

MORGANNWG LOCAL MEDICAL COMMITTEE

Suite G1, Britannic House, Llandarcy, Neath, SA10 6EL

Office Hours: 9.30a.m. – 1.00 p.m. Monday – Friday

website: www.morgannwglmc.org.uk

Tel: 01792 815954

Fax: 01792 814938

email: morgannwglmc@btconnect.com

MINUTES

MORGANNWG LOCAL MEDICAL COMMITTEE

TUESDAY 11 MAY 2010

The Towers Hotel, Jersey Marine, Swansea Bay, SA10 6JL

Sponsor: Eli Lilly/Pfizer

Items in normal text were for consideration / *items in italics were for information*

GUEST

Professor Stephen Monaghan, Executive Director of Public Health, ABMU HB attended the meeting to introduce himself to the LMC and to discuss matters of mutual interest. He told the LMC that he had been a GP Trainee in Uplands & Mumbles Surgery and had done some of his Public Health Medicine training in Swansea. He is now Director of Public Health for ABMU. He commented that there would be difficult times ahead because of the financial position of the country and the change of Government will invariably bring some change in policy.

He then went on to discuss items and answer questions from LMC Members. The local structure for Public Health in ABMU HB was raised and SM advised that the three local teams are likely to stay at present as the Localities are developed. However, he felt there was a need to strengthen dialogue with clinicians, particularly in Primary Care. Public Health Wales is still settling in (as are the new Local Health Boards) and not all key personnel are in post.

AR commented that Public Health has a vital role and needs to assist in developing effective strategies. He said that the Clinical Strategy Board has not always had the information to make the key decisions. One area to be explored is the development of Specialised Services that may be at the detriment of basic Medical and Surgical care. SM agreed that the information and knowledge in Primary Care are needed to get behind the statistics. AS asked about the relationship between ABMU and beyond (i.e. local versus central). SM felt that the relationships with the Directors of Public Health Medicine are strengthening although they are all new in post. Part of the effect of the reorganisation of the NHS in Wales is that Public Health has got smaller in and he felt that there was a need to “work smart”. Questioning was done presently is important and central intelligence is helping with this.

SN asked about GPs as advisers in ABMU Public Health and SM commented that some are employed by Public Health Wales and some within ABMU but these links have not been firmly established locally at present. AB asked about the join-up between Public Health Wales and Public Health at Local Health Board level but this is still under development.

SM went on to discuss a possible “wish-list” for Public Health but to achieve this, there would need to be some capacity building for Public Health in the system. The key areas are:

- **Strategy** – improving the health of the population/the Healthy Public policy and the Healthy City. Local examples were given.
- **Health Protection** – the Consultants in Communicable Disease Control (CCDCs) will remain unchanged.
- **Public Health input into improving services** – there will need to be a critical relationship with Primary Care who are the generalists within the NHS.

He is well aware that making decisions is harder when there is not so much money around.

SN asked about information sources especially during Pandemic Flu and CJ and IM reported on the GPC Wales work which had taken place throughout the Pandemic to improve communications. GPs could also help this by emptying their Practice mail boxes regularly and sharing information across the Practice.

AM felt that the biggest challenges are in Mental Health as some of the poorest services in Wales are in ABMU. He described

a patient who had required prescribing for Substance Misuse and this had been delivered through a neighbouring LHB within 5 weeks whereas ABMU time for an appointment is 1 year. AR felt that an engagement of GPs to deal with Substance Misuse could be better and this could take some of the load off the services locally. SM described the new policy of Area Primary Boards for Substance Misuse but these are yet to be clearly defined. There was some scepticism from LMC Members about yet another initiative / plan for Substance Misuse in Wales.

IM asked the question of rationing and felt that this should not be left to the GPs to tell the citizen at the point of need or want that the service was no longer available. SM felt that low-effectiveness procedures need to be reviewed and quoted the example of tonsillectomies and grommets where the numbers performed in ABMU HB (and in North Wales) are significantly higher than the rest of Wales.

The Chairman thanked Professor Stephen Monaghan for his attendance at the meeting and asked that a "Who's Who" directory should be made available as soon as the structures are in place in ABMU HB. She also suggested that the LMC may wish to assist in feeding independent advice into the Board via Public Health.

Professor Stephen Monaghan was invited to remain in the meeting and did so for a number of items which followed.

Email of thanks to Professor Stephen Monaghan

Future Guests:

- **Dorothy Edwards, Hilary Dover and Chris Jones (Locality Directors for Bridgend, Neath Port Talbot and Swansea)** will be invited to the LMC meeting in July 2010 to discuss matters of mutual interest. **Email invitation**

GENERAL

1. **Attendance:** Drs: A Bradley, M Dehghani, C Jones, IM Millington, AM Muir, S Nazeer, E Owoso, A Pritchard, AP Rayani, C Rosser, N Shah, A Stevenson, A Delahunty, P Ramkumar, S Jones and H Walters, (GP Trainees) and Mrs L Rudd, PA.
2. **Apologies:** Drs: O Aung-Kyi, CE Danino, RB John, G Ratnalikar, S Rix, DJS Werner, SP Young, D Roberts and J Harrison. Erica Stamp, Richard Lewis (BMA) and Ann Burtonwood, Practice Manager.
3. **Notice of any other urgent business.** The Secretary added a number of late items to the Agenda (see below).
4. **Matters transferred from the "for information" sections of the Agenda.** None.
5. **Minutes of:**
 - Full LMC 09 March 2010 were ratified by the Committee and signed by the Chairman.

