Minutes of the Meeting of the GP Sub-Committee of the Lothian Area Medical Committee held at the Holiday Inn Edinburgh City West on 12 January 2015

Dr Catriona Morton in the Chair

Present - Drs Ashcroft, Balfour, Bickler, Black, Blake, Cowan, Crawford, Crookes, Donald, Duncan, Flynn, Gallagher, Mrs Grigor (minutes), Drs Haigh, Harkin, McDermott, Ms McNeillage, Drs McNutt, Marshall, Milne, Morrison, Morton, Philip, Shishodia, A Small, Mr D Small, Drs Tapsfield, Thomas, Turvill, N Williams, R Williams

Absents - Drs Bock, Cobbett, Cook, Fulton, Hardie, Mr Lawrie, Drs Reid, Tucker

1. Apologies - Drs Bock, Cobbett, Cook, Fulton, Hardie, Mr Lawrie, Drs Reid, Tucker

Presentation from David Small (Joint Director of Health and Social Care, East Lothian) on Integration Joint Boards and the East Lothian strategic plan (as an example)

Mr D Small gave 2 presentations:

Integration and the formation of Integrated Joint Boards (IJBs)

IJBs are currently being approved by Councils and the Health Board. The GP Sub-Committee will be asked to comment on draft plans, and July 2015 is the likely implementation date. There are 2 models, one in which either the Council or the Board is the ‘lead agency’ (Highland have adopted this), the other the ‘body corporate’ model, where there is equal representation from each - the IJB then develops strategic plans for all of its delegated functions. Lothian has adopted the ‘body corporate’ model and will have 4 IJBs. The IJB comprises elected councillors and Board members in equal numbers, with voting rights, and also non-voting members (including 2 doctors, including one practising GP). Each has a Strategic Planning Group which has much wider membership. The IJB receives budgets directly from the Health Board and Council to provide services agreed in the plan, but does not directly own premises or employ staff (except for the Chief Officer and Finance Officer). The possible delegated functions have been listed by Scottish Government and include: all independent contractor functions and health services, all non-acute hospitals (and some acute hospital services), all adult social care, with optional inclusion of Children’s Community Services and Criminal Justice Social Work. The HB remains the contracting body for GMS, but Primary Care services are then directed by the IJB and its Strategic Planning Board - GPs will therefore have a role in planning, as well as delivering, services. Edinburgh IJB will have 4 localities for GP involvement, whilst East, Mid- and West Lothian will each have a GP forum.

Mr D Small then answered some questions from Committee members and made the following points:

- GPs are non-voting members of the IJB, but the hope is that there will be consensus decision-making with all participants having an equal standing - without resorting to voting;
- It is anticipated that, at practice level, GPs will become gradually more involved in their localities, developing solutions to problems in each area, which may involve more local enhanced services and so on. Dr Bickler added that there should be a growing relationship between health and public services.
- Mr D Small emphasised that, if the resource was there and the criteria right, this could work in driving through the best sort of change. The trick would be to ensure involvement by GPs, despite their stress and workloads, with good representation at every level.
- He clarified that - for instance - health budgets could not be used for Council work but that financial risk sharing is necessary and legislated for. An example was given in East Lothian,
where investing in particular types of care beds may save health spend and the long term hope was for a ‘virtuous circle’.

Committee members were keen to maintain a person-centred approach and it was not clear how this could be managed with large budgets. Mr D Small responded that there were models for targeting investment to maintain this focus, an example being the ‘patient navigator system’ in Cumbria.

It was suggested that East Lothian is quite advanced in its planning, but some other areas (e.g. Edinburgh) still have unknown / unresolved problems.

**East Lothian HSCP Draft Strategic Plan**

This was presented as a working example, is currently out for consultation, and constantly changing in response to this. The ‘Strategic Plan’ is required by legislation and forms the blueprint for how the HSCP will shape and deliver services - to meet nationally-defined health and wellbeing outcomes. It forms an overarching strategic document for all services for which the Partnership is responsible. The planning process has included mapping of need (including future projections), morbidity and various other health-related outcomes, deprivation, identifying planning gaps, and considering how best to organise GP practices into appropriate clusters on this basis. The Plan includes much detail round health and social initiatives in the community (see [https://eastlothianconsultations.co.uk/](https://eastlothianconsultations.co.uk/) for full details).

