is expected of them.
- The community matron will be able to sign prescriptions and become nurse prescribers and safeguards for primary prescribers must be secured.
- The community matrons will be able to co-ordinate hospital care for these patients, and it is essential for practices to be dealing with the same community matrons.
- Concern that if district nurses are recruited to run the service this may result in a recruitment and retention problem for existing nursing services.

The Committee also discussed the impact of Practice Based Commissioning and it was pointed out that if a PCT included patch based services in their LDP, practices will not be able to commission anything other than that.

Comment was made concerning the Galvani Practice in Middlesbrough who only had 52 patients at a cost of £2,000 per patient per annum which was felt to be an appalling waste of funding.

05/01/15 CHILDCARE PROVISION FOR GPs

Dr Canning advised members that the NHS co-ordinator for childcare provision for GPs covering the Tees area was Julia Newton based at the Workforce Development Confederation (01642 352063). Julia thought that all PCTs had service level agreements with the local authorities who provided childcare information. All GPs could enquire about childcare provision through SureStart or Childcare Information Centres. Crèches were available at Hartlepool, North Tees and James Cook hospitals but priority went to Trust staff ahead of GPs.

Dr Canning **AGREED** to pass this information on to GPs.

05/01/16 JOINT GPC/ROYAL COLLEGE OF NURSING LETTER re PRACTICE NURSES & AGENDA FOR CHANGE

There was no new money to cover Agenda for Change in general practice. It was felt that there would not be a problem recruiting nurses between practices but there would be a problem between practices and hospitals because of the different pay and conditions hospital staff will be receiving.

05/01/17 LMC SURVEY re GP APPRAISAL

The LMC had undertaken a survey in March 2003 to ascertain GPs views on the appraisal process and their experiences whilst undertaken appraisal.

It was **AGREED** that the LMC should carry out another survey to gain an update on GPs experiences.

05/01/18 REPORT FROM GENERAL PRACTITIONERS COMMITTEE

Dr Canning explained that the following news items were from GPC News issued after the November and December GPC meetings. The GPC did not meet in January as there was insufficient new business to justify the costs of a meeting. The January GPC News was issued to provide an update on key matters which have arisen since the December meeting.

M4 : November 2004

NHS Employers
The negotiators met for the first time specifically with the new NHS Employers rather than the NHS Confederation. In terms of personnel there is not as yet any change. The Chairman of the General Medical Services (GMS) Contract Negotiating Team, Chris Town, is still in place and the secretariat, from the Primary Care Contracting section of the new organisation,

is the same. They are in the process of selecting a new negotiating team from the service which should be finally in place in the New Year.

NHS Employers is a subsidiary of the NHS Confederation, but with its own elected 204-member Assembly, which will provide the 22-member Policy Board, and its own full-time business team. The Director will be Steve Barnett, a previous DH Deputy Director of HR, who will formally be in post from the New Year. The main purpose of the new organisation is to take on responsibility from the Department of Health for most of the NHS HR agenda. NHS Employers is an England-only body but can be mandated also by the other countries to negotiate on their behalf. In terms of GMS, Scotland and Wales have indicated that the past negotiating arrangements are likely to continue. The position is unknown in Northern Ireland. The Department of Health in England will be retaining responsibility for Personal Medical Services (PMS), Primary Care Trust Medical Services (PCTMS) and Alternative Provider Medical Services (APMS). We believe that the Pay and Negotiation section of the new organisation will be responsible for GP Registrars, but we do not yet have an answer to our queries about where responsibility will lie for salaried and sessional GPs, GP trainers, educators and academics, or GPs working in community hospitals. The GPC's proposals for negotiating arrangements, as well as the negotiating priorities for the coming year, are due to be discussed at the next plenary meeting.

Open-but-full lists

The most controversial item on the agenda was the continuing pressure from Ministers and from NHS Employers for, at the very least, further guidance on open-but-full lists to the extent of pushing practices down the list-closure route if they wished not to take new patients. The main concern of the service is with practices that regularly and frequently say they are open one day and full the next, especially when they do not communicate their status to the Primary Care Organisation (PCO), and with areas where a number of practices have full lists simultaneously. Given the obligation of the Secretary of State, via PCOs, to ensure the provision of primary medical services, it was unacceptable to Ministers and NHS Employers that PCOs would not know from one day to the next where they might be able to send new patients to register.

While the negotiators supported good communication between practices and PCOs locally, it was not acceptable that practices should be threatened with a reduction in enhanced-services contracts or be forced down the list-closure route, when there was a legal and reasonable avenue for them to pursue when, for workload and capacity reasons, it was not possible for them to take on new patients at that time. The focus of a long-term solution should be on providing the necessary resources to ensure sufficient capacity at all times, not an amendment to Regulations or stricter guidance to stop practices from being able to claim they were full. In line with this, the previously published GPC guidance "Focus on Patient Registration" including open-but-full lists remains unchanged.

The negotiators reiterated their offer to speak to LMCs where the Departments or NHS Employers had evidence of practices genuinely being unhelpful in terms of alternating status regularly and failing to engage in a constructive dialogue with the PCO. Thus far, the negotiators had not been presented with any evidence of actual difficulties.

