Patient Participation Meeting
Monday 9th September 2013, 7pm

Present

Dr Elwyn Davies
Brenda Anderson
Roger Coe
Stasia Taylor
Alan Taylor
Elizabeth Parry
Kokila Lane
Dr Claire Laband
Anne Dormer
Suzanne Green
Charlotte Laband
Pauline Drummond

Agenda

- National changes to the NHS and how General Practice might be affected – Dr Elwyn Davies
- Practice survey – review of poll and suggestions for questions for annual survey
- Care Quality Commission (CQC)
- Health and Social Care Information Centre (HSCIC)
- Chairperson/Secretary roles of the PPG
- PPG and vPPG being combined
- Any other business

National Changes to the NHS

Dr Elwyn Davies joined the meeting to explain some of the changes to the NHS which are being suggested and how these might impact how general practices are able to work. He pointed out that the environment is changing very quickly