An open meeting of the Walsall Local Medical Committee was held in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall on Monday 2nd April 2012 commencing at 19.45 hours, which was attended by 23 people.

**PRESENT:**

Dr.A.J.Desai    Chairman
Dr.H.S.Syed    Medical Secretary
Dr.N.Ahmad
Dr.A.T.Askey
Dr.A.Ghosh
Dr.A.S.Gill
Dr.A.S.Khan
Dr.R.Mohan
Dr.A.S.Suri

**Also present:**

Dr.N.S.Sahota    Associate Medical Director for Black Country Cluster
Dr.Nick Hall    Responsible Officer/NHS Walsall
Dr.Isabel Gillis    Director of Public Health/NHS Walsall
Fiona Pendleton    Head of Corporate Communications and Marketing/Walsall Healthcare NHS Trust
Lin Gostling    Matron for Community Midwifery and Antenatal Clinic/Supervisor of Midwives/Walsall Healthcare NHS Trust
Karen Palmer    Head of Nursing and Midwifery/Walsall Healthcare NHS Trust
Bob Lee    Informatics Programme Manager/Walsall Healthcare NHS Trust
Dr.S.Handa    Black Country Regional GPC representative
Dr.J.K.Bipin Chandra
Dr.I.Majid
Dr.B.C.Pal
Dr.R.M.Patel
Dr.N.K.Pillai
Dr.C.J.Spurlock

**Minute Secretary**
Carolyn Andrew    LMC Executive Officer
The meeting was opened at 19.45 hours by the LMC Chairman, Dr. Ajit Desai, who welcomed speakers, guests and members.

**WELCOME:**
Dr. N.S. Sahota   Karen Palmer  
Dr. Nick Hall     Bob Lee       
Dr. Isabel Gillis Fiona Pendleton  
Lin Gostling     Dr. S. Handa 

1) **APOLOGIES:**
Dr. U. Ahmad     Dr. S. Manthri  
Dr. R.T. Cheriyan Dr. L.S. Nambisan  
Dr. A. Iqbal     Phil Griffin   
Dr. F. Mahmood   Dr. S. Yuen 

**Chairman’s Announcement**
The LMC Chairman, Dr. Ajit Desai, informed colleagues of the withdrawal of the agenda item on the Development of the Frail Elderly Pathway by Walsall Healthcare NHS Trust. The Trust had requested a new date to enable them to make a more comprehensive presentation.

The Chairman invited Lin Gostling and colleagues to update LMC members on the Maternity Information System (Clevermed).

2) **Maternity Information System/Clevermed – Lin Gostling/Karen Palmer/Bob Lee**

Lin Gostling: Matron for Community Midwifery and Antenatal Clinic/Supervisor of Midwives/ Walsall Healthcare NHS Trust  
Karen Palmer: Head of Nursing and Midwifery/ Walsall Healthcare NHS Trust  
Bob Lee: Informatics Programme Manager/ Walsall Healthcare NHS Trust 

Lin and Karen welcomed the opportunity to come to the LMC meeting, as they were aware that the introduction of Clevermed had upset GPs and Lin explained that she was very sorry for this. They were hopeful that GPs would come to recognise that they were very much a part of the system and also how much the introduction of it would improve care for pregnant women in Walsall. They wanted to understand GP concerns and they had brought Bob Lee along to handle any technical questions. Lin had also been out to locality meetings to explain how the system works.

At present Midwives come out to surgery and input information into the GP clinical system and also write in the hand-held notes. New hand-held records are being introduced (given to new patients only), which will contain a lot of information. They are only in English at the moment but other languages will be available. The pregnancy book currently issued by the Department of Health will be withdrawn.
Using Clevermed, when the Midwife sees the patient for the first time they will initially put the data onto the GP clinical system and onto Clevermed and a printed copy will go into the handheld record. This will go with the patient wherever she goes. Currently information is only put onto the GP clinical system when the patient attends the surgery but soon there will be an icon on GP systems which they can use to track the entire patient journey. They will be able to see scans, blood tests, visits etc. With the new maternity tariff coming in next year patients will be categorised into low/medium/high risk and GPs will be able to check this and also see whether a patient has changed category. Karen informed GPs that this would assist them to plan services according to their patients’ requirements.

