Meeting of Patient Participation Group, Woodstock Medical Centre

The Meeting Room, Woodstock Medical Centre

Wednesday 30 August 2023; 1830-2000

1. **Welcome, introductions and apologies noted by the Chair and below:**

   Present:
   David Inglis, Primary Care Team, NHS Lanarkshire
   Eleanor McLean, PPG Chair
   Hazel Kay, PPG Deputy Chair
   Colin Angus, PPG member
   Neil Campbell, PPG member
   Leonard Gray, PPG member
   Elaine Young, PPG new member
   John Taylor, PPG new member
   Elizabeth Hunter, PPG new member
   Ruth McCallum, PPG new member

   Apologies: -
   Clare Baxter, Site Manager, Woodstock
   Lesley Barrie, Nurse Consultant, Woodstock
   Craig Cunningham, Head of Commissioning & Performance, SL HSCP
   Liz Forbes, PPG member
   Fiona Thomson, PPG new member
   Alister McInnes, PPG new member

2. **Previous Minutes of 21 June:** agreed and approved for distribution 25 July 2023

   No matters arising

3. **Approval of agenda items and matters arising not on the agenda:**

- Urinary Tract Infections – difficulty in management of symptoms and process for treatment

4. **Review of Terms of Reference**: revised ToR agreed 09 August 2023 and circulated; reference to practice Equality, Inclusion and Diversity policy, Vice Chair will distribute

5. **Practice Update:**

   i. **What is a multi-disciplinary team (MDT)**: paper provided for information.

   Group acknowledged the information in the paper was helpful and informative but further clarification was sought regards a breakdown of staffing levels and Whole Time Equivalent (WTE) for the staff group, leading into point ii.

ii. Staffing and skill mix: (also included discussion on points iii.; v.; vii, viii; 6i & ii)

Details provided that 1 WTE Nurse Consultant (NC), who is a highly experienced primary care Advanced Nurse Practitioner (ANP) based solely at Woodstock and a further 2 ANPs on any given day (1 WTE ANP based solely at Woodstock). Enquiry was made about WTE GPs, and Dr RL advised that having salaried or employed GPs in a practice was a thing of the past, and WTE was interpreted differently for doctors, with the focus being on sessions. Dr UR explained further that on engaging any GPs, we adhere to the principals of the BMA Safe Working in General Practice Guidance (Safe workload guidance for GPs in Scotland (bma.org.uk)), whereby any appointment is 15 minutes in length, with no more than 25 patient contacts across a working day. With regards to the presence of GPs on site, we aimed to provide 6 sessions, which equated to 3 GPs per day. Further reflection was provided that the historical workload of a GP during the course of a day was between 40-50 patient contacts and therefore in order to provide a similar level of GP availability, 2 GPs were needed now to provide the same workload.

Dr UR confirmed that there is 1 x NC, 1 x ANP and 1 x Mental Health Practitioner (MHP), all full time and aligned to Woodstock, as well as 1 x Physician's Associate (PA) and 1 x Nurse Practitioner (NP) providing support daily. Discussion about the role of the PA followed, and explanation provided that these roles were similar to Junior Doctor level, but without ability to prescribe, they followed a medical curriculum. There were plans for this staff group to be regulated by GMC in next few years. These professionals were well utilised in primary care in England but mainly within acute care in Scotland. Dr RL indicated training of PA workforce across UK. It was explained that the role of the PA expands the capacity of the MDT, but that it required appropriate supervision and support, so utilised within the Urgent Care Team (UCT) to ensure support and mentorship from a GP whilst on site.

A question was asked if all the MDT reported to the NC, and it was explained that the role of the NC involves providing clinical leadership and support to the MDT, and that if there were staff who required further supervision such as PA's this would be provided by the GPs or the Partners.

It was further noted that the reception/admin team were not always answering the phone in a similar way, including indicating their name, this feedback would be provided and refresher training given if required to ensure the Group approach to answering calls was applied.

