[Private & Confidential]

GREATER GLASGOW & CLYDE AREA MEDICAL COMMITTEE

General Practitioner Subcommittee

DRAFT

MINUTES of the MEETING of the COMMITTEE held on 19th June 2017 in the Committee's offices at 40 New City Road, Glasgow G4 9JT

SEDERUNT: Drs Ronnie Burns, Maureen Byrne, Louise Dytch, Gordon Forrest, Parisa Ghanbari, Michael Haughney, John Ip, Susan Langridge, Jim Mackenzie, William Macphee, Alan McDevitt, Kathryn McLachlan, Chris McHugh, Hilary McNaughtan, Christopher Mansbridge, Graeme Marshall, Paul Miller, Steven Miller, Patricia Moultrie, Kerri Neylon, Jim O'Neil, Alex Potter, Jean Powell, Mohammed Sharif, Alastair Taylor, Chris Tervit, Michael Rennick and Blair Walker.

CHAIR: Dr Alastair Taylor, Chair of the Committee, chaired the meeting.

APOLOGIES: Apologies for absence were received from Drs Vicky Clark, John Dempster, Mark Fawcett, Norrie Gaw, Punam Krishan, Euan Mabon, Bob Mair, Paul Ryan, Mark Storey, David Taylor, Alasdair Wilson and Raymund White.

ATTENDING: Mrs Mary Fingland, Secretary of the Committee

REVISED AGENDA: The GP Subcommittee received the Revised Agenda.

MINUTES: 17/015 The GP Subcommittee received the Minutes of the meeting held on 15th May 2017.

The Minutes of the 15th May 2017 were approved and signed by the Chair.

MATTERS ARISING: 17/016

(a) GP Appraisal Steering Group

GP Appraisers

The GP Subcommittee had been informed that post retiral GP appraisers can continue to act as an appraiser for up to five years. Members heard from Dr Neylon, speaking in her role as CD, this had been agreed nationally by the Primary Care Leads Group.

Sessional GPs in GGC

The GP Subcommittee was told that Sessional GPs on the GGC performer's list are to be divided amongst HSCP Clinical Directors (CDs). The GP Subcommittee heard that it was not possible for 400 plus sessional GPs in NHSGGC to be overseen by one person although Dr Neylon, the North West CD, would act as CD with particular interest in Sessional GPs.

A member advised the GP Subcommittee that to change agreed process without consultation via the BMA would cause potential problems nationally and that agreed national processes should not be changed to meet local needs. It was therefore recommended that any change such as to post retiral GPs continuing to act as appraisers beyond the currently agreed national time limit should be taken through the appropriate groups.

Members heard it would be useful to remind GPs what revalidation was and that revalidation should not be confused with appraisal. Dr Neylon advised that it is her intention to write to all GPS in GGC in regard to this and to detail in the letter the local process followed and how submitted form 4s are currently accessed and used by CDs. The committee were of the view that there is national agreement as to who has sight of Form 4s and that nationally agreed procedures should be followed in this regard. Members were told that NHS GGC Form 4s would only be viewed by an overseeing CD in exceptional circumstances.

Action: Dr Neylon to take forward with the relevant groups that agreed national processes are being followed in NHSGGC. Dr Neylon in her role as CD intends to write to all GPs in more general terms about appraisal and in this communication will provide detail of who has access to Form 4 and under what circumstances within GGC local CDs have access to Form 4s.

(b) Minutes of the Executive GP Subcommittee of 3rd April 2017 and Items and Reports:-

1. MSK Services Access to Services Presentation

Received.

The GP Subcommittee noted that the service had been advised that 'back to referrer' as a means of referral management was not acceptable. Members heard that referral guidance was welcome but was simply that and the decision to refer is a clinical one. The GP Subcommittee heard there was still a lot of work to be undertaken on MSK proposals. The MSK service had also been advised that the proper channel for proposals on referral guidance would be through the Referral Management Group.