MATTERS ARISING NOT ON THE AGENDA

1. **Community Health Councils in ABMU Health Board** – the Secretary advised that the new appointments were expected at any time but were not at hand for the meeting.

CONTRACTOR SERVICES

1. **Additions/Removals - Medical Performers List / Partnership Changes / Other List Matters.**
 - (i) *SEE APPENDIX 1 ATTACHED.*
2. **Pharmaceutical List:**
 - (i) *SEE APPENDIX 1 ATTACHED.*
3. **Other Contractor Services/List Issues:**
 - (i) *Seniority Payments for 2006/7 - Seniority payments under the new GMS Contract are reduced to 60% for those earning less than two thirds of average superannuable income and are not paid for those earning less than one third of average superannuable income. The level of average superannuable income over the new Contract has had to be estimated to enable timely payments to be made as the final figures are not available for approximately 2 years after the year end. The estimates for Wales were too high for 2006/7 but this has now been corrected and so GPs should check with their accountant that they are aware of potential underpayments. The final average superannuable income for Wales for 2006/7 is £82399 compared with an estimated figure of £95355 and the qualifying income levels have been adjusted pro rata:*
 - *£54932 to £63570 - Eligible for an additional 40% to make it up to a full Seniority payment for 2006/7*
 - *£27466 to £31785 - Eligible for a new payment of 60% of the Seniority figure for 2006/7**Contractor Services will have made these changes on the March 2010 statement and will have made the payments.*

GPs are advised to check these particularly in the case of part time Partners. Also, Partners who have left the Practice should receive their due Seniority entitlement for 2006/7 and it is up to Practices to ensure that these payments are made.

KEY ISSUES:

1. Pre-Operative Assessment Clinics:

- **BP Requirements** – a number of BP readings (see attached paper).
- **Referral to Treatment Time (RTT)** - Removals and Reinstatements.

The Secretary gave an overview of the issues whereby patients are being removed from RTT and Waiting Lists because of medical conditions without any clear indications as to what these are, what actions will be taken by the hospital to remedy some of these, what actions are advised to the GP and how the patient gets back onto the Waiting List.

AB quoted two examples where a patient had been requested for a hip replacement but the Anaesthetist wanted “better control of the patient’s diabetes” although it was unclear as to what this should mean, how this should be achieved and who would be responsible for taking this forward. The second example was a patient who had a slow pulse which was hardly surprising as he was on Bisoprolol betablocker. It was unclear as to whether the patient had been referred to Cardiology and the GP received no letter from ABMU about this.

The Chairman suggested a meeting with the Anaesthetists and the LMC to reach a reasonable compromise and this was seen as a way forward for most Members although AR disagreed on the basis that it was not for GPs to sort out the confusion. Basically, he felt that patients who were unfit for Anaesthetic should be referred to the appropriate Specialty for further investigation and treatment. CJ agreed that it was poor information overall and that individual cases needed investigation. IM suggested that incidents relating to Pre-Assessment Clinics should be reported as a Significant Event to ABMU HB and that a copy should be sent to the National Patient Safety Agency (NPSA). AR felt that the stumbling block might be that GPs were not keen on paperwork but IM felt that it may be the only way to effect change.

CJ felt that pre-assessment was done in better areas of ABMU with few complaints from the Bridgend Locality. AP felt that there should be both approaches to this whereby there should be a meeting and significant incidents should also be reported.

EO described a letter that he had received from the hospital suggesting a new referral to the same specialty that the patient was already attending for advice and treatment of Chronic Pain as the patient would be seen sooner than waiting for the follow-up appointment from the hospital. CJ agreed that the policy was wrong and IM described it as unsafe and unreliable. Further, it is not the role of GPs to sort out this confusion. It was suggested that examples should be sent to the Medical Director of ABMU and to the Assistant Medical Director (Primary Care).

The Chairman summarised that the two issues were about Pre-Assessment Clinics and removal from Waiting List and the Chronic Pain pathway. AR felt that there had been no benefit from Pathways work and doubted whether GPs were using the Pathways. CR felt there were no clear access points back onto the Waiting List when patients have been removed and there needs to be. SM felt that the issue of re-referrals had changed in that the health Board does not have the perverse incentive regarding the purchaser-provider split, although there are some incentives in RTT, especially at the end of the financial year. It was agreed to progress these issues via the LMC Executive. **Action: LMC Executive**

2. **District Nursing Specification** – it was agreed that this be deferred until July 2010 because of the absence of SPY and JH. One principle agreed was that there must be consistent specification across the three Localities of ABMU HB.
3. **Unscheduled Care** – ABMU Health Board is addressing this as a matter of high priority. Documentation includes:
 - **Welsh Audit Office report:** http://www.wao.gov.uk/assets/englishdocuments/UnscheduledCare_Eng_Web.pdf
 - **Primary Care Foundation report: Primary Care and Emergency Departments (March 2010)** <http://www.collemergencymed.ac.uk/CEM/About%20the%20College/Current%20Issues%20and%20Statements/Primary%20Care%20and%20Emergency%20Departments/default.asp>

It was agreed to move discussions on this item to the July LMC as there are key discussions ongoing which would inform the possible structure of this within ABMU HB.