Bob Lee explained that the system was very similar to Fusion but will require GPs to log in. He added that they wanted to use pilot sites to test the system first before rolling it out to all GPs. There would be on-site training for GPs and staff. Using the Medical Interoperability Gateway (MIG), which is available on EMIS systems, it should be possible to integrate information directly into GP clinical systems. Lin stressed that they want GPs to use the system as well as hospital and Midwives to allow for a full exchange of information. There are 156 standards that they have to abide by and the system will also capture all public health data – Smoking/BMI etc.

Dr. Narinder Sahota, Medical Director and PEC Chairman, pointed out that some really good data had been put into GP systems by Midwives and the main issue as far as GPs were concerned is that this data would be lost as a result of the introduction of Clevermed. Lin responded that she wanted to encourage communication between GPs and Midwives as this was really important. She added that Community Midwives had had to take a lot on board with the new system but it is working well. She confirmed that bookings and antenatal care would always be done in the GP surgery. Lin reminded colleagues that the new Midwifery Led Unit had opened its doors to patients that morning and would have 24 hour midwifery cover.

The LMC Chairman, Dr. Ajit Desai, asked to raise some issues:
1) When will the pilot be happening?
2) Members have informed the LMC that antenatal clinics have been cut – why is this?
Bob responded that the pilots would be starting in about 3 to 4 months and Lin added that if clinics were being reduced it was because numbers were going down and if the numbers increased again they would be restored. Dr. Desai felt that there were communication issues there as GPs were not being told why clinics are reducing. Lin confirmed that there were 84 antenatal clinics and 14 postnatal clinics running weekly at present.

Dr. Haris Syed, LMC Medical Secretary, asked for confirmation that in the transition period midwives would be continuing with dual entry and that all Midwives were aware of this. Lin agreed that this should be the case and if there were any instances where this was not happening she would like to know about it. She added that it was not desirable for Midwives to be dual entering over a long period – they should be out seeing patients rather than entering data.
Dr. Pillai asked whether all test results will still come back to the GP and was told that GPs can access blood results and they will also be in the hand-held record. Screening results will still come via Fusion rather than path links. Bob informed members that the Trust now has to provide Maternity Discharge Summaries and said that Clevermed will enable this.

Dr. Nick Hall, Deputy Medical Director and Responsible Officer, enquired how many other areas were using this system and was told there were other sites across the country where it was in use and working well. The system was well used within the neonatal networks (badgernet) but the maternity system was fairly new, however it had the advantage that it could be used throughout the whole pregnancy pathway and not just in the intrapartum period.

Dr. Avi Suri asked how long it would take to merge the data and Bob responded that it will probably be towards the end of 2012 as it is a fairly new system. They are looking to use MIG for clinical documents such as discharge summaries. Dr. Suri offered his practice as a pilot site and Bob agreed to contact him to arrange this.

Members showed their appreciation for the information provided by Lin and colleagues and the LMC Chairman introduced Dr. Isabel Gillis to discuss the reconfiguration of vascular services.

3) Reconfiguration of Vascular Services & roll-out of Abdominal Aortic Aneurysm (AAA) Screening in the Black Country– Dr. Isabel Gillis

Dr. Isabel Gillis: Director of Public Health/Walsall Healthcare NHS Trust

Dr. Gillis explained that vascular services are being reconfigured nationally in response to the requirement for the introduction of a national screening programme for the detection of Abdominal Aortic Aneurysms (AAA) that all screen detected aneurysms are treated in a surgical centre serving a population of at least 800,000 in order to achieve the best clinical outcomes and minimise clinical risk and peri-operative mortality.

