Cleveland Local Medical Committee

Chairman: Dr D Donovan
Vice Chairman: Dr I Bonavia
Secretary: Dr J T Canning
Medical Director/Asst Secretary: Dr J-A Birch
Development Manager: Ms J Foster
Office Manager: Ms C A Knifton

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Minutes and report of the meeting of the Cleveland Local Medical Committee commencing at 7.00 p.m. on Tuesday, 5 July 2011 at Norton Education Centre, Norton, Stockton on Tees TS20 1PR.

Present:

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

In attendance: Ms C A Knifton : Office Manager

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The Chairman welcomed two new members, Dr Pawanjit Singh (Billingham) and Dr Debs White (Hartlepool locum), to the meeting. A vacancy still remained for a further Hartlepool GP representative on the Committee.

The Chairman congratulated John Canning, the LMC Secretary, for receiving the BMA Medal for his services to the BMA and LMC, and everyone showed their support in a round of applause.

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11/7/1 APOLOGIES

Apologies had been received from Dr M Betterton, Dr S Burrows, Dr S Byrne, Dr G Chawla, Dr A Gash, Dr C Harikumar, Dr R Mudalagiri, Dr T Nadah, Dr V Nanda, Dr N Rowell and Mr G Wynn.

Janice Foster, the LMC Development Manager, was also absent following dislocation of her left patella though she was valiantly attending work with the aid of a knee brace and a borrowed automatic car.

11/7/2 MINUTES OF THE MEETINGS HELD ON 24 May 2011 (previously circulated)

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

11/7/3 MATTERS ARISING FROM THE MINUTES OF PREVIOUS MEETINGS

11/7/3.1 Sexual Health Contract - Update
Ref Minute 11/5/7

11/7/3.1.1 Karen Hawkins, Business Manager at NHS Tees was contacted to ascertain if details were collated on the number of patients that commence treatment/testing with Assura but then return to practices or other providers for treatment. The following response was received:

"Currently we do not receive this level of data as we receive the total numbers screened and the total positive. I have asked Assura if they are able to provide a report on those positive, the proportion seen within hubs/spokes/subcontractors, and those that wish to go back to their GP. Following a conversation with commissioners it was confirmed that historically the patient pathway was always to offer patients the opportunity to return to their GP if they did not wish to attend a clinic. I understand there were concerns re Assura referring patients back to their GP practice where the practice are not subcontracted, however, for your reassurance it would not be financially viable for Assura to do this as standard practice, therefore, those patients opting to be seen in practice that would be referred back to a GP practice should only be where the patient will not attend a Sexual Health clinic."

NOTED.

11/7/3.1.2 Report from meeting with Dr J Kibirige, Assura representative / Dr J-A Birch, LMC Medical Director @ LMC : Thursday, 23 June 2011

Topics of discussions had centred around:

- **Patients being seen and tested by Assura for chlamydia but being sent to their GP practice for treatment:** In future this option will not be offered to patients unless their practice has sub-contracted to do chlamydia screening, however, a patient may choose to go to their own GP but Assura will try to persuade them to have treatment from themselves.
- **GP not receiving information following referral by them:** Assura will always write back to a GP who has referred a patient to Assura, to update them on treatment.
- **Lack of list of participating practices/clinics**: Assura say they cannot produce a leaflet with times of all the clinics because they are still fluctuating. A list will be produced in about 6-12 months time. The Assura website has up to date current list of venues/times: www.sexualhealthteesside.nhs.uk - click on 'Contact Us' then 'Clinic locations and times'.
- **Governance/Audits**: Assura has to meet KPIs and quality markers and has a clearly defined governance structure and audit teams in place. CQC visit awaited. Assura has inherited a service with performance issues which they are working to improve and standardise.
- **Communication with LMC**: Assura keen to have a named LMC contact and it was agreed LMC Medical Director would continue in this role.
- **Pathways**: Assura looking at developing service protocols etc on contraception for under 13s/vulnerable adults, CAF and sexual assault. Pathways will be sent to LMC for comment.
- **New developments**: Assura working closely with Local Authority and Public Health around teenage pregnancy / STDs / vulnerable groups who do not access mainstream services. Providing clinics in drug and alcohol centres. Going into schools/colleges using "clinic in a box" to provide contraception/GUM diagnosis/management and treatment.
- **Phone enquiries are triaged and patient directed to clinic that meets their needs:** Patients may not be able to be seen locally if it is judged that they need to attend clinics with higher level practitioners present i.e. Nexplanon, IUD, IUS. Few nurses are trained to issue first pill prescription; training is to be given. Assura say they have a doctor or nurse prescriber in clinics 90% of the time.