Challenges were highlighted when seeking to book appointments in advance to facilitate discussion of results; advised that next pre-bookable appointment is 3.5 weeks away. Dr UR provided overview of planned capacity and actual capacity that has been made available; but appointments were being scheduled e.g. review with same clinician., which was having an impact on our "on the day" availability. Having become aware about this, appointment availability had been locked so that this would help to alleviate the situation.

The level of emergency appointment only message on phones was raised. Dr UR described the challenges of managing annual leave for our employed staff when there is little control over when locum GPs take their leave, and with ongoing workforce recruitment challenges, it was becoming more difficult. Whilst it was recognised that this was not ideal, it was critical we allowed our team to have leave to avoid burnout. Reference was made again to the BMA Safe Working in General Practice Guidance.

Dr UR advised that it would be necessary to give consideration to how access was being provided, and that this could involve a service redesign including a move to the majority of appointments being booked in advance, or retain as a hybrid of on day and pre-booking.

Further enquiry was made if consideration of additional recruitment had been made. Dr RL advised about the expense of backfilling into leave periods from mid-June up until w/c 21 August because of when leave is focused during that time and the impact of moving staff during these weeks had resulted in a very challenging period of time. There still remain historical issues with the practice when trying to recruit to posts at Woodstock, and this had been discussed at length previously with the PPG last summer. Dr RL advised that there had been a number of resignations from both the clinical and non-clinical team coming from the immense demands from patients, the escalation in **violence and aggression (V&A)** resulting in a detrimental impact on the whole team. This also impacts on the clinical consultation, with 2/3 of the clinician's time taken up by patients airing grievances rather than dealing with their medical conditions. Within the next month we will lose a WTE ANP from Woodstock, as well as other members of the clinical team becoming unwilling to travel to the Lanark site to work. Dr RL advised this is resulting in the Group losing experienced clinical staff. Examples were provided of 2 recent cases where Police Scotland were called to remove patients from the practice due to levels of V&A. A V&A risk assessment has been carried out, and there may be some changes in the practice due to this. The admin team is working short staffed, with some members of the team absent with stress. Whilst we have a duty of care to patients, as employers we also have a duty of care to our staff, and the process for warning patients has been re-enforced with them.

Enquiry was made about how the practice was covering admin absences, and LJ advised that both she and LW had been and would continue to come to the practice until the situation resolved.

Dr UR then provided an overview for the benefit of the PPG. The clinical team are experiencing burnout resulting in our NC resigning, and advising that in their opinion the NHS is broken and they will be unlikely to continue to work in it. A further 2 ANPs who work regular sessions in Lanark have also submitted their resignation. They have advised the workload pressures as the main, but not only reason. Preferential NHS Terms & Conditions were offered within the Health Board and this was also a driver, longer shifts, shorter working weeks, enhanced payments for working unsocial hours, increased annual leave and benefits such as maternity leave.

A questions was raised to establish if the Primary Care Team (PCT) in NHSL had a workforce/recruitment and retention strategy to help support primary care and GP practices. David Inglis, PCT advised that GP Practice is a business and the Board has limited resources. They were aware that practices were struggling to recruit GPs to join as Partners, resulting in practices either merging or contracts being resigned and handed back to the Board. The PCT do not have the resources to support in the way they would like, but their hands are tied as to what they can do.

Enquiry was made about what happens if a contract is resigned and handed back to the Board. David Inglis explained that it was a costly exercise for the Board, to take over the running of the practice, especially if staffing with locums, given the expenses involved.

Dr RL raised the recent Agenda for Change (AfC) pay awards, provided to NHS staff employed directly by the Boards and how this was significant increase in some instances as much as 19%, when in comparison the GP uplift award negotiated through the Doctors and Dentists Remuneration Board (DDRB), advised 5% for practices to pass on to their teams. This makes retaining staff even more difficult.

