Health and Social Services Committee

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Date: 8th March 2006
Venue: Committee Rooms 3 & 4, Assembly Offices, National Assembly for Wales
Title: Minister's Report

1. Home Oxygen Service Contract

2. Visit to the Heads of the Valleys GP Recruitment Project in Blaenau Gwent Local Health Board

3. General Medical Services Agreement for 2006/7

4. National Service Framework (NSF) for Older People in Wales Consultation Outcomes

5. Update on service development and commissioning directives for Arthritis and Musculoskeletal conditions

6. Robotic Pharmacy at the Royal Gwent, Prince of Wales and Royal Glamorgan Hospital

7. Renewable energy in Hospitals

8. Child Suicide rates

9. Inequalities in Health Fund

10. Hydatid Disease in Wales

11. Publication of Welsh Cancer Intelligence Surveillance Unit (WCISU) update on surveillance of Non-Hodgkin's Lymphoma around the Nant-y-Gwyddon Landfill site

12. Chief Medical Officer's Review of the E-coli outbreak

13. Local Health Board's level of debt

14. Alzheimer's drugs

15. The appointment of Dr Tony Jewell as the Chief Medical Officer for Wales

Updates

- Children's Social Services in Bridgend County Borough Council: Progress Report as at 31 December 2005

- Inspection of Children's Social Services in Blaenau Gwent: Progress Report as at 31 December 2005

- Inspection of Children's Social Services in City and County of Cardiff: Progress Report as at 31 December 2005

Legislation updates

The Statement of Financial Entitlements (Amendment) (Wales) Directions 2006

The Alternative Provider Medical Services (Wales) Directions 2006 and The Local Health Board Medical Services (Wales) Directions 2006

1. Home oxygen service contract

1.1 Following the introduction of the new home oxygen service on 1st February a number of issues have arisen with Air Products Ltd, many of which I have discussed at length in this committee and elsewhere. I continue to be grateful to those pharmacists who have extended their service to patients throughout February and into March. When working effectively this service helps patients manage their symptoms at home, not in hospital.

1.2 The problems experienced have not been peculiar to Wales, with much of England also being serviced by Air Products. However, the problems have not been confined to Air Products either, with the other suppliers being used in some areas of England experiencing similar difficulties. My officials have been involved in meetings with Air Products throughout February and have also been liasing with Department of Health throughout.

1.3 Air Products are recruiting more staff to cope with the sharp increase in demand. Pharmacists have continued to operate the old system in tandem with the new to relieve the pressure on the new contractor, and I am most grateful for their co-operation and professionalism. The validity of WP10s has been extended to last until 31st March to ensure that they continue to be rewarded for their efforts.

2. Visit to the heads of the valleys gp recruitment project in blaenau gwent local health board

2.1 On 26th January 2006 I visited practices in Nantyglo and Brynmawr that have benefited from the Heads of the Valleys GP Recruitment Project.

2.2 This project was introduced by the former Gwent Health Authority to support practices in Gelligaer [Caerphilly] and Brynmawr [Blaenau Gwent]. The project involves the recruitment of salaried doctors to work in practices that are directly managed by the Local Health Board and has links with the department of General Practice at Cardiff University. The Assembly provided funding support of £180,000 per year for the first three years of the project.

2.3 The impetus for the project arose because of retirements of largely single handed GPs and subsequent difficulties in recruitment. Blaenau Gwent LHB now manages a network of practices within the project. They have been successful in recruiting GPs when other practices have been struggling. I was most impressed with the joint working between the LHB and the practice teams in maintaining and improving patients' services.

2.4 During March I will be visiting the Gelligaer practice in Caerphilly LHB which is also part of the project.

3. General medical services agreement for 2006/7

3.1 As outlined in my letter of the 1st February to the Chair of the Committee, a review has been undertaken of the General Medical Services Contract. Following that review changes have been made at UK level. These can be accessed at:- http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=12414.

3.2 The key points are that important new clinical areas will be inserted into the Quality and Outcomes Framework ie heart failure, palliative care, dementia, depression, chronic kidney disease, atrial fibrillation, obesity and learning disabilities. There will be no uplift to any existing element of the contract for inflation in 2006/07. All new investment would be via new Directed Enhanced Services.

