Minutes of the Meeting of the GP Sub-Committee of the Lothian Area Medical Committee held at the Holiday Inn Edinburgh City West on 8 June 2015

Dr Catriona Morton in the Chair

Present - Drs Ashcroft, Balfour, Bickler, Blake, Bock, Cowan, Crookes, Duncan, Flynn, Fulton (from item 6.1), Gallagher (from item 4.1), Mrs Grigor (minutes), Drs Haigh, Lomas, McDermott, Ms McNeillage, Drs Marshall, Morrison, Morton, Reid, Sengupta, Shishodia, A Small, Mr D Small, Drs Tapsfield, Thomas, Tucker, Turvill

Welcome to new members
The Chair welcomed Drs Annie Lomas (GP Partner at the Linden Medical Practice, Broxburn) and Fergus Sengupta (GP Partner at the Deans & Eliburn Medical Practice, Livingston) to the Committee. Drs Lomas and Sengupta are new West Lothian representatives, having replaced Drs Andrew McNutt and Sheena Milne.

1. Apologies

- Drs Cobbett, Cook, Donald, Hardie, Mr Lawrie, Drs Philip, R Williams

Absent - Drs Black, Lints, Rahman, N Williams

2. Minutes of the last meeting held 11 May 2015

The minutes of the meeting of 11 May 2015 were approved and signed by the Chair.

The following additional matter arising was discussed:

11/05/15 item 10 - GIRFEC update
Dr Morton had confirmed with Sally Egan (Associate Director and Child Health Commissioner, Strategic Planning, Performance Reporting and Information) that GIRFEC applied until age 18 (or until the person left school) but that Health has named-person responsibility only for the pre-school population. Once a child is in school the named-person role transfers to education (or the Local Authority if the child is home-educated). For children attending independent schools the named-person service is provided by that school. If a young person has been in receipt of through- or after- care (i.e. has been in Looked After Care settings covered by GIRFEC), then ‘named-person’ regulations apply up until the 26th birthday, which is very challenging.
She reported that Chris Ridley has just been appointed to Lothian’s GIRFEC Development Manager Post and will have a remit to explore learning and development needs of Primary Care staff too (including GPs).

3. Matters Arising / Actions from last meeting

3.1 RefHelp - update (reps and process)
Dr Mike Ryan had offered to take on the 2 outstanding RefHelp workstreams (general surgery and orthopaedics). He had noted the previously-minuted concerns that only one specialist and one GP were involved in the process and offered to be involved in reviewing proposed changes. The final versions of the RefHelp advice will come to the GP Sub-Committee for signing off but it was agreed that Dr Ryan’s involvement at an earlier stage was welcome and he will be informed of this.

ACTION: LMC Office

3.2 Funding of LMC / GP Sub Office
This had been discussed with Professor Alex McMahon at the ‘Primary Care Propositions meeting’ (26/05/15). The GP Sub-Committee is a Board Committee but - other than reimbursement for part of the Co-ordinator’s salary and some Office costs - the Committee
receives no resource at all for its work. This was due to be discussed at today’s CMT meeting, but that had been cancelled and so Dr Morton is to meet Professor McMahon separately to take this forward. Ms McNeillage was thanked for her support in the discussions.

**ACTION: CM**

### 3.3 **LMC Office lease**

It had been agreed at the LMC that the Office could be sited in one of the NHS family buildings - including Astley Ainslie Hospital. This will be investigated further.

**ACTION: PS**

### 3.4 **Frail elderly and 2020 Vision, and the 24/06/15 Board meeting**

See Chair’s Business, item 4.1 below.

### 3.5 **ANDI TF draft template for SCI and Trak changes**

[ANDI TF is the NHS Lothian Additional Needs and Diversity Information Task Force]

A letter to GPs had now been drafted and will be disseminated once the SCI Gateway changes have been finalised. The Task Force perceived that progressing such work was slower now that there was not a GP Sub-Committee representative at its meetings (previously Dr Hamish Simmers), and was keen to have a replacement. There are 4 funded meetings per annum. The Task Force supports processes and services to reduce inequalities round disabilities, ethnicity, language or other barriers to care. Some of these relate to Scottish Government directives. The group is chaired by Professor Raj Bhopal.