In the Black Country – Dudley, Walsall and Wolverhampton PCTs and their respective Clinical Commissioning Groups and Acute Service Providers have been collaborating through the Black Country Vascular Services Reconfiguration project to develop a services specification and a procurement process for the selection of a provider for AAA screening and the selection of the site for the hub for complex vascular interventions in the Black Country Vascular Network. Services for Sandwell are being aligned with Birmingham.

Clinical Case for Change

- Reducing mortality
  - nationally, there are 6,000 deaths per year from ruptured AAA
    * 104 in-hospital deaths * 284 out of hospital deaths

The majority of deaths due to ruptured aneurysm occurred before the patient got to hospital. The case for screening for AAA met all the criteria and was approved by National Screening Committee for roll-out in March 2009.
- **Improving outcomes**
  - Requires vascular hub serving population of 800,000 for accreditation (based on data from NVD)
  - Equates to more than 100 cases in 3 years
  - Reduce per-operative mortality rate for elective infra-renal AAA repair to <3.5%

There is good evidence to show that increased volume equates to decreased risk.

**Choosing the site for the Vascular Hub**

The Black Country Clinical Leaders Senate*** agreed:

- the Clinical case for change (endorsed by National Clinical Advisory Team – visit in September 2011)
- the service specifications for the AAA screening programme/Vascular Network
- approach to procurement
  - NHS Supply to Health for screening contract
  - Procurement ring-fenced to existing providers for hub

[*** Narinder Sahota, Amrik Gill and Sudhir Handa have all been a part of this]

There were 3 potential providers for the screening programme and the vascular hub:

- New Cross
- Manor Hospital
- Russells Hall

The Manor Hospital decided not to tender for the vascular hub and after evaluation of both the remaining providers (into which there was clinical input) the contract was awarded to Russells Hall. The hub and screening office will be in Dudley, with spoke sites in Walsall and Wolverhampton. Spoke sites will provide:

- Out-patients
- Investigations
- Minor procedures
- Rehabilitation
- Follow-up
  - Screening will take place in community locations

Dr. Gillis informed colleagues that there will be no closure in any of the vascular sites.

**National Screening Programme – 65+ Men**

The National Screening Programme is very tightly proscribed and leaflets will be coming out to GPs to hand out to patients very soon. Dudley had to submit a business case to provide the screening programme, which they have done.

**Roll-out of AAA Screening**

- All service staff have now been employed
- Screening technicians have started training
- Service to have access to database of eligible men in April 2012 (for planning)
- Staff training will be complete by June 2012
- Invitations will go out to Walsall patients in July 2012
- Publicity for Programme and information presentations to GPs already commenced in Walsall
✓ Locations for screening sites under negotiation – 5 Walsall GP surgeries already agreed to host clinics (more needed)

Screening Manager, Tracy Bayliss, has already started to visit some practices – any practice interested in being a screening site should contact Tracy through Joanne Wood. Screening sites will be distributed across Walsall (according to numbers of eligible men). Dr. Gillis said she would get Jo Wood to map the distribution of 65+ males and sites and make the information available to GPs.

For further information please contact:
Dr. Isabel Gillis, DPH, NHS Walsall Isabel.gillis@walsall.nhs.uk
Joanne Wood Joanne.M.Wood@walsall.nhs.uk
AAA screening programme http://aaa.screening.nhs.uk

Dr. Gillis agreed to take questions from members:
Dr. Raj Mohan – (i) Which cases will be left to vascular surgeons locally?
Dr. Gillis – There will be a phased migration to the hub –
Phase 1 – all abdominal surgery
Phase 2 – peripheral vascular surgery
The other vascular sites will do outpatient work and some minor surgery
(ii) If a patient has a rupture in A&E at the Manor is there the facility to handle it here?
Dr. Gillis – The idea is that if there is a suspected rupture the patient will go straight to the hub – a 24/7 in and out-of-hours vascular rota covers all three hospitals. It is really a case of clinical judgement – either the surgeon will go to the patient or the patient will go to the hospital where the surgeon is on-call.