The GP Subcommittee heard that MSK had also made reference to having met with some GP clusters to discuss/consult on the MSK referral changes and that it was inappropriate for services to seek to bring about service change through contact with GP clusters as opposed to the GP Advisory structures.. Members heard the host HSCP for Primary Care was taking forward a strategic oversight of service changes and where such work is directed.

Members noted that loss of MSK service will result in an increase in GP referrals to Orthopaedics. MSK had been the agreed avenue for fast tracking appropriate patients directly into Orthopaedics. Members heard that patient

access to MSK services was already under strain with the loss of the Back Pain Service Consultant. Members felt it was short-sighted to reduce funding for MSK services especially at this time of change.

Action: Raise concern regarding potential changes and future access to service for red flag back pain.
A member enquired where complaints should be directed about the loss of service and heard the CEO has overall responsibility for service provision. A member was concerned it appeared the MSK traffic light only allowed a limited number of conditions to be referred.

2. Report of the Child Protection Interface Monday 15thMay 2017

Received.

The GP Subcommittee was told that a local and national review of the school nurse service was being undertaken at the present time. Members were informed that, as part of the review, it had been suggested that school nurses may have a less central role in Child Protection. Members were clearly concerned that there should be no weakness in child protection procedures for school age children introduced by changes to the role of School Nurses. The risk of GPs being seen as the default providers where other services step down from responsibilities was discussed. Members heard that the new GP contract would be explicit on what is and is not appropriate work for GPs.

3. Report of the HCSWs Forum meeting held on Thursday 11th May 2017

Noted.

4. Report of the Practice Nurse Forum meeting held on Wednesday 3rd May 2017

Noted.

5. Report of the MUPE meeting held on Wednesday 31st May 2017

Noted.

6. Report of the GMS eHealth meeting held on Thursday 25th May

Noted.

UNSCHEDULED CARE: 17/017

(a) Unscheduled Care - Presentation Dr David Stewart Medical Director Acutes NHSGGC

Dr Stewart was welcomed by the Chair and introduced to GP Subcommittee members.

Dr Stewart began with an acknowledgement and apology that the presentation

was Acute focussed as the Acute sector was experiencing exceptional demand but assured members that engagement with Primary Care was in sight going forward.

Members heard that the QEUH, GRI and RAH were currently running above 85% occupancy and the Board was now looking at the demand side and whether its facilities were being used in the best manner to manage demand. A member observed that many years ago the original bed number calculations for the Acute Services review had been incorrect leading to some of the difficulties faced today.

Members were told that GGC's non elective admission rate was higher compared to other health board areas. The GP Subcommittee heard that it was hoped that by identifying the top 10 to 20 conditions leading to admissions and managing these conditions more effectively could save resources and free up beds. Members heard that alternatives to admissions from Care Homes were being explored and work was currently underway to offset such admissions through improved care pathways.

The GP Subcommittee noted that work on reducing Emergency Department (ED) admissions included looking at:-

- Consultant led front door triage.
- Flow management.
- Alternatives to admission i.e. ambulatory care, redirection and alternative care pathways for frail elderly.

Members noted that amongst the key recommendations as an alternative to admission was the use of condition specific pathways, improved management of inpatient capacity and use of eHealth and IT which would be beneficial for real time information on bed availability and management. Members heard that achieving a reduction of 250 admissions would see the Board attain its 85% admission threshold.

Dr Stewart told members that a major part of joined up work would involve what HCSPs were undertaking and managing chronic conditions more effectively in the community. Dr Stewart mentioned COPD support in Greater Glasgow which involved nurse specialists and pharmacists and the excellent work being undertaken by the team as an example. In spite of this good work members heard there were no lines of communication between the COPD team and Secondary Care which could benefit from the team's input.

A member raised the issue of nursing homes and the need for a properly funded nursing home enhanced service. Members heard that the additional workload generated by having a nursing home attached to a practice may also be a barrier to recruitment. Another member referred to a recent public health paper which had shown change could not be achieved unless funding was released to pump prime community services.