Dr Canning emphasised that practices must have a criteria for the use of an Open but Full List, because under the Freedom of Information Act patients can ask to see why they were not accepted. He offered to send copies of his own practice's criteria, to those GPs/practices who contacted the LMC office.

QMAS

Quality and outcome framework management and analysis system (QMAS) will be further enhanced so that practices can log their aspiration points. The GPC is aware some Torex users are experiencing problems with QMAS. It would be helpful if LMCs could send exact

details of the problems to Rachel Merrett (rmerrett@bma.org.uk) so that this can be addressed by the National Programme for IT.

Choose and Book

Some practices are currently being invited to be involved in Choose and Book pilots. Before agreeing to be involved the GPC strongly suggests that LMCs and practices consider the following:

Workload

The GPC are very concerned about the workload implications of Choose and Book. The GPC has worked to find ways of reducing the workload of GPs. Choose and Book is in danger of counteracting these efforts and will place a further burden on practices.

Time Constraints

It will be difficult for GPs to complete a Choose and Book appointment within the confines of a ten minute consultation, and we are concerned about the consequent effect on the quality of those and subsequent consultations.

Additional Resources

Choose and Book is not a requirement of the new GMS contract and therefore resources are not included in present funding flows to enable GPs to take on this additional work. The GPC will be working with the Department of Health to address this issue but until an agreement is reached, practices should be aware that legitimate additional resources are unlikely to be made available to them.

All hospital trusts invest a significant amount in managing referrals and booking appointments. Choose and Book moves a lot of current activity in to primary care without an equivalent shift in resources.

Confidentiality

The GPC are concerned that the Choose and Book procedure cannot be completed until the GP has sent an electronic referral. The GPC has not yet been shown how this will work. We understand that the system is supposed to automatically extract data from the patient's GP computer record. This is an area of enormous complexity and will require close examination. The automatic extraction of data from GP computer records is fraught with all sorts of difficulties. This process may have to be overseen by the referring GP because no other clinician will know what information needs to be sent. It is also possible that this process may result in relevant (and or irrelevant) patient data being passed to the "spine" of the NHS Care Record Service and therefore raises all the issues and anxieties reflected in the 2004 LMC and ARM motions on the Care Records Service. These motions advised that GPs should not, at the moment, allow patient identifiable data to be sent to the spine. GPs that use Choose and Book and have sent e-referrals should be aware of LMC Conference policy. The GPC will be raising this as a matter of urgency with the Department of Health.

Security

The GPC has not seen the technical specifications for Choose and Book and cannot vouch for its security. We are unaware of any technological provisions to protect privacy and confidentiality. We are also raising this with the Department of Health.

Limitations when referring

When using Choose and Book, practices can only request a booking for a service commissioned by the local PCT. The PCT will determine the list a GP can choose from.

Rejections of bookings

The hospital can accept or reject a booking request. We understand that the hospital's response to the booking request is not subject to any nationally applicable targets. Apparently best practice is to be agreed locally. It is not clear what is expected of a GP if a request to book is rejected.

Performance of PCTs

The PCT's performance indicator is only whether or not the system is 'available' to GPs. There is no performance measure made of the PCT based on actual usage.

Summary of the GPC's position

The GPC welcomes any development which improves patient care and the working practices of GPs. We would also welcome the opportunity for patients to be more involved in deciding

where they are referred to and when they will be seen. However, we are extremely concerned that there are a number of unresolved issues relating to Choose and Book which could jeopardise the confidentiality and security of patient records. We are also concerned about the workload and resource implications of Choose and Book. The GPC are willing to work with the Department of Health and the National Programme for IT to resolve these issues. Until then, we suggest that practices carefully consider the implications of being involved in Choose and Book. Choose and Book is not part of a GP's contractual obligations and therefore practices can decline to be involved.

Dr Canning emphasised that if using Choose & Book was creating additional workload then practices should be resourced accordingly. Electronic referrals will take longer and patients must make the choice without being influenced by the GP. There is not guarantee that the preferred surgeon will undertake the procedure.

The five choices available at present would ultimately extend to free choice to use any provider anywhere in the UK or abroad, but that was a long term project.

Formula review

The allocation formula review group is currently being established and will include three GPC representatives, made up of two negotiators and one other GPC member, who will be elected by the whole committee. The GPC and NHS Employers will jointly select the chairman of the review group and the experts that will advise it. The objectives of the review will be to:

- evaluate whether the current formula delivers a fair distribution of resources
- consider whether the balance of the resources between global sum, enhanced services and quality and outcomes framework (QOF) provides practices with sufficient incentives to meet key priorities
- consider redistribution of resources to areas of high health inequalities and workforce shortages
- promote equality of access to services
- distribute effectively the resources available within the global sum

The review group is due to meet first in December and regularly thereafter, with a view to delivering changes to the formula by April 2006.

GMC good medical practice review

As part of an informal consultation, the GMC is also reviewing its core guidance booklet, "Good Medical Practice", to ensure it is up-to-date, fit for purpose and that it reflects a consensus between the profession and the public. Once the GMC has had the opportunity to analyse responses received from this initial consultation period, it will be working on redrafting the guidance before sending out a formal consultation in the second half of 2005. Comments from the committee will feed into a BMA-wide response.

