Session 1 INTRODUCTION OF THE GREENAWAY REPORT

Group 1

Aspect

Most people work where they train, therefore we need to train people where we need them to work.

Questions

1. Do we know how many Dr's we need in Scotland?

2. Do we need more GP's or do we need more AN Others?

3. Should we have a "lock in" i.e. if you train in Scotland should you be obliged to work in Scotland?

Discussion Notes

Lack of attraction of GP's/GP Trainee's; Life-Work balance of FY1/FY2's; Generation Y -31 days after starting a new job begin looking for a new job - we need to change; most people work where they train therefore we need to train people where we need them to work; Are hospitals more family friendly than GP?; Modern Dr's want more flexible careers

Panel Notes

Using that. There should be much more exposure to General Practice during training. There needs to be a big shift in the amount of training undertaken in Primary Care and General Practice. This should happen early in the training process.
Different doctors with different skill sets encourages the need to attract medical student candidates for a wider range of backgrounds than is traditional. Improving accessibility to medicine.

Group 2

Aspect

Models are context specific -Community Hospitals work differently accross Scotland

Questions

1. How do we avoid the danger in trying to homonnize the role/service?

2. In what way is the "Hub/Intermediary" GP different from current Community Hospital roles?

3. How will it be funded?

Discussion Notes

-What might work in some places may not work in others; Shortage of GP's as it is -will another
role squeeze services further?; What is the plan? -24/7? or GP's picking up the slack?; Concern are
GP's going to have a choice?; Is intermediary GP a separate entity?; Unclear -what is he difference between the "hub" and what happens already?; Benefits -recruitment and retention;
Concern -"Community Physicia" new title will confuse patients.

Panel Notes

Looking specifically at Community Hospitals and a trend for the centre to push for a consistency in the level and range of service provided from such assets : Do we not run a real risk in demotivating and compromising the level of service being provided by some hospitals in the pushing of this policy. Flexibility and variance to meet local needs should be encouraged not discouraged.

Group 3

Aspect

Service delivery vs training -GP's vs hospital jobs. "Contract" cannot change in isolation e.g. more in team (number and diversity). Support for extended role but are we the exceptions.

Questions

1. We need flexibility....
2. How do we get more flexibility into GP education?
3. How do we get more exposure for medical students?

Panel Notes

Exposure to GP work in medical training is crucial. This is totally inadequate presently and although 100% of students experience GP in their curriculum there is an opportunity to broaden and deepen their exposure. Only 30% of foundation doctors have a placement in general practice and while there is a shared aspiration to increase undergraduate exposure, to have an increased proportion of foundation doctors experiencing GP, and more of GP specialty training being based in GP, there are real capacity issues that need to be better understood and addressed.

Universities need to change the culture and attitudes towards primary care and recognise
how crucial this is to future doctor training.

GROUP 4

Aspect

"Back to the future"

Questions

1. What do community hubs look like (particularly in an urban setting) and how will we have the capacity to staff them?

2. Can NES ensure that every FY2 Dr has an opportunity to do 4 months in General Practice?

3. What happens to a surgical trainee who decides part way through training they want to be a GP....easy to change?

Panel Notes

Back to the future

Increase flexibility in training and accessibility of differing disciplines of Medicine through a career.

Often undergraduates are not ready to make a decision of the speciality they wish follow at the time the current system demands they should. Changing career path should be much more flexible than is the current scenario

Group 5

Aspect

All Dr's should learn Generalist skills

Questions

1. Is research overvalued and undertaken at the wrong time (especially in specialist care)?

Panel Notes

Generalist skills are essential and current less than needed and desired. In this very blame and fail focus of the modern world doctors need a much better understanding of risk management. Confident doctors best learn risk in medicine on the job training in General Practice.

General Practice has to give undergraduates a good and positive experience. General Practice needs to understand this and talk the job and opportunities up and not stick on the negative.

Group 6

Aspect

Excellent care can only be achieved with quality relationships founded on trust

Questions

1. Is excellence a facet of the individual or team?

2. How can we promote trust in primary care teams?

Discussion Notes

Can training guarantee excellence? ---Are we saying that we are not excellent enough? Normalisation of expectations and communications with families How much experience in the community should trainee's receive? Should there be career-long peer support? What is excellence? -6 Dimensions of quality?; delivery of appropriate care? How do we engender trust? Quality of relationships matter.