3.3 The UK agreement commits us to £6.7m of new investment and we are talking to the General Practitioner Committee for Wales about the following proposals:-

- Access - the current Access DES is to be expanded to ensure appointments can be booked in advance, improve call handling, help patients to see a doctor of their choice and to get practices to look at the access needs of patients with disabilities;

- IT DES – This will focus on data quality and better electronic communications with patients;

- Mental Health DES – improving services to patients with serious mental illnesses;

- Learning Disability DES – an annual health check for patients with severe learning disabilities;

- Maternity – providing a minimum threshold for locum reimbursement for GPs in line with Agenda for Change; and

- A new system for the remuneration of dispensing doctors has been developed which removes the direct link between drug costs and what the doctor gets paid, the so-called "perverse incentives".

4. National service framework (nsf) for older people in wales – consultation outcome

4.1 The draft NSF for Older People in Wales was issued for formal consultation from July to mid October 2005.

4.2 179 responses were received, giving overall support to the NSF and its potential to improve services for older people. Minor changes and additions to the text have been made as a result, and the accompanying Medicines and Older People booklet has been incorporated as a 10th standard.

4.3 Concern was expressed about two key issues:

- Lack of time scales - a 3 stage implementation plan has now been developed which aligns with the timeframe for Designed for Life. Actions have been set for the first 2 years of implementation (stage 1), followed by a formal review of progress in 2008 and the setting of further actions for stage 2 - 2008 to 2011. Stage 3 will follow from 2011 - 2015.

- Resources - respondents did accept that some improvements could be made within existing resources, however there was concern that some of the service improvements would need additional resourcing. Many of these will be implemented as part of mainstream service development and improvement - e.g. stroke services and Intermediate Care, which feature in the SaFF for 2006/7. Progress will be closely monitored within the context of resource planning.

4.4 The revised NSF will be launched at an inaugural conference on 20 March 2006. It will be accompanied by an Executive Summary and a public information leaflet aimed particularly at older people.

5. Update on service development and commissioning directives for arthritis and musculoskeletal conditions

5.1 The Service Development and Commissioning Directives for Arthritis and Musculoskeletal Conditions are currently being finalised. These will be the first of a series of service development and commissioning documents to improve chronic disease management under the title "Designed for People with Chronic Conditions". It will form a key part of the programme to improve services for chronic disease management across Wales as identified in Designed for Life.

5.2 The arthritis and musculoskeletal document aims to strengthen prevention, early intervention, and the proactive management of these life long conditions. It also aims to ensure that services become as locally accessible as possible and are provided through multi-disciplinary teams in order to strengthen current services and bridge the gap between primary and secondary care. The approach to improving the health and well being of people with musculoskeletal conditions is underpinned by a care pathway approach which places the patient firmly at the centre of services and aims to ensure that services are provided in a seamless way.

5.3 The draft document will be submitted to me in March prior to its release for external consultation.

6. Robotic pharmacy at the royal gwent, princess of wales and royal glamorgan hospital

6.1 On 26th January I officially launched the newly installed automated pharmacy dispensing system at the Royal Gwent Hospital. This completes the second phase, which included Royal Glamorgan and the Princess of Wales.

6.2 The first phase which began in 2003 comprised Llandough, West Wales General and Ysbyty Glan Clwyd.

6.3 The decision to invest in automation in Wales was made following the publication of A spoonful of sugar –the Audit Commission's report on medicines management in NHS hospitals. The commission recommended the automation of hospital pharmacy services. The same recommendation was also made in Remedies for Success the Pharmacy strategy for Wales. The main purpose being to improve patient safety by reducing dispensing errors and release staff to patient focussed services.

6.4 Data collected by the phase 1 sites has shown an average reduction in dispensing errors of 69% in addition patient focussed services have been facilitated and implemented successfully. This is excellent news and bodes well for sites in the following phases.

6.5 We are planning to install further systems in 2006 and in the following years to continue to drive the modernisation of hospital pharmacy which places these services in Wales at the forefront of European development.

7. Renewable energy in hospitals

7.1 The 57 largest hospitals in Wales have been supplied with 100% Green electricity from 1st April 2005 following a new all Wales electricity supply contract. These 57 sites account for 89% of the electricity consumed by the NHS Wales and smaller hospital sites will be addressed as their electrical supply contracts are renewed.

