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

18th September 2002

Present:	Dr JM McAughey (Chair) Dr CS Wilson Dr A McKnight Dr M Brown Dr M Brown Dr Keegan Dr R Thompson Dr D Boyd Dr JR McCluggage Dr J Porteous Dr H Curran Dr LA Dorman
In Attendance:	Dr I Carson (DCMO) Dr N Chada Mr J Livingstone Mrs K Oldham
Guest Speakers:	Mr J Thompson Mr F Bradley Mr N Lunn

1. INTRODUCTIONS AND APOLOGIES

[redacted]

2. MATTERS ARISING

Minutes of the Last Meeting

[redacted]

GP Appraisal

[redacted]

Practice Accreditation

2.5 Dr Livingstone informed the Committee that the practice accreditation proposal was meritorious but that there were a number of outstanding issues to be considered. In particular he explained there was still a need for refinement of the new GMS contract, which was still under negotiation, since this would effectively be the driver of the quality framework.

2.6 Dr Boyd explained that the Northern Health and Social Services Board (NHSSB) would be going ahead with Practice Accreditation since they already had 8-10 practices in the NHSSB who had agreed to undergo the process.

3. UPDATE ON WORKFORCE PLANNING

3.1 Paper 3/01, prepared by Dr Woods was tabled. Dr Chada summarised the main points which were that the average age at retirement had dropped, work patterns had changed and new demands were being made on Practitioners' time. Dr Woods had summarised the numbers needed and proposed that at a minimum the number of GP registrars is increased to 45.

3.2 The Committee unanimously shared the opinion that Dr Wood's proposals were not adequate. Dr McAughey requested that it be noted that workforce planning needs to take account of changing workforce issues.

3.3 Other comments on the issues involved included Dr Curran's remark that increasing workload was not just about the new pressures from LHSCGs (and indeed it was questionable whether this would have any impact if GPs did not participate in these), but also about work moving from secondary to primary care. He stated that an increase to 45 could only be accepted as an interim measure.

3.4 Dr McKnight stressed that the proposed modest increase in training to address shortages in numbers would not be acceptable. She also expressed concern that the proposals did not adequately address the fact that in some years as many as 70% of new trainees are female, who often do not wish to work full time.

3.5 Dr McCluggage questioned the state of the Department's workforce plan. Dr Carson agreed to check on the progress of the plan. Dr McCluggage concluded that Dr Woods' plan did not allow the flexibility required, particularly in light of many female GPs desired work patterns. It was also suggested that Dr Woods could identify trends by utilising Central Service

Agency data which purportedly monitored the number of full time and part time doctors over the last five years. Members agreed that they would be very happy to meet with Dr Woods to discuss these issues further.

Action Point 1: Dr Carson to report back on the progress of the Department's Workforce Plan.

4. SHO MODERNISATION

[redacted]

[redacted]

5. UPDATE ON THE IT STRATEGY

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6. UPDATE ON LOCAL HEALTH AND SOCIAL CARE GROUPS

6.1 Mr Thompson attended and informed the Committee that all 15 Local Health and Social Care Groups configured through a series of working groups organised by Health and Social Services Boards had been established. Interim Chairs had been appointed over the summer months

and it was expected that permanent Chairs would be appointed by the end of September early October. All the manager posts had been advertised and this had resulted in a good response with a strong field of candidates. Interviews for manager posts were currently taking place and should be concluded by early October with appointments being made within three months. Allocations had been made to allow the Groups to begin to establish their infrastructure and for primary care development. This latter element of the budget would work out on average at approximately £250k per Group (the exact amount would be determined on a capitation basis). An additional sum on a non-recurring basis would be freed up from the balance of GP Fundholders savings and this would also be allocated to LHSCGs for service development. Over-all the allocation for primary care development would be substantially greater than had been anticipated and this provided a good launching pad for the Groups. The Groups are working with Boards to develop their Primary Care Investment Plan and this would establish their work programme for the coming year.

6.2 Minister was very clear about the need for Groups to begin to develop commissioning expertise and it is expected that all Groups will commission some services from next year. By 2005 it was expected that 30% of all health and social services would be commissioning by LHSCGs. The Department was working very closely with LHSCGs and Boards to ensure that this challenging timescale was met.

6.3 Mr Thompson acknowledged that there was some anxiety amongst Group members at the absence of GPs. There is recognition within the Groups of the significant contribution which General Practice could make to the planning and delivery of services and there is genuine concern that an opportunity to improve services for patients may not be fully realised. Group members remained hopeful that they would receive GP cooperation at local level even if they did not wish to participate on the management board.