- **GPs not being informed of patients attending Assura clinics with STIs:** No letter can go to GPs unless patient with STI agrees to letter being sent. Assura will ask patients proactively if they can send a letter.
- **GPs being informed of issue of contraception:** Should Assura inform GP each time they prescribe repeat prescription? No. For new treatment for pill, depo, nexplanon and IUD/IUS – letter should be sent to GPs. No letter required for reviews. Letter required for changes to contraception. No requirement for a standard template letter.
- **Assura can refer direct to Gynae:** GPs would like to be informed of any direct referral by Assura. LMC to put to Consortia for discussion. This contrasts to the new rules for all consultant to consultant referrals, apart from 2 week rule, which now come back to the GP – consultants do not know all the health problems pertaining to the patient whereas GP does, they can also make sure that the referral is warranted. Was an audit carried out as to whether or not referrals were appropriate? Was Map of Medicine being followed? It was pointed out that the majority of referrals are for termination of pregnancy and things like retrieval of IUD – it would be inappropriate for these to come back to the GP and it would cause unnecessary delay.

Weblink for Assura is: http://www.assurastocktonllp.co.uk.

Dr Gossow, Tees Medical Adviser, asked that any further problems be fed back to him so that he could take it forward with the contracting team.

NOTED.

11/7/3.2 Summary Care Records – Proposed draft letter to GPs - Update
Ref Minute: 11/5/10

Following the May LMC Meeting, questions were raised with Dr Nicholas and his answers are shown below to specific items raised.

1) Further information requested with regard to SCR access security and, in particular, smartcard use in hospitals (junior doctors' lack of access to smartcards and danger of smartcards being left in computers). *It was explained that consideration has been given to security of access and a business model has been put in place but that the business model is currently under review due to practicalities on the ground. A copy of the amended business model would be helpful to accompany the response to the query.*

JN response: I will ask Ruth to forward that to you. In addition here is a briefer description of how SCR is to be used at James Cook hospital.

Great care is being taken to ensure that organizations accessing the SCR understand their responsibilities in seeking patient consent and ensuring that the information is accessed in a way that ensures clinical accountability for such access.

At James Cook hospital, which started accessing the SCR a few weeks ago, only clinicians (doctors, nurses or hospital pharmacists) can view the clinical information using the Summary Care Record application (SCRa). SCRa is a web based application only available on the N3 network to staff with smart cards with permission to view the SCR.

Because most clinicians still access patient information on paper in James Cook hospital, patients are asked for consent to view and print the SCR for inclusion in the hospital notes.

Initially it had been hoped that permission to view and print the record would be requested and recorded by an admin member of staff. The SCR would then be viewed and printed by a clinical member of staff (admin staff members do not have smart card permission to view SCR clinical details). However this proved to be unworkable as (particularly for emergency admissions out of normal hours) there often wouldn't be an admin member of staff available. The revised protocol now allows the clinician to both get and record the consent and then view and print the SCR.

The recording of consent and viewing the SCR are both recorded in the audit trail. Moreover because the same person has both recorded consent and viewed the record an alert will be sent to an IG officer in the hospital. These alerts will be checked to ensure that the patient has actually attended the hospital for treatment. Any instances where the SCR has been accessed without record of hospital attendance will be further investigated.

In situations where the patient cannot give consent e.g. the unconscious patient the SCR can be accessed but the user has to record justification for their action. In addition a specific alert about the fact that the SCR has been viewed without consent which is again sent to the IG officer.

Patients have the right to be supplied with details of organizations which have accessed their SCR. At present such requests would be channelled through the PCT IG lead.

No record system including paper records and locally held electronic records can be 100% secure. However to provide safe and effective care we use records. We know that a significant proportion of medical mishaps are related to medication. We also know that hospitals frequently do not have reliable information about current medication particularly when GP surgeries are closed. By making medication information available the SCR has the potential to considerably reduce risk and increase the effectiveness of care. Against this there is the small risk that such medication information may be accessed inappropriately. The security features of SCR do minimize this risk. In addition the likely impact of inappropriate access to a record is several orders of magnitude smaller than the impact of a medication mishap.

