Minutes of the Meeting of the GP Sub-Committee of the Lothian Area Medical Committee held at the Novotel Edinburgh Park Hotel on 9 May 2016

Dr Catriona Morton in the Chair

Present - Drs Ashcroft, Balfour, Black, Blake, Cobbett, Cowan, Crookes, Flynn, Fulton, Gallagher (from item 3.4), Graham (observer), Mrs Grigor (minutes), Drs Haigh, Hill, Ms Horne, Dr McDermott, Ms McNeillage, Drs Morrison, Morton, Philip, Reid, Sengupta, Shishodia, A Small, Thomas

Welcome
The Chair welcomed Dr Ann Graham, GP Registrar at Firrhill Medical Practice in South West Edinburgh, who was attending the meeting as an observer.

1. Apologies
- Drs Bickler, Captieux, Cook, Donald, Duncan, Hardie, Lomas, Marshall, Mr D Small, Drs Tucker, Turvill, N Williams, R Williams
- Absent - Dr Lints

2. Minutes of the last meeting held 11 April 2016
Subject to the following amendments, the minutes of the meeting of 11 April 2016 were approved and signed by the Chair:

- The first sentence under ‘Nurse Verification of Expected Death’ (page 2) to be replaced with “Ms Ireland explained that a revised policy and procedure had been approved in December 2015 and that GP-signed forms for this were no longer required under a new Lothian policy. The requirement now is for there to have been a multidisciplinary conversation and for the decision to be recorded in the patient record”.
- Slight amendment of the wording of item 3.2 ‘Area Clinical Forum representative’ (page 4) with regards ongoing GP Sub-Committee involvement with / representation on the ACF.

3. Matters Arising / Actions from last meeting

The following additional matter arising was discussed:

11/04/16 item 8 - 22/09/15 Data Sharing Partnership minutes
At the last meeting there was discussion of the Fire and Rescue Staff review of fatalities following fires, aiming to address the needs of the vulnerable population. Since then there has been further debate on the Scottish LMC Secretaries ListServer: in another Health Board, staff from the Fire service can be invited to be in attendance at GP practices when flu clinics are taking place - giving them an opportunity to speak to vulnerable patients at the same time. Dr Gallagher agreed to feed this back.

ACTION: JG

3.1 Nurse review meeting - Monday 23 May
The Committee was informed of this important meeting: unfortunately it is taking place on a Monday thereby precluding many GPs from attending. It was noted that Drs Bickler and Cowan will be going, and possibly Dr Morton if she can secure locum cover.

3.2 Nurse verification of expected death
This issue was discussed at the last meeting, when Committee members had not had sight of the up-to-date document. Fiona Ireland (Deputy Director, Corporate Nursing, NHS Lothian) has advised that, as Chair of the Clinical Policy Committee, she has made contact with the authors of the policy regarding the implementation and communication of the revised
document. She is also meeting with the Royal College of Nursing later this month. She has apologised for omitting the GP Sub-Committee in the communication round the development of this document, which is now established NHS Lothian policy. The document was felt to be a major improvement over the previous policy, but it seems that many District Nurses still don’t appear to know about it!

The Committee indicated that there are too many provisos round verifying a “sudden” death, which is often not suspicious, and examples have been requested. The Committee also noted that the guidance states that, if a registered nurse is not available, another suitably qualified professional should attend: clarification is required that this should be another nurse in the first instance, and not automatically default to the GP.

Section 4.1 outlines that the process applies when death is “imminent” and then requires 6-monthly reviews if the patient is still alive at that time. However - as an example - in advanced end stage dementia, death is to be expected, but the timing is not always predictable and death not necessarily ‘imminent’. The Scottish guidance (page 5) is that expected deaths are defined as those “occurring at a stage in the patient’s disease process at which death is inevitable and no active treatment is planned or appropriate”, and does not mention a timescale. It was suggested this would be a useful phrase to be added to the KIS-ACP. It was commented that death is always ‘sudden’! - but that did not equate with suspicious - and felt that care should be taken round the terminology used.

Dr Reid advised that Dr Tucker is very concerned as this disproportionately affects out-of-hours working, and it was noted that the final statement in the flowchart in Appendix 4 indicated that the death could be notified via LUCS, rather than the practice when it was next open. The Committee’s concerns will be fed back.