Committee members highlighted that funds set aside for acute care, including A&E, meant that the necessary transfer of money from secondary to primary care would be made more difficult.

Dr Turvill described that 20 - 30% of frail elderly in hospital do not need to be there, and the problem was lack of alternatives. Examination of individual patients with high health care costs often revealed low levels of social care. The East Lothian proposal is to look at the top 10 users of services in each practice, as an initial focus for planning.

Another area of concern was simply the feasibility of this approach, noting the decade-long rising spends in secondary care, with poor day-to-day services in primary care. Some felt that the aspirations were not achievable, and that the evidence that such care was cheaper in the community was not there either. It was noted that a further 5 years of austerity is anticipated, that both the Board and Councils are overspent, and there is an ongoing expectation that additional work needs to be done in the community, with resources ‘catching up’.

Finally, it was commented that some high health spend patients who are not getting social care have refused it, and it was suggested that ‘Scott’, the Lothian ‘patient’ representing the elderly population should have this trait.

2. **Minutes of the last meeting held 8 December 2014**

The minutes of the meeting of 8 December 2014 were approved and signed by the Chair.

The following additional matter arising was discussed:

08/12/14 item 10 - ENT and Snoring

Dr Blake (Chair of Lothian Area Medical Committee) advised that, as requested at the last Committee, the AMC did discuss this issue, particularly with regards to mandibular splints. However, there was only one hospital specialist in attendance, though a good GP turnout, so the discussion very much reflected that of the GP Sub-Committee. This led to a wider discussion regarding specialities no longer wishing to see patients with certain conditions. The AMC has no qualms about NHS Lothian not providing - in this case mandibular splints - when there is no evidence base. However, RefHelp is more conservative and, under ‘coping strategies’, suggests their use. The Committee felt that GPs should be able to continue to refer patients to ENT for snoring. Dr Morton agreed to take this to the Out Patient Review Programme Board.

**ACTION: CM**
3. Matters Arising / Actions from last meeting

3.1 Withdrawal of free Occupational Health Services

The Committee considered a briefing sheet on Occupational Health Services written by Dr Chris Kalman (Director of Occupational Health Services, NHS Lothian). It emphasised the advantages of:

- an Occupational Health record for all staff - and that this ideally should not be maintained by an employer for ethical and governance reasons
- a pre-employment health assessment
- ‘health clearance’ procedures - necessary for those undertaking exposure-prone procedures
- maintenance of ‘clearance’ over time
- Occupational Health input for issues round fitness for work, planned return to work
- needlestick injuries.

Dr Morton had subsequently met Dr Kalman and Mr Alan Boyter (Director of Human Resources and Organisational Development, NHS Lothian) on the 11 December 2014. She emphasised again the Committee’s objections to the withdrawal of free Occupational Health Services for Lothian practices but that, if the changes were to go ahead, the preference would be for costings on the basis of practice size, rather than numbers of GPs. The free service was to be extended to the end of March 2015 to allow further negotiations to take place.

Dr Kalman stated that he felt the Lothian needlestick policy was the best in Scotland, but that it could not be offered to practices in isolation as it depended on Occupational Health having a record of the affected staff member’s vaccination and immunity history. Dr Morton indicated that some of this was ‘best practice’ and that it was up to GP practices (as small businesses) to identify the level of service that they wanted to pay for, and that many of the services on offer were not obligatory. It was noted that all practices need to have an internal needlestick procedure, and that staff can access A&E and Infectious Diseases, too, as required. Most needlestick incidents were in fact low risk and did not require intervention beyond the initial assessment.

There had been discussion too about charges GPs can make for Occupational Health reports (Dr Kalman had confirmed £27.15 was the nationally-agreed sum, but that NHS Lothian had since increased this to £36.00).

The Committee noted that the Primary Care Joint Management Group is currently discussing clearance for those joining the NHS Lothian Performer’s List, and Dr N Williams indicated that he would expect this service to be provided free by Occupational Health (many doctors have clearance earlier in their careers, or as medical students). Other aspects of the service will also be discussed at LMC, and Dr Morton will then feed back.

