Minutes of the General Practice, Public Health and Occupational Medicine Specialty Board Meeting held at 1.30 pm on Wednesday 17 February 2016 in Room 1, Westport, Edinburgh

Present: Gordon McLeay (GM) Chair, Frances Dorrian (FD), Ellie Hothersall (EH), Moya Kelly (MK), John Kyle (JK), Anthea Lints (ALi), Miles Mack (MM) part meeting, Paul Ryan (PR), Jane Steven (JS), Andrew Thomson (AT).

By videoconference: *Dumfries* – Nigel Calvert (NC).

Apologies: David Bruce (DB), Stewart Mercer (SM), Tara Milne (TM), Rowan Parks (RP), Jean Robson (JR), Ashleigh Stewart (AS), Iain Wallace (IW), Carrie Young (CY).

In attendance: Christopher Duffy (CD), Helen McIntosh (HM).

Action

1. **Welcome, introductions and apologies**
The Chair welcomed all to the meeting and apologies were noted.

2. **STB membership changes**

2.1 **Occupational Medicine TPD**
MK reported the post has been advertised twice so far without success. The advert has been revised to include a wider range of potential applicants and will be sent to the STB for its information.

3. **Minutes of the meeting held on 16 December 2015**
The minutes were approved as a correct record of the meeting and will be posted on the website.

4. **Matters arising/action points from previous meeting**

4.1 **Leadership for Integration**
The course was a joint NES and RCGP initiative and information circulated by both.

4.2 **Medicine STB CMT survey**
The item was deferred.

5. **STB update for MDET**
There was no specific update however GM circulated the STB section for the Annual Report for information. For the 2017 Annual Report he will include feedback from trainees using headline information from the GMC survey and STS reports.

6. **MDET Updates**
There were no specific updates however GM circulated the NES Board paper on the NHS staff survey for information. He highlighted the high response rate and noted that NES will look at those areas areas where performance was less good. The survey will be paused this year and iMatter used across the NHS. MK noted this was the first time that GP trainees have had input to the survey and this was likely to have skewed results. She felt there were better ways of finding out GPST views.

7. **Recruitment updates**

7.1 **GP**

Round one recruitment has now finished. There was a slight increase in the number of applications and 11 more offers will be made next week however 40 withdrew at this stage last year. In 2014 56% of those who withdrew did not take up NTNs elsewhere and there was no information on what they subsequently did. The 57 doctors who did not need to attend the selection centre because of their high score at stage 2 will receive offers separately and will be tracked.

Derogation of the Gold Guide was sought to allow GPSTs to defer for a year and to make OOP opportunities more flexible via step off/step on arrangements. However this was not agreed across the 4 nations. Following legal advice, England, Wales and Scotland will go ahead with the derogation. Fourteen trainees have indicated they will seek deferral.

MDRS at HEE commissioned an evaluation of the GP recruitment process and while it confirmed there were no issues of concern with the current process it had made a list of recommendations. However these were not well modelled and NES has replied and made its own recommendations. Responses from all stakeholders were sought by 18 February. As this was wider than GP alone changes made would affect other specialty recruitment. The MDRS Quality Standards Group will review all responses in March.

Meantime the Round 1 readvert process will run in May following the same process as Round 1. Dependent on outcome it is likely there will be a Round 2 for February 2017 start. This will be the first time Scotland has participated in Round 2 and although this will cause issues in programme management it should reduce gaps in programmes. AT felt that appointing trainees who would be out of sync by 6 months would not help hospital rotations and suggested that 18 months in GP at the end of training might help. GM confirmed that some areas of England offered this. Scotland felt it was better to get experience of GP at the outset however they will consider all options. In terms of the 100 extra GP posts announced by Scottish Government - as yet there was no confirmation of funding and they could not be taken forward at present although some preparatory work has taken place.

GM also noted that preferencing information was not yet available and will not be known until offers were made. The potential impact/risk of the imposition of the junior doctors' contract in England and the Scottish Government's launch of a social media campaign on opportunities in Scotland were unknown factors.