**ACTION: CM**

### 3.3 Diabetes LES

A letter had been sent to all practices from the LMC, outlining the Committee’s recommendations, namely that, as the Diabetes LES resource has been withdrawn, GPs revert to referring their patients with new-onset Type 2 Diabetes to secondary care for initial assessment. Feedback had been received in the Office: some practices were electing to continue to refer but they, and some others, had also written to NHS Lothian expressing their dismay at the decision. There are to be ongoing talks. Both Drs Nicola Zammitt (Diabetes MCN Lead Consultant) and David Farquharson (Medical Director) had agreed that the ideal place for this diabetes work to be done was in General Practice - but that the resource needed to be provided too. A small group has been convened, and an LMC representative invited to join.

Dr Shishodia had received a letter from a Diabetologist indicating that a patient he had referred would not be seen: it seems that many of the Diabetologists are unaware of the new situation in Lothian. Dr Haigh reported that this had now been discussed at the West Lothian Interface Group, so that relevant staff at St John’s would now be aware. It was agreed that Dr Zammitt would be contacted to ask how others were being informed.

**ACTION: CM**

### 3.4 Area Clinical Forum representative

Dr Blake had raised this previously as the ACF is reviewing its constitution and he indicated that the GP Sub-Committee would be concerned if not included. It has been agreed that the ACF Chair will be a GP, and the Vice Chair a Consultant - or vice versa - and this was felt to be acceptable. Dr Morton has now reviewed previous minutes and noted that many of the issues (physiotherapy, pharmacy, IT governance and eHealth, HSCPs, nursing, laboratories, GIRFEC, and nurse revalidation) are now covered at the Medical Directors Group, or other
meetings that Committee members attend. It was noted that when the ACF was first convened, the GP Sub-Committee didn’t have representation. Dr Morton suggested that she, Drs Morrison and Shishodia discuss this further to determine whether the Committee retain a place in case of no alternative representation, or request a caveat that GP representation be revisited if there is no GP on the Board.

**ACTION: CM/PS/IM**

### 3.5 11/02/16 PCJMG - patients’ sharps disposal / collection

As noted at the last meeting, Ms McNeillage had been working towards a solution which would ensure no additional work for GPs. However, she has since been in touch with Danny Gillan (Head of Soft Facilities Management, NHS Lothian) who advised that the necessary funding stream had not been identified (an initial estimate of £30K) and, therefore, was unable to take this any further forward.

It was thought that whoever supplied the sharps to patients should also offer a disposal service (the previous GP Sub-Committee position on this), and it was suggested that this was perhaps something for cluster groups or localities to progress.

### 4. Chair’s Business

#### 4.1 List of current members / responsibilities

It was noted that Dr Ashcroft, GP Retainer Representative, will be leaving the Committee as her Practice retainership post comes to an end. Dr Morton noted that she had undertaken a great deal of excellent work for the Committee, contributing to meetings and undertaking the NHS Lothian MSK work. She is also the GP representative for the Rheumatology RefHelp guidance: the draft version of this is about to be considered by the Committee but was felt to be excellent and very clear. Dr Ashcroft had previously undertaken work for PLIG (Primary Care Laboratory Interface Group), where she had also made an invaluable contribution, particularly in the development of Immunology and LFT guidance. Dr Ashcroft was thanked for all her work and wished the best for the future. It was highlighted that the move from CHPs to HSCPs may have resulted in further changes and Committee members were asked to inform the Office of these, and any other amendments.

**ACTION: ALL**

It was also noted that the POCT (Point of Care Testing) group now has a GP representative who does not sit on Committee, namely Dr Shelagh Stewart, GP Partner at Prestonpans Group Practice. [The POCT group feeds back to PLIG] A request for a Diabetes MCN GP lead was listed in error - this post is to be advertised by NHS Lothian in due course. An updated list will be circulated to Committee following the next round of change.

**ACTION: LMC Office**

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

##### 4.2.1 IJB presentation - what and who and when

There was further discussion of the proposal to meet with IJB and HSCP leads, and the suggestion was to base a presentation on that given to the Board in January 2015, but with an update of the current state of play of Lothian General Practice.

