MORGANNWG LOCAL MEDICAL COMMITTEE

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MINUTES

MORGANNWG LOCAL MEDICAL COMMITTEE

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

TUESDAY 13 September 2016

*items in italics - for information / * indicates additional papers*

GUESTS AT FUTURE MEETINGS:

- **08 November 2016: Speaker to be confirmed**
- **10 January 2017: Dr Richard Lewis will attend to provide an update in respect of his role as National Professional Lead for Primary Care (rearranged from 8 Nov 16)**

A Soapbox session preceded the main meeting and details are summarised at the end of the Minutes

GUESTS:

Dr Mark Goodwin, GP and Cluster lead in NPT provided an inspiring talk on the work he has been involved in to develop the GP Fellowship scheme to support practices in the area who are struggling to recruit GPs and locums and manage increasing workloads. Mark had identified, through examination of current weighted list size per GP session per practice, that there was a shortfall in GP numbers equating to approximately 7 whole time equivalents.
Funded mainly from unused Cluster funds it was agreed that attempts should be made to recruit a group of salaried GPs to work on a rotating basis within vulnerable practices. The posts were being designed to appeal to younger GPs willing to commit for one or two years. Mentorship would be provided outside of the practice and GPs would be encouraged to broaden the scope of work by attending meetings, working OOH sessions and in NPT Acute care. A competitive salary and Terms and conditions equal to or above BMA would be available. A job description had been agreed by ABMU Health Board who would employ the GPs and advertisements would be placed soon. If successful the scheme would be rolled out in other areas of ABMU.
There were enthusiastic comments and applause from LMC members following Mark's talk. NS proposed a vote of thanks.

1.	**ATTENDANCE:** **LMC Members:** S Bassett (SB), C Danino (CD), P Evans (PE), I Harris (IH), S Hlaing (SH), C Jones(CJ), J Kletta (JK), E Owoso, A Rayani (AR), M Rickards (MR), N Shah (Chair), (NS), H Wilkes (HW), P Williams (PW); Mrs M Liddell (Executive Officer)(ML) **Dyfed Powys LMC**: L Williams (LW) **Practice Managers**: D Blower (DB), C Boland (CB), S Kiley (SK)

	ABMU: S Lingard (SL)	
2.	**APOLOGIES:** Drs O Aung-Kyi, A Bradley, L El-Sharkawi, A Hussain **ABMU**: H Dover**,** S Hayes, N Williams **PRACTICE MANAGERS**: Mrs J Carter **Registrars**: L Kerrigan	
3.	**MINUTES :** • **Full LMC Tuesday 12 July 2016** – the Minutes were approved and signed by the Chairman	
4.	**4.1 OCCUPATIONAL HEALTH SERVICE for GPs:** Further information about the service had been requested from the lead nurse. **4.2 SNAP 11 PROJECT:** DB confirmed that NWIS was developing a new survey but the cluster planned to purchase a stand alone version. **4.3 RECRUITMENT OF UMD and CDs:** The appointment of Dr Alastair Roeves as Unit Medical Director and Drs Heather Potter and Richard Tristham as Clinical Directors (Primary Care and Community Services) had been confirmed. Dr Roeves would attend the LMC meeting in January 2017. Dr Naveed Akram's appointment as Clinical Governance lead was also confirmed. It was noted that Dr Anjula Mehta had been appointed as the Head of the sustainability team.	**ACTION ML**
5. **5.1**	**LMC VACANCIES:** Resignations had been received from Drs K Muthuvairavan and Phil Morgan who were unable to continue their LMC membership due to other commitments. Letters of appreciation for their contribution to the LMC had been sent. There was now one vacancy in Bridgend, three in NPT, two in Swansea and five sessional. The LMC election process for the period 2017-20 would commence in January 2017. **NEW ADDITIONS TO THE MEDICAL PERFORMERS LIST (MPL)**: The recently updated welcome letter sent by BroTaf LMC to new GPs included on the MPL had been circulated and was discussed. It was agreed that a similar letter should be sent by the LMC to new GPs on the ABMU MPL and also one for inclusion in the induction pack for registrars on the VTS. It was agreed that freelance sessional GPs would not be asked to pay a fee for membership of the LMC.	**ACTION AR/ML**
6. **6.1**	**SUSTAINABILITY PROGRAMME:** Constituents had highlighted delays in the delivery of agreed plans and it was hoped that the new appointments made would help delivery. **PRACTICE SUPPORT TEAM VISITS. (standing item)** The PST visits which involved an LMC member remained of value as they provided the opportunity to meet GPs and practice staff face to face.	