There was also the possibility of filling gaps with Career Development posts with GP experience and this will dealt with regionally.

7.2 **Public Health**

EH reported recruitment will be held next week and she and NC were both involved (for the first time in her case). Forty four applications were received for the 7 vacancies in Scotland, 23 from non medics; 15 candidates were invited to interview and 7 of those were non medics.

Following discussion FD agreed to check the specialty's GMC approved name and report back. **FD**

7.3 **Occupational Medicine**

FD reported there were no NES funded posts; there was one industry funded post and one vacancy in North identified too late for recruitment. If it was agreed to run national recruitment in February - the post could be recruited then otherwise it would remain a LAT for one year.

8. **Quality Management – Quality Improvement**

8.1 **GP, OHM, PH**

8.1.1 **Specialty Quality Management Group**

Two documents for the sQMG were circulated for information. These demonstrated the huge amount of work involved behind the scenes eg 68 papers were presented. This was the only sQMG which had to sign off approval/reapprovals for practices and Educational Supervisors and this will be done on a 3 yearly basis to a standard format. New Educational Supervisors or changes in practice would trigger visits. Information will be circulated regularly. MK noted it would be helpful to highlight instances of good practice.

As yet there have been no visits for Public Health or Occupational Medicine. EH confirmed that she and NC will work on how to document the quality and validity of training environments. **EH/NC**

It was noted that Quality Reports were publicly accessible and therefore could be subject to FOI requests. GM will flag this up to DB and AMcL. **GM**

9. **Shape of Training Review**

This remained a standing item. Some projects were underway eg Scottish Government proposal for credentialing for SAS Development but nothing cohesive. MM reported the College was frustrated by the lack of movement on Enhanced GP Training and Shape of Training. JK added that certain specific projects will be allocated to each country eg Scotland will take responsibility for SAS and the primary and secondary care interface otherwise there were no major developments.

10. **Public Health Workforce/Public Health Review**

EH reported the Public Health Review for Scotland has been published. The report made no specific recommendations and from a training perspective it had little to say. However, in terms of workforce it stressed the need for greater visibility and improved leadership. There was a desire within the specialty to professionalise and NES could be expected in the future to support the workforce. NC noted that Health Boards had been holding back posts until the report was published – he hoped these would now be filled.

EH noted the Report's Executive Summary which suggested they may want to consider the English structure and especially the Health Promotion model. The Report will be circulated on request.

11. **Directorate Workstreams**

11.1 **Training Management**

All training sites must be recognised by the GMC. Training Managers were working to update information by 28 February. The Gold Guide Version 6 has been published and will be checked to ensure compliance. A session on ARCPs was held earlier in the week.

Turas has now been released to TPDs and Health Board staff – study leave approval will now be done via the system. JK noted there was little descriptor space in Turas; MK has fedback this and other issues to the support team. FD confirmed that individual TPDs received a budget for their programme based on the numbers in programme. They had some discretion eg to pay travel expenses and will balance the budget to allow each trainee to access it at some point but not necessarily at the same time. GM noted there have been differences across the regions however the new Study Leave Guide aims to ensure consistent application and Assistant Directors will look at its implementation and interpretation.

The Performance Support Unit has been approved and was now moving into the implementation phase. They were looking first at local programmes and will then set up an overarching group and the PSU itself.

11.2 **Quality**

No update was received.

11.3 **Professional Development**

The Scottish Government was particularly interested in the GP Returners scheme. Since June, 69 enquiries have been made to the GP Careers Advice mailbox of which 40 were taken forward; 6 of these were Returners and 2 were ready to go on Enhanced Induction and one was ready to go. They were actively advertising in Australia, New Zealand and Canada and ALi will be leading a workshop at the Ottawa Conference in Perth Australia in March to meet face-to-face with anyone interested in returning. Doctors did not have to be resident in Scotland to quality for the scheme but had to prove their commitment to living and working in Scotland. They also provided bespoke advice via the mailbox and all queries will receive a response.