Dr Morton is meeting with Eibhlin McHugh (Midlothian HSCP) tomorrow (10 April), and has contacted Rob McCulloch-Graham (Edinburgh HSCP) and Mr D Small (East Lothian HSCP) to propose a meeting. Any Committee members would be very welcome to attend, and an invitation will be sent out once the date has been confirmed. She also offered to separately meet interested leads from West Lothian HSCP.

**ACTION: LMC Office**
4.2.2 Primary Care Transformation Fund (PCTF)
The bids for this fund had had to be submitted within a very short timescale. The suggestion was to pull together ideas for change that colleagues have had over the past 2 to 3 years and develop a list of Committee priorities, so that a ‘package’ of preferred options was available should there be future requests for such proposals. Dr Black advised that bids were received from all over Scotland, and that replies / feedback should be sent to bidders shortly. He felt there was an opportunity for the Committee to influence submissions. The next step is for the Board to have further dialogue.

4.2.3 Rheumatology RefHelp work
Dr Ashcroft had sent the Office the new Rheumatology RefHelp section - updated following discussion with Professor Stuart Ralston, Consultant Rheumatologist - and Dr Morrison had reviewed the pages and tracked some changes. It was generally thought that the documents were clear and straightforward and it was agreed that these would be sent to Committee members for further review.

ACTION: ALL
It was commented that GPs receive no indication that RefHelp sections have been updated, and queried who was responsible for this. Dr Morrison agreed to inform practices on this occasion.

ACTION: IM
It was also suggested that, in future, the authors of updated RefHelp sections write a short summary at the end of each workstream for inclusion in ‘GPs Only’.

4.2.4 Also discussed - for information only:
• Discussion with Drs Tricia Donald and John Steyn re Primary Care workload - data extraction / analysis proposal, and analysis of SPARRA / QOF discrepancies in disease registers.
  In Dr Donald’s absence, this item was deferred until the next meeting.

ACTION: LMC Office

5. Medical Secretary’s Business

5.1 New LMC Office Bearer - Iain Morrison
Dr Morrison was congratulated on his appointment as LMC Medical Secretary, and welcomed as an Office Bearer.

5.2 GP Sub-Committee / LMC Office premises
Dr Shishodia had been informed that Pentland House staff are to move to Waverley Gate. Ms McNeillage confirmed this but advised that the proposal will have to go through several Committees first. As previously indicated, the GP Sub Committee / LMC Office is to be relocated to NHS premises, and it is unknown how this proposal will affect such a move. The Office Bearers are in touch with Alex McMahon (Director of Strategic Planning, Performance Reporting and Information, NHS Lothian) on this, and discussions have been underway since last summer.

6. Minutes of other committees / groups
None.
7. **Health and Social Care Partnerships / Integrated Joint Boards**
   It was noted that Edinburgh GPs had twice been invited to a meeting at very short notice which had provoked considerable feedback. There had, however, been some miscommunication as 2 GP representatives across the whole of Edinburgh had been invited to a hub learning event, as opposed to 2 reps per practice! The email migration was cited as being part of the reason for the delay in the invitation going out.

8. **SEA recommendations**
   In Dr N Williams’ absence, this item was deferred until the next meeting.
   