2) Is it possible to simultaneously alert practices/other providers when an SCR is accessed in another location? *It was explained that the PCT can access data as to how many SCRs have been viewed and that it has been requested, at the SCR panel, that practices were alerted on a weekly basis how many SCRs belonging to their patients were viewed.*

JN response: Although practices will not be alerted when patients' SCRs are accessed a full audit trail can be requested if required. However as indicated above, the IG officer in the viewing organization does receive alerts when:
1. The same clinician both declares a legitimate relationship with the patient AND accesses the SCR for that patient.
2. The SCR is accessed in an emergency where the patient is unable to give consent e.g. the unconscious patient.

3) GP2GP does not always transfer data accurately - where does the responsibility for the accuracy of the information lie and what governance is in place to address this?

JN response: GP2GP transfers the whole GP record. Only medication and allergy information is made available without active practice involvement. The medication and allergy information shown on the SCR will match the information held at the practice when it was last updated provided a smart card was in use. The date the SCR was last updated is clearly displayed on the SCR. The training given to users of the SCR application emphasizes that the SCR information applies to that date. Clinical judgment is required in interpreting all patient information including SCR information. CfH has in partnership with the Medical Protection Society produced a series of FAQs on this and related issues. This advice is available at http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/faqs/mpsfaqs.

4) The original concern with regard to presumed consent and lack of patient understanding was also raised - this is still a real concern for some GPs who do not yet feel reassured that it has been addressed.

JN response: When patients attend for care they WILL be asked for consent before the SCR is accessed. The initial upload process only makes the medication and allergy information potentially accessible. This is necessary because most GP data is held on practice based servers which cannot share data outside the practice. Work done with patient focus groups

indicates that patients do want essential information to be available wherever they attend for treatment. Indeed many patients already believe that hospitals can access their GP information and are surprised this is not the case. A considerable amount of money has already been spent publicizing SCR. All patients did receive a letter about SCR in February 2010 and there has been (and will be further) coverage in the media. Even more money could be spent on publicity but would this represent good use of NHS resources?

NOTED.

At the latest LMC/GPCC Leads Meeting, concern had been raised that if a practice did not sign up to SCR and a patient complained that their records had not been released and their care may suffer because a hospital could not access their details, where would the practice stand? It was commented that even if the SCR was available to the hospital, staff would still have to go through the process of checking it was correct with the patient.

Practice computers seemed to work very slowly with the Smartcard in use and it may be more useful for admin staff to do a bulk upload/updates than individual ones. Practices should be making patients aware of computer problems associated with SCR uploads/updating.

The point was made that the programme asks questions about the patient before you can get into the patient's records so you don't know the answers and tend to bypass the question in order to gain access.

11/7/4 COUNTY DURHAM & TEES VALLEY COMPREHENSIVE LOCAL RESEARCH NETWORK RESEARCH SITE INITIATIVE
Communication from Dr T Butler & Dr J Larcombe, CLRN Exec Members

"We would like you to consider becoming a research practice. Research is an essential element of modern day health care and remains a high priority within the NHS. Indeed research funding has been protected from recent cuts and appears not to be in-line for any imminent reductions. Research activity can also be submitted as evidence for annual appraisal.

We are coming up to 4 years of a successful primary care research practice scheme within County Durham and Tees Valley (CDTV). The aim of the scheme is to develop the primary care element of National Institute of Health Research.

We continue to develop and now have 20 GP practices, 1 dental practice and 1 pharmacy actively engaged in the current CDTV CLRN research scheme. We are seeking to further expand the network to encourage growth in research undertaken in CDTV. This is part of a national scheme in line with the NIHR Primary Care Research Network Research Site Initiative (RSI).

Please take to time to review the outline of the RSI scheme. We would normally expect practitioners who are new to research to apply for Level 1 status. All primary care providers wishing to be part of the initiative and receive funding will need to submit an application form and we would encourage you to apply. Although the majority of our current sites are GP practices, research opportunities are expanding for other disciplines and we welcome all applications.

The RSI funding is designed to compensate practices for meeting the extra requirements of the service level agreements eg preliminary study work, networking, and achieving simple nationally recognized quality marks. All research undertaken carries additional study-specific funding at a level dependent upon the complexity of the research and the number of patients recruited. All research should be cost effective allowing practices to make a small profit from activity.

