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

23rd July 2003

Present:
Dr JM McAughey (Chair)
Dr CD Leggett
Dr B Patterson
Dr A McKnight
Dr M Brown
Dr C Fitzpatrick
Dr D Boyd
Dr J Porteous

In Attendance:
Dr I Carson
Dr N Chada
Miss S Barfoot
Mrs Karen Oldham

Guest Speakers:
Dr G Mock
Dr M Briscoe
Dr D McMahon
Ms B Bergin
Mr S Holland
Mr J Thompson
Mr I McMaster
Dr T Maguire

1. APOLOGIES

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2. MINUTES OF THE LAST MEETING

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Action Point 1: Mrs Oldham to chase up response on behalf of the Committee.

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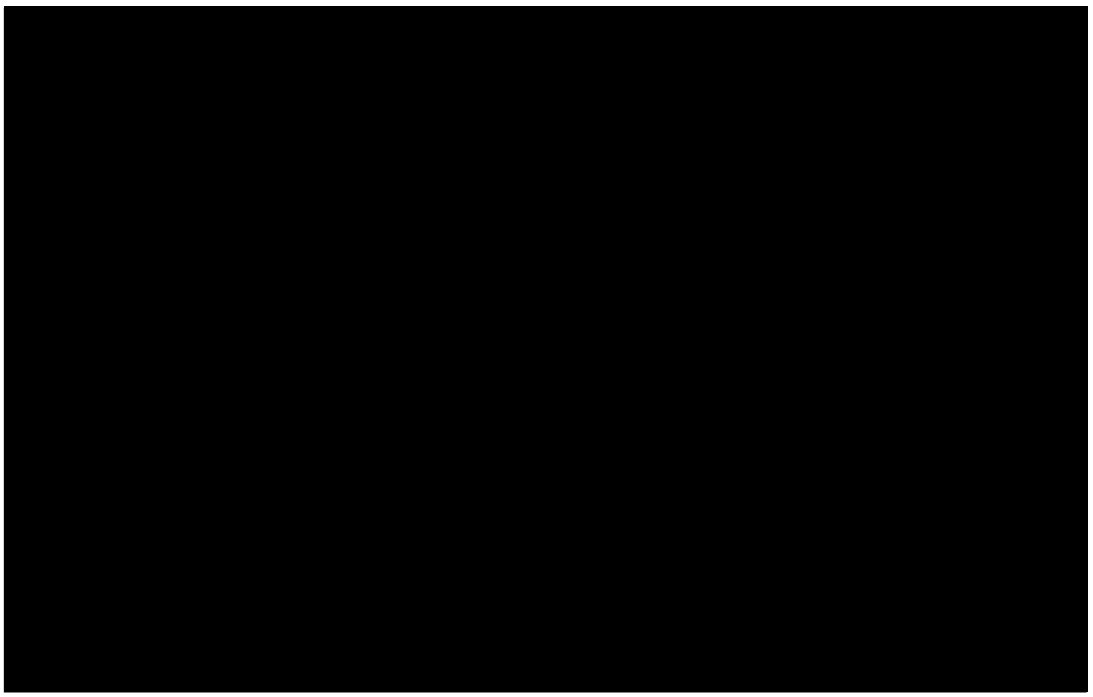

3. DEVELOPING A REGIONAL STRATEGY FOR THE HEALTH AND PERSONAL SOCIAL SERVICES

3.1 Dr McMahon, Mr Holland and Ms Bergin attended the meeting to discuss this item. Dr McMahon stated that he was keen to engage with the Committee and with GPs generally. He added that the paper, which had been made available to the Committee at a previous meeting, was not reflective of what the final strategy would look like and that nothing final had been written as yet. He pointed out that Dr Leggett had been heavily involved in the processes.

3.2 Dr McMahon outlined the key themes emerging from consultations as-

- Workforce issues were very important;
- Primary and Community based care should be emphasised and should match the Primary Care Strategy

He added that the consultation process has been an emerging one and that GPs had shown much interest. Multidisciplinary meetings with various groups had taken place. Work was currently being undertaken in relation to the setting up of working groups. Drafting of an informal version of the strategy would take place in the autumn and this would be circulated (hopefully in time for the next GMCSC meeting). It was hoped that formal consultations would be completed by the end of the current year.

3.3 Dr McKnight added that educational issues were a vital consideration and asked if there were plans to meet with the NICPMDE (Northern Ireland Council for Postgraduate Medical and Dental Education). Ms Bergin confirmed that the group had asked Joyce Cairns about progress with the workforce plan to inform this process and Mr Holland added that specific formal consultation with the governing bodies for education was intended.