7.2 It is planned that the new hospitals Ysbyty Cwm Rhondda and Ysbyty Alltwen (North Merioneth) will include wood-burning boilers for the provision of heating and hot water, they have obtained grants from the Wood Energy Business Scheme (WEBS) for the provision of these central wood-burning units.

7.3 Welsh Health Estates (WHE) has formed a renewable energy group to examine how renewable energy can be utilised in the NHS in Wales. The group has representation from the Welsh Assembly Government, WHE, the Organisations for the Promotion of Energy Technologies (OPET), the Carbon Trust Wales and the Welsh Health Environmental Forum to represent NHS Trusts.

7.4 Welsh Health Estates in partnership with the Carbon Trust has commissioned a study into the feasibility of wind power generation at hospitals in Wales and is now intending to conduct in-depth assessments at those sites identified as being potentially most suitable.

8. Child suicide rates

8.1 In light of the recently issued ONS statistics to the BBC on child suicide, I have asked officials to look at the child suicide figures, which are of concern to me, to see if there are any common factors and consider what further investigation may be helpful.

8.2 In addition, there are a number of issues that can affect the interpretation of the data including recording practice by coroners between accidental death and suicide.

Mortality from suicide and undetermined injury in children aged 11-17, by country of residence, 1995-2004

Number			Age-specific rate per 100,000 aged 11-17		
	ENGLAND	WALES		ENGLAND	WALES
1995	10	4	1995	0.2	1.6
1996	10	4	1996	0.2	1.5
1997	12	4	1997	0.3	1.5
1998	10	5	1998	0.2	1.9
1999	13	3	1999	0.3	1.1
2000	12	3	2000	0.3	1.1
2001	10	2	2001	0.2	0.7

2002	11	4	2002	0.2	1.5
2003	12	6	2003	0.3	2.2
2004	11	5	2004	0.2	1.8
1995-2004	111	40	1995-2004	0.3	1.5

Notes

[1] Data selected using the International Classification of Diseases codes:

1995-2000	ICD-9	E950-E959, E980-E989 excluding E988.8
2001-2004	ICD-10	X60-X84, Y10-Y34 excluding pending verdicts

[2] Data are for occurrences of death in each calendar year.

Source: Office for National Statistics

Advice from Professor Richard Williams, the Assembly's advisor on CAMHS issues is that :

"With small figures of this size, it should be borne in mind that a single coroner may more readily ascribe death to suicide rather than accident or misadventure, which could possibly account for the entire variation and more. In research on suicide in adults, it has become usual to combine coroners' returns for accidental deaths with those for suicide."

9. Inequalities in health fund

9.1 On 16 February 2006 I announced that the 62 projects currently funded from within our Inequalities in Health Fund will be extended for a further year to March 2008.

9.2 The First Minister opened the first Inequalities in Health Fund national conference.

9.3 An interim report was published "The Inequalities in Health Fund -making a difference" copies of which have been sent to Committee members. The report highlights examples of positive action and results achieved by the projects in delivering targeted action on coronary heart disease. During the extension period, the projects will have the opportunity to generate more evidence of what is working.

9.4 This evidence will be considered carefully alongside the outcome of on-going independent evaluation. It will provide information about how health improvement and prevention initiatives can be used to complement our modernisation plans for health and social care.

10. Hydatid disease in wales

10.1 Hydatid Disease causes cysts in the major organs e.g. lungs, liver and brain. This is a parasitic disease caused by a dog tapeworm. The dog becomes infected through eating infected sheep containing cysts. These mature in the gut of the dog to produce tapeworms, which produce eggs. Humans acquire eggs when handling infected dogs. Treatment in man requires specialist surgery.

10.2 A control scheme of dog dosing in Powys in 1983 reduced infection in dogs. An educational programme in Powys has not continued the success of the dog scheme as recent studies indicate a return to previous high levels of carriage. There is a risk of a corresponding re-emergence of human disease. Dogs affected show no signs of disease. The effect on the sheep industry is negligible. The principle risk is to man. Failure to respond to this increase in dog carriage will lead to a return of Hydatid Disease to Wales.

10.3 Action is needed to reduce the infection rate before there is a fatality through re-emergence in man. Publicity to raise awareness among stakeholders and the veterinary profession has begun.