However, the Chairman raised the issue of “8 ‘til 8” opening which was Tory/Lib/Dem policy and also that of the Assembly First Minister. SN asked if this would be incorporated into Localities but IM indicated that there had been no discussion on this locally as it is a UK contractual matter. However, in his role as GPC Wales Negotiator, he had met with a group that had included Dr CDV Jones and it had been agreed that there was no funding for extending GP hours.

AR questioned whether “8 ‘til 8” applied to 5 days or 7 days. Again, it was emphasised that this would be GPC UK negotiations but AR disagreed in that changes to the Contract can be imposed with 3 months notice. Further, England has alternative providers. IM suggested that there may well be resignations if the GP hours were increased but AR felt that this was not likely as many GPs are too financially committed to their present arrangements. There was some agreement that patients should have times when they are able to access their own GP for chronic care although again, extending this beyond 6.30 pm was not seen as a viable proposition except as the Extended Hours LES. EO questioned as to why it should be “8 ‘til 8” and it was suggested that focus groups in the South East of England would be the source of this. However, SM felt that availability of GP appointments is a bigger issue than Extended Hours and if this is addressed, the call for extended hours for GPs may not be so strident. MD asked about the European Working Time Directive and it was advised that GPs who are Independent Contractors fall outside this although employed GPs are subject to EWTD. IM commented that there are problems with access locally with some Practices providing Advanced Access which contracts all the telephone calls for appointments into a very short time slot in the mornings and this was the biggest source of complaint to the Minister, AMs, Health Boards and CHCs in Wales. CJ felt that the view of the LMC is that there is no wish for “8 ‘til 8” opening although noted ARs exceptional view on this. AR felt that we should look for solutions but be clear at the costings associated with this as this will make a final decision much clearer.

Action: “8 ‘til 8” as Key Issue on LMC Agenda July 2010 / Encourage Practices to re-examine Access

LMC MATTERS

- 1. Annual Conference of LMCs – Thursday 10 & Friday 11 June 2010 in London:**
 - *Morgannwg LMC Reps – Drs: C Danino, E Owoso and Dr A Stevenson with Dr N Shah as Observer. Drs I Millington and A Rayani will be attending as GPC Wales Reps. Dr Charlotte Jones will have an automatic place as a Member of GPC UK.*
 - *Motions to Conference (copy attached) – these were submitted before the closing date and the publication of the final Agenda for Conference is awaited.*
- 2. Medical Reports for Life Insurance Companies** – report of correspondence from an LMC Member who had been asked to complete a Medical Report for Life Insurance and Critical Illness by a Life Insurance Company. The Company stated that they had the patient’s verbal permission as a recorded telephone conversation and had asked the doctor to proceed on that basis, or alternatively, the GP could seek written consent from the patient. Further, they had suggested that the doctor was also responsible for contacting the patient if they wished to see the report. The Secretary wrote to Dr Peter Holden, Chairman of the Fees Committee of GPC on 08 April 2010 and a reply is awaited. Other examples were raised by LMC Members. Clearly, central guidance is required on this.
- 3. NCAS Conference 25/03/2010** –IM had circulated a copy of his report to the GPC Wales Negotiating Team following attendance at the Conference with the Past Chairman. The greatest concern from the Conference was the issue of the Responsible Officer with particular concerns about doctors with no experience of General Practice being asked to sign off General Practitioners. This matter is under discussion at a UK level.
- 4. Statement of Fitness for Work: Med3 04/09** – *the Med3 Fit Note is now in operation and some issues have arisen mainly around the failure of employers to understand the Regulations. Under the new Fit Note, there is no requirement to sign a patient as fit to return to work and employers cannot insist on this. Other issues have arisen and guidance is likely to be issued in the near future.* Members had been invited to report any difficulties with the new fit note but none were forthcoming.
- 5. Voluntary Levy 2010** – *e-mail from Dr BD Keighley, Treasurer and Director, General Practitioner’s Defence Fund Limited advising that, for the second year running, the GPDF Limited has accumulated funds and is sharing some of these with LMCs. As a result, the Directors have authorised him to rebate the LMC part of the 2009 levy amounting to a little over 26%. As a result, the Voluntary Levy payment for 2010 will be £15,097.67.*

SESSIONAL GPs

- 1. Swansea Sessional GPs (SSGP)** - *The next meeting of Swansea Sessional GPs will be held at 7:00pm on Thursday 20th May at the Village Hotel, Swansea and a hot finger buffet, tea and coffee will be provided. As proposed at the inaugural meeting last year, elections for the posts of Secretary, Chair, Vice-Chair and Treasurer will be held so please contact the Secretary of the SSGP if you are interested and would like more information on the constitution. The Group will also*

consider Significant Event Analysis so please let Secretary of the SSGP know if you would like to share a significant event with the group. Following this, there will be a long summer recess with an Autumn meeting planned for September. Please email to the Secretary of SSGP at swanseasessionalgps@googlemail.com if you wish to attend.

GP TRAINEES

1. **Engaging GP Trainees with the LMC** – OA-K had made some suggestions as to how this could be improved and these will be taken forward by the LMC Executive. GP trainees present at the meeting were invited to raise any issues both at the meeting and in the future with particular reference to extended GP training and other changes that are taking place. The Chairman made it clear that GP Trainees are always welcome to attend the meetings of the LMC.