**ACTION: CM**

3.2 Faxes

It had been agreed that faxes were required by some secondary care and other departments as a safety net (including for business continuity). Dr Cook had explained that it was not possible to establish who had faxes in secondary care, and Ms McNeillage offered to ask Wilma Cameron (telephone department) if she is able to provide the information.

The Committee agreed a list of fax destinations it would consider essential, and considered that what was required was one secure fax for each destination, with no gaps, regular checking, and details easy to find on a directory. It was felt that not all of secondary care is aware that practices have retained fax machines, nor of the GP practice clinical email box system. It was also noted that West Lothian GPs no longer faxed referrals for terminations, but that the current mechanism was extremely bureaucratic and time-consuming: the ideal was a SCI referral system in common with the rest of Lothian. The Committee’s conclusions will be forwarded to Dr Cook.

**ACTION: CM**
3.3 Reports and respite medications
Mr D Small will make enquiries in Edinburgh with regards day centres requesting:
i) 6-monthly update reports from GPs, and ii) medications afresh for each respite admission.

ACTION: DS

3.4 Clostridium difficile infection
The Committee noted that an article on *C. difficile* had been included on the front page of the latest issue of the ‘Lothian Prescribing Bulletin’. Dr Cook has advised that there is to be new guidance regarding the ‘4C’ antibiotics, and will keep the Committee informed.

ACTION: BC

Dr Simon Hurding (Medicines Management Adviser, NHS Lothian) had looked at some additional co-amoxiclav prescribing data (in PRISMS) to try and identify whether there were longer courses being prescribed in Lothian. One measure is DDD/item, with an expected value of around 7. [DDD = defined daily dose] This is the case for most Boards, but 3 Boards are higher including Lothian (9), implying courses of a longer duration. Dr Hurding is keen to hear examples, which can be emailed to him at Simon.Hurding@nhslothian.scot.nhs.uk.

There was further discussion of requests for forms to be completed. This was felt to be acceptable in severe cases and deaths but not for every case. Committee members agreed and one commented that it had taken 20 minutes to complete the form.

3.5 Oxygen supplies for emergency use in practices
Some LMCs elsewhere do provide funding or oxygen directly to practices. Ms McNeillage has stated she has no obvious funding stream for this. It was suggested that we need to establish the scale of need.

ACTION: PS

3.6 Presentation to the Board of NHS Lothian
Committee members were thanked for their feedback, and various changes to the workshop specified by the Board were discussed.

3.7 LUCS Review - DRAFT response
Committee considered a draft response which highlighted:
- that the service was run on a minimal budget (the cheapest in Scotland) and this particularly applied to funding of management posts
- that we had already fed back on other potential options to support Mid- and East Lothian sites and these were reiterated
- the need to adequately expand in anticipation of future demographic change
- support (with some further suggestions) for encouraging GP recruitment, improving safety and effectiveness, and integration
- that PLT should be supported and that GP practices would not start undertaking out-of-hours care again as this related to our national contract.

There was some discussion of the negative impact of appraisal / revalidation on GP decisions round retirement, with various views as to how much of a factor this was. Dr N Williams outlined that LUCS do support the process with treatment analyses, performance and referral reviews. There might be scope for further development of this. It was noted that another hurdle was the additional medical defence organisation payments required (a national issue).

The response will be amended and sent to Dr Tucker.

ACTION: CM

It was noted by Committee that over the festive break (Christmas and New Year), LUCS had managed 8,240 patient contacts (compared with 4,550 in A&E), with the 2 January 2015 being the busiest day ever recorded.
3.8 **Eye Pavilion - Acute Eye Referral Service**
Dr Ian Dickson (South Central Edinburgh GP) had designed a SurveyMonkey questionnaire on the Eye Pavilion Acute Eye Referral Service which was disseminated to all GPs in Lothian, with the maximal 100 responses being received very quickly. Overall, it would appear that GPs use the service 4 to 7 times a year, with two thirds of patients receiving a same- or next-day appointment at PAEP. Over 50% of those that responded are happy with the service but a small number are not. Dr Hilary Devlin (Consultant Ophthalmologist, NHS Lothian) will discuss the survey feedback with her PAEP colleagues, Dr Jas Singh (Clinical Director), Gemma Cousar (Service Manager) and nursing colleagues.