6.4 The Committee questioned the lack of participation by GPs and what steps the Department was taking to address this. Mr Thompson explained that Minister and the Department had gone to considerable lengths to meet GPC demands but unfortunately it seems this was not enough to allow them to recommend participation. The Minister has twice written to GPC comprehensively addressing the concerns they had raised and on each occasion it was felt that the proposals put forward would satisfy their requirements but this apparently has not been the case. Mr Thompson emphasised that the policy on LHSCGs had emerged from a lengthy and detailed consultation process to which all parts of the service had contributed and it was not possible to enter into negotiations with any single interest group about policy determined in this way. There were other key interests to be considered. All the other primary care professionals were participating fully and enthusiastically and others who were not involved wanted to be on board. Dr Livingstone added that those other groups who were involved were working hard to make the process work and it would be inappropriate for the Department to change direction just to accommodate GPs.

6.5 The Committee questioned what exactly the GPC wanted, Dr Curran who is due to become a member of GPC felt that he was not yet in a position

to speak on their behalf and that the matter could not be fairly discussed in the absence of any GPC representatives. Some members of the Committee expressed concern that the Department appeared unwilling to get involved in mediation or conciliation to attempt to resolve this issue. Dr Livingstone explained that it would be totally inappropriate to consider mediation on the fundamentals of a government policy. The Committee questioned which functions the groups might undertake in the absence of GPs from the management board. Mr Thompson said that the Groups would be able to take forward most of the functions proposed for Groups in "Building the Way Forward for Primary Care" but initially it had been decided that they would not have responsibility for GMS or prescribing budgets and incentive schemes. These aspects of the budget would continue to be administered by HSS Boards. However, it was fully recognised that Groups would be more effective if GPs were on board.

6.6 Dr McAughey stated that a dual message needed to be sent to the GPC and to the Department that this issue needed to be resolved. Dr Livingstone assured the Committee that he would not be giving up but that there was a fundamental problem with conciliation and mediation. Dr Keegan commented that it might be helpful to have a view from CMAC on this topic representing a broadly based advisory grouping. To facilitate this discussion it would be of assistance to have a summary of the issues involved. He concluded that the key issues should be spelt out and presented to CMAC. Dr Curran agreed to ensure a GPC perspective was sent to CMAC.

~~Action Point 4: Dr Curran to arrange for GPC perspective on this issue to be~~ sent to CMAC.

7. DEVELOPING BETTER SERVICES

7.1 Mr Lunn outlined the responses received so far to the consultation paper. In summary, in relation to the proposals on acute hospitals, arguments were being advanced to the effect that both an acute and an Enhanced Local Hospital in the South-West were not sustainable and, also in terms of sustainability, that Enniskillen was not a viable option for the location of the new hospital. It was also being argued that people living in areas in South-East and South-West Fermanagh would not be prepared to use hospitals in Cavan and Sligo - a team from the Department is to visit the hospitals in the South to establish the capacity to deal with patients from Northern Ireland. The proposal to transfer acute services from the Mater Hospital has been met with considerable dismay and many people consider that this is unrealistic because of the capacity problems in Belfast.

7.2 As regards the proposals for maternity services, Mr Lunn said that the responses showed that there were concerns about the sustainability of maternity services at the Mater, Causeway and Daisy Hill Hospitals. A number of obstetricians had expressed strong concerns about the safety of stand-alone midwife-led maternity units. Doubts were also being expressed about the demand for such units, the willingness of midwives to participate in them, and that these units might compromise the sustainability of neighbouring consultant-led units.

7.3 Mr Lunn said that few responses had so far been received on the reform of HPSS structures. Of those responses that had been received to date, all were supportive of the proposal for a single Regional Authority. There was concern, however, that reducing the number of Trusts in the Belfast area could result in very large and unwieldy organisations. Following discussion of the responses at the Executive, it is hoped that final decisions can be taken in the course of 2002.

7.4 Dr McCluggage pointed out that whilst this was going on developments were taking place in other areas and the configuration of hospitals could change through other systems. Questions were also raised in relation to the absence of mental health services from the document. Mr Lunn acknowledged this and said that this would be corrected in the implementation plan to take forward decisions.

7.5 Some members of the Committee also questioned what local hospitals would look like as they felt this was still not clear from the document and was not as specific as the details set out in the original Hayes Report. Mr Lunn accepted that the model was in need of development. Other comments included the view that there would be some difficulty in sustaining services on more than one site in the South West and that a single hospital was the best solution.