LMC/LHBs/BSC LIAISON GROUP 17 March 2010

1. **Access to GP Services:**

- (i) **Access to GP Services** – IM reconfirmed the status of the GPC Wales paper as guidance on Good Practice and all agreed that this had been extremely helpful. IM went on to emphasise that the document needed to be viewed in the context of each General Practice and was not a fixed rule book. Morgannwg LMC, with ABMU Health Board had led the way in Wales in producing the earlier paper which was expanded into the GPC Wales paper.
- (ii) **WAG pressures to deliver on Access** – IM reported that a recent letter from WAG was asking for information on cover provided by or for General Practice from 8.00 am to 8.00 pm. This went beyond the GMS contracted hours so many Practices had suggested that the enquirer contact the OOH contract holder for details of the out-of-hours arrangements for their Practice.
- (iii) **Monitoring of Practices against AOF4** – the Localities reported as follows:
 - **NPT** – this is going well.
 - **Bridgend** – there is one outlying Practice in the Locality but this one has shown considerable improvement in its access arrangements.
 - **Swansea** – there are two Practices which are outlying with one having a Comms issue and the other having more fundamental problems with Access. Both have been approached by the Locality to remedy these.
- (iv) **AOF6 requirements for 2010/11** – Localities will now be required to look at appointment systems although most of the difficulties around these appear to relate to Advanced Access which is covered in the Access to GP Services paper. AR felt that it was worth discussing the issues in advance of roll-out to Practices although he made the point that this will need to be cost-neutral. Also, at a time when Practices had received a zero pay rise, a negative increase in their expenses and a further deduction for efficiency savings, this was not the time to be wanting more out of existing resources although there was some scope for better use of the existing resources. DE commented on recent publicity about Demand Management and IM asked about the use of other Health Professionals to see patients, although there was a feeling that many patients who did not need to be seen by the Health Service still turned up at GP surgeries. IM felt that this was a “Hearts & Minds” job and that ABMU is ahead of many areas in Wales. AR advised that GP Wales is seeking information from all Assembly Members as to the number of complaints that directly related to GP Access and the LMC also asked if ABMU could provide similar information (which was agreed). DE suggested a possible Workshop to explore the maximisation of the use of appointments by Practices by learning from those who have resolved the issue.
- (v) **Unscheduled Care** – AH indicated that the A&E departments in ABMU HB were not reaching their performance targets and a Steering Group had been set up to resolve the issue. The Primary Care Foundation had looked at a number of areas of Unscheduled Care including Urgent Care in General Practice both in-hours and out-of-hours. AR asked that the LMC be part of the Steering Group to deal with the in-hours component. It was agreed to place this item on the Agenda for the next Liaison Group Meeting.

Liaison Group May 2010
- (vi) **Patient Experience Survey 2009/10** – this was progressing well with only minor problems reported. One such problem reported by the CHCs was the different way in which the survey forms were given out in one Practice, where only patients seeing the GP were given the forms. The survey will be coming to an end shortly.

(vii) **Patient Experience Survey 2008/09** – to date, there was no information on progress of Appeals that are with WAG.

(viii) **Pandemic Flu Targets & PES 2008/09 Easement** – the overall immunisation levels in ABMU were below 50.4% of the target group to date although some returns were still to come in. IM reported that many Practices were likely to see some easement because of their immunisation performance under this arrangement.

2. ABMU Health Board:

(i) **Structures: Localities / Consortia** – this was discussed in some detail at the Clinical Strategy Workshop on 09 March 2010 and the Secretary had attended.

(ii) **GP input into ABMU Structures** – the adverts for Medical Directors at Locality levels will be going out shortly and all Practice Managers will be e-mailed to share the information within the Practice. JH reported that the flexible careers structure for Doctors wishing to be involved with ABMUHB work is “on track” and the MDs are completing this package. A Practitioner who wishes to be involved in this will also have a package that includes gaining experience by working in A&E, Neurology and Dermatology. The LMC is supportive of this scheme.

(iii) **Management Arrangements / Appointments** – the key Locality appointments are being made this week and the work is likely to progress at a faster rate once this has been done.

(iv) **Lay Members for various Committees / Groups** – IM reported that there are real problems in obtaining Lay Members to sit on various groups and panels including Violent Patient Scheme and Performance Panels. DE reported that the CHCs had not wished to be involved in the membership of these groups and panels because of the changes within their organisation and because of some perceived conflicts of interest. ABMU are looking at alternative ways of ensuring Lay Representation. HA commented that authority would be required for alternative Lay Members. JH felt that this was a gap that needs to be resolved. **Action: AH – ABMUHB**

3. Estates Strategy for Primary Care in ABMUHB:

AR stated that the LMC welcomed larger Primary Care developments such as the Port Talbot Resource Centre but asked specifically about development of existing GP premises. AH reported that this was now with the Director of Planning for ABMUHB and that he was considering GP Premises in the light of the previous LHB Estate Strategies which may need to be revised. There was some general discussion about National and Local issues in relation to GP and Primary Care premises including the WAG policy and sources of funding. AH felt that Consortia should help Practices to work differently and that this would produce a link to the Primary and Community Services framework. DE felt that there was scope for looking at Branch Services, GP surgeries and Clinics to ensure that the best model could be produced in any Locality or within a Consortium. IM reported that the LMC will shortly send out a questionnaire to Practices to ask about their current premises and requirements for the future and this may help to steer the discussion.