   **ACTION:** LMC Office

9. **Lothian Interface Group (LIG)**
   Drs Morton, Morrison and Small had attended the first LIG meeting on the 13 April, which had been very productive and interesting with a wide variety of people round the table. The group membership had been specifically selected, and LIG is funded by Professor Alex McMahon (Director of Strategic Planning, Performance Reporting and Information, NHS Lothian). This initial meeting had focussed on what the group was trying to achieve, and a list of potential workstreams was drawn up. The group was to consider what might be the top ten areas but agreed that communication is an over-riding issue to focus on initially.
   A few ‘quick wins’ had been identified, e.g. updating the contact details on all secondary care templates to include email addresses and phone numbers, exploration of the potential to use SCI Gateway differently (e.g. including clinical inbox email addresses automatically), and so on. It appeared that many secondary care clinicians were unaware that their existing template letter does not always include basic information such as contact phone numbers.
   Dr David Farquharson (NHS Lothian Medical Director, and LIG Co-Chair (with Dr Carey Lunan)) indicated that LIG needed to change things and ought to cease if it was unsuccessful in this. It has also been agreed that LIG minutes will come to the GP Sub-Committee, and it was suggested that a timeline be added to any resulting actions.
   One Committee member advised that, on returning from annual leave, a one-day survey identified that 35 of the 130 Docmans he had received had been sent to the wrong doctor.
   In terms of patient safety, it was suggested that there be a box at the top of ALL clinic / discharge / outpatient letters with 3 mandatory fields: diagnosis, recommended treatment, and other arrangements (including what the patient has been advised, scripts, follow up, and so on). It had also been suggested that there is a need to use plain English, and reduce the high usage of acronyms in correspondence.
   It was suggested that any results be listed in alphabetical order to make them easier to find; Dr Farquharson was also keen to know why patients don’t receive a copy of their results - it is often unclear whether a patient has been informed of them or not.
   NHS Lothian had been asked about discharge letters from the Princess Alexandra Eye Pavilion, and the perceived poor quality of some of these has been fed back very strongly to the Scottish Government.
   A Committee member commented that, in his experience, the standard of psychiatry letters in West Lothian is excellent, and suggested that this reflects the training junior doctors receive, i.e. good practice on a ‘top down’ basis.

10. **OPD bloods**
   Dr Morton had discussed a scenario with Dr James McCallum (Associate Medical Director, St John’s Hospital) whereby a patient of hers had been referred to Maxillofacial at St John’s and, whilst at the clinic, had been told to go to their GP for bloods. Dr McCallum had felt that this was not unreasonable, so Dr Morton agreed to seek the Committee view.
It was agreed that General Practice is not a phlebotomy service for hospitals, despite any such perception, and this has already been fed back strongly. It was considered that this applied particularly in this case when the patient was actually at the clinic and then had to attend the practice subsequently. However, it was considered that a bigger burden is the interpretation of the test results and any follow up, and not just the blood-taking itself. It was suggested that use of the van service in such instances also be extrapolated to demonstrate the enormous costs of the overall service. Dr Morton will feed back the Committee’s views.

**ACTION: CM**

11. **PLIG**

There had been a very lengthy PLIG meeting in April, and Dr McDermott will discuss the minutes of that formally at the June meeting.

In order that the Committee was kept abreast of potential developments, the following brief summary was outlined:

- Dr Charu Chopra has started as a new Lothian Immunology Consultant at the RIE, and it was felt that she will provide a very valuable contribution in this area.
- HbA1c may be rolled out very cautiously for diabetes diagnosis - NOT as a first line test but, if initial blood sugar is borderline, to avoid an oral glucose tolerance test. The laboratories have significant worries about the cost implications.
- POCT - A new group has been established with a GP representative, Dr Shelagh Stewart as mentioned above (see item 4.1). The group hopes to support near patient testing in primary care - perhaps initially largely round INRs - but potentially many other tests in the future too. The group will report to PLIG.
- There may be a case for the further rolling out of faecal calprotectin testing in Primary Care, following the initial pilot.
- Review of phoning limits for abnormal results - a proposal to accept stricter ones recommended by the Royal College of Pathologists.
- GPOC / ICE - there are multiple issues around the screen format and content with much room for rationalisation. Dr Morton had met with Carol Thompson, Laboratory IM&T Manager, and some changes have now been made. One example is CKD where the previous screens automatically tested for calcium, albumin and a FBC (possibly more a requirement for renal failure or severe disease than ‘mild’ CKD). Some DMARD screens had too many tests. Overall this revision should result in fewer results coming to practices so should help with workload. This will be discussed further and there is to be an update at the Safety SESP meeting on 31 May.