Pre-booking of appointments for patients with Long Term Conditions (LTC) was raised, was there any way in which pre-booking could be prioritised for that group. Dr RL said this is something that we can review, there are some ideas about how this could be managed, but would need to be clearly mapped out. If patients were looking to book specific clinics or appointments, we should be encouraging them to call out with the triage time of 8am – 10am, if pre-bookable appointments were made available.

Community Treatment Assessment Centre (CTAC) was in place at the Lanark HC and this would begin to be utilised by the practice nursing team to provide an improved recall system, this could also utilise the skills of our clinical pharmacist with chronic disease management (CDM) for those patients with long term conditions (LTC).

Enquiry was made if the pharmacist could be contacted directly, and the difficulty when calling for a medication review, between 8am – 10am was highlighted. These appointments should be pre-bookable and a review of current access, would look to ensure that these appointment requests could be made outside that timeframe.

Dr UR wanted to share positive news and provided details about GP recruitment that had been undertaken. The start date was to be confirmed, but the GP would be predominately working with the Urgent Care Team (UCT) working 3 long days, and offering evening access until 8pm, for a trial period. Dr RL also advised that a 2nd GP joining, date to be confirmed, providing 8 sessions across the week, 4 sessions on site and 4 sessions remotely. Both GPs were travelling some distance to be here and it was critical that this trial period was successful, allowing the extended hours to build up gradually, in order to avoid burnout.

It was noted that whilst it was helpful to hear the issues being experienced, patients also needed to be aware about the challenges so that there was an understanding about the difficulties and challenges faced alongside the positive news.

Dr UR advised that we had recently improved our communication with the issue of a practice newsletter, but that following our quarterly meeting with the Board it was felt there was perhaps a need to strengthen our presence on social media, to enable sharing of information and expectations about patients' behaviours. Development of a practice charter, outlining the practices and the patients' responsibilities was briefly discussed, but it was questioned whether this would change patient behaviour.

There followed discussion about development of community engagement, Dr RL described patient group consultations that had been provided at our Strathaven practice with support from our Mental Health Practitioner (MHP) from Lanark, offering a traditional practice presence back into the community; providing opportunity to meet the practice team. It was commented that de-medicalisation of care has been undertaken in other areas of the country and this would benefit patients, community and the practice. There were a number of locations locally that could provide accommodation for these to take place, LJ and DI would engage further about this. Dr RL advised there could be a quarterly event to allow an opportunity for everyone to come together. An example was provided, Seniors Together meeting, where the practice could be invited to present. The PPG would be supportive of this and would welcome involvement of the roll out of these sessions.

Reference was made to the newly formed Facebook Lanark Patients Action Group, which appears to have been formed following an online petition. This has approx. 450 members and is being managed by 5 individuals, one the recent former vice chair. The practice team were aware about this page and it was adding to their stress, the inception of this Group appears to align with the increase in appropriate behaviours. The team had highlighted that it appeared members were being encouraged to sit in the practice waiting room and record interactions between staff and patients and post on the group page. There were concerns that patients' confidentiality may be breached as well as other data protection legislation. It was also brought to the attention of the PPG that unsolicited contact with Moffat and other community support pages had been made. There were unpublished reasons why the Group left NHS Dumfries & Galloway area, which the Health Board were fully aware of, this included behaviour by a small pocket of the local Moffat community that had caused significant impact on the clinical team, and involved Police Scotland. The Group advised they were due to meet with the Board at their quarterly meeting on Friday and would highlight this situation.

iii. **Patient Services**

iv. **Palliative Care**

A question was raised regarding someone being discharged home who is in need of palliative care as there had been comment by a Consultant in Acute

that a GP needed to visit to complete paperwork prior to being offered a care package. Dr RL advised there are some forms that require a GP to complete, such as a DS1500, for benefit payment; Dr RL would anticipate that care packages are required prior to discharge and this be completed by the hospital. DI advised that communications between hospital and the Integrated Care Team (ICT) take place and they would have conversation regarding appropriate packages of care to then organise daily visits. It would sit with the ICT. Dr RL further advised that if a GP felt someone needed referred to Macmillan services, this is certainly something that the GPs would undertake. CA will raise this with the implementation group.