4. Enhanced Services in ABMUHB 2010/11:

(i) **Basket of Enhanced Services**

Diabetes DES – JH reported on the discussions at WAG level between the Medical Directors of Health Boards, GPC Wales and WAG to try to find a better solution to the current problems with the Diabetic DES. Part 1 of the DES is about registers and this has gone well but Part 2 is about targets, some of which are difficult to obtain and there is some evidence that they may not be clinically appropriate because of more recent clinical studies. JH felt that GPs could be jeopardised by exercising clinical judgment and that this would need to change. As a result, a paper has been drawn up and this is under discussion between WAG, the LHB Medical Directors and GPC Wales. IM confirmed support for JH in developing the changes. Also, IM indicated that there is support for JH in developing a “fix” for 2009/10 because of the effects of the above and this is currently under discussion. NPT LHB had changed the DES to a LES in which the targets had been split and this had actually produced satisfactory results for all concerned.

Extended Hours DES – this is being reviewed on account of generally poor uptake and whether this is producing the best value for money. AR asked about whether Saturday mornings could be included in the DES and was advised that this option was already available to HBs and could be considered. IM indicated that it was unlikely that this would be popular with GPs and it was not LMC policy.

(ii) **Existing Enhanced Services** – most of these will be carried over from 2009/10 to 2010/11 although the Care Homes LES is under review as there are some difficulties in delivering this in the Neath Port Talbot area. Also,

in Bridgend, a significant number of Practices had not opted to deliver the Nursing Home LES so a Salaried GP had been employed to provide the service to those patients not covered by their own Practice. IM felt that this should still be offered to Practices and that the Salaried Doctor option should only come in should there be problems getting Practices to do the work. JH felt that the Nursing Home LES was one that could be delivered on a Consortium basis where the Consortium may wish to consider employing a doctor to carry out the work on behalf of some or all the Practices.

(iii) **Locality variations** – there are unlikely to be significant Locality variations in the offering of Enhanced Services in 2010/11.

(iv) **Accreditation of GPs to provide Enhanced Services** – JH reported that she was looking at this for ABMUHB and that there may be an opportunity to include a self-accreditation record which would avoid much of the paperwork. A small Working Group will be set up to take this forward.

5. **Addendum to Minor Surgery** – JH updated the Liaison Group on the three areas which had been under consideration since the LMC meeting on 09/03/2010:

- **Multi-Disciplinary Teams** – GPs with the necessary Minor Surgery experience could apply to become part of the Multi-Disciplinary Team and could then be approved for removal of BCCs.
- **Appeals** – this was now being clarified.
- **Private Patients** – AR felt that GPs should be allowed to carry out cosmetic minor surgery on their own patients who would not be eligible under the NHS although there was a general feeling that the Regulations precluded this. He felt that Travel Services were provided for patients of a Practice in similar circumstances but this was not sufficient grounds to proceed. DE suggested that there may be an opportunity to set up a 'not for profit' organisation or that a Consortium could have flexibility to offer services for Practices within its framework. This work is ongoing.

6. **All Wales Performance Procedures** – minor changes have been made to these to reflect the new structure of the NHS in Wales and these will be signed off shortly prior to distribution to Health Boards. Overall, the procedure should continue as previously.

7. **Pandemic Flu Immunisation Campaign:**

- Phase 1** – the plan is for this to continue beyond 31/03/2010 with GPs offering immunisation to patients in the high risk groups who had not already been immunised. AR reported that vaccine deliveries have now ceased although IMM thought that supplies will still be available from ABMUHB.
- Phase 2** – this will close on 31/03/2010. The latest numbers were not available. AR reported on one maternal death in the area which had occurred some 10 days after initial diagnosis and that anti-virals did not seem to have prevented this sad outcome.

8. **Closed Lists & Practice Areas** – IM reported on the contract negotiations whereby the DOH were intending to abolish Practice areas as part of its intention to allow patients to access GMS in more than one Practice. All present agreed that this would create significant problems and could be more expensive than the present system.

9. **Work in Progress**

- **Community Nursing Services** – the Secretary reported that Local meetings had been progressing along the lines of Phase 1 defining the existing District Nursing Service with Phase 2 of the work after 01/04/2010 which will look to the future service model. IM also reported on the Community Nursing Strategy for Wales where Paras 11-13 had been amended and the RCN had been tasked to work with the BMA/GPC to produce an implementation plan for Primary Care Nursing. Unfortunately, there has been a delay in setting up the meetings because of some issues raised by WAG.
- **Health Visiting Services in ABMU** – IM will meet with AH and VF on 22/03/2010 to discuss this matter further.

10. **Any Other Urgent Business:**

- **Removal of syringe drivers by District Nurses** – AR reported that there have been problems whereby District Nursing Services will not disconnect or remove any equipment such as syringe drivers and catheters from a patient unless a doctor has confirmed that life is extinct. This is creating some tensions in the out-of-hours environment.