Dr. Gillis added that they still have to sort out the detail of the patient pathway and at what point the patient transfers over and back between the hub and the spoke. She acknowledged that they are not as far forward with the contract mobilisation as they would have liked. The biggest improvement in mortality is likely to be at the end of the patient pathway, where re-vascularisation has failed and amputation becomes necessary.

There has to be a vascular surgeon available 24/7 for on-table emergencies in spoke sites. Screened patients will have their aneurysm measured and those of normal size will be dealt with electively. The aim of the screening procedure should be that there will be no more emergency ruptures. There will be a facility for patients with family history of AA to self-refer to the service.

Dr. Pillai commented that one of the difficulties with combining Walsall with Wolverhampton is Medicines Management (MM), which is very good in Walsall but less so in Wolverhampton. He asked whether there was any way of bringing MM in Wolverhampton up to the same standard as Walsall. Dr. Gillis responded that they would have to get MM teams together in all three areas.

Dr. Christina Spurlock asked how would the ambulance service decide which acute abdomen cases need to go straight to Russells Hall and would this re-organisation lead to de-skilling of vascular surgeons at spoke sites? Dr. Gillis agreed that vascular staff would need to agree clear criteria for the decision making process but did not accept that the re-organisation would lead to de-skilling.
Dr. Sudhir Handa, GPC Regional Representative for Black Country observed that two-thirds of patients with ruptured AA died out of hospital and Dr. Amrik Gill, Walsall CCG Clinical Chair, commented that there had been much debate about vascular services in the Black Country Clinical Leaders Senate and there was clear evidence from other areas to support that this model works.

In conclusion, Dr. Gillis advised that the Stroke Service across the Black Country was being looked at also.

The LMC Chairman thanked Dr. Gillis and requested that Dr. Narinder Sahota address GP Colleagues concerning the future use of the RCGP Toolkit for Appraisal and Revalidation Support.

4) **Use of RCGP Toolkit for Appraisal/Revalidation – Dr. N.S. Sahota**

**Dr. Narinder Sahota:** Associate Medical Director for Black Country Cluster

Dr. Sahota said that he and Dr. Nick Hall had been asked to come to LMC to clarify the email that had been sent out by NHS Walsall in the previous week concerning the use of the RCGP Toolkit for the appraisal process in Walsall in the future. Unfortunately, Nick had been called away and Narinder conveyed his apologies.

**Appraisal**

Narinder explained that at a meeting of the Black Country Cluster Responsible Officers (ROs) recently, all Toolkits had been reviewed for quality and costs in regard to revalidation support and the RCGP Toolkit was considered the best as a revalidation support system. The RCGP Toolkit is free for members and free for PCOs, however non-members will have to pay to use it.

Currently in Walsall there are GPs using both Clarity and RCGP Toolkits. Those GPs using Clarity will have to move to their new Toolkit so NHS Walsall wanted to inform GPs that if they were considering changing they might want to move to the RCGP Toolkit as they were offering a discount to people who joined before 31st March 2012 – hence the email was sent out. If it had not been for the deadline to join to get the discount this would normally have been presented at LMC before the email was sent.

Narinder added that GPs can continue using their existing Toolkit until their next appraisal where they can discuss with their appraiser what would be best to do in the future. Appraisal training for GPs has been arranged where these issues can be discussed and the PCT will provide as much training and support as is needed.