3.8.1 **Optometry Services**
On a separate but related issue, Ms McNeillage advised the Committee that following the presentation by Kevin Wallace (Optometric Advisor, NHS Lothian and Borders) to Committee last March, the Eyecare Integration Project was launched in December in North West Edinburgh. Posters and publicity materials for GP practices and optometrists are being designed. This is currently a pilot, and Ms McNeillage agreed to forward information on this to both Drs Morton and Turvill.

**ACTION: AMcNe**

3.9 **Sponsorship of monthly meetings**
As noted at the last meeting, it had been possible that Pfizer would be unable to continue sponsoring monthly Committee meetings. However, funding has now been identified and GP Sub / LMC meetings will continue to be held at the Holiday Inn Edinburgh City West for the remainder of 2015. [As a one-off, the LMC will pay for the January meeting] It was suggested that a thank you be sent to the Pfizer representatives for their support over the years. Pfizer have also requested a better idea of catering numbers: the LMC Office will consider how to gather this information from Committee members.

**ACTION: LMC Office**
It was, however, noted that the hotel is informed of numbers prior to each meeting and so any such catering requests / refusals will not be set in stone.

4. **Chair’s Business, and Medical Secretary’s Business**
It was noted that there was no Chair’s Group meeting in December due to the festive period.

4.1 **08/01/15 meeting with Tim Davison and Alex McMahon**
Drs Morton and Shishodia had met with Mr Davison and Prof McMahon, but discussion was entirely about the 14 January presentation to the Board and so it is not yet known what will happen to the £40million from the Scottish Government.

5. **Minutes of other committees / groups**

5.1 **Primary Care Joint Management Group - 13 November 2014**
The above minutes were circulated with the agenda papers for information / exception reporting and were received by Committee. It was noted that domiciliary phlebotomy figures are to be tabled at the next PCJMG meeting, and Mr D Small will query whether there is the right capacity for domiciliary phlebotomy with regards Health Care Assistants, and governance about what they can, and cannot, do.

6. **Health and Social Care Partnerships**
HSCPs were already discussed during Mr D Small’s presentations (*see pages 1 and 2 above*).
7. **GIRFEC Pathways Workshop - Tuesday 3 February, 9.30am to 1pm in The Library, Quaker Meeting House, Victoria Terrace, Edinburgh**

A Committee representative is required to attend this workshop, although locum reimbursement funding has yet to be confirmed. The ‘named person’ initiative will also be discussed at the workshop. Any Committee member interested in attending was asked to let the LMC Office know.

**ACTION: ALL**

8. **Immediate Discharge Letter**

A copy of the Immediate Discharge Letter GP Survey feedback (prepared by Dr M Luke Beagan, December 2014) was circulated with the agenda papers for information. This feedback had already been sent to Dr Cook and Dr David Farquharson (Medical Director, NHS Lothian), and is to be discussed at the February Medical Directors Meeting. The feedback is very lengthy, and will perhaps be shortened before it is sent out to Lothian GPs, although some may wish to view the complete survey?

Dr Beagan had collated the results but had not drawn conclusions: it was noted that Dr Farquharson is very keen to take this forward.

Dr Bickler advised that the reason this had come through Committee is that there is no home for this type of work and so it had been piggy-backed onto the eHealth pathway. Dr Morton confirmed that Dr Farquharson and Miss Tracey Gillies had asked for the survey to be undertaken.

9. **Flu vaccinations for housebound**

The Committee noted that there has been some reaction from practices regarding the recent letter re ‘mop up’ of influenza vaccinations for housebound patients, and frustration that this has come at the tail end of the vaccination programme. There are also payment issues.

Dr Cowan advised that it was clearly stated in a letter in June that the community teams would be involved in vaccinating all primary school children, and that, having completed this programme, might have some spare capacity, and the recent letter reflected that. There was no way of knowing at the beginning of the programme how long this would take.