**ACTION: ALL**

### 3.6 **List of current members / responsibilities**

This was circulated with the agenda papers for information, and it was noted that Dr Ashcroft has kindly agreed to take on the MSK representative position. Following recent changes in Committee membership, there are now several vacant positions, some of which have been unfilled for a while. There is now one fewer Area Medical Committee representative, an important position, and a West Lothian PLIG (Primary Care Laboratory Interface Group) representative is also required. Dr Duncan may know of a West Lothian GP who may be interested in the PLIG position, and this may be pursued if no Committee members volunteer.

**ACTION: ALL**

### 3.7 **eMCCD (electronic Medical Certificate of Cause of Death), Death certification out of hours, Procurator Fiscal referrals**

Following an initial delay due to a Docman issue (practices received further advice on this), the system is now operational.

### 3.8 **Pregabalin/Lyrica®**

This was discussed further at Chair’s Group and the national advice sent to practices.

### 4. Chair’s Business

#### 4.1 **Frail elderly and 2020 Vision, and the 24/06/15 Board meeting**

This was discussed further at Chair’s Group (25/05/15) and again at a ‘Primary Care Propositions meeting’ (26/05/15) which was attended by Drs Shishodia, Tucker, Professor Alex McMahon, and PCCO and Community Nurse Manager colleagues. A copy of the ‘Primary Care and Lothian Unscheduled Care Services’ report, and draft 24 June presentation to the Board were circulated with the agenda papers.

Tim Davison (NHS Lothian Chief Executive) has asked Dr Morton and Mr D Small to give
a joint presentation to the Board and this was briefly discussed. Committee members were asked to email the Office with any suggestions.

**ACTION: ALL**

The report was drafted by Professor McMahon and Alyson Cumming and is a summary of the previous presentation to the Board with an additional new section on LUCS. This report may also go to Board members as a handout.

The £1.1 million identified for the top 6 ‘quick wins’ was felt to be marginal, and will not necessarily be recurrent. Referring to section 3.3 on page 2 of the report, Mr Small advised that the funding has now been divided into 3 tranches of roughly £1m each:

- the 6 ‘quick wins’ (discussed at May’s Committee);
- the second £1 million is for recruitment and retention and an ‘emergency’ fund;
- and lastly, for frail elderly.

There will be some overlap between the tranches. Mr Small advised that propositions for frail elderly care will be considered further at a meeting on 16 June.

### 4.2 From 25 May Chair’s Group meeting

#### 4.2.1 End of life referrals to centre for integrative care

This relates to mistletoe therapy which is offered at the former Glasgow homeopathy hospital. It was felt by Chair’s Group that this should be a specialist, rather than GP, referral.

#### 4.2.2 Exercise Silver Swan - Pandemic Influenza

Dr Morton had previously asked the CH(C)P representatives whether they were planning to attend this national meeting in September. Drs Morton and Shishodia will review the arrangements to consider whether other representative groups should be approached.

**ACTION: CM/PS**

It was noted that a response has been received from Dr Alan McDevitt (SGPC Chair) regarding flu prophylaxis in care homes, and that he will be taking this forward in a meeting with Public Health later this week.

### 5. Medical Secretary’s Business

None.

### 6. Minutes of other committees / groups

#### 6.1 Primary Care Joint Management Group - 9 April 2015

Mr D Small reported that several recent committee sessions had been in private, to consider the medical practices currently in difficulty and requiring extra help. It was felt that it would be useful to know about these in terms of gauging the size of the problem, but also to see if lessons could be learnt - both in preventing future occurrences, and the best means of helping practices who needed it. There appeared to be no single factor causing practices to require help: often these were small to middle-sized practices where one or two adverse events led to a crisis. Commonly GP numbers were the crucial factor. It could then be difficult to recruit new staff, particularly when there are so many other Lothian practices with vacancies. Some felt a particular risk was when practice income had gone down: a GP leaving in that context could result in failure to recruit and a practice collapsing. It was acknowledged that many practices are working “closer to the edge” and difficulties can be readily compounded. The crucial step is to let the CHP and PCCO know as soon as a practice feels itself to be in difficulty, and some have alerted these bodies at very short
notice.