12. **FGM**

This had previously been considered by the Committee and a response sent to Dr Susan Kidd (Consultant Paediatrician) who is developing the Lothian guidance. She and Dr Morton had subsequently had a long telephone conversation to discuss the proposed Lothian guidance and that which had been issued nationally in the interim. It was noted that the Scottish Guidance did not have a GP on the SLWG and Dr Kidd reported, no clinician with direct experience in this area (including the writing of the national flow charts which were very simple compared with Lothian’s). Dr Kidd had sent revised guidance including flow charts (which are detailed, but felt necessary to capture all the potential individual scenarios, thereby leaving no doubt as to what to do in each situation), an updated protocol and a 2 page summary for Primary Care. The original documents had also been amended to make it clear that GPs were NOT expected to complete the risk assessment document, but might find it useful as a resource. Dr Morton also reported that there had been 2 new cases of FGM in Lothian girls since this was last discussed.

Committee members still had major reservations: that the documentation was still wordy,
that it was unrealistic for GPs to take this on, and that expecting them to do so also reflected
an unrealistic view of General Practice, when GPs have no access to maternity notes and
travel clinics are often not run by GPs. It was noted that GPs are not ‘allowed’ to code
someone as a sex offender in the GP record and felt unrealistic for practices to add or
remove a variety of codes relating to FGM. The guidance encourages practitioners not to
use loaded or offensive language, but also to code using terms like ‘mutilation’. There have
to be concerns round such codes being inadvertently made available to others. It was noted
that the coding recommendations had come from the national (Scottish) guidance. Others
felt that multiple links in a document wouldn’t work when information needed to be
immediately apparent, and not too lengthy.
It was remarked that this is a national (UK) issue and that awareness was needed, but that
this disproportionately affected small pockets of the population. A Committee member
recounted her previous experience of working in London where dealing with FGM was seen
as much more commonplace, and conversations round it essentially ‘normalised’. There
was considerable support for a single point of access (a phone number) to a specialist who
could then either give advice or take over the case as appropriate. It was felt that the
pathway needed to be absolutely simple: another Committee member related the experience
of a practice colleague who had written an SEA following a discussion about FGM with a
patient who had undergone the procedure. It had been difficult to manage, and required
calls to the on call paediatrician and Social Services. After much investigation it was felt
that the children in the family were not at risk.
It was recognised that it is difficult to strike a balance between not policing or
‘criminalising’ ordinary people and - what the non-medical specialists advocate - being
prepared to cast a net wide and not assume that FGM will not be present, a factor in the low
pickup of cases.
Finally, there was some opposition to the concept of ‘safeguarding’, e.g. undertaking checks
for families travelling to high prevalence area in the anticipation that FGM might take place.
It was felt that - again - GPs were being asked to police a societal issue. However, the
alternative view is that this guidance protects GPs (and patients) too as they may be seen as
having a liability where FGM was a real possibility for a girl travelling to an affected
community.
Dr Morton suggested contacting the Scottish GP Committee as this was also a national issue
and it appeared that they had not been involved in these discussions, and will also feed back
to Dr Kidd.

**ACTION: CM**

13. **AOCB**

13.1 **District Nurse assessment documentation for domiciliary visits**
Dr Flynn reported that community nurse teams have to complete extensive assessment
documentation, which can take up to 1 hour for even a simple housecall requiring
15 minutes of clinical work. [The documentation has to be partially written in the patient’s
home, and the nurses then input the rest onto the computer at their base]
Dr Morton agreed to obtain a copy of the documentation and to ask that this be discussed at
the Nurse Review meeting on Monday 23 May (see item 3.1 above).

**ACTION: CM**

13.2 **Steve Faulkner’s retirals**
Committee members noted that Steve Faulkner (Primary Care Contracts Manager, NHS
Lothian PCCO) will be retiring this Thursday 12 May. The Committee view is that
Mr Faulkner has been a loyal friend of General Practice and Primary Care, and has worked
very hard over the years. He will be a big loss and is not going to be easy to replace. He
was incredibly helpful and always supportive of general practice.
Mr Faulkner will be presented with a cheque for £465 (from the retirement collection co-ordinated by the GP Sub-Committee / LMC Office) and a number of cards from practices at a meeting on Thursday afternoon.

14. **Date of next meeting** - Monday 13 June 2016, 7.30pm, Novotel Edinburgh Park Hotel, 15 Lochside Avenue, Edinburgh EH12 9DJ
   *(deadline for submission of papers - Monday 6 June 2016)*