10.4 Officials will scope the work involved in determining the extent of Hydatid Disease in dogs in Wales and produce a further advice and proposals for tackling the disease, including a public awareness campaign.

10.5 This also went to the Environment, Planning and Countryside Committee on 16 February 2006.

11. Publication of welsh cancer intelligence surveillance unit (wcisu) update on surveillance of non-hodgkin's lymphoma around nat-y-gwyddon landfill site

11.1 The Welsh Cancer Intelligence & Surveillance Unit (WCISU) published an updated report on their ongoing surveillance of Non-Hodgkin's Lymphoma (NHL) around Nant-y-Gwyddon Landfill (NYG) Site on 28th November 2005

11.2 This updates earlier work and covers the period 1981-2003.

11.3 The report concluded that the increased relative risk of NHL in the Nant-y-Gwyddon region for the period 1998-2001, no longer reached statistical significance (although remains raised) and that the addition of the extra data for the year 2002 still produces no evidence of a significantly increased risk of NHL in the area.

12. Chief medical officer's review of the e.coli outbreak

12.1 I have agreed with the Chief Medical Officer the membership of his team tasked with following up and implementing the recommendations from his review. The implementation team is formed from members of the original team, as follows:

- Dr Mike Simmons (Acting Deputy Chief Medical Officer) (Chair)
- Ronnie Alexander (Chief Environmental Health Adviser)
- David Seal (Wales Centre for Health)
- Prof. Stephen Palmer (Cardiff University)
- Peter Farley (Public Health Protection Division)
- Louise O'Hanlon (Public Health Protection Division - Secretariat)

12.2 I am pleased that the team will also include a representative from each of:

- The National Public Health Service
- The Food Standards Agency
- The Welsh Local Government Association
- The Chartered Institute of Environmental Health
- The Directors of Public Protection in Wales

13. Local health board's level of debt

13.1 The whole issue regarding the £190m was covered in the Audit Committee and in the responses to the audit committee's recommendations. The issue was successfully dealt with in the completion of the 2004/05 accounts and in our management letter the Wales Audit Office complemented the Health and Social Care Resources Directorate on how the issue was resolved.

13.2 The £190m has nothing to do with past deficits or debts associated with deficits. In the past Health Authorities were allowed to raise debtors with the Assembly to cover anticipated cash they would receive to cover their general expenditure. These debtors were always high because of timing differences between recording the expenditure and the cash settlement of this expenditure.

13.3 Under Resource Accounting, which was introduced for the first time for LHB's

in 2003 these debtors should not exist and LHB's had to make significant changes to remove these debtors from their balance sheet.

13.4 This was a significant technical accounting issue at the end of the 2003/04 accounts process and this is why the Auditor General referred to it. However, it was purely a Technical accounting presentational issue and it had no impact on the financial performance of LHB's, their SCEP's or their overspends.

14. Alzheimer's drugs

14.1 NICE issued guidance of the use of donepezil (aricept), rivastigime (exelon) and galantamine (reminyl) in 2001, recommending that these drugs should be used in the treatment of people with mild to moderate Alzheimer's Disease in England and Wales. The Institute is currently reviewing that guidance and provisional findings raised doubts over the clinical and cost effectiveness of these drugs. However, responses received during the consultation suggested that the drugs may be effective for certain groups of patients and NICE decided to issue a revised Appraisal Consultation Document (ACD) recommending that these drugs continue to be prescribed for patients with moderate Alzheimer's Disease.

14.2 The deadline for replies to the revised ACD was 13 February and the Institute is currently considering responses, with a view to issuing its final guidance in July this year. Until then, NICE's original 2001 guidance remains in force. I believe that NICE has handled this appraisal appropriately, and has undertaken all the necessary additional steps to ensure that all the available evidence is gathered and properly considered. Whatever the final outcome of the NICE Appraisal process, I can assure you that I want every Alzheimer's patient and their carers, to receive the very best quality, evidence-based care and support.

15. The appointment of dr tony jewell as the chief medical officer for wales

15.1 Dr Tony Jewell has been appointed as the Chief Medical Officer for Wales.

Dr Jewell is currently Clinical Director and Director of Public Health in Norfolk, Suffolk and Cambridgeshire Strategic Health Authority. He was a GP in inner London for 10 years before training in public health in East Anglia. He has worked in the Department of Health and is currently the President of the UK Association of Directors of Public Health.