Dr Tucker had spoken to other boards and some (e.g. Forth Valley) had emergency measures including pharmacists, paramedics undertaking home visits and recognised escalation steps. Dr Bickler highlighted that governance structure was crucial, so that GPs are aware of what is available and when additional help should be sought. Developments are taking place to establish more standard approaches to the measures that can used to support practices. David White is taking much of that work forward, but all Partnerships have to work with their practices.

Dr Duncan outlined that in West Lothian a risk register has been developed, and that often the crucial factor did not relate to clinical care, but the ability to respond to a crisis. The difficult balance is between practices maintaining a ‘pure’ independent contractor status (without additional responsibilities) and supporting each other, possibly in clusters. There are new concepts emerging and these are not always widely shared, or agreed, and practices can be resistant to these until something goes wrong. It was suggested that more generally we are in a transition phase with a new environment and new approaches. Dr Reid outlined that Midlothian may be looking at risk scoring.

Dr Marshall outlined work being done at a UK level, with the development of resilience tools and ‘health checks’ for practices. There is great concern that, particularly as pensions and other conditions change, many more GPs will leave. It is crucial that practices are given correct advice from Board agencies, and he reported that this does not always happen. Such work relies on the LMC working with the Board, too.

There was a suggestion of having a crisis team to support those who were struggling, perhaps including GPs and Practice Managers, but the difficulty always was the shortage of the former. It was also felt important to get the balance right between maintaining failing practices (emergency measures) and supporting more widely the generality of practices (noting, too, that difficulties are not limited to Edinburgh). It was noted that in the recent LMC survey, 21 of responding practices were unable to fill vacancies.

Drs McDermott and Morton reported that at the recent UK LMC Conference there were reports of the ‘last man / woman standing’ scenario, whereby the single remaining partner became liable for the lease, redundancy payments and so on. In such situations, medical defense fees were being calculated at an individual level, reflecting the potential liabilities, but also crippling the GP. It had been thought that some practices were ‘too big to fail’, but this had not been the case in Chesterfield, where a 27,000 patient practice foundered, leaving a quarter of the town’s population without a GP.

Finally, there was some discussion of whether the Board was fully aware of these current and emerging risks, that the financial aspects were crucial and that these issues would be highlighted further at the Board meeting in June.

7. **Health and Social Care Partnerships**

Mr D Small advised that the Integrated Joint Boards (IJBs) in Edinburgh, East and Midlothian would be established by the 27 June, with West Lothian following a month or two later. East Lothian IJB is scheduled to hold its inaugural meeting on the 1 July, Edinburgh the second week in July, and Midlothian in August. All HSCPs are set to go live in April 2016, and will be tasked with taking forward the NHS Lothian Strategy. It was noted that the Health Board has appointed 3 professional health members to each IJB: the current CHP clinical director, the chief nurse, and a hospital clinician. East Lothian has also added a further non-voting GP member.

8. **GP follow-ups**

Following initial discussion at the May GP Sub-Committee, it had been agreed to reconsider this issue, when Dr Cook could be present. He subsequently sent apologies for this meeting, and Dr Morton proposed that she ask Dr David Farquharson to take this to the Medical Directors Group, which also has a wider secondary care membership. Dr Morton had
brought a file of letters sent to the Office so far in 2015, the recurring themes being: outpatient processes, prescribing (multiple issues), handling of results and letters, discharge summaries, work for pre-operative checks, and hospital colleagues asking GPs to perform a multitude of other tasks. GPs are now undertaking considerable secondary care work, and Professor Alex McMahon has suggested that Drs Cook, Farquharson and Morton meet to take this forward, and identify a system for dealing with this better (perhaps adopting the Borders system, with one central contact).

A Committee member stressed the need for this to be taken seriously, particularly the ever-increasing tendency to “just ask your GP…” It was noted that secondary care seemed to consider it acceptable practice to inform the patient of the results of their test(s) at their next hospital appointment, which may be several months away. It was noted that Urology was especially problematic with repeated problems round outpatient attendances, and examples of other ‘transferred’ workload outlined, collectively enormous. There is also a real problem of transmitting information through secondary care, faxes being just one example of this.