Health Protection Agency information

The prescribing subcommittee met recently and would like to reiterate the point previously made that GPs do not have to supply the Health Protection Agency with data relating to flu and pneumococcal immunisations. GPs should be aware that they are not contractually obliged to supply this information.

Prescribing issues at primary care trust (PCT) level

The prescribing subcommittee discussed the on-going inquiry by the Health Select Committee into the influence of the pharmaceutical industry. It was recognised that many PCTs try to restrict the contact GPs can have with representatives of the pharmaceutical industry. We would invite LMCs to send in examples of such policies in their area.

The prescribing subcommittee would also like to ascertain how many PCTs have produced patient group directions (PGDs) for practices to use. Please forward any correspondence on the above issues to: SBlass@bma.org.uk.

Conflict resolution training
The counter fraud and security management services are organising conflict resolution training for GPs and their staff in England. It is mandatory for all English PCTs to offer this, although it is up to individual practices to decide whether they wish to participate. We would recommend that practices do participate, and PCTs should support them in so doing.

M5 : December 2004

Enhanced services floor
The Department of Health in England had tabled a discussion paper about the anticipated underspends by PCTs against their PCT-level expenditure floors for enhanced services in 2004-05. Although it was clear this was not just an England problem, the data available thus far are only from England. From the second quarter Financial Information Monitoring (FIMS) returns, it appeared that about 80 PCTs might well not meet their funding floors. A number of possible reasons were suggested including coding errors, rounding errors and 'slippage' on schemes, but most worrying was the suggestion that some PCTs had planned to underspend, with some intending to use the underspend to cover expected overspend for the Quality and Outcomes Framework achievement for 2004-05. With regard to this last scenario, the negotiators were clear that other arrangements existed to assist PCTs with QOF liabilities and it was therefore entirely inappropriate and unacceptable for PCTs to use enhanced services monies to pay for QOF expenditure, which would be an inappropriate precedent to be set given that PCTs were not supposed to be able to vire money between the different funding streams of the contract, other than using PCO-administered funds.

As far as the coding errors were concerned, it seemed that the form and guidance for completing the returns for the first quarter had confused some PCTs leading to mistakes which had then been compounded in their returns for the second quarter. The Department and the Technical Steering Committee had worked to clarify the arrangements for the third-quarter returns and it was anticipated that more accurate data, and presumably fewer reported PCTs underspending on enhanced services, would be available with the third-quarter returns.

The negotiators had previously discussed cases with the Department and NHS Employers where the Strategic Health Authority had proposed to PCTs to use underspends on enhanced services to cover deficits elsewhere in their budgets or be vired into the following year's expenditure on enhanced services. The position in these discussions had been clear that such arrangements were unacceptable. While the position of all three parties remains strong against redirecting enhanced services monies to pay for deficits, the Department and NHS Employers are now more keen to pursue the option of allowing PCTs, principally where this has been agreed by the LMC and Professional Executive Committee (PEC) locally, to vire enhanced services underspend into the following year's enhanced services expenditure. At present, the negotiators have continued to oppose this given that past experience of viring funding forwards has led to recurrent underspends, with such monies rarely being spent as had originally been intended, and this was neither a situation the negotiators wanted to create in relation to enhanced services expenditure nor was it a precedent they want to set which might then be used for other funding streams. The negotiators continue to believe that local discussions should still be focused on spending this year's enhanced services money before the end of the financial year, as this is the best assurance that this money will be spent in general practice.

Technical Steering Committee
We have received a report from the Technical Steering Group about progress on the General Medical Services (GMS) and Personal Medical Services (PMS) funding envelopes: finalising

actual spend for 2002/2003 and the subsequent envelopes for 2003-06. The envelopes in England have been provisionally agreed, subject to any further changes arising from announcements of additional funding. In Scotland, the envelopes are under further discussion with Scottish (SGPC), given concerns over some of the original and subsequent calculations arising from further scrutiny, particularly with regard to funding for superannuation contributions. In Wales it is expected that agreed envelopes will be available for the January plenary meeting. Discussions are still taking place about the Northern Ireland envelopes and there are still a number of concerns about them.

The Shipman Inquiry - Fifth report

The committee discussed the Shipman Inquiry's Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future. Concerns raised ranged about from the general negative tone of the document to the specific recommendations. It was felt unfortunate that there had not been greater input from patient groups other than those directly affected by Shipman and from the current working members of the General Medical Council (GMC) fitness to practise panels.

While many of the recommendations were viewed as a continuing development of good working practice, there was also concern that some showed misunderstanding of primary care realities.

The GPC has long been calling for the introduction of individual prescribing numbers for all GPs and this recommendation was welcomed. The committee also supported single handed practitioners getting the support they needed. There was general, if not qualified, support for the recommendation of mortality monitoring. However, in other areas, it was felt that the capacity of Primary Care Organisations (PCOs) was over estimated.

The recommendations relating to the complaints system met with concern, as they appeared to move away from recent moves to ensure that complaints were resolved locally wherever possible without the need to involve Primary Care Trusts (PCTs).

There was general concern about the possibility of altering the appraisal and revalidation system at this point in time and the committee decided that an evolutionary approach was preferable.