11. **Next meeting:** 12.30 – 14.00hrs Thursday 27 May 2010 at NPT Locality Offices

ABERTAWA BRO MORGANNWG UNIVERSITY HEALTH BOARD

1. General Issues:

- i. **ABMU Clinical Strategy Board 21/04/2010** – AR had attended and advised the LMC that the detailed discussions at this meeting were confidential. However, it is common knowledge that there is discussion about the configuration of services at the four main hospitals in ABMU HB and that it is likely that emergency and urgent care rotas will be concentrated at Princess of Wales Hospital and Morryston Hospital. CJ commented that the plans are to move GP Out-of-Hours Services from Singleton to Morryston but there are concerns as to how the service could be accommodated at Morryston. The discussion broadened into access to certain hospitals within the area and it is clear that there is a problem with Singleton switchboard. Apparently, the Singleton Switchboard number that GPs can use has been sent to GPs (although there is some doubt as to whether this has been done in all three Localities). **Action: IM to investigate whether Singleton Switchboard number has been distributed to all GPs**
- ii. **Changes to Service Configuration: Baglan Hospital** – verbal report of meeting between LMC Secretary and Representatives of Neath & District Trades Union Council on 26/04/2010 to discuss changes to service configuration of Baglan Hospital. The N&D TUC is extremely upset about the possibility of losing the Minor Casualty Service although this has been nurse-led for some time. Formulation of the LMC views may be helpful as this matter is likely to be in the public domain in the near future. CJ commented that the Minor Casualty Unit at Baglan is nurse-led but the numbers of patients attending are low. A Junior Doctor rota to staff it as a Minor Casualty is unsustainable and the costs are such that it is likely that there may be reduced hours from 8.00 am to 8.00 pm with closure overnight. AM was concerned about the closure of the medical intake at Neath Port Talbot as he did not believe that there was sufficient capacity at Morryston to cope with the increased numbers. IM was concerned that GPs are having to take on increasing amounts of work and to manage patients in increasingly difficult circumstances whereas many Consultant colleagues are happy to practise “excellence” without reference to the numbers waiting to be seen. This issue will create tensions in the future.
- iii. **Safeguarding Children** – *This has a high priority across Wales and ABMU Health Board has a duty to ensure that it delivers on the recommendations of various bodies / enquiries, including ensuring that GPs/Practices deliver on the elements relevant to them. Current issues relevant to GPs/Practices are:*
 - **PISF Forms** – *the Secretary met with Janet Morgan, ABMU who has the lead on safeguarding children. Following discussions about the PISF Forms, a clearer draft policy has now been agreed and this will be rolled out to GPs on 01 June 2010.*
 - **Audit for ABMU Health Board** – *Janet Morgan has been asked to undertake an audit following the Health Inspectorate Wales (HIW) recommendations following the Safeguarding inspection and subsequent report late last year. The recommendation states the following: All GP Practices across Wales should ensure that they comply with “A Guide for Safeguarding Children and Young Persons in General Practice” issued by the National Public Health Service in 2007”. This has gone out to Practices and replies should have been sent.*
- iv. **Oxygen Contract Monitoring Group 16/03/2010** – *the Secretary attended on behalf of the LMC. The Oxygen/Respiratory Nurses are working very hard to reduce the costs of oxygen to those who are on inappropriate amounts or are using inappropriate supply equipment (e.g. lightweight portable sets when they do not leave the house) but they are now reaching a hard core of patients who refuse to co-operate with any reductions or even to allow the engineer into the house. Guidance from WAG is being sought as to how hard these patients should be pursued to ensure that their oxygen supplies match their assessed clinical needs. Also, the Oxygen Contract is up for renewal in 2011 and this is a good opportunity to feed in problems that exist.*
- v. **ABMU HB Clinical Audit and Effectiveness Committee 22/03/2010** – *this is essentially about Secondary Care Audits and much seems to be about ticking the appropriate boxes.*

2. Primary Care Issues:

i. General Issues:

- **Community Integrated Intermediate Care Service (CIIS)** – AS updated the LMC on the fact that the Steering Group has been in operation for some time but a Clinical Governance Group has now been formed and it met for the second time on 11/05/2010. The issues around prescribing had been raised in that

there were different arrangements in the Swansea area with the Intermediate Care Services (Consultant led) and in the Bridgend and Neath Port Talbot areas (the original CIIS areas). The lines of responsibility for Clinical Governance need to be clear and scripts issued by Independent Prescribers need to be identified for Clinical Governance and costings. SN commented that that there had been different policies of taking bloods and following up results but that some changes had been made recently.