15.2 The Chief Medical Officer for Wales plays a vital role in protecting the public health of people in Wales. I have every confidence that Dr Jewell will fulfil this role and continue the good work already underway in this field.

Updates:

16. Children's social services in bridgend county borough council: progress report as at 31 december 2005

16.1 Introduction

In my report of 1st February, I informed the Health and Social Services Committee of the steps the authority has taken following the decision of the Chief Inspector to invoke the Protocol for responding to serious concerns about children's services within the County Borough of Bridgend.

A team of inspectors from SSIW have visited the authority to validate and monitor the progress the authority has made in meeting the targets set for the quarter ending the 31st December 2005 and to undertake an audit of files to assess the quality of social work practice in the authority.

16.2 Progress

Inspectors found that managers within the authority have undertaken a manual audit of 150 child protection files to establish a reliable database for these children. However more work needs to be undertaken to devise more systems for monitoring other social work activity.

Inspectors found that the authority has implemented a robust system for monitoring referrals and the target set for the completion of initial referrals has been exceeded, but the authority is starting from a low base. Data has now been produced for the completion of core assessments and progress will be scrutinised. Their performance in relation to timely reviews of children on the child protection register needs improvement but performance for reviews of "looked after" children was better.

The review of case files by SSIW indicated that the authority need to bring about an improvement in social work practice, but their progress is impeded by the lack of experience amongst social workers and managers. However inspectors found that managers throughout the division were clear that there were signs of improvements within the organisation. Communication had improved and the division was more cohesive. Whilst they were realistic about the size of the task ahead of them they indicated that they were committed and positive about securing the required improvements.

16.3 Monitoring

The Chief Inspector has now set a series of targets for the authority until the end of the year. They are stretching and challenging. The task facing the authority should not be underestimated.

The Chief Inspector will receive quarterly monitoring reports from the authority, which will be validated by visits by SSIW Inspectors. The next monitoring quarter ends on the 31st March.

I will meet the Leader, the Lead member and Senior Officers to discuss my concerns and to reinforce the seriousness of their situation and the need to secure improvement.

17. Inspection of children's social services in Blaenau Gwent: progress report as at 31

December 2005

17.1 Introduction

In my report on 23 November 2005 I provided an update on progress in Blaenau Gwent to the end of September 2005.

In January, two inspectors visited the authority to monitor its progress in meeting the expectations of the Chief Inspector for the end of December regarding areas for improvement, targets and timescales. The Chief Inspector met with the Director of Social Services and Assistant Director Children's Services earlier in February to discuss progress.

17.2 Progress

The local authority continues to make progress in delivering its recovery plan for social services. It is co-operating well with the monitoring process and seeks to ensure compliance with the expectations of the Chief Inspector.

From September most of the core assessments have been undertaken by the First Service Team (an intake and assessment team) and recorded in a standard format. There has been significant improvement in the numbers of core assessments completed within required timescales.

The authority has continued to develop its quality assurance processes and it has maintained its arrangements for producing detailed monthly data about performance.

The pre – accommodation panel (placement panel) is becoming established and undertakes resource management and quality assurance functions.

There has been continuing attention to workforce issues and there has been a generally stable workforce during this period. A full senior management team is in place. All team manager posts are filled and recruitment for permanent staff is presently taking place for the team manager positions filled on temporary basis. The increased responsibilities of the First Service Team has been recognised in the creation of additional posts of social worker and assistant team manager.

CSIW inspected adoption services in September and reported in December. It was acknowledged that the recently established adoption team was only at the beginning of establishing a framework for operation. CSIW report a constructive response in progressing an action plan to meet requirements.

The authority is maintaining progress in a positive direction while it continues to be realistic about the scale of the challenges remaining and the need for sustained momentum in addressing the agenda for change.

SSIW will be undertaking a children's services inspection beginning 13 March.

17.3 Monitoring

The Chief Inspector will continue to set quarterly performance targets, monitor the authority's performance through receipt of quarterly performance reports and continuing visits to the authority by inspectors. The inspection of children's social services will provide a more in depth analysis of the nature and quality of services.

I will continue to receive regular reports of progress.