Details and examples of portfolio studies can be found at :

http://public.ukcrn.org.uk/search/Portfolio.aspx?Level1=7&Level2=354&Status=All

If you would like further information please contact Sarah Daniel or Angela Atkinson on 01642 615600 or email us on enquiries@nyren.co.uk. Applications can be downloaded from the PCRN N&Y website www.nyren.co.uk. Please return these forms electronically to these two email addresses:

PCRN N&Y - enquiries@nyren.co.uk
and
Lorraine Atkinson CLRN Manager - lorraine.atkinson@stees.nhs.uk

Completed applications should reach us by 15 August 2011.

Sites / Practices are selected by the Primary Care Working Group of the CLRN. We will inform you of the outcome of your application by 2 September 2011.

We look forward to hearing from you. We do encourage you to apply and start participating in clinical research."

NOTED and **RECEIVED**.

It was pointed out that there was a national fund available to GPs seeking money to engage in research – The Claire Wand Fund – which is a nationally recognised charity and will support sensible applications. Further details can be obtained by writing to Mrs Jane Cope at The Claire Wand Fund, BMA House, Tavistock Square, London WC1H 9JP, or by telephoning 0207 383 6334. You can also email clairewandfund@bma.org.uk.

NOTED.

11/7/5 RESIGNATION RECEIVED

Dr Vaishali Nanda, Middlesbrough GP representative, had resigned from the LMC effective from 5 July 2011. Increased commitment in the Clinically-led Commissioning Group (GPCC) resulted in difficulty to contribute effectively to LMC meetings. This resulted in a vacancy for Middlesbrough which would be advertised.

NOTED.

11/7/6 TEES MEDICINES MANAGEMENT COMMITTEE
Communication from Joanne Linton, Assistant Director Medicines Management, NHS Tees

"As part of the recent PCT reorganisation on Teesside, and in support of the development of GP Commissioning Consortia, we have undertaken a review of our structures and processes for medicines management and decision-making on new drugs.

The PCT Executive Team, in collaboration with GPCC leads (and LMC), has supported proposals from the PCT Medicines Management team to establish a Tees Medicines Management Committee (Tees MMC) where local decisions on commissioning and prescribing of medicines across Teesside would be made. The need for such a group was identified in a recent review of local decision-making processes by the SHA, with the support of the National Prescribing Centre..

The PCT and emerging GPCCs would very much welcome your organisation's support and participation in the new Tees MMC, and I would like to formally invite a representative to attend the first meeting of the committee, scheduled for ***Thursday, 14 July 2011, 2.00-4.00 p.m. at Riverside House, Middlesbrough****.*

Future meeting dates are:

Thursday, 8 September 2011 : 2.00 – 4.00 p.m. : Riverside House
Thursday, 13 October 2011 : 2.00 – 4.00 p.m. : Riverside House
Thursday, 10 November 2011 : 2.00 – 4.00 p.m. : Riverside House
Thursday, 8 December 2011 : 2.00 – 4.00 p.m. : Riverside House "

The LMC Medical Director would attend the meeting on 14 July and it was **AGREED** she should continue as the LMC representative. There were representatives on the Tees MMC from each of the consortia.

11/7/7 UPDATED LMC BOARD MEETING DATES

The meeting scheduled for 13 September has had to be re-scheduled for 20 September. A list of forthcoming dates for the remainder of 2011 is:

5 July
20 September (previously 13 September)
18 October
6 December

Dates for 2012 should be available for the next LMC meeting in September and would revolve around the LMC Annual Conference date which would be earlier than usual.

RECEIVED.

11/7/8 LMC/NEGOTIATOR REGIONAL MEETING – OPEN TO ALL GPs

An LMC/Negotiator Regional Meeting will take place on Wednesday, 9 November 2011 between 7.00 – 9.00 p.m. (refreshments from 6.30 p.m.) at The Holiday Inn, Emerson Road, Washington. The speaker will be Dr Beth McCarron-Nash. All GPs are invited to attend. Please contact Maxine Allan on gstlmc@tiscali.co.uk to confirm your attendance.

NOTED and **RECEIVED**.

11/7/9 REPORTS FROM REPRESENTATIVES

11/7/9.1 LMC Annual Conference, London : 9/10 June 2011

Drs Donovan / Canning / Birch had attended Conference with Ms Foster as an Observer. Major issues had centred around cuts / reforms / pensions.

NOTED.