Physical Activity Prescription (PAPs)

A recent meeting was held about above where statistics were shared of the uptake of these services, and it appeared that the practice were not referring into this service. As discussed previously DI will link in with Ryan Gilmore and liaise with practice.

Mental Health and Young People

LJ would liaise with Health Improvement to reach establish if there is any support our Mental Health Practitioner can offer to this group. Details have been passed on to Steven of UC which he will share with LJ.

vi. **Woodstock Key Performance Indicators**

LJ circulated a document providing oversight of July statistics for patient awareness and education. The statistics provided details across a number of practice workload metrics. Workload in General Practice could be described as an iceberg, whereby the work seen by patients, such as direct patient contacts, sit above the water level and the majority of the workload sits underneath.

A questions was asked if Did Not Attends (DNAs) are an issue, this wasn't something that the practice was currently concerned about.

Comment was made that whilst KPIs outline successes through targets set by ourselves, were there other KPIs that could be looked at. LJ suggested that other KPIs that we are monitored against are complaints, as the numbers and themes are provided to the Board on a quarterly basis and this is something we would look to improve, for instance a reduction in numbers. Other practice based metrics would be about improving access, absence management, staff retention.

The group agreed production of KPIs on an ongoing monthly basis would be worthwhile, especially as sharing locally to help inform the community.

Details were provided about a pilot regarding incoming mail – volume of mail that requires to be filed vs mail that requires to be sent onto a clinician. LJ advised that a similar piece of work was undertaken some time ago, and this process, Workflow Optimisation, is currently carried out in all our practices.

Dr RL highlighted that the figures reflected were during the period of leave discussed earlier, with the pressures of annual leave commitments. Enquiry was made about the breakdown of calls made vs calls answered; LJ advised approx. 50/50.

Dr UR highlighted that given the overall access provided, and the earlier conversation about staff absence and ongoing retention issues, based on the patient list size, the number of appointments offered was similar to what would be expected. There is a generally accepted formula that 72 appointments should be provided for every 1000 patients per week, from across the extended practice team.

However, Dr UR felt that service redesign was considered to decide how to re-shape delivery of care. He reflected upon his own experience, training and ethos of leaving training and becoming a Partner, and how this is not commonly shared by GPs nowadays who then choose to be a locum.

AOCB Practice Newsletter would continue to be issued.

Note taken to ensure names of new PPG members were added onto the website and noticeboard.

Lunchtime closures put in place with immediate effect due to ongoing V&A and staffing issues. However, it was highlighted that Woodstock is an outlier in lunch time closures, this has been common place across practices in Scotland for many years.

Hearing aid batteries were now available in libraries

Further information was shared about Zero Tolerance Policy, local H&S Violence & Aggression Risk Assessment and other potential measures that may be considered, this could involve front door closure or Security Guards.

Progress regarding care navigation crib sheet. LJ advised the admin team currently use a crib sheet to ensure appropriate appointment booking, on day demand or unscheduled care need pass onto the urgent care team. However, there was a plan to review this and refresh care navigation training.

Urinary Tract Infections: Specific criteria for people to present via pharmacy first

Dr RL tick sheet – pre-populated by patient to bring in alongside sample

Dr UR support from PPG will help staff morale, number of patients who do have good experiences; reaching out for some positive stories to be shared with the team would be helpful. There are surveys utilised in practices previously, however this is used for clinicians for professional feedback on their consultation as part of the formal appraisal process.

Date and time of next meeting: 25 October, 6.30pm – Boardroom, Woodstock Medical Centre