Overall it was recognised that how the government responds to the report will be very important, and the GPC response needed to be measured and proportionate. The GPC will be in discussion with the Royal College of General Practitioners (RCGP), GMC and patient groups about the way forward. The statutes and regulations subcommittee, the prescribing subcommittee and the education and professional development subcommittee will look at recommendations most pertinent to them and the negotiators would take forward the GMC issues. The BMA as a whole is likely to respond to a tranche of the recommendations as changes to the GMC and appraisal and revalidation process would be likely to affect all doctors. The GPC's response will draw particular attention to those issues that will have the greatest impact on the workings of and recruitment into general practice.

Alternative Provider Medical Services (APMS)

PCOs can enter APMS (health board primary medical services in Scotland) contracts with any individual or organisation that meets the provider conditions set out in the Directions (please see below). These individuals/organisations include the:

- Independent sector
- Voluntary sector
- Not-for-profit organisations
- NHS trusts (in England & Wales)
- Other PCOs
- Foundation trusts (in England & Wales)

- General Medical Services (GMS)/Personal Medical Services (PMS)

There are two main areas of possible impact on general practice as a result of the promotion of APMS:
a) It further encourages any member of the private/voluntary sector (e.g. not GMS or PMS contractors) to bid for enhanced services and thus increases the fragmentation of general practice
b) It opens up the provision of essential services to providers other than GMS and/or PMS practices, although it is anticipated that APMS will be used initially for specialised clinical services such as additional/enhanced/out-of-hours (OOH) services

The areas of risk relating to enhanced services are not wholly unfamiliar to GPs following the introduction of enhanced services under the new contract. However, those relating to essential services require further consideration.

Alternative Provider Medical Services (APMS) is one of the four contractual options available to PCTs in England for the provision of primary medical services to patients, in addition to GMS, PMS and Primary Care Trust Medical Services (PCTMS). The Department of Health in England issued the NHS Act 1997 Alternative Provider Medical Services Directions 2004 on 21 April 2004, which were amended on 3 November 2004, and are available on the Department of Health (DoH)

National Primary Care and Care Trust Development Programme (NatPaCT) has produced a useful question and answer document on APMS

GPC model retainer scheme
The GPC approved a revised model GP retainee contract, subject to some small amendments, produced by the GPC's sessional GPs subcommittee. The model contract is based on the salaried GP minimum terms and conditions with some enhancements and is also similar to the GPC's flexible career scheme model contract. The retainer model contract will be published in early January, as comments from some other bodies are outstanding.

Treating patients out of the core hours period
We have received reports that some GPs are unclear as to whether or not they can treat their patients out of the core hours period if they are no longer responsible for their patients' out-of-hours care. The core hours period runs from Monday to Friday, 8.00am-6.30pm, but there is nothing to stop a practice that has opted out of out-of-hours work to run an evening or Saturday morning surgery if they wish to do so.

Dr Canning reiterated that doctors could treat their patients out of core hours if they so wished.

GP Training and out-of-hours (OOH)
The committee was informed about a private OOH provider contacting GP trainers in the Stockport area informing them that GP registrars would no longer be able to attend their paid OOH shifts for training purposes. Further reports were received from GPC members that some PCTs were attempting to include registrar training in their APMS provider contracts, but without making financial provision accordingly, arguing that this was already being paid for via the registrar salary supplement. PCTs should know that this interpretation is incorrect and this will be flagged this up with the NHS Employers not only to ensure that the message is absolutely clear, but to ensure that strategic health authorities performance manage their PCTs to discharge their responsibilities.

The GP registrars subcommittee also met this week and discussed this issue and it will be raised at an informal meeting with Committee of General Practice Education Directors (COGPED) next week.

This issue needs urgent clarification from the Department of Health and the GPC will be writing to the Department of Health, copying in the NHS Employers, Joint Committee on Postgraduate Training for General Practice (JCPTGP), RCGP and COGPED and citing the example given, to say that it is completely unacceptable for registrars' OOH training not to be commissioned by private providers in this way. Not only would this have implications for the future involvement of GPs in OOH care, but it has wider far-reaching implications for training in general within the setting of private sector/provided healthcare. Non-voluntary contractors eager to cut costs may see training as both expensive and having the potential to slow work down. It is paramount that the financial provision for training is agreed upon in contracts with private providers from the outset.

Please can members feed any further reports of related problems to the GPC secretariat and we will keep you updated on any developments.

GP appraisers
We have recently received notification that the Pensions Agency has agreed that GP appraiser work is pensionable. NHS pension contributions on any net profit resulting from this work will need to be made.

Is jury service proving a problem issue for GPs?
At the last meeting of the statutes and regulations subcommittee the issue of jury service was raised. Discussion focussed on whether it was becoming a problem for GPs to serve on juries due to either the cost of providing a locum, or owing to the stringent guidelines making it difficult for GPs to defer their service.

Given that the first ten days of jury service are reimbursed at a rate of up to £52.63 per day to cover loss of earnings (rising to up to £105.28 thereafter), the loss to a practice could be considerable. Doctors were exempt from jury service until 2 April this year, when major changes to the Criminal Justice Act came into force. If you have any feedback regarding this issue please email Anna-Marie Davis.