7.	**GP CLUSTERS / GP LEADERSHIP FORUM (standing item**): The GP Leadership forum scheduled for 22 September 2016 had been cancelled and was now being incorporated in the IMTP PRIMARY CARE WORKSHOP which was being held on the same day. AR would attend.	**ACTION AR**
8.	**LMC/ABMU LIAISON GROUP:** • **17 May 2016:** The draft minutes had been circulated for information	
9.	**LMC/ABMU ENHANCED SERVICES STRATEGY / STEERING GROUPS:** ABMU was proposing to develop alternative specification and delivery options for cluster local enhanced services for Zoladex / shared care / wound care. DB confirmed that one practice in Bridgend was threatening to withdraw from the wound management LES at the end of October 2016 and could be followed by two other practices. IH would make the Health Board aware of this**.** If an alternative acceptable proposal were not forthcoming the LMC may have to advise that wound care be handed back for Health Board management. The alternative may be to retire the LES. IH would provide a further update following the ES Steering group meeting on 18 October 2016.	**ACTION IH**
10. **10.1**	**LMC EXECUTIVE COMMITTEE:** • **15 June 2016:** The draft minutes had been circulated for information. **UNAVAILABLE MEDICATION IN COMMUNITY PHARMACIES:** The LMC was proposing to write to ABMU requesting that the medicines management teams be more proactive by providing practices with a list of those medicines which were not available or at risk of low supply and what was available as a substitute.	**ACTION AR**
11. **11.1** **11.2**	**ABMU OOH SERVICE (Standing item).** SB (Clinical Director OOH/111) advised that the closure of the PCC in NPT hosp overnight on a small number of occasions was in part a tactical measure. The service was currently reliant on a small pool of GPs overnight and it was necessary that other options for cover be considered including a review of skill mix and the introduction of remote triage. Further strategic closures may be required if it was possible to cover the service over two sites. HW voiced concern that it was always the NPT site which was affected and believed that this disadvantaged NPT patients. SB provided an assurance that no changes would be made without consulting the LMC. **IHR (Welsh GP Record**): no new concerns reported **111 PILOT:** SB confirmed that the launch timetable had been revised with a soft launch in Bridgend and NPT on Tuesday 4 October and in Swansea on Tuesday 11 October 2016 ***(following the meeting the LMC was advised that there would be an extension to this date which would be confirmed to practices***.) IT work was almost complete and recruitment of call handlers and nurse advisers was good. The clinical support hub was also staffed. He was confident that the ABMU service was resilient and much more so than OOH services in other parts of Wales	
12. **12.1**	**ISSUES RAISED BY PRACTICE MANAGERS (**standing item**)** **SERVICE MISUSERS and ABUSERS:** CB provided details of a project she has been involved in together with ED and WAST about the formation of a formal MDT structure to manage patients identified as misusing/abusing emergency and Primary care services. This had been	

	highly successful in respect of a patient from her surgery and the scheme may be considered for roll out in other areas of ABMU. GPs did not necessarily have to be involved in the MDT.	
13.	**ISSUES RAISED BY CONSTITUENTS:**	
13.1	**MENTAL HEALTH CRISIS TEAM:** Concerns had been raised about access to the service particularly in the Swansea area. This would be raised at the Liaison Group meeting on 20 September 2016.	**ACTION IH/AR**
13.2	**PRACTICE BOUNDARY ISSUES:** Concerns had been raised about the process for requesting changes to practice boundaries and would be raised at the Liaison Group meeting.	**ACTION IH/AR**
14.	**ISSUES RAISED BY CO-OPTED MEMBERS (**standing item)	
14.1	**PUBLIC HEALTH WALES** **MEASLES UPDATE:** SL confirmed that a resurgence of measles had been seen in mid and west Wales during the summer. Two cases had been confirmed in Swansea and one in Port Talbot. Hwyel Dda had also been affected. An association with attendance at music festivals had been identified and there was a failure to engage in the vaccination programme by some patients. GPs in areas affected were being made aware. There was a push on for a cohort of teenagers who may have missed the MMR to be vaccinated as they were now of University age and many were attending festivals. **MENINGITIS**: Members were reminded that for Meningitis the LES covered patients up to the age of 25 and/or in first year at University. Patients on a gap year should also be included. **CONJUNCTIVITIS:** SL confirmed that PHW do not routinely recommend exclusion from school/nursery. IH thanked SL for sending the Public Health Guidance on Infection control in School and other Childcare Settings. This would be circulated to ABMU practices and would be useful as a reference document when parents were directed to surgeries by school and nursery leaders.	**ACTION ML**
15.	**ALL WALES ACCESSIBLE HEALTHCARE STANDARDS**: (Standing item) IH reported that the audit against the All Wales Standards as agreed by the Director of Therapies had been undertaken in OakTree Surgery, Bridgend and proved to be a very worthwhile exercise which had identified that most of the standards were being met. He felt it would be good if other practices volunteered.	
16.	**WAST**: A response had been received from WAST which confirmed that the telephone triage system determined the level and timeliness of response and the location had no bearing on this outcome. Delays were due mainly to off-loading difficulties at EDs. Details would be sent to Practices who would be asked to make the LMC aware of any continuing problems / delays with response times.	**ACTION AR/ML**
17.	**GPC WALES:** (standing item): IH reported that he had attended his first GPCW meeting on 28 July 2016. He confirmed that contract negotiations had commenced for the following year. NS had been appointed to the negotiating team.	
17.1	**FIREARMS LICENSING PROCESS/FEES:** The Police letter was now being sent to Practices **prior** to the issue of a firearm and/or shotgun certificate. BMA/GPCW advice to practices remained unchanged and was that they should return the letter to the police explaining that they were unable to undertake the work due to a lack of funding or for conscientious objection to gun ownership. Practices would be reminded of this	

		ACTION AR/ML
18. **18.1** **18.2** **18.3**	**LMC ANNUAL CONFERENCES: (**Standing item) **MEDICAL SECRETARIES CONFERENCE**: 24 November 2016: BMA House London: AR/ML would attend **WELSH LMC CONFERENCE:** 4 March 2017: Celtic Manor Hotel: Members were asked to contact the LMC office if they wished to attend. **LMC UK CONFERENCE:** 18-19 May 2017: International Conference Centre, Edinburgh. This would be the last 2-day conference following the creation of GPC England.	**ALL TO NOTE**
19.	**SWANSEA SESSIONAL GP GROUP:** no new issues reported	
20.	**DYFED POWYS LMC**: No new issues reported	
21. **21.1**	**NWIS** **Information Governance Toolkit:** A new Information Governance (IG) toolkit developed by NWIS had been circulated to practices. There was no statutory obligation to complete but members agreed that the toolkit which replaced the previous ISMS questionnaire would be helpful for practices to assess themselves against national policies and standards. DB confirmed that he had found it easy to complete and had received assistance from NWIS. Practices would be encouraged to complete it.	**ACTION AR**
22.	**WELSH MEDICAL PERFORMERS LIST:** A list of changes to the ABMU MPL between April -August 2016 had been circulated to elected members	
23.	**DATE OF NEXT MEETINGS:**	
	• **LMC EXECUTIVE Meeting – Tuesday 11 October 2016 – venue tbc** • **FULL LMC Meeting – Tuesday 8 November 2016 - The Towers Hotel, Jersey Marine.**	

SOAPBOX SUMMARY

Members were invited to speak for one minute on a hot topic

1. **Why are we being asked to make 'drug switches' particularly when this can incur significantly greater costs and have a huge impact on workload?**
   LMC RESPONSE: This will be brought up at the PCPAG
2. **Why are we being asked to undertake blood tests for secondary care clinics when this could be undertaken by the clinic and a form issued directly to the patient?**
   LMC REPONSE: The responsibility lies with the requestor although in practice most of us do it! We will raise in Liaison meeting.
3. **PPV for Enhanced services – why are the rules being made up as they go along eg payment for administration of zoladex?**
   LMC RESPONSE: Be careful what you negotiate in ES – we need to keep a close eye on this.
4. **Why does the xxxx Local Housing Authority insist on dragging GPs into meetings involving patients with MH issues?**
   LMC RESPONSE: Suggest use of advocate.
5. **Why do we spend hours signing repeat prescriptions?**
   LMC RESPONSE: The software is there but just not in use – add to survey!
6. **Why do secondary care continually request us to prescribe despite repeatedly saying no and referring them to the guidance documentation?**
   LMC RESPONSE: Keep pointing out the guidance – everyone needs to do it.
7. **Why are we receiving requests for titrating drugs eg MH patients on treatment resistant meds?**
   LMC RESPONSE: Responsibility lies with the prescriber!
8. **Why are the primary care reps on Commissioning Boards always GPs. Surely there are other members of the primary care team who could undertake the role and be as effective and cheaper?**
   LMC RESPONSE: The Commissioning Boards feel they need to have GPs to enable engagement with secondary care although there are some meetings where practice staff could be used.
9. **Why are care homes so risk averse and contact the surgery unnecessarily when there is no clinical reason? OOH has same problem.**

LMC RESPONSE: We will raise with CSSIW - ? monitor

10. **Why is it so difficult to refer young patients to CAMHS?**

    LMC RESPONSE: CAHMS is a priority for the Children and Young Persons cancer commissioning board. We will highlight at the liaison group meeting.

11. **Why can DNs not syringe terminally ill patients' ears**

    LMC RESPONSE: why not? We will highlight at the Liaison group meeting

12. **Why can DNs not take bloods for INRs at weekends? (Swansea)**

    LMC RESPONSE: Patient should be readmitted. ? GPs should not be prescribing warfarin

13. **How should we deal with patients who move out of area but do not want to leave the practice?**

    LMC RESPONSE: If not offlisted when they move it may not be possible to request that they leave later unless there is a bona fide reason.

14. **Why despite a SOP to the contrary is it so difficult to arrange a MH assessment OOH if the patient has not been seen face to face?**

    LMC RESPONSE: We will raise at the Liaison group meeting

15. **Why is the cut off for doing dopplers in Ambulatory care in NPT 5.30pm- make it 7pm? / why do DNs not do near INRs / why is there a discrepancy in discharge info – sometimes excellent , sometimes nothing**

    LMC RESPONSE: re discharge summaries – doing what we can – now up to 29% in 5 days.

16. **Why is it so difficult to access MH services in Swansea and especially emergency services?**

    LMC RESPONSE: Bridgend has a good system with single point of access – why not Swansea - We will raise at Liaison meeting

17. **Is the Chronic pain service effective. They seem to increase opiate Prescribing resulting in GPs being criticised?**

    LMC RESPONSE: agree it is not doing what it was set up for. Worked well in Bronllys. We will raise at Liaison group

18. **The Neurosurgery pathway does not work. Only one consultant does Discharge summaries**

    LMC RESPONSE: This is a real Clinical governance issue – We will raise both issues at the Liaison group meeting.

19. **ACT/CRT – There is a lack of clarity around the role of these**

    LMC RESPONSE: Bridgend and NPT service is good - We will raise Swansea issue at the Liaison Group meeting.

20. **I.T SURVEY – The pre-procurement survey needs to be completed to ensure that all IT issues are highlighted**

LMC RESPONSE: We will encourage practices to complete the survey

21. **AMs need to be made aware of the out of area and other problems being experienced by practices.**
    LMC RESPONSE: A new head of public affairs will be appointed from 5/10/16 (GPCW) – educating and meeting AMs a priority
22. **Why are we being asked to expedite letters for admitted patients?**
    LMC RESPONSE: We will raise at LMAG
23. **Why are flu PGDs not ready for the flu season**
    LMC RESPONSE: JK will raise in SIG
24. **Why can't we log in to PCs with thumbprint?**
    LMC RESPONSE: In hands of NWIS – complete the survey!
25. **Why can't all DNs confirm death?**
    LMC RESPONSE: Training needs to be more widely available
26. **What are the benefits of PGD's?**
    LMC RESPONSE: ?
27. **Are there sufficient DNs to respond at EoL**
    LMC RESPONSE: We will raise at Liaison
28. **HIV Legislation interferes with duty of care**
    LMC RESPONSE: GPC Wales
29. **Patients are being discharged at EoL without full information**
    LMC RESPONSE: Exmples required for further investigation
30. **The chronic pain team should accept any form of referral and not just their specific template.**
    LMC RESPONSE: eventually the WCCG letter will be the only referral template and all others will be turned off
31. **Councils have a SPA for all calls – why can the hospitals not have the same?**
    LMC RESPONSE: agree it would be helpful
32. **#HELLOMYNAMEIS – sec care colleagues seem reluctant to give name on phone**
    LMC RESPONSE: Cultural change required. We will raise at Liaison group meeting and LMAG
33. **Why are seniority payments based on earnings and not hours worked**
    LMC RESPONSE: cannot be changed – fully discussed with GPCW
34. **Pension contributions are difficult to calculate when locums work different hours / session**
    LMC RESPONSE: regulations cannot be changed.

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