18. Inspection of children's social services in city and county of cardiff: progress report as at 31st December 2005

18.1 Introduction

I provided an update on progress at the end of September 2005 in my November 2005 report. The Chief Inspector has put in place a formal programme of monitoring with targets set on a quarterly basis which are aimed at moving the authority to the point where:

It responds promptly and appropriately to referrals of concern about children

The management of work with children and families is strengthened, there is compliance with regulations and guidance, and services safeguard children and promote their welfare

These targets cover the production and implementation of guidelines and procedures, the process of strengthening management information systems, and improving service performance.

Inspectors visited the authority to validate the information provided on performance in January 2006 and conducted interviews with a range of managers. The Chief Inspector met with the Corporate Director and Chief Officer for Children's Services earlier this month to discuss the progress.

18.2 Progress

The authority's continued commitment to improve services has been demonstrated in the data submitted again this quarter. This shows that it is responding effectively and quickly to all referrals and its performance in decision making within 24 hours is satisfactory. All referrals to the authority are now risk assessed at the point of referral and this system appears to be well embedded. There has been significant progress in the improvement of core assessments with targets set being exceeded. There has been a dip in performance in relation to the completion of initial assessments this quarter as a result of some staff moving to other posts within the authority. Overall the timeliness of all initial assessments

has been maintained. The child health and disability team's performance has improved this quarter.

Performance in relation to reviews for children on the child protection register has reached its highest point to date but performance in relation to reviews of "looked after" children has dipped slightly this quarter.

The authority continues to implement its whole system commissioning strategy to improve the stability of placements of children who are looked after. This includes increasing support for placements to enhance stability and timely and effective implementation of care planning for children. Inspectors have found evidence that it is beginning to demonstrate positive outcomes for children. The implementation of their family support strategy to prevent children becoming looked after continues. The authority has started to provide parenting support centres as opposed to day nursery provision. The new contact service provided by a voluntary organisation will also start taking referrals this quarter

The Chief Inspector is of the view that the authority continues to demonstrate progress in most key areas The report of the inspection of children's social services is due to be published in March and will provide detailed evidence as to the extent of improvement in children's services.

18.3 Monitoring

The Chief Inspector will continue to meet with the Director and Chief Officer for Children's Services and to monitor the authority's performance. The Chief Inspector has set performance targets until the end of March when he will be in a position to evaluate the extent of progress taking account of the findings from the report of the inspection.

I will provide this Committee with a further update in my next Ministerial Report.

19. The statement of financial entitlements (amendment) (Wales) directions 2006

19.1 I wish to inform you about an amending direction that has been made under Standing Order 29. The Direction is the Statement of Financial Entitlements (Amendment) (Wales) Directions 2006, which came into force on the 1st February 2006. Unfortunately, I had to disapply all the requirements under Standing Order 29, given the urgency of making this amending Direction. By the time my officials were aware of the need for making this amending Direction, and after consultation with the General Practitioners Committee Wales, which we are legally obliged to do, I was left with no option but to disapply the requirements under SO29.

19.2 The urgency for bringing this amending direction into force on 1st February 2006 was because of the new Home Oxygen Service, which commenced on that date. This service replaced that previously provided by dispensing doctors and community pharmacists. This meant that the payments identified in the Statement of Financial Entitlements (SFE) for dispensing doctors ceased. However, to ensure a smooth transition to the new service, amendments needed to be made to the SFE, to allow dispensing

doctors to continue claiming fees for a transitional period. Although these were the main amendments made, a few corrections of technical errors were also included.

20. The alternative provider medical services (Wales) directions 2006 and the local health board medical services (Wales) directions 2006

20.1 The above two sets of Directions came into force on 1st March 2006. These Directions revoke previous Directions. The changes are necessary to align these Directions with changes in the NHS (Primary Medical Services) (Miscellaneous Amendments) (Wales) Regulations 2006 and the General Medical Services Transitional and Consequential Provisions (Wales) (Amendment Order) 2006 which came into force on the same date. The amendments are minor in nature but must be incorporated. It is essential that both Alternative Provider and LHB Medical Service contracts are on the same footing as GMS contracts and come into force in the same timescale.

20.2 Alternative Provider Medical Services Directions allow Local Health Boards to enter into a contract with an Alternative Provider of Medical Services, which could be an individual, company or partnership, to provide primary medical services for its area.

20.3 LHB Medical Services Directions allows LHBs to establish one or more practices to provide primary medical services in their area.

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