

**MINUTES OF THE SCRUTINY REVIEW - ACCESS TO PRIMARY HEALTHCARE FOR PEOPLE WITH LEARNING DISABILITIES**  
**TUESDAY, 9 JANUARY 2007**

Councillors \*Jones (Chair), \*Dogus, \*Oatway, \*Whyte and \*Wilson

\* Member present

Also present: Dr. Sherman

**LC36. APOLOGIES FOR ABSENCE**

None.

**LC37. URGENT BUSINESS**

None.

**LC38. DECLARATIONS OF INTEREST**

None.

**LC39. MINUTES**

It was agreed that consideration of the minutes of the meeting of 11 December would be deferred until the next meeting.

**LC40. IMPROVING ACCESS TO PRIMARY HEALTHCARE FOR PEOPLE WITH PMLD - FURTHER EVIDENCE FROM STAKEHOLDERS**

The Panel received evidence from Dr. Sherman, a local GP. He had practiced in the Bounds Green area for 20 years. His interest in learning disability (LD) issues arose from the role that he had as a clinical assistant at the Edwards Drive respite care centre. Although the unit was intended to provide just respite care, there were some clients who lived there permanently. When long stay hospitals had closed down, patients were brought back into the Borough and some families were unable to cope and some of these patients had been accommodated in the centre. Some of them had developed dementia, which was common amongst older people with LD. In some cases, there was now minimal contact with their respective families.

There was one other GP who took a particular interest in LD and this was Dr. Mary Phimester who was located in the south of the Borough. She had been scheduled to also speak to the Panel but had unfortunately been unable to attend.

GPs did not receive any specific guidance or training on LD issues. The provision of appropriate user friendly guidance by the PCT would assist them. GPs had received local guidelines on other issues from the PCT and were open to such advice. He found working with patients with LD to be a rewarding experience but it could sometimes require some specialist knowledge. There had been a specialist consultant linked to the Learning Disabilities Partnership who could be referred to. One particular additional method of sharing best practice and advice would be through the collaborative clusters of GP practices that existed within the Borough.

GPs had limited amounts of time to undertake learning. They were now subject to appraisal and this had a particular educational component. In addition, the Quality and Outcomes Framework now had some reference to LD within it. One possibility

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would be for specific GPs within practices to adopt particular specialisms but this was only feasible in the larger practices. However, all GPs generally dealt with people with LD and he felt that this was beneficial as it helped to develop their overall awareness. Some patients with LD could become very attached to specific health professionals and in such circumstances it would be better if they saw the same GP. Efforts were normally made to ensure that this was possible.

As far as he knew, LD was not currently an integral part of doctors training – he was not aware of any specific modules relating to it although it might be referred to as part of the mental health component. Generally speaking, whether patients with LD were able to access a GP with particular relevant knowledge was something of a lottery.

The majority of GP practices did not undertake any special measures to accommodate people with LD. GPs did not always know which of their patients had LD and it was often up to receptionists to identify them from their behaviour. Their role was key to how people with LD/PMLD were dealt with within practices. The Practice Managers Forum would therefore provide a useful and effective route for delivering training, developing awareness and sharing good practice.

There was currently no specific responsibility for GPs to routinely review the health of people with LDs, unlike the situation with mental health patients. People with LD normally attended surgery with their carers or an advocate. It was generally a matter of judgement whether to address the carer/advocate or the patient but most GPs tried to at least include the patient in the discussion. However, if GPs were pressed for time they could sometimes just communicate with the care/advocate. Whilst carers/advocates could often simplify the consultation, they could sometimes also complicate it.

It would not be easy for surgeries to give people with LD early appointments as these were normally under heavy demand from commuters. Older people and the under 5's were normally given priority. If another group of patients were added to this list, this could lead to longer waiting times for other patients. There were frequently complaints about long waits.

The Panel felt that special arrangements to accommodate patients with LD should be a matter for local discretion so that local conditions could be taken into account. One possibility would be to set particular times for such patients in less busy periods. One possible way of accommodate the range of health needs of people with LD would be to hold multi disciplinary sessions for people where they could access a range of healthcare such as chiropody, physiotherapy and dietary advice. This would need to be arranged by the PCT though. It was recognised that there were severe staff shortages in some disciplines such, particularly physiotherapy.

He felt that the best ways to increase the take up of routine screening were to advertise its availability and to work closely with carers and support staff to promote it. There were ethical issues involved in screening people with LD who might be frightened of medical procedures. What was done if they were not happy with being screened depended on an assessment of their competency in making a decision. With the exception of cervical screenings, all screenings were arranged by the PCT.

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GPs could help to support people with LD and PMLD when they were hospitalised by informing the hospital of any special needs that they might have. Care plans for people going into respite care were often very detailed. It would be help GPs and hospitals if this information could also be shared with them.

Training sessions were arranged regularly for GPs in a range of settings. It was, however, up to them if they attended and they often had limited time. He felt that training on LD issues should be part of the under graduate curriculum so that it could be ensured that all doctors received some sort of training on the issue. After they had qualified, they could pick and choose which training that they attended.

He felt that a structured programme of care with clear goals and methodology would help in improving the health and well being of people with LD /PMLD. Primary care practitioners would be assisted by employment of community matrons with special interests in LD/PMLD. In addition, specific training for receptionists would assist as they were normally the first point of contact for people with LD and their carers. Practices would welcome this provided that it was not too time consuming. Finally, there needed to be better links between primary and secondary care.

The Panel thanked Dr. Sherman for his assistance.

**LC41. PROGRESS WITH REVIEW**

Noted.

**LC42. NEW ITEMS OF URGENT BUSINESS**

None.

**Cllr Emma Jones**  
**Chair**