Patricia McIntosh (Clinical Nurse Manager, NHS Lothian) had advised that, in other parts of Scotland, community nurses administer all housebound flu vaccinations.

Dr Cowan confirmed that practices are not obliged to participate in this ‘mop up’ exercise, and suggested that perhaps practices take a stand with Public Health, the Board, etc. Others felt that this year might be the ideal time to do this, and that it is not part of the GP contract. Dr Cowan will feed this back.

**ACTION: JC**

Dr Bickler suggested that the way forward is to have a comprehensive service for treatment at home.

Dr Marshall mentioned a letter received today suggesting that, where there are clusters of flu cases in nursing homes, all other patients in the home be given oseltamivir. It was, however, noted that 10% of patients given the drug will experience side effects so this has huge implications, particularly when there is no evidence for its use in this way.

Dr Duncan reported that Dr Tucker (LUCS) had been called in to swab entire nursing homes, e.g. 50 people, and felt that there should be Public Health staff available when this is required. Dr Haigh queried Public Health recommending administration of oseltamivir despite what was seen in the Cochrane Review: there is advice for community staff but the only evidence relates to secondary care.
10. **DRAFT 09/10/14 PLIG minutes**
A copy of the draft 09/10/14 PLIG minutes was circulated with the agenda papers for information. Dr McDermott advised that the faecal calprotectin pilot in primary care will be going ahead. It was also noted that any problems/issues with GP Order Comms are being taken forward through PLIG, although unfortunately the labs can’t readily add secondary care details on GP Order Comms (for bloods GPs do on their behalf). Dr Crawford commented that sometimes clinical details are entered which don’t then come back with the results. Dr Morton advised that this is a known glitch and has already been fed back.

11. **AOCB**

11.1 **DEXA scans**
The Committee was informed that 17% of osteoporosis diagnoses are missed by DEXA scans, and that advice in RefHelp currently differs from Lothian Joint Formulary recommendations. It was queried whether this has been done elsewhere, or if Lothian is a first? Dr Shishodia advised that this is not national, and Dr Morton added that Professor Stuart Ralston (ARC Professor of Rheumatology, WGH) is Chair of the SIGN guideline group for osteoporosis.

11.2 **GP Order Comms / procurement of labels**
Dr Balfour advised Committee that practices can only order 6 rolls of labels at a time from Procurement, which is an inadequate supply for larger practices. Such restrictions used to be the case for prescription pads but should not apply when ordering labels. Ms McNeillage agreed to ask Craig Horn in Supplies about this.

**ACTION: AMcNe**

11.3 **Western General Hospital**
Dr Balfour briefly updated the Committee on the new admission and assessment processes at the WGH. This is a 700-bed hospital which receives 70 - 100 admissions a day. If a patient is at the ARU (Acute Receiving Unit) before 1pm, there is a 20% chance of admission - if seen after 8pm, this increases to 85%. There is now a 10-bed surgical unit where a surgeon is based all the time. There is also possibly going to be a frailty unit. When phoning Bed Bureau (or the WGH directly), GPs are to be asked whether it would be helpful to speak to a Consultant, and there are other new assessment options, too. The WGH unit will accept responsibility for organising transport where required. Dr Balfour is currently in negotiation with the ambulance service, and, in addition, the WGH has contract taxis and its own ambulance. Email correspondence on the new service was sent to all practices on the 7 January 2015.

Dr Balfour advised that a February PLT has been arranged where Dr Dave Caesar (Clinical Director of Emergency Medicine at the Royal Infirmary of Edinburgh; and Clinical Director, WGH) and colleagues will present during the first half, and the second half will relate to Rheumatology and Urology ‘open door’ access, where patients are seen quicker and better and so are less likely to be admitted.

Dr Turvill advised that Dr David Farquharson (Medical Director, NHS Lothian) will add Rheumatology and Urology to the next Medical Director’s Meeting agenda, because of other clinical governance issues.

12. **Date of next meeting** - Monday 9 February 2015, 7.30pm, Holiday Inn Edinburgh City West, 107 Queensferry Road, Edinburgh EH4 3HL

(*deadline for submission of papers - Monday 2 February 2015*)