A member commented that GPs do not have the necessary teams to facilitate this change and noted that the COPD model would be very expensive to roll out to all areas. The GP Subcommittee heard it would be at least five years before GPs could take on that role and Secondary Care could not function at its optimum unless Primary Care was also.

Dr Stewart told members condition specific pathways need to work right through the system and the use of virtual clinics with funding released from Secondary Care could help achieve this. In response the Chair advised that in relation to Virtual clinic development the GP Subcommittee need to be involved.

Another member commented that lots of unnecessary investigations also fuel demand and was concerned at patients being discharged without investigative results being known and no contact details for the team involved in the patient's care.

Other members suggested that the 4 hours target needed to be removed as it was having unintended consequences and that Anticipatory Care Plans (ACPs) are useful and if formulated they should be read in Secondary Care.

Dr Stewart told members the 4 hour target shone a spotlight on services and was a double edged sword and agreed that communication between Primary and Secondary Care needed to be improved. A member observed that there was a need to change dynamics and people's behaviour and suggested that good team working needs to be established at the start. The GP Subcommittee heard that working more collaboratively through the use of clinical knowledge pathways would be discussed at the Interface Group.

It was suggested that in referrals to emergency departments it would be useful for the GP to indicate whether the patient is being sent for assessment or admission and for that to be acted upon by the hospital. Dr Stewart agreed it would be very helpful to have that information. A member suggested that interventions to prevent admissions have to be developed and managed by the right staff bandings to succeed.

NOTES AND REPORTS OF MEETINGS 17/018

(a) HIV Prevention and Treatment Committee meeting held on Wednesday 24th May 2017

Received.

Members noted that P-prep will be delivered by specialist services who would like it added to GP IT systems. A member queried whether it would be worthwhile having a standard way of doing this. Members commented this had been discussed in the past and wondered if there was a need to revisit this issue. A member noted a recent system change in EMIS and F9 key was very helpful in allowing hospital prescribed drugs to be added to GP systems alleviating earlier GP concerns.

Action: Look at hospital issued prescription being added to GP systems again and take forward.

Members heard there was a need to strengthen information lines for professionals because of new drugs.

(b) Hospital Subcommittee meeting held on Tuesday 6th June 2017

Noted.

(c) Verbal Report of the AMC meeting held on Friday 16th June 2017

Received.

Members heard Mr Scott Davidson gave the same presentation as tonight on Medical Receiving to the AMC. A longstanding member commented that all of this work had been undertaken before and, as in the past, without fully resourcing Primary Care would not happen.

The GP Subcommittee noted that Dr Alastair Taylor is the next Chair of the AMC.

HEALTH SOCIAL CARE PARTNERSHIPS 17/019

(a) HSCP Update

Board Wide CQL Meeting

The GP Subcommittee heard that a Board-wide CQL meeting was held last week with presentations received on Inverclyde, COPD and Govan SHIP. Members noted it had been an interesting meeting and things were still moving forward albeit slowly.

Local Pathways East Renfrewshire

Members heard that East Renfrewshire HSCP was looking at developing a local pathway for people who suffer falls with the aim of reducing hospital attendance at emergency departments. East Renfrewshire physiotherapist was working with Scottish Ambulance Service to develop this pathway.

HSCP Chief Officer (CO) Attendance at the GP Subcommittee

It was suggested a request should be made for a deputy CO to attend the GP Subcommittee when the nominated CO was unable to do so. Members agreed it was beneficial having a CO in attendance and that a deputy should be suggested.

Action: Write to David Leese CO East Renfrewshire and Lead CO for Primary Care to request consideration of a deputy to attend the GP Subcommittee in his absence.

CHANGES TO THE MEDICAL LIST: 17/020

(a) Inclusions, Mergers, Resignations, Retirals

Noted.

AOCB: 17/021

There was no further competent business.

DATE OF NEXT MEETING

The date of the next GP Subcommittee meeting is **Monday 18th September** 2017. GP Subcommittee business was conferred to the Executive Committee for the summer recess.

The date of the next Executive meeting is Monday 3rd July 2017.