Fellowship posts were about to be advertised however due to poor uptake Occupational Health will no longer be offered.

12. **Specialty updates**

12.1 **GP**

GM reported the recent realisation that Foundation Supervisors in practices must be recognised as Educational supervisors and will require appropriate training. The GMC also has a list of approved learning environments which extends to Foundation and therefore additional approval is required for that as well as for GP Training Practices.

He also noted the Faculty Development Alliance and SPESC were undergoing restructuring and will receive less administrative support. Capacity for this will be looked at if the 100 new GP posts are created.

The GP Directors Group discussed the changing nature of GP service delivery and its impact on training and in particular exposure to telephone triage and the potential of reduced exposure to undifferentiated illness if this was filtered out by GP Nurse Practitioners. The Group agreed to seek evidence from practices on how to GPSTs were exposed to telephone triage and other types of patient presentations and will monitor how this was done. JK felt there was an argument for placing trainees in 2 different practices to ensure broader experience. GM agreed this could be helpful but did not happen routinely in Scotland as this was balanced by continuity in supervision. MK noted practice swaps in the last few months of GPST3 were

encouraged.

12.2 **Public Health**

12.3 **Occupational Medicine**

No updates were received.

13. **Service update**

PR reported that a high level of GP retiral. As many were Educational Supervisors training successors was vital.

PR confirmed there was no central listing of practice vacancies as most were advertised via SHOW or informally by word of mouth. FD noted the Medical microsite when launched will contain this information.

14. **DME update**

14.1 **HB approach to trainees with dyslexia**

GM and JR had considered this and discussion at the GP Directors Group clarified the situation within NES. If a trainee failed 2 AKTs they would be directed to undertake a dyslexia self-assessment. If the subsequent screening test showed a need for detailed assessment previously they were referred to Occupational Health by the TPD. However it has now been agreed the TPD will refer the trainee to NES HR Department for assessment. For those trainees employed by Health Boards the TPD should refer them to their DME to discuss any further assessment. NES will fund this for trainees in NES employment but it was unclear whether this happened at Health Boards for trainees in hospital training. It was stressed this was a patient safety issue. It was felt that numbers will be small. GM will feedback discussion to JR. **GM**

It was noted the Faculty of Public Health required evidence from within the last 3 years; RCGP required assessment after the age of 18.

15. **Academic update**

16. **BMA update**

17. **Lay representative update**

No updates were received.

18. **RCGP update**

MM noted the College was working with Dr Emma Watson on the GP career flow and reported interesting discussions with undergraduate departments. The biggest challenge was to produce a GP product they could be proud of and could promote.

Work in the Quality stream to replace QOF is progressing and quality improvement training may extend to educational opportunities. Much work was ongoing including work on the interface of care.

19. **Trainee update**

JC noted the imposition of the Junior Doctors' contract in England; the Scottish Government will not do this and has launched a recruitment campaign. The Junior Doctors' Committee was due to meet at the weekend.

20. **Mental Health Strategy**

GM noted that few of the listed commitments in the previous strategy related to

training. MM noted the ALISS system of geographically based practical resources although these may become stretched due to other pressures. GM stressed the need for a joined up approach to information on available resources. He asked the board to send him any ideas and he will feedback these to NES by 23 March. In his response he will highlight the need for services to be accessible and joined up for trainees and GPs.

21. **AOB**
No other business was raised.

22. **Date of next meeting**
The next meeting will take place at 1.30 pm on Wednesday 6 April 2016 in Room 5, Westport, Edinburgh.

Actions arising from the meeting

Item no	Item name	Action	Who
7. 7.2	Recruitment updates Public Health	To check the specialty's GMC approved name and report back.	FD
8. 8.1 8.1.1	Quality Management – Quality Improvement GP Specialty Quality Management Group	To work on how to document the quality and validity of Public Health training environments; to flag up to DB and AMcL potential FOI requests.	EH/NC GM
14. 14.1	DME update HB approach to trainees with dyslexia	To feedback discussion to JR.	GM