7.6 It was felt to be very important to have adequate training for primary care workers including GPs to take on the expanding roles described. The possibility of providing more services in primary care was considered attractive but members emphasised that adequate resources needed to be provided. Similar concerns were raised about the rapid responder schemes; it was felt that these would require a considerable investment in the ambulance service. The Committee also raised concerns about managed clinical networks and the possibility that in practice this could mean hospital guidelines being imposed on GPs.

7.7 The Committee questioned the stand-alone maternity unit described in the document; in particular they were concerned that stand alone maternity units were previously closed for being dangerous. Mr Lunn confirmed that current Departmental policy does not support stand-alone units - the proposal in *Developing Better Services* was that pilots should be established and evaluated. He confirmed that views from prominent obstetricians were not encouraging. Dr McAughey offered to construct a response from the Committee highlighting concerns.

Action Point 4: Dr McAughey to respond to consultation document on behalf of Committee.

8 BEST PRACTICE/BEST CARE

8.1 Mr Bradley attended the meeting and informed the Committee that the HPSS Quality and Implementation Regional Bill would have its second reading on the 2nd October. He explained that the Bill only gives effects to certain elements of the Ministers announcements. The Health and Social Services Regulation and Improvement Authority would be established and concentration would be on CHI functions of the

Authority, which included service reviews and events investigation. Governance guidelines and standards would be addressed next.

8.2 He informed the Committee that a letter had been sent to the service at the end of July setting out the main details. The service had been advised that individuals should be identified to lead on governance, a group/committee should be identified as the forum for discussions and by 3rd January 2003 an initial assessment of progress should be completed. Comments had been received back from the service and it was hoped to issue another circular within the next few weeks. Over the next few months a multidisciplinary team from the Department would visit the HPSS and would form a support team to provide help with initial assessments. The level of support and composition of the team would be discussed with the HPSS. At present the Branch were in the process of recruiting a Head of Branch for the standards and guidelines unit to deal with the administrative side of this work.

8.3 In relation to the work carried out by the National Institute for Clinical Excellence (NICE), the Department had encountered legal difficulties in commissioning services from NICE. This was currently being addressed in conjunction with the Department of Health in England and hopefully a way around the problem has been identified. In addition project officers would be appointed to look at the development of care standards for domiciliary care homes. Mr Bradley assured the Committee that the development of care standards would be done in liaison with professionals. He explained that Northern Ireland was not large enough to replicate all the GB bodies and so the way forward had to be to establish arrangements with key GB bodies.

8.4 Some members of the committee urged caution in relation to the timetable particularly in relation to general practice where they felt GPs were not yet ready to enter into such arrangements. Mr Bradley assured the Committee that standards could be phased in over a number of years but concluded that things would have to look to be progressing.

9. USE OF UNLICENSED DRUGS IN PRIMARY CARE SETTING

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[redacted]

10. FOLLOW UP ON THE ROLE AND METHOD OF WORKING OF THE GMCSC

10.1 Dr McAughey stated that it was important for members to inform the secretariat of any agenda items they would like discussed. She informed them that the working group had considered that three meetings per year seemed adequate and had felt it was important not to lose sight of items discussed at previous meetings. She added that where appropriate she would be happy for documents to be e-mailed to people and to receive and collate responses on behalf of the Committee.

10.2 Dr Curran expressed his concern that the Committees opinions did not always appear to be taken on board by the Department. Dr Livingstone's response was that the role of this Committee at the interface was very important, but that the Department would not always be able to give the desired outcome. However he felt that there was real opportunity for debate and suggested that a series of workshops should be set up where GPs and the Department can work together to address issues.

10.3 Dr McAughey pointed out that a lot of meetings and negotiations took place in parallel to the GMCSC and felt it would be helpful to have minutes and information. Dr Livingstone explained that minutes of meetings between the Department and the GPC cannot be made publicly available as they are classified as commercially sensitive.

10.4 Dr McKnight expressed some concern about the role of GPC in wider negotiations. Whilst she accepted that the GPC have a role in negotiating terms and conditions of service for GPs, she felt that areas such as LHSCGs embraced wider issues and yet other GP voices did not appear to be heard. She felt that this had resulted in GPs who wanted to get involved being unable to do so. Dr Curran accepted that there were other forums for discussion but added that a collective decision had been made by the people who GPs had voted for.

10.5 Dr McAughey added that if anyone had any other comments to make on the way the Committee worked she would be happy to receive these.

11. ANY OTHER BUSINESS

Sterilisation of surgical instruments

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[redacted]

Items for Information

[redacted]