The Committee is aware of the need for a new generic approach and, if Lothian were to adopt the Borders model, this will require high level buy in. There was some discussion round involving Dr Caroline Whitworth in these discussions.

**ACTION:** CM

9. **General Practice Intervention Programme (GPIP)**

In Dr R Williams’ absence, full discussion of this item will be postponed to the next meeting. However, it was noted that GPIP involves a huge amount of money (around £4.5million) and that by, for instance, switching from capsules to tablets, etc, there are considerable savings to be made. Dr Cowan advised that GPIP has generated significant efficiency savings each year - and it wouldn’t be proposed if it didn’t work! It was suggested that there may be increased enthusiasm for GPIP in the East Lothian GP community if savings were redirected into pharmacy advice (for practices) and noted that active recruitment is ongoing in this area. Given the current GP recruitment crisis, a Committee member queried whether the GPIP changes cost less to do that the savings made. However, it was noted that GPIP is a funded activity which practices can choose to do or not, and that there were ways of undertaking this very efficiently and that much of the work could be done by other practice staff.

**ACTION:** CM

10. **Sleep Apnoea services**

Sleep apnoea had been discussed by the Committee earlier in 2015, after which Dr Morton fed back to Dr Ninian Hewitt that GPs would be happy to refer patients for smoking, obesity, alcohol management at the same time as a sleep apnoea referral, but that patients shouldn’t be denied access to treatment. It was noted that sleep apnoea treatment is only available in secondary care. A Committee member recounted that he had visited the clinic approximately 2 years ago, and felt that there were efficiencies which could be made to streamline the service. If the proposals were adopted, the Committee felt that the sleep apnoea service needs to write to patients to explain why they are unable to access treatment despite being referred by their GP. It was noted that the SIGN guidelines indicate the opposite to what is being recommended, and the comment was made that the Lothian proposals clearly redirect new work to GPs. Dr Morton summarised that there were several aspects of the proposal which were entirely unacceptable, particularly round denying patients effective treatment, and agreed to draft a response, which will be sent to Chair’s Group for comment.

**ACTION:** CM
11. **AOCB**

11.1 **Sexual health update**

Dr Duncan (GP representative on the Sexual Health Strategy Project Board Clinical Services Sub-group) had been asked to update the Committee regarding problems experienced with Chalmers Clinic. It was noted that Chalmers remains reluctant to remove genital warts but has now agreed to do so if these are large and uncomfortable. It may also help if such patients could provide proof (just a couple of lines on a SCI referral...) that they have seen their GP. Patients with warts do constitute the highest DNA rates of all at Chalmers.

It was confirmed that all those testing positive for gonorrhoea should be referred. The wrong phone number had been given out with test results, but this has now been corrected.

It was suggested that it would be useful to include this information in the weekly distribution from the PCCO. It was queried why the laboratories could not make a direct referral to Chalmers but Committee members felt uncomfortable with this in terms of patient consent, and that there was always the danger of patients falling through the net. Dr Lomas highlighted that this had happened with some post-menopausal bleeding referrals. Dr Morton has had discussions about this with Dr Gerry Beattie and the issue will be brought back to the next meeting.

**ACTION: CM**

11.2 **LBC 1936 Study**

Dr Shishodia has had sight of 2 letters regarding patients who have participated in the LBC 1936 Study being undertaken by the Wellcome Trust Clinical Research facility at the Royal Victoria Hospital. In both cases the patients were found to have low / borderline testosterone, and the research clinician requested that the GP repeat the test in a month’s time with a sample taken between 8am and 11am. It was queried who would follow up these results and commented that this is one of the difficulties with research studies, particularly as there is poor advice round these particular tests. Committee members suggested re-checking the clinical protocols round testosterone, particularly as the advice (available in PLIG guidance) was generally not to test asymptomatic individuals: testosterone levels fall with age. Dr Shishodia will feed back to the Department of Medicine for the Elderly on this. (An example of a low haemoglobin was also given but it was felt that there was not much option but for the GP to take this on)

**ACTION: PS**

12. **Date of next meeting** - Monday 10 August 2015, 7.30pm, Holiday Inn Edinburgh City West, 107 Queensferry Road, Edinburgh EH4 3HL

*(deadline for submission of papers - Monday 3 August 2015)*