3.4 Dr Patterson added that the Primary Care Strategy was welcome but that GPs were concerned that there was a lack of GP involvement in the

implementation group and questioned why the Chair of GMCSC was not on the group. Mr Thompson indicated that the group in question was the Primary Care Strategy Project Board. Dr McAughey confirmed that she would be willing to be involved and Mr Thompson agreed to look at the possibility of her inclusion on the group. Finally Dr McAughey thanked Dr McMahon for the amount of time put into the consultation processes on the Regional Strategy which she felt would help make it a useful document which GPs would feel some ownership off.

Action Point 2: Mr Thompson to look into the possibility of Dr McAughey being involved in the Primary Care Strategy Project Board.

4. UPDATE ON LOCAL HEALTH AND SOCIAL CARE GROUPS

4.1 Mr Thompson informed the Committee that the groups were continuing to make progress. He added that they were developing their infrastructure and identifying premises and office equipment. They had begun the process of needs assessments in their respective local areas and Mr Thompson tabled a paper setting out a list of primary care development projects being undertaken in each Board area.

4.2 Mr Thompson pointed out that there was great potential for change but expressed concern about the continuing non-participation of GPs in the groups. The Groups themselves were still keen to see General Practice get involved and were forming informal links, where possible, with General Practice in the community. Mr Thompson said that he recognised the concern for GPs was the groups longer term future and where they would fit in to the overall HPSS structure. He felt that GPs were keen to get involved but that they were still concerned about the utility of the groups. He emphasised the importance of GPC taking a step of faith with the groups to give them greater influence in future strategy development, he was not asking for a lifetime commitment.

4.3 Dr Patterson pointed out that he had met with former minister Des Browne in the previous January and discussed GPC concerns that the groups be empowered and meaningful organisations. Mr Browne had asked if he gave assurances in this respect would GPs get involved in order to help achieve this outcome. GPC had agreed to this. Dr Patterson stated that the GPC still felt this way and although there were other outstanding issues he felt that most of these were addressed through the new GMS Contract and other strategies. He still required the reassurance promised by Des Brown but not yet forthcoming. GPC intend to meet Angela Smith on 8th September and Dr Patterson hoped that she would be able to provide the necessary reassurance about the future of the Groups.

4.4 Dr Leggett expressed his concern that the issues of conflict between the GPC and Department had still not been resolved. He felt strongly that GPs were missing out on important developments and opportunities, that they should be involved and that in their absence it was not possible for the Groups to function effectively. He felt everyone was losing.

4.5 Discussion followed as to the legal position of the Groups with regard to their possible involvement in the administration of the new GMS contract. Mr Thompson explained that they were statutory committees of the Health and Social Service Boards and Board functions could be delegated to them. Dr

Fitzpatrick expressed some concern about this happening before Groups were able to cope with such responsibilities. Mr Thompson clarified that he was simply confirming the legal position but that any steps in this direction would require careful timing.

5. REVIEW OF NORTHERN IRELAND COUNCIL FOR POSTGRADUATE MEDICAL AND DENTAL EDUCATION

5.1 Dr McAughey introduced this item by summarising the discussion at a previous meeting where it was felt by the Committee that General Practice was not viewed as an important area in the review.

5.2 Dr Chada summarised the responses from the consultation exercise. The results still had to be presented to the Minister but generally speaking the responses were supportive of the recommendations. A common theme emerging was the issue of communication between training bodies and the service. Dr Chada pointed out that there was not a lot more he could add in light of the fact that this still had to be presented to the Minister.

5.3 Dr McAughey added that the Committee would like assurance that their comments had been taken on board. In addition she asked if there was any update on the proposed changes to the statutory position of the Council. Dr Chada agreed to feed this back to Joyce Cairns.

Action point 3: Dr Chada agreed to feed back Dr McAughey's comments to Joyce Cairns.

5.4 Dr Carson added that PMETB (the Postgraduate Medical Education and Training Board) would be in place by September/October. He added that Northern Ireland, Scotland and Wales would each have 2 places- one medical and one lay, on the Board. He added that this would be a very important body and forming relationships between them and the deanery would be a key new area of work. He added that it was important that the Board was seen to be balanced. Announcement of the new Chair by the Secretary of State in England is expected shortly, to be followed by administrative arrangements. Medical and lay appointments in England would be made following nominations received from the other three countries.