Panel Notes

An atmosphere of Trust is essential to developing the doctor of the future. Excellence in the individual and the team is equally important to the success of going forward. Equally important is excellence in the environment around development and innovating services. Getting this right makes excellence more likely and its most effective application more likely.

Group 7

Aspect

GP's at present do have skills to undertake general intermediate care but require infrastructure, capacity and professional support to have time and confidence to implement it. In addition, we support training and funding in a range of specialist skills within each practice.

Questions

1. How can Greenaway be made compatible across the UK given a separate contract for trainees in England?

2. If GP's do have the skills to undertake intermediate care, how do we ensure that other colleagues around us take up the slack ("work to the top of their licence") to allow us to do so?

3. How do we ensure that GP's have the authority to be the "conductor of the orchestra"?

Panel Notes

GPs have a wide base specialist skills and want to acquire more but they need an

environment of positive and supportive encouragement. Not good enough at present. Some concerns expressed about achieving a consistent training process across the UK when the contracts will likely be different. It is also important that the training decided upon should be a 4 year highly skilled training.

Sharing clinical information is also a significant challenge and needs much more work in any new service.

Session 2 NEW GP CONTRACT

Group 1

Q1 are you negotiating a pay rise

Q2 now that QOF has gone what will assure clinical quality

Does it just rely on professionalism?

How do we know that the new contract will improve conditions for GPs?

Panel Notes

Not convinced the new contract will solve some of the pressing issues. With QOF out how do we effectively measure and ensure quality. The temporary arrangement fronted by Clusters will explore and test data sets that best serve. This will inform the future 2017 onwards. The quality leads in the process will prefect their input and influence. Professionalism is important and can be used very supportively to address quality. Money is not the basis of dissatisfaction it is concerned with work loads and levels of responsibility being better understood. We need to be careful about the amount and type of data we collect. We need to go from data to intelligence.

Group 2

The renegotiation makes sense but we need more detail

Q1 contract issues
what are the limits of responsibility GPs asked to train mentor nurses whereas there are limits on registrar GPs

Q2 how do we ensure community hospital budgets are protected and invested in

Q3 stability of practice staff with the loss of QOF

Q4 what are the likely unintended consequences of losing QOF

Panel Notes

Renegotiation makes sense but more detail please. Is the bed in a community hospital under locality care or is it part of the full hospital service. How do we ensure the CH budget are protected and invested in. We need to be sure the facts support the CH bed as such or is it more a framework of care in the community which might or might not include a CH. It is important that general practice has to ensure that GPs are fully integrated in the service development within a community. Solutions will and must vary according to locality need.

Group 3

We recognise the need for change but are uncertain that these changes will help erosion of GP / patient relationship – of community of care

Q1 will the new contract be attractive to next generation of GPs

Q2 why not just have the extra bits with the old contract

Panel Notes

Recognise need to change but worried about interference with patient continuity. Will the new contract be attractive to new GPs. Listening to what younger doctors think and want. Salaried will always be available if not convinced by the changes in the new contract. The old contract has failed so it must change and if you have any ideas use the website. Contracturalism. Professionalism. Consumerism. The world has moved on and through the open contracting process.

Group 4

Contract is about time quality politics teamwork pay and perceptions

Q1 what is the role of the tax man in the contract discussions -independent / salaried

Panel Notes

Role of the tax man. Maintain independent contractor status remains quite workable and the need to protect that is well understood. What would make the contract attractive the balance of opinion is independent contractor status. The centre does not want salaried practices.

Group 5

Want a contract that is supportive (not restrictive) that enables trained individuals to utilise the skills – expertise that they have

Manage uncertainty
Discuss complex cases
Work with teams

Q1 how does the GMS contract fit with negotiating activities that GPs are interested in doing
Teaching Community hospital GPWSI clinics

Q2 how will the new contract reflect workload and varied non GMS activities such as teaching and community hospital work

Q3 is GMS only negotiation fragmentary

Q4 will the new contract promote, support flexibility and diversity

Panel Notes

Contract that is supportive
How will the contract reflect all work of GP's beyond GMS.
Contract sets conditions to outline the engagement of provision rather than seek to cover all aspects. It should not be restrictive but facilitating. The biggest changes in the market place where we work will be out with the details commissioned within health care contracts. Outputs will be the driver in measuring those and quality.