- **Guidance for Prescribing at the Primary/Secondary Care Interface across the ABMU HB** – this paper had been to the LMC previously and there had been some minor updating to reflect the changes in ABMU HB. Overall, the LMC had supported this in the past but it was agreed that all Members should see the paper before the final LMC sign-off is given. **Action: IM to send paper to LMC Members**
- **ABMU Mental Health Drugs & Therapeutics Committee** - Invitation from Stuart Evans, Interface / Formulary Pharmacist ABMUHB to nominate an LMC Member to sit on this Committee. Dr A Rayani expressed an interest and was duly nominated. **Email to Stuart Evans ABMUHB**
- **Minor Surgery** – the issues of shave excisions and cautery and of rationing of minor surgery under the umbrella of “cosmetic lesions” has now been raised with the WAG at the GP Forum on 28/04/2010. It was agreed to defer further discussions on this until GPC Wales had received a reply from Paul Williams, Director of NHS Wales. In the meantime, there are concerns in the Swansea Locality that a more rigid approach is being applied to the interpretation of Minor Surgery than in other areas of ABMU Health Board. **Liaison Group May 2010**
- **Inspecting GP Medical Bags at QOF visits** – letter from a Constituent GP who objected to having his medical bag examined at QOF visits on the basis that his medical bag is his private property. He further objected to the fact that as a single-handed GP, his bag will be inspected on every occasion whereas Group Practices will only have a sample number of bags selected for inspection. He felt that this was an infringement of his rights. It was clarified early in the discussion that this was a Clinical Governance issue taken forward at the time of the QOF inspection rather than anything directly related to QOF. There was minority support for the GPs views in relation to the medical bag but the vast majority of the LMC Members were more concerned that any policy relating to the contents of a GP’s bag should specify that the drugs are “appropriate” rather than being fully descriptive and that the GP should be able to demonstrate that the drugs are up-to-date. EO felt that there were professional principles involved and that the medical bag should be fit for purpose and be available. **Letter to GP who raised the issue**
- **Prescribing Leads 19/03/2010** – Members reported that the key issues had been about self-prescribing (GPs should be following GMC advice on this), anti-malarials being prescribed on the NHS, EPO (which is being taken back into Secondary Care, as should be the monitoring) and aspects of prescribing around Palliative Care. The issue of self-prescribing or prescribing for close members of the family was discussed in more detail at the LMC and the key points are that the GP should be able to justify this and must make and keep adequate records. The Secretary felt that any GP treating a member of his/her own family must treat that person as a patient first and a relative second and that overall, it is better avoided.

ii. **Swansea Locality:**

- **QOF submissions** – Swansea Locality appear to be demanding additional information from Practices to demonstrate that they have carried out the requirements of certain elements of QOF (e.g. copies of the Patient Information Leaflets used by the Practice for Primary Prevention in CVD, those used for giving advice on Long-Acting Reversible Contraception and a written protocol of how Practices are meeting the 4 questions in Dementia) rather than accepting a signed statement that the Practice is adhering to the guidance in these areas of QOF. There was some discussion as to the precise requirements around LARC and the overall feeling was that the leaflet should be given. However, some anomalies had been thrown up in that Practices had introduced sensible prescribing policies whereby multiple scripts were issued for contraceptives to avoid giving large quantities but Swansea Locality were now insisting that an LARC leaflet should be given with each script issued. This was felt to be rather excessive. The issue of SEAs was also raised on the basis that these should be done at a Practice level rather than as a shared experience across more than one Practice and that the numbers are important. There were mixed views as to whether this was advisable as SEAs are a valuable learning tool for all who are involved. It was agreed to seek examples of what appeared to be

excessive demands under QOF submissions. **Action: E-mail Practice Managers / Liaison Group May 2010**

iii. **Neath Port Talbot Locality:**

- *None*

iv. **Bridgend Locality:**

- *None*

2. **Secondary Care Issues:**

i. **Prescribing on the advice of a Consultant** – correspondence from Constituent GPs who have been asked to prescribe or provide:

- **Atypical anti-psychotics for a child under 16 years of age** – the patient had moved into one of the ABMU Localities from a Trust in England where he had been under psychiatric treatment. The GP in the ABMU Locality was unhappy to pick up the prescribing of the drugs that were being used outside his clinical experience. The GP referred the patient to CAMHS for advice but was left with the problem of having to prescribe these drugs for the patient before advice or an appointment was forthcoming.
- **Gentamycin by Nebuliser to a Respiratory patient** – the Consultant had recommended that the GP Prescribing intravenous Gentamycin by Nebuliser to do this but the GP was unhappy as he had no experience of using this drug off label.
- **Solefenacin** – a Consultant had sent a letter to the GP to prescribe this drug for a patient but had failed to advise the patient to contact the GP surgery and as a result the prescription was not given.
- **Bottles and forms for MSUs** – letter from Constituent GP whose patient was seen in the Urology Department prior to cystoscopy but was suspected of having a urinary tract infection on dip testing. The patient was given a prescription and told to ask her GP for a “urine bottle and form” for an MSU. This seemed extremely inappropriate in view of the fact that the hospital had very adequate supplies of these.

It was agreed that these issues be raised as part of the need for a Prescribing Interface policy to be effective and enforced (*see 2 (i) Guidance for Prescribing at the Primary/Secondary Care Interface across the ABMU HB*)

Action IMM: Paper on Patient Safety Issues at the Primary Care / Secondary Care Interface

ii. **Physiotherapy Services in the Swansea Locality:**

- **Physio Direct** – reports from a number of Practices whose patients are having some difficulty in accessing Physio Direct. There seems to be some confusion around the service which is no more than telephone assessment before an appointment is given (if appropriate). There have also been some practical difficulties including wrong telephone numbers inserted on correspondence.
- **Practices with in-house Physio** – it appears that some patients from other Practices will be given access to these services as part of the reorganisation of Physio services.

There has been some confusion about service delivery and most Practices who had previously had in-house physio have been moved back into the general system for the Locality with some deterioration in the service for their patients. Written GP Referrals to the service were still acceptable but there were a number of issues that needed clarification.