Narinder went on to say that there is a very good appraisal process in Walsall and this means that there will probably be little change here. Dr. Nick Hall is the RO for Walsall, the Cluster ROs looked at all revalidation support systems – Clarity and RCGP Toolkits are both good. They also looked at the cost to the Clusters and currently across the Black Country, Walsall PCT is the only one that pays the PCT element of the licence. The RCGP Toolkit is free to members and PCOs, therefore the cost will be zero to PCOs. For the next 12 months, if with Clarity or RCGP or any other Toolkit GPs can use whichever one they like. PCT has paid the licence for Clarity until October 2012 and after this it will not be renewed.
After October 2012 the PCT will not be able to access information on the Clarity Toolkit so GPs using Clarity will have to send the data to the PCT electronically. Narinder mentioned that GPs intending to stay with Clarity for this year may be advised to book their appraisal to be done before October. In the long term it will probably make the appraisal process easier for GPs if they are using the RCGP Toolkit, cost is £120 per year for non-members and Clarity costs £60 per year. The cost of the PCT element of the licence for Clarity is £12K per year. Walsall PCT cannot justify the payment to Clarity when none of the other PCOs in the Cluster are paying.

Narinder advised colleagues that, for the Black Country Cluster, 8 appraisal training sessions have been booked – two in each of the four areas – and GPs can attend any session. Appraisers need training also and in Walsall all appraisers have been trained except one. There will be lots of different Toolkits available in future to choose from, the Cluster PCOs have decided to use the RCGP Toolkit as it is considered to offer the best support for revalidation and it is cost zero for PCOs. The RCGP Toolkit has a grid at the front which tells you whether you are ready for revalidation using Red/Amber/Green ratings. In Walsall the first revalidations are likely to start in October 2012. Walsall PCT has all the appraisal data (summary of discussion Form 4 and PDP) for the last 10 years.

LMC members were advised by the LMC Medical Secretary, Dr.Haris Syed, that it was possible to join the RCGP as an Associate Member and then the Toolkit would be free to use – check the RCGP website to find out how - http://www.rcgp.org.uk/bjgp

Haris also pointed out that colleagues who had given credit card clearance to renew when they moved to the new Clarity Toolkit would need to cancel this if they intended to change to RCGP.

Dr.Sudhir Handa, GPC Regional Representative for Black Country, referred to the fact that GMC and RCGP were giving out different messages regarding revalidation and added that the GPC still had issues that had not yet been resolved:
(i) Revalidation for Sessional GPs
(ii) Remediation – who will fund it where required?

He added that it would be helpful to know who the Appraisers are across the Cluster and asked whether it would be possible for GPs to select an Appraiser from another area? Narinder responded that Appraisers will be Cluster-wide and they are looking at this. Appraisers may be generic i.e. anyone from Cluster. Narinder was asked when Appraisers would be notified to GPs and said this would be sometime in April. Dr.Haris Syed commented that PCTs have been told that the process must start but are still waiting for details of the process. He cautioned colleagues that they must be prepared.

**Revalidation**

Narinder advised that all doctors will get a letter from the GMC to say revalidation is starting in 2012/13 however no national guidance had been agreed for which doctors should be first to be revalidated. The GMC will instruct PCOs to choose which doctors are to be revalidated first. He added that money will be tight and the likelihood is that GPs may have to pay for their own remediation where it is required. Dr.Haris Syed said that there may be a West Midlands solution for this but talks were ongoing.
The main point that Narinder wanted to get across to colleagues was that if they did not get revalidated they could not work. The process of revalidation will be decided locally and the PCT will have to revalidate all of it’s doctors over the next five years. Dr.Hall, as RO, will have to look at appraisals and also to investigate any other issues that may be relevant. It is possible that the PCT may ask for GP volunteers to be revalidated first.

5) Any Other Business

NONE.

6) Date of Next Meeting:

The LMC Chairman informed colleagues that the date of the next LMC meeting, currently scheduled for Monday 30th April 2012, might have to be changed and that information would be circulated about this as soon as a decision had been made.

The main session was closed at 21.10 hours by the Chairman and Committee Members were requested to remain for the In-Committee session.