It was **AGREED** that CLMC make formal approaches to PCTs concerning suitable reimbursement for jury service.

BMA and National Honours system
The representation subcommittee recognised that LMCs may not be aware that they can nominate suitable candidates for the BMA Association Medal or Admission to the Roll of Fellows. Any LMC requiring more information on either of these may obtain details from the BMA's Council Secretariat. The GPC may consider endorsing such recommendations and the representation subcommittee wishes to see the consideration of the awards as part of the annual GPC timetable.

With regard to National Honours, LMCs may submit nominations for members who they feel have given an outstanding contribution to general practice, directly to the Ceremonial Secretariat in the Cabinet Office (www.cabinetoffice.gov.uk/ceremonial/.) The Association also makes recommendations, usually via the Chief Medical Officer, of people who have made a valuable contribution.

M6 : January 2005

Enhanced Services subgroup of the Primary Care Development Subcommittee
It was agreed at the November meeting of the GPC that an enhanced services subgroup of the Primary Care Development Subcommittee would be established, to aid LMCs in their ongoing deliberations with PCOs.

The principle purpose of the subgroup is to streamline and simplify the current processes that exist within the GPC secretariat and negotiating team for dealing with LMCs' queries on enhanced services. Currently, LMCs direct their questions via the relevant LMC Liaison Officer in the GPC secretariat for advice, for example, whether or not a certain service should count towards a PCO's enhanced services spending floor. This will continue to be the correct procedure, however, these queries will now be posted on to a dedicated enhanced services subgroup listserver. It is important that any issues regarding enhanced services are still raised in this way, via the LMC Liaison Officer, so that the relevant member of the secretariat is able to keep an overview of the situation in their region. The subgroup will also make recommendations to the negotiators where a dispute between an LMC and PCO has reached the point whereby it should be considered by the Implementation Coordination Group (ICG).

In anticipation of the new BMA website facility whereby LMCs will be able to post and access LES specifications online, the GPC secretariat is happy to hold a central electronic database of LESs as an interim measure.

QOF and the Freedom of Information Act (FOIA)
The GPC is aware that in England, PCTs are receiving a number of requests to release practices' aspiration points, and interim achievement results following QOF visits. Currently there is confusion among PCTs and practices about what information they need to make available under the Freedom of Information Act (FOIA). The GPC has agreed with the Department of Health that where all the information was formally recorded with the PCT, and is available in complete form, as is the case with aspiration payments, then this should be released under the Freedom of Information Act. However, there is reservation about interim achievement results being released, especially given that not all QOF visits have been completed and the accompanying guidance that should go with achievement results has not yet been agreed. Further advice is being sought and NHS Employers will be issuing guidance to PCTs about how to respond to FOIA requests shortly. The GPC will in turn issue guidance to GPs.

Quality and Outcomes Framework: National Prevalence Day
As LMCs will be aware, Disease Prevalence Day, 14 February, is less than a month away (though data relevant to the period up until and including the 14 February will continue to be collected until the 31 March – National Achievement Day). The link below to Department of Health guidance gives a useful overview of disease prevalence and how it is calculated. Note:. This guidance applies to England only. www.lmc.org.uk/prevalence_guide_v12.pdf

GPs might also find it helpful to re-read the 'Focus on QMAS' guidance note as produced by the GPC secretariat in October 2004.
www.bma.org.uk/ap.nsf/Content/FocusQMAS1004?OpenDocument&Highlight=2,focus,on,QMAS

The GPC will be producing a 'Focus on achievement payments' document in due course.

Tidying of QOF data
Practices should remember that prevalence factors that exist on 14 February 2005 will be used as the prevalence factors in calculating the year's payments. The calculation of the prevalence factors that applied on 14 February 2005 will not take place until 31 March 2005. The data is collected for automated practices on 14 March allowing practices to bring all data up to date. However, we strongly suggest that practices should not leave the tidying up of data to the last minute and should begin the process as early as possible. Further information is available in the 'Focus on QMAS': www.bma.org.uk/ap.nsf/Content/FocusQMAS1004

Normalisation
Following queries from LMCs that, despite increases in list size, some practices have been receiving lower payments in one quarter for their global sum than in a previous quarter, the

GPC has written to the Department of Health outlining a potential problem with the application of the normalisation process. In these instances, practices' actual list sizes have increased but the weighted lists were going down with a consequent decrease in the global sum payments, yet no dramatic changes in patients characteristics have occurred.

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, a decision has been taken to delay payments in quarter 4, in order to correct this. Practices can expect to receive accurate quarter 4 payments very soon, if they have not already done so.

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

Lithium ranges in QOF Mental Health indicators
Practices have raised concerns about the lithium range specified in the QOF and QMAS (0.6 - 1.0) where there are different local therapeutic ranges.

Although the achievement score and payment will initially be calculated by QMAS using the specified range, the PCT has the ability to amend a practice's achievement score after the 31 March. It can amend the numerator and denominators for the practice to show the correct figures as calculated using a local range.

There are two routes to this: the practice can approve its achievement and the PCT then amend it before payment (a revised score/payment will be presented to the practice for reconfirmation); alternatively, and probably the most sensible route, the PCT can make the alterations before the practice approves its achievement.

All this is predicated on the practice/PCT knowing the correct numerator and denominator figures for patients monitored using the local therapeutic range, for which an alternative extraction tool will need to be used.

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.

Access and the Primary Care Access (PCAS) Questionnaire
A new question on the PCAS return for the November survey in England, which asked how far in advance patients are able to book an appointment with a GP led to a number of enquiries from GPs. The main concern for the GPC was that we had not had advance sight of the question for which the list of potential answers included allowing for patients to book up to four weeks or longer in advance. This clearly goes further than the 24/48 hour access covered by the specification for Access Directed Enhanced Service.

This was raised with the Department of Health before Christmas, and it has now confirmed in writing that practices' responses will not have any bearing on the access bonus payment

under the QOF for 2004-05, and that this will be based on actual performance as reported through PCAS on the established questions for the period December 2004 to March 2005. The Department also confirmed that practices need only comply with the current DES specification or with any local variation already agreed with the PCT.

GP retainer scheme model contract

The GPC's model contract for the GP retainer scheme has recently been revised and is now available on the BMA website: (www.bma.org.uk/ap.nsf/Content/Hubretainerscheme). This is based on the minimum terms and conditions for salaried GPs employed by a GMS practice or PCO since April 2004 (the model salaried GP contract) with some enhancements. It also takes account of the specific conditions of the retainer scheme. We advise that the retainer model contract is read in conjunction with the GPC's 'Focus on salaried GPs' guidance note.

GP appraisal

We have recently written to the Department of Health asking for appraisal form 4 to be revised to ensure that it is clear that the form must contain the appraisee's name, GMC number and signature. This is to ensure that the form is attributed to the correct person, as there was an example of an appraisee only signing the form and the form then being attributed to the wrong person! In the meantime, GPs undertaking their appraisal should ensure that the correct information is contained on their appraisal form 4.

Community hospital GPs

The GPC's guidance note on community hospital GPs is currently being finalised. It will be sent out in the next couple of weeks and will also be available on the website.

Chickenpox vaccination

On 4th December 2003 the Chief Medical Officer issued a circular regarding the new chickenpox vaccination policy. This recommended that all non-immune healthcare workers in general practice who have direct patient contact should be offered the vaccine and that it is for PCTs to implement a timetable which reflects local circumstances and resources. We are aware of some PCTs who have not yet offered this vaccine to those with direct patient contact in primary care. Given that the CMO's circular was issued over a year ago, we have asked the Department of Health for a deadline to be set by which time all PCTs should have implemented this.

LMC Conference

The new standing orders for the LMC conference, approved by Conference last year, can be obtained from the CLMC office.

- Topical Issues Debates

Topical Issues Debates were introduced at last year's conference. These debates are introduced by speakers for and against the motion, followed by contributions from the floor and typically last for approximately forty minutes. The agenda committee has the responsibility to choose these debates after consultation with LMCs.

LMCs are invited to suggest potential topics, if possible with names of speakers, who may not necessarily be members of conference. In order to allow us to select the themes and approach speakers, please let us know your suggestions by the end of January.

- Themed debates

Themed debates comprise two parts. The first is a presentation on the theme by an expert, who need not be a member of conference, followed by contributions from the floor; the second being motions arising from the presentation and submitted during the conference for debate in the normal way. The total time required for a themed debate will be about one hour.

As with topical issues debates, the agenda committee chooses the topic after consultation with LMCs. Again, LMCs are invited to suggest themes, if possible with names of potential speakers, who may not necessarily be members of conference. In order to allow us to select the themes and approach speakers, please let us know your suggestions by the end of January.

LMCs should e-mail suggestions to Anna-Marie Davis at the secretariat: adavis@bma.org.uk

It was **AGREED** that important items from the above should be included in a newsletter to all GPs.

05/01/19 REPORTS FROM MEETINGS

05/01/19.1 Meeting with Mr Sheffield, HM Coroner on Friday, 26 November re Verification of Death Policy & Procedure. Attended by Dr Canning (LMC), Ms V Hall (MPCT) and Dr E Summers (Primecare)

This item had already been covered under 05/01/01.

05/01/20 REPORTS FROM REPRESENTATIVES

No reports had been received.

05/01/21 ROYAL MEDICAL BENEVOLENT FUND : CHRISTMAS APPEAL (Extract)
(Cleveland LMC donates £500 annually each December)

"The Royal Medical Benevolent fund exists solely to support our colleagues and their dependants who have fallen on hard times. Tragedy can strike unexpectedly and all too often does – not least to younger members of the profession and their families. Examples of such unexpected ill-fortune can be found on our website: www.rmbf.org. For well over one hundred years the RMBF has been there to help in times of need and never is that need more evident than at Christmas. A seasonal gift can transform a rather cheerless Christmas into a very happy one and this is especially true when children are involved. There was a magnificent response to my appeal last year, over £90,000, and I very much hope that colleagues and their families will contribute handsomely once again. Contributions may be sent to Christmas Appeal, RMBF, 24 King's Road, Wimbledon, London SW19 8QN."

RECEIVED.