6. DEPARTMENT'S WORKFORCE PLAN

6.1 Mrs Oldham tabled some pages which had been inadvertently missed from paper 6/02 issued to members. Dr McAughey explained that Joyce Cairns had hoped to attend the meeting but was now unable to. She added that there appeared to be some discrepancy with the figures with figures of 23% and 33% both being used in relation to the proportion of the workforce who were female. She also was concerned about how the plan was to be implemented.

6.2 Dr Chada informed the group that Minister had endorsed the report and the responsible branch was looking at how the recommendations were to be implemented and resourced. He stated that any comments could be fed back to the responsible branch.

6.3 Dr McKnight informed the Committee that all this work should have started two years ago and added that she was concerned about the burden this work now posed since GP training took three years and the GP Registrar element was already felt to be too short. She emphasised that recruitment was to year one and that therefore new recruits would not be finished training for three years.

6.4 Dr Leggett expressed concern about the statement in the report that indicated that there was no shortage of GPs in the province. He felt that this was factually incorrect and that the Committee at previous meetings had made the issue of the locum pool being stretched. Other members pointed to the demands that participation in LHSCGs would bring and the unknown demands that the new contract could bring. Dr Fitzpatrick pointed out that the opting out of out-of-hours work would take several GPs out of the system. Dr Patterson added that all these points had been made before to Dr Woods but the document does not reflect these and is out of date already. He stated that as a user of the system he was aware that there is no spare capacity and he aired his concern that the new contract may in fact mask capacity problems. Miss Barfoot pointed out that she had spoken to Dr Woods about these issues and he had been mindful of them when addressing this work.

6.5 Dr Leggett agreed that rather than anecdotal evidence there was a need for a mechanism to identify capacity problems. Dr Patterson felt that such mechanisms may be developed when the superannuation situation in respect of locums was clearer. There was some general discussion about the impact of the increasing number of female recruits to training programmes since many would not wish to participate in out of hours work and may wish to work less than fulltime. Dr McKnight pointed out that there was a lack of interest in general practice generally and there were currently no reserves for the GP SHO programme.

6.6 Dr Carson concluded that although the Minister had endorsed the document recommendations, revisions to the report would be necessary over the years to take account of changes to working practices. He added that the GMCSC would need to look at ways of implementing the programmes.

6.7 Dr Porteous suggested that a monitoring group was required to keep track of these issues rather than relying upon the identification of problems by GMCSC or Dr Woods. Dr McAughey added that this had been offered before but that this offer of involvement should be fed back to Dr Woods once again. In addition she added that this item should be added to the agenda for the next meeting.

Action point 4: Dr Chada to feed back the offer of GMCSC involvement to Dr Woods and add this item to agenda for next meeting.

7. UPDATE ON NEW GMS CONTRACT

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8. UPDATE ON GP APPRAISAL

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9. UPDATE ON THE USE OF UNLICENSED DRUGS