Group 6

Welcome complexity – need realistic public exception, political support data outcomes -quality process professional

Q1 how do we design this change to allow locality team excellence 24/7

Panel Notes

Welcome complexity need to manage expectation. Need not simply want. What do we need to do to get the right excellence 24/7. GP's need to be informed of what happens to your patients at whatever time day or night. The GP contract needs to be seen as part of a wider structure and not a stand alone event. There is the challenge. Need to get better on concentrating on the issues and processes that have the greatest return and this is not necessarily historical date sets.

Group 7

Q1 how will this be resourced

Q2 how do we ensure other professions work to the top of the licence

Q3 how do we mitigate risk relating to non GP practice

What is a cluster

How do we manage other professions
How do we get them to work at top of licence
How do we manage inter cluster workforce

What is the make up / geography of clusters
Where does social work budget fit in a cluster
What is the risk of carrying the can for other professions. What does mitigation look like
Will GPs become deskilled
Contractor versus employed modes
Have we gone nuts over clusters
Broadly in support of GPs being expert medical generalists

Panel Notes

How do we get all AHPs to work to extend of their licence. Output targets set for these groups and instilling some service authority in the GP practice to drive this. Better team working by establishing trust in an encouraging culture. Top of the licence is not helpful a better descriptor would help. The thrust has to support the integration of aligned professionals across the 'employer' group. Better perhaps to feed the funding for services through the GP giving the right of input.

Session 3 LAUNCH OF COMMUNITY HOSPITAL ALUMNI REPORT

Group1

Cannot imagine working as a GP without access to a community hospital

From long stay – intermediate care

Nature or nurture

Community hospital a place of learning and skills development

Positive experience for patients and staff

Without the right model of care community hospitals will be a spectacular failure

Successful Community Hospital needs motivated highly skilled multi disciplinary teams

Opportunities for GPs in community hospitals need better promotion
Needs a clear vision for service scope/models plus delivery

Consultant engagement plus support is crucial to effective use of rural community hospital

Effective leadership
Continuity of GP input
The right infrastructure (facility)
On-going training plus education for the whole team
Q1 is there an ongoing need for a SACH COMMUNITY HOSPITAL type organisation
Q2 how do we get better information to GPs to promote Community Hospital work
Q3 how do we increase the capacity for education plus development within the community setting

Group 2

Team work job satisfaction
Community Hospital challenged by urban vs rural
Benefits of community hospital should be available to urban communities
Compassion for patient care -GP as main driver bespoke , individualised tailor made care
Community hospitals modify risk
Bring back SACH COMMUNITY HOSPITAL important and valuable
Network to support training new doctors in their roles “mentoring”
For those who do not need specific specialist care
Services provided multiple “hub” idea
Maintaining skills accountability importance of continued training
OOH is an integral part of team
IT infrastructure

Aspect comment
We see Community Hospital as a vital part of the community but recognise the need for further OOH integration and more support for training

Q1 without SACH COMMUNITY HOSPITAL how will we support community hospitals going into the future

Group 3

It is a pleasure
Get it right it makes a better GP
Happy GPs
Improves recruitment
Support for practice
Peer support
Regional groups national
Education training hobbying

Group 4

Working in a community hospital is great and needs to be resourced
Q1 should we have organisational targets around the things we want to see
Q2 how do we help the public to understand risk/realistic medicine

Group 5

Lack of care packages
Lack of control
Valued by patients and communities
Trained to meet the needs for community
How do we make sure our community hospitals are resourced appropriately

Group 6

Be clear about the role contribution of a community hospital –
ensure patients are there
for the right reason
Right person
Right place right time
How do we ensure appropriate investment in our community hospital
Money for GPs so can spend time in Community Hospital
Near patient testing

Rapid results
Trained nursing staff
Rehab staff and sufficient of them
IT
Liaison with secondary care
Lean thinking

Group 7

Whole system thinking is good

Panel Notes

We need a continuation of SACH

Do commissioners of health and social care really understand what community hospitals do or could do? No was the feeling

Do the conference doctors feel OOH is an integral part of the job. Large majority stated Yes

Should we have structural targets for community hospital services. Need to think about it but unintentional consequences might be serious. Providing a good job is necessary but in the real world of attracting funding.

Under resourcing of nursing in community hospitals. Issues falls on GPs. We need better communication links with specialists.

How do we encourage health boards to support community hospitals appropriately. We need to talk to the IJB rather than boards. We need to be better at demonstrating care offering and its quality. We are not good at capturing the essence of what community hospitals do and the high level of performance.

ISD has resource to work on local data projects. Use them.

Most people are in favour of integration. But all parts expect other to change. All parts will need to change so think hard on how to position the community hospital offering.