11/7/9.2 Annual Representatives Meeting, Cardiff : 27/30 June 2011

Dr Canning had attended the ARM. There had been a lot of discussion on pensions.

NOTED.

11/7/10 MEETINGS ATTENDED BY LMC SENIOR OFFICERS (since LMC Board Meeting on 24.5.2011)

26.5.11	Liaison meeting with NEPCSA @ LMC office – John Canning / Janice Foster / Chris Knifton
8.6.11	Review of Medicines Management Functions, Riverside House – Janice Foster
9.6.11 & 10.6.11	LMC Annual Conference, London – Danny Donovan / John Canning / Julie Birch / Janice Foster
14.6.11	PCT Exec Meeting, Riverside House – Janice Foster
15.6.11 & 16.6.11	Commissioning Show, Olympia, London – Janice Foster
16.6.11	LMC/GPCC Leads Meeting, Teesdale House – Julie Birch
17.6.11	Urgent Care Meeting, Teesdale House – Janice Foster
22.6.11	BMA NE Regional Meeting, Washington – Danny Donovan
23.6.11	Meeting with Assura representative @ LMC – Julie Birch
29.6.11	Karen Hawkins & Andrew Gowland re Enhanced Services @ LMC – Janice Foster
5.7.11	Meeting of CLMC Regulations Sub-Committee – John Canning / Danny Donovan / Julie Birch / Iain Bonavia

11/7/11 ANY OTHER NOTIFIED BUSINESS

11/7/11.1 Pensions

The ARM took the view that if there is an unsuccessful outcome to the pensions review consideration may be given to balloting BMA members of the profession about what, if any, action to take. Various issues including added years and dynamisation could mean some members of the scheme may find themselves caught by the annual pension allowance of £50,000. Everyone should be taking advice on their pensions.

Members said that the NHS Pension Scheme was refusing to give pension estimates. They are obliged to give a statement no more than once a year on what your pension will be, based on your contributions. They are obliged to give you a list of what you have contributed up to that date listing all your employers and all your contributions whilst you are/were in the pension scheme. People should check their contributions are correct for their different employers, and that all their employers are listed.

GP Pension Choice Packs are being issued and you will have three months to decide whether to remain in the current scheme or to move into the new scheme.

Pension information should be available on http://www.nhsbsa.nhs.uk/pensions.

It was **AGREED** that the LMC should organise a Teesside meeting in the autumn with a representative from BMA Pensions being invited to attend and talk on this important subject. The local BMA divisions should also be involved.

11/7/11.2 Cost Rent

There had been items in the press recently concerning the cost rent scheme and inferring GPs were making huge profits from it. The Public Accounts Committee are going to review the scheme. The government's Private Finance Initiative (PFI) provides funding at high cost to the borrowers.

NOTED.

11/7/11.3 Violent Patients Scheme, Redcar & Cleveland PCT area

It had been mentioned at the last LMC meeting that it was not known if there was still a VPS in Redcar & Cleveland and the Tees Medical Adviser had been making enquiries within the PCT / NEPCSA. It would appear there has been an organisational oversight and the LMC were not contacted regarding moving the VPS from Huntcliffe Surgery to Eston Grange NHS Health Care Centre. The LMC have 2-monthly meetings with NEPCSA representatives so this should not happen again. Any problems contact NEPCSA.

NOTED.

11/7/11.4 Revalidation

The Tees Medical Adviser reported that the General Medical Council were impressed with the North East's approach to appraisal who were further ahead than other areas, and wanted the North East to be an early adopter of revalidation. Majority of doctors will be going through revalidation in 2013, volunteers (i.e. appraisers, trainers, GP tutors) may be requested as an early adopter in 2012.

Discussion centred on the fact that appraisal is a 5 year programme but the new system would be expected to be in place in 2-3 years time instead of 5 years. Material saved over the 5 year period would not be admissible in the new revalidation process. It will be material from April 2012 that will be required.

The new revalidation process will cover all the health profession not just doctors, so hospital staff will also have to submit to the new process. Difficult areas will be FMEs, occupational health, academics, etc.

It was pointed out that revalidation was first mentioned in 2000 and it was not definite that it would commence in 2012 or 2013.

NOTED.

11/7/12 RECEIVE ITEMS

11/7/12.1 Improvements to older people's mental health services in Stockton Letter from Martin Barkley, Chief Executive, TEWV NHS Trust

"In line with the national dementia strategy our aim is to make sure that, where possible, people receive the care they need in their home environment. We have reduced inappropriate admissions to hospital and removed delays in the assessment and treatment processes so that patients get the care they need as quickly as possible.