E-mail to Swansea Locality re Physio services

iii. **Primary Care Interface Group 20/04/2010** – a number of important issues were discussed as follows:

- **Colorectal Care Pathway / Downgrading USCRs** – pressure from GPs to resolve these issues
- **Minor Surgery and Cosmetic Lesions** – still unclear (now a GPC Wales issue)
- **School Health Nursing: Swansea Locality** – there is a WAG directive to introduce this and some non-recurring funds have been made available in 2010/11. The human resources will come from the Clinic Nurses, some of whom are attached to General Practice Health Visiting teams.
- **Unscheduled Care** - see Key Issues.
- **Palliative Care/End of Life Care issues** – including District Nurses and syringe drivers.
- **Primary Care Interface Action Plan** – includes District Nursing Project / Treatment Room Services / Leg Ulcer Pathway / Adult Mental Health Action Plan.
- **Pre-op assessment** -see Key Issues.
- **Acute Neurosurgical Problems** – the local care pathway should be for GPs to refer to Secondary Care for assessment prior to transfer to Tertiary Care if appropriate but the arrangements do not seem to be widely understood by hospital staff. EO raised concerns about the local Care Pathway although that it may be that

it had only just come into operation at the time of the difficulties he had experienced on behalf of his patients.

IM to check that all GPs had been circulated

- iv. **Podiatry Referrals from Community to Hospital** – letter from Constituent GP re the requirement of GPs to make the referral. Apparently, this relates to the fact that Community Podiatrists operate within certain Clinical Governance arrangements whereas Podiatrists in Secondary Care are under the Clinical Governance of a Consultant.

E-mail to Medical Director, ABMU HB for clarification

- v. **Facial Lacerations: Maxillofacial / Plastic Surgery Rotas** – e-mail from LMC Member re confusion, delays and lack of information for GPs when referring Facial Lacerations as an Emergency.

E-mail to Medical Director, ABMU HB

WELSH AMBULANCE SERVICES NHS TRUST

1. None.

PUBLIC HEALTH WALES AND IMMUNISATION ISSUES

1. None.

GPC WALES / GPC UK

1. **GPC/LMC Roadshow 25/03/2010** – most of the items had been discussed as part of the LMC Agenda.
2. **Negotiations Report: April 2010** (copy circulated by email to LMC Members) – issues of particular relevance to Morgannwg LMC are:

- **Diabetic DES** – this is awaiting Ministerial sign-off before it goes into the DES basket for 2010/11. It will include exception reporting to get over the changes to the advice on HbA1C and BP control for the elderly.
- **Minor Surgery** - GPCW has concerns that LHBs appear to be trying to decommission swathes of minor surgery procedures. This was partly on the back of HCW criteria designed for tertiary cosmetic services and partly on the development of lists of “interventions not normally funded” (INNFs). Most of these lists as pointed out last week have exceptionality clauses in respect of patient distress and diagnostic uncertainty and GPC and LMCs should be very clear in discussions that these clauses are clinically not managerially determined. GPCW is asking the Director of NHS Wales for a reasonable level of service for patients to be applied consistently across Wales and for patients and that CHCs should be explicitly informed of any planned reduction of available service. GPC Wales has also reiterated concerns about guidance on shave excisions previously agreed being accurately applied when haemostasis after the shave excision is achieved using cautery.

Other areas in the report are for information but NHS Pensions – Making the Choice and Seniority Payments for 2006/7 will require action by Practices.

BRITISH MEDICAL ASSOCIATION

1. **BMA Divisional AGM 22/03/2010** – CJ reported that there had been change of officers with Chair: Dr Mark Temple & Secretary: Dr Sophie Carter-Ingram.
2. **BMA Charities:**
- The Dane Fund – this meets the educational costs for doctors’ children in specific circumstances.
 - The Earnshaw Bequests – this provides one-off grants for doctors/dependents for palliative/terminal care subject to certain conditions having been met.

The Chairman also raised the issue of other charities including the Clare Wand Fund. It was agreed to publish details of the BMA Charities in the LMC Newsletter and on the LMC Website. **Action IMM: LMC Newsletter / Website**

GENERAL MEDICAL COUNCIL

1. **Consultation on Revalidation** – The link for this is <http://www.gmc-uk.org/doctors/licensing/5786.asp> All doctors are encouraged to have their say on this before the consultation closes on Friday 04 June 2010.

WELSH ASSEMBLY GOVERNMENT (WAG) / DEPARTMENT OF HEALTH (DH)

1. **Ministerial Letters:**
 - *None.*
2. **Consultation Documents:**
 - *None.*
3. **CMO Letters:**
 - *None.*
4. **Other Letters:**
 - ***Safeguarding Vulnerable Groups Act 2006 (Controlled Activity) (Wales) Regulations 2010: WSI 2010/1174w104*** – *this Statutory Instrument has now come into place and it relates to Vetting & Barring. Further information can be obtained from the Secretary.*

KEY ISSUES – For Next LMC Meeting

1. *Unscheduled Care.*
2. *District Nursing Specification.*
- 3.
- 4.

ANY OTHER BUSINESS

- *To be notified by the Chairman at the start of the meeting. None.*

ITEMS RECEIVED FOR INFORMATION

(BLUE FILE CIRCULATED AT THE MEETING)

MEETINGS

(YELLOW FILE CIRCULATED AT THE MEETING)

DATES FOR DIARIES

-

NEXT LMC MEETINGS

- *LMC Exec 7.00 pm Tuesday 8 June 2010 venue to be confirmed.*
- *Full LMC 7.00 pm Tuesday 13 July 2010 at The Towers Hotel, Jersey Marine.*