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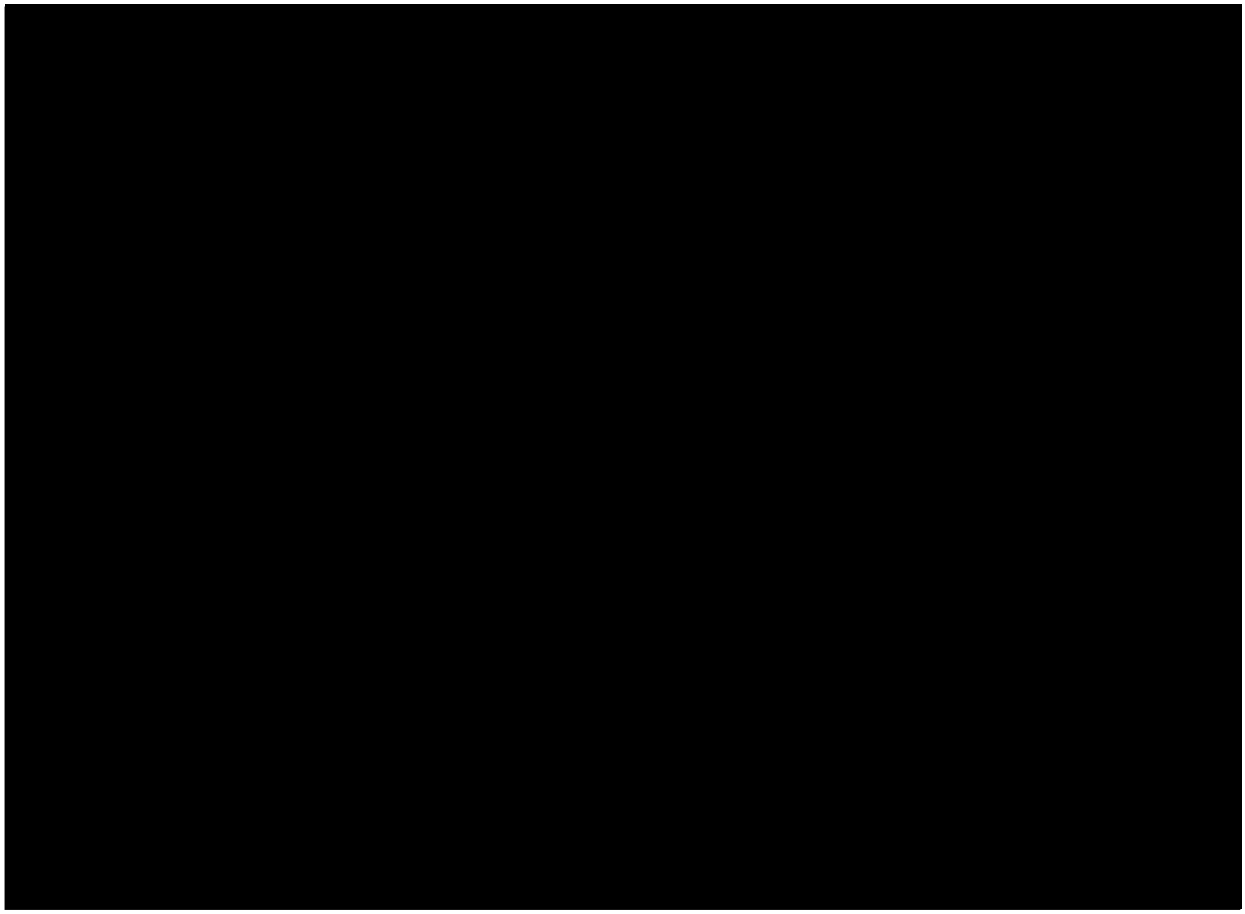

10. REVIEW OF CHILDREN WITH DISABILITIES

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11. GUIDANCE FOR SUPPLEMENTARY PRESCRIBING BY NURSES AND PHARMACISTS

11.1 Dr Maguire explained that the Government aimed to enhance patient care through better access and use of health care workers' skills. Previous descriptions in relation to supplementary prescribing had referred to independent and dependent prescribers and in summary this meant that another health care professional could take over prescribing once the care plan had been determined. The plans must be patient specific, be with patient agreement and be of worthwhile benefit to the patient. Patient safety was a key principal. In practice the independent prescriber had to be a doctor or dentist and the supplementary prescriber had to be a pharmacist or nurse. A common patient record was required and a written plan with a review date was essential. Dr Maguire added that controlled drugs may be included either next year or the year after and off-licence prescribing would also be included.

11.2 Dr Maguire added that where a supplementary prescriber requests so, the independent prescriber must resume clinical responsibility. A training programme was about to be put in place and the Department were currently putting the necessary regulations in place. The first wave of pharmacists was scheduled to commence training in November 2003 and to have completed their training by March 2004. He confirmed that decisions in respect of funding for practices providing mentoring services had yet to be taken. Practices

needed to consider if using supplementary prescribing pharmacists was to its benefit. If it was then they needed to see how training could be supported.

11.3 Dr Patterson pointed out that GPs had been complaining about their workload for some time and this appeared to be a good opportunity to shift some of the work. He warned that the process was likely to be fairly bureaucratic and that unless it becomes custom and practice, people were unlikely to utilise the opportunities as it will be easier to carry on doing the work one's self. He also expressed concern about the vicarious liability at paragraph 66 of the document since it was likely that the independent prescriber will also be the employer within general practice. Dr Maguire explained that he had contacted his insurer in respect of pharmacists and had been advised that a pharmacist would need to ensure they had professional indemnity if they are providing services to a practice and the requirement would be that they act within context of the plan. Where the responsible GP did not review the plan within the agreed timescale then this would be the GP's responsibility. Dr Patterson felt that this needed to be made clearer in the paper.

12. TREATMENT OF CANCER PATIENTS IN LIGHT OF PROPOSED CLOSURE OF CANCER FACILITIES AT BELVOIR PARK HOSPITAL

[redacted]

13. THE USE OF ULTRAVIOLET UNITS IN GENERAL PRACTICE

[redacted]

14. NOMINATIONS FOR GMCSC MEMBER TO CMAC

[redacted]

15. NOMINATION FOR REPRESENTATIVE TO SIT ON BREAST SCREENING ADVISORY COMMITTEE

[redacted]

16. ANY OTHER BUSINESS

[redacted]