05/01/22 SUPPLEMENTARY AGENDA

05/01/22.1 Opening Hours for Pharmacies

Dr Lone stated that MPCT did not have late opening chemists in their area, with virtually all chemists closing at 5.30 p.m. whilst surgeries worked until 6.00 p.m. Boots on the Retail Park was open, but for patients with no transport this was impractical. MPCT proposed to take this issue up with pharmacists who would be shortly having their own contracts, together with Saturday half day closing.

North Tees – had Teesside Park
Hartlepool – No problems mentioned

Langbaurgh – Still had chemists open until 6.30

In the light of surgeries not opening on a Saturday morning, would it not be more practical for pharmacists to remain open later during the week?

Dr Canning reminded members that, in practice, doctors could still write "urgent" on a prescription and the police could arrange for it to be dispensed.

05/01/22.2 GP Appraisers : Data Protection Registration

Dr Canning explained that following discussions with the Information Commissioner Notification Helpdesk, the GPC were advised that because Appraisers are employed by the PCT, it is the PCT, not the Appraiser, that must be covered under the Data Protection Act for the storing of computerised information on appraisees. The fact that the appraisee information is stored on a computer in the practice is irrelevant. Appraisers do not have to change their DPA registration details. Because Appraisers are employed by PCTs, they will be superannuated.

RECEIVED.

05/01/22.3 Blood tests for research projects

Dr Canning explained that the Institute of Cancer Research (and Breakthrough Breast Cancer) are carrying out a study entitled "Generations" and a number of patients have been approaching their GPs requesting that a blood sample be taken in conjunction with the Generations study. The GPC have written to the Institute of Cancer Research pointing out that under the new GMS contract GPs are not obliged to undertake work of this nature, the very real issue of GP capacity and workload, that not all surgeries have dedicated full time practice nurses, and how GPs are concerned about the doctor/patient relationship if they do not participate in the study. The Institute were asked to take these points into consideration and the GPC offered to comment on any provisional wording to be included in future Generations study publicity material.

RECEIVED.

05/01/23 ANY OTHER NOTIFIED BUSINESS

There was no other business for discussion.

05/01/24 RECEIVE ITEMS

05/05/24.1 Medical List

Applications:

Effective Date	Name	Partnership	PCT Area
01.10.2004 *Salaried GP*	Dr N J Roberts	Marske Medical Centre	L PCT
01.01.2005	Dr E P Castilla	Dr Nath & Partners	M PCT
01.01.2005	Dr F J Houldsworth	Dr Davidson & Partners	L PCT
01.01.2005	Dr R Chaudhury	Dr Lone & Partners	M PCT
10.01.2005	Dr S Torres-Moreno	Dr Chappelow & Partners	M PCT
01.01.2005	Dr A Albaladejo Serrano	Dr Contractor & Partners	NT PCT
10.01.2005 *Salaried GP*	Dr G Coleclough	Dr Olding	NT PCT

Resignations:

Effective Date	Name	Partnership	PCT Area
30.09.2004 *Resigned*	Dr F Houldsworth	Dr Lakeman & Partners	M PCT
15.10.2004 *Resigned*	Dr W M Moore	Marske Medical Centre	L PCT
31.10.2004 *Resigned*	Dr R T Lama	Dr Datta & partners	NT PCT
06.01.2005 *Resigned. Remaining on list in capacity of locum. Moving out of the area.*	Dr R Leyshon	Dr Sagoo & Partners	NT PCT

RECEIVED.

05/01/24.2 GPC News No. M6 (21 January 2005)

Negotiator/GPC-LMC visits
As the last round of Negotiator/GPC-LMC visits took place relatively recently (at the end of November), it has been decided not to hold a second round in February/March as originally planned. However, the GPC secretariat will be liaising with LMCs to arrange visits for the

last week of April and the timing of these visits will helpfully coincide with the start of practice based commissioning and QOF achievement payments.

The Annual Conferences of LMCs in Scotland, Wales and Northern Ireland are scheduled for March/April and as a result, having taken advice from the national secretariats and chairmen, we will not be arranging Negotiator/GPC-LMC visits outside of England.

The last round of (England) visits were held in or close to Bristol, Birmingham, Manchester, Newcastle, Newmarket, Leeds and London. It is likely that the same cities will be invited again to host to the forthcoming round.

In the future, the negotiators will aim to visit LMCs twice a year, in September/October and February/March.

Nursing student placements within GP practices
During their 3-year undergraduate course student nurses spend time in practice within PCT's. Ideally this placement will include practice experience with all members of the Primary Health Care Team. However it is traditionally the District Nurses and Health Visitors who provide the placement and mentorship. Time spent with Practice Nurses and within Practices as a whole varies with some students not being afforded this opportunity. However, it is also acknowledged that some GP's and Practice Nurses provide extensive practice experience although this tends to be the exception rather than the rule. Concerns regarding time and cost of placements are common, as unlike medical student placements there is no direct payment for supporting nursing students.

The ageing nursing workforce and demands for new ways of working have led to increased pressure to commission more training places. Many nursing students see their future within Primary Care, but there is a need to increase placement opportunities during their course in PCT's. If Primary Care is to respond to the national agenda, in particular the NHS Improvement Plan the practice education of our future workforce must be addressed. This is a prime opportunity for GP's and Practice Nurses to become involved in providing practice placements and consequently inform Universities of the clinical competence requirements of our future nurses.