Staff at Lustrum Vale (our 22 bed inpatient unit for older people in Stockton) have transformed the way they work to improve patient care and reduce the time individuals need to spend in hospital. Patients are receiving more support in their home environment, and bed occupancy on the ward has decreased dramatically since the beginning of the year.

Over the last three months there have been less than five patients from Stockton on the 22 bed ward at any one time and currently there is only one patient on the unit.

Keeping empty beds open is not a good use of taxpayers' money, which could be used to help support people in the community. The Board of Directors has, therefore, agreed to temporarily close the unit from 1 July. From this date patients will be admitted to Westerdale Ward at Roseberry Park, Middlesbrough (next door to James Cook Hospital) where we have sufficient bed capacity.

This is a temporary closure and the unit can be re-opened at any time should this be necessary. In the meantime staff from Lustrum Vale will be redeployed to other inpatient units for older people and to community services in Stockton.

We will closely monitor this over the coming months and review the decision in October 2011, or earlier if required, in conjunction with the local Primary Care Trust. A full public consultation would take place before any decision on the permanent future of the unit was made.

I hope you find this information useful but if you have any queries please contact our Director of Operations for Teesside, David Brown, on 01642 853560, email david.brown@tewv.nhs.uk."

RECEIVED.

11/7/12.2 Medical List

Applications:

Effective Date	Name	Partnership	Practice Area
18.7.11 *Salaried GP.*	Dr I Garcia Vega	Chadwick Practice	H PCT
6.7.11 *Salaried GP.*	Dr A Kant	McKenzie Group Practice	H PCT
1.7.11 *Salaried GP.*	Dr V R Yatham	Thornaby & Barwick Medical Group	NT PCT
1.8.11 *Salaried GP.*	Dr S B Jones	Arrival Practice	NT PCT
2.6.11 *Salaried GP.*	Dr A Farzam	Prospect Surgery	M PCT
1.7.11 *Partner.*	Dr V Nanda	Discovery Practice	M PCT
19.7.11 *Returning to work following 24 hours retirement.*	Dr W J D O'Flanagan	The Saltscar Surgery	R&C PCT
20.6.11 *Salaried GP. APMS practice.*	Dr H H A Omran	Skelton Medical Centre	R&C PCT

Resignations:

Effective Date	Name	Partnership	Practice Area
31.5.11 *Resigned. Partner.*	Dr E Z George	Queenstree Practice	NT PCT
31.5.11 *Resigned. Salaried GP.*	Dr M F Cheyne	Eston Grange NHS Healthcare	R&C PCT
15.7.11 *Taking 24 hours retirement. Returning 19.7.11.*	Dr W J D O'Flanagan	The Saltscar Surgery	R&C PCT

31.7.11 Dr E B Ackroyd-Parkin Skelton Medical Centre R&C PCT
Salaried GP. APMS practice.

RECEIVED.

11/7/12.3 Surgery Relocations wef Monday, 4 July 2011

11/7/12.3.1 Dr Stocking & Partners are moving into new premises at: The Coatham Surgery, Coatham Health Village, Coatham Road, Redcar TS10 1AR. Tel. 01642 483495

11/7/12.3.2 Dr Robson & Partner are closing their branch surgery at Grangetown and moving it to: Low Grange Health Village, Normanby Road, South Bank, Middlesbrough TS6 6TD. Tel. 01642 511567. Their main practice in Jubilee Road will remain open.

RECEIVED.

11/7/12.4 Report the receipt of:

GPC Newsletter M10 – Thursday/Friday, 9/10 June 2011 – Conference News (available on www.bma.org.uk)
BMA NE Regional Council minutes of meeting held on 4 April 2011
Sunderland LMC's minutes of meeting held on 17 May 2011
Co Durham & Darlington LMC's minutes of meeting held on 3 May 2011
Co Durham & Darlington LMC's minutes of meeting held on 7 June 2011

RECEIVED.

11/7/12.5 Date and time of next meeting

Tuesday, **20 September 2011** : 7.00 p.m. : Norton Education Centre, Junction Road, Norton, Stockton on Tees TS20 1PR.

RECEIVED.

There being no further business to discuss, the meeting closed at 8.00 p.m.

Date: Chairman: