GENERAL MEDICAL CARE SUB-COMMITTEE OF THE CENTRAL MEDICAL ADVISORY COMMITTEE

Minutes of the 30th meeting of the General Medical Care Sub-Committee held on Wednesday 16 June 1999 at 2.00pm in Room C3.18, Castle Buildings

Members Present:
Dr HA Jefferson (Chairman)
Dr B Patterson
Dr E Deeny
Dr E Beckett
Dr B Dunn
Dr WR Thompson
Dr L Maguire

Present:
Dr M Brown (in place of Dr McConnell)
Dr K Booth (in place of Dr Stewart)
Dr U Gillan (in place of Dr Telford)
Dr JD Boyd (in place of Dr J Watson)
Dr P Colvin

In Attendance:
Dr E Campbell (CMO)
Dr P McClements (DCMO)
Dr M Briscoe
Mr J Thompson
[redacted]
Mrs J Stewart

1. **APOLOGIES**

[redacted]

2. **MINUTES OF THE LAST MEETING**

[redacted]

3. MATTERS ARISING

3.1 Vocational Training Review

Dr Briscoe advised that most of the recommendations of the review were in the process of implementation. Concerns regarding this year's selection of trainees had resulted in a meeting with Dr Agnes McKnight of the Northern Ireland Council for Postgraduate Medical and Dental Education and Hugh McPoland of the CSA who promised a timetable before the summer to ensure adequate representation on selection panels. Any concerns regarding the timetable should be referred to Mr McPoland. The importance of the availability of information to junior doctors at an early stage was to be taken forward by the NICPGMDE. Dr Patterson welcomed this news in the light of concerns expressed on the composition of the selection panels that had occurred this year.

3.2 Cardiology Review

3.3 Workforce Planning

4. **FIT FOR THE FUTURE**

The Chairman stated that this whole issue was currently marking time due to the delay in setting up the NI Assembly. CMO added that some issues around Fit for the Future needed to be addressed and as soon as a clear message was received decisions could be made. Dr Jefferson also pointed out that hospitals were now unresponsive to approaches from fundholders regarding new contracts. Members discussed the difficulties caused by the unclear future in particular for fundholding staff as being very unfair and not sustainable.

5. **COMMISSIONING PILOTS**

The Chairman introduced Mr Jim Thompson from the Department to speak on this topic.

Mr Thompson stated that the pilots were set up to provide an opportunity for professionals to work together to assess need and commission services. The pilots were designed to provide lessons for the future and some useful lessons had been learnt already. He added that the Health and Social Care Research Unit at Queens University was carrying out a formal evaluation on the commissioning pilots.

The five pilots were at varying stages of development and they were planning to undertake a wide range of project work. All had employed a full time pharmaceutical adviser. Mr Thompson was working with PGMCC to design a package of training courses to cover the broad range of competencies required for commissioning and it was hoped these would begin at the end of September giving everyone involved an opportunity to attend. He mentioned that the Executive was considering how to take forward primary care commissioning but would make an announcement shortly. Dr Patterson pointed out that new applications should be sought from the whole of NI if there was a second wave and not just those applications already held reconsidered. Mr Thompson accepted this point. Dr Brown wished to put on record that the WHSSB was not opposed to pilots and applications from potential pilots in the area would be forwarded in the coming weeks.

Dr Jefferson (who is Chairman of the Lisburn Group pilot) pointed out that one of the main emerging problems was communications, particularly in the pilots which were spanning several practices over a wide area. He added that it was absolutely essential to get the partnerships to sign up to an agreement which was workable. The development of relationships within the pilots not only between GPs but across all primary care professionals is one of the major outcomes from the pilots.

Dr Beckett (Armagh pilot) stated that the initial enthusiasm for commissioning had been dented by the time delay in considering business cases and the subsequent financial restraints imposed. Mr Thompson recognised the difficulties and explained the background to the financial package. He felt that despite this there was a strong commitment to the objectives of the pilots and considerable enthusiasm amongst the members.

A discussion followed in which members voiced concerns over the current uncertainty for the future of primary care commissioning policy.

6. CLINICAL QUALITY AND CLINICAL GOVERNANCE

The Chairman invited DCMO to update members on this issue.

Dr McClements informed members that a quality framework document was almost ready, taking national initiatives on board but with a local ownership, and we were already developing co-operative links with GB and Scottish bodies. The view expressed by the service was that we should build on the CREST initiative for standards and guidelines. The formation of an independent monitoring body for Health and Social Services was under consideration. Continuing professional development was seen as an integral part of clinical governance. Primary care professionals increasingly saw themselves linked to Trusts, others saw clinical governance delivered through the Boards through the Directors of Public Health.

The Chairman introduced a paper he had received from Dr Agnes McKnight, NICPMDE, whose view was that the Council has the infrastructure to provide support for all primary care governance and would like to assist commissioning groups by providing audit etc. Their proposed model covered three main areas of risk management, clinical effectiveness and continuing professional development and was based on three stages:-

Year one – would effectively measure the 'status quo' and act as a benchmark
Year two – 50% move towards the desired standard
Year three – achieve the desired standard

Dr Jefferson felt it would be difficult to sell this paper to the average GP. A critical mass of support was going to be needed for clinical governance to work. He commented that the paper had some good ideas but was conceptually the wrong way round and was moving too quickly in light of other developments. The document was generally welcomed and a discussion followed in which all agreed on the importance of local ownership and the need for the rate of improvement to be in the hands of the profession, not an external body. Dr Colvin felt the profession was willing to come on board and input to the criteria. Dr Deeny added that he would like to see the paper widely distributed. It was the general view that the NICPGMDE role was in support and in education and training.

Dr Brian Patterson emphasised that clinical governance plans were on a 10 year time frame. The need for a multidisciplinary approach was essential. While standards may be set nationally, local ownership was essential. It was agreed that adequate resourcing was needed.

7. **R & D STRATEGY**

The Chairman referred members to Paper 5/99 which was currently a consultation document. He mentioned the reduction in total funding to R & D and reminded members that, as the Culyer Report was not implemented in NI and we had lost some funding, we were still in a catch up situation. He requested that the final document should be easily readable and accessible to all.

CMO advised that the comments of the committee would be passed on and that the R & D office was aware of the need to promote research in primary care and ensure the correct infrastructure was in place. She recognised that new investment was required for R & D.

Dr Deeny stated there was a need to identify where the money was being spent. There was a suspicion that some research money was being used to fund service posts instead. CMO added that GPs must be ready to avail of any new R & D opportunities as they presented themselves. Dr Patterson commented that a practising primary care doctor should be representative on the strategy group. Dr Colvin added that everyone needed to look at positive ways in which research could be facilitated so that primary care could be competitive in future research bids.

8. **INFLUENZA IMMUNISATION**

[redacted]

[redacted]

9. **CROWN REVIEW OF PRESCRIBING, SUPPLY AND ADMINISTRATION OF MEDICINES**

Dr Jefferson introduced Paper 6/99 which detailed the summary and recommendations of the recent report. He stated that the report addressed the concerns of professionals as to how the growth in prescribing could be managed. He invited Dr Briscoe to outline some of the recommendations.

Dr Briscoe stated that the main change was the introduction of two tiers of prescribers – independent and dependent prescribers. Dependent prescribers would be given responsibility for prescribing within tight guidelines for patients who have already had a diagnosis made by a professional (independent prescriber) and also given limited discretion to vary treatment. New groups would have to apply to a committee to gain authority to prescribe and receive appropriate training. She added that there was a potential here to considerably change primary care operation in the long term.

Members raised a variety of questions on the operation of the scheme such as issues surrounding indemnity, access to medical records. Dr Dunn commented that the report raised more questions than answers. Dr Patterson noted the importance of ensuring there would be no conflicting interests involved. The Chairman pointed out that the issue was a long way from moving ahead.

10. **SERVICES FOR PEOPLE WITH LEARNING DIFFICULTIES**

[redacted]

11. **ANY OTHER BUSINESS**

YEAR 2000 PHARMACY ISSUES

[redacted]

[redacted]

PRESSURE ON ACUTE SERVICE BEDS

[redacted]

12. **DATE OF NEXT MEETING**

[redacted]