If your Practice is interested in becoming involved contact your local Clinical Placement Facilitator or education provider.

The Foundation for Credit Counselling
GPC have been contacted by the Foundation for Credit Counselling, which is a debt charity and the umbrella organisation for the consumer credit counselling service.

The Foundation is offering to provide leaflets to be made available at GP surgeries, and also can offer access to an 0800 number through which borrowers can be helped free of charge.

For further information and copies of leaflets, please contact Jan Smith at jans@cccs.co.uk.

RECEIVED.

05/01/24.3 Letter from Mr Richard Burrell, Chairman of the Investment Board, Medical Property Fund, Chester

"I am writing to introduce myself and the Medical Property Fund. The Fund was established a year ago with funds of £400 million to invest in the improvement and development of primary care premises. Our arrival provides GPs and PCTs with a new opportunity to accelerate the

renewal of primary care properties which is so badly needed; not just because of government targets but because GPs are keen to deliver the best possible primary care and that demands modern premises.

There are a number of trends which can adversely affect the delivery of new premises:

- The average cost of a building for a modern primary care centre is around £5 million or more;
- The capital commitment and property management issues are an increasing burden on GPs;
- Fewer GPs are interested in premises ownership;
- 60% of new GPs are women with different career goals;
- some GPs have poor performing endowments and want to release extra equity now, rather than wait until retirement.

Even with LIFT and the £108 million of extra funds announced in September, there is a large shortfall of funding to meet GPs aspirations. Many GPs have been left frustrated with no funding available for their plans for new primary care premises.

If I can be of any assistance to GPs in your area, I can be contacted directly on 01244 893 681 or 0207 659 6271."

RECEIVED.

05/01/24.4 Letter from HPCT re Professional Executive Committee Chairman

"As a result of recent developments, Dr Carl Parker will act as interim Professional Executive Committee Chairman with immediate effect until end of February 2005. Members of the Professional Executive Committee have expressed support for this arrangement, which was approved by Hartlepool PCT Board on Thursday, 7 October 2004. The Professional Executive Committee will be electing an interim Vice Chairman at their meeting on Tuesday, 19 October 2004"

RECEIVED.

05/01/24.5 Letter from TNEY re The National Programme for IT

"An information pack about our implementation of the National Programme for IT has recently been circulated to all Trust and Trust/Social Services sites. The National Programme for IT is all about improving the way that we record and share information about our service users, and will bring in new national booking and care records systems that will replace our current patient administration (PBIS) system. The National Programme for IT affects all Trust staff who work with our service users, be they in direct contact or in a support role. Should any of your members require further copies of any of the information in the pack, please contact Jeanette Coser, NPfIT Project Administrator on 01642 283944 or email **jeanette.coser@tney.northy.nhs.uk**."

RECEIVED.

05/01/24.6 Report the receipt of:

Minutes of Sunderland LMC's meeting held on 19 October 2004
Minutes of Sunderland LMC's meeting held on 16 November 2004
Minutes of Wakefield LMC's meeting held on 12 October 2004
Minutes of Durham LMC's meeting held on 7 December 2004
GPC News No. M4 : Friday, 18 November 2004 (also available on www.bma.org.uk)
GPC News No. M5 : Friday, 17 December 2004 (also available on www.bma.org.uk)
GPC News No. M6 : Friday, 21 January 2005 (also available on www.bma.org.uk)

RECEIVED.

05/01/24.7 Date and time of next meeting

Tuesday, 1 March 2005, at 7.30 p.m. in the Committee Room, Poole House, Stokesley Road.

NOTED and **RECEIVED.**

Business discussed "below the line" by GP members only

05/01/25 REPORT BY ScHARR re LEADING MEDICAL CONSENSUS : LMCs IN THE 21st CENTURY

Ref Minutes 03/12/4 : 04/01/12 : 04/03/10 : 04/11/24

Dr Canning spoke on the paper which had been tabled. He explained that what was needed was a person to do some of the day to day contact with PCTs, liaising with them and attending meetings, and to be available in the Secretary's absence. It was important that the jobholder liaised also with Practice Managers with time being spent visiting practice to discuss any problems and reinforce accurate information. Most LMCs had a Liaison Officer who undertook this role on their behalf. The post would require to be superannuable, as would the other key Officers and staff in the LMC.

It was the intention that the Liaison Officer would work with PCTs to establish GP Forums. It transpired that Langbaurgh did not have one, neither did Hartlepool. Eston tended to meet in different areas of Middlesbrough and normally there were no members of the public in attendance, with GPs attending only if they were interested.

The question of holding GP Forums in hours or out of hours was discussed, with payment for attending in-hours meetings being raised. The meetings could be a mixture of in-hours and out of hours, with them being held solely by the LMC, the PCT or a combination of both.

The LMC is resourced via practice based levies so it was essential that there was a good working relationship with Practice Managers.

It was **AGREED** to support the recommendation of employing a Liaison Officer and an article would be inserted into the next Newsletter accordingly.

There being no further business to discuss, the meeting closed at 9.35 p.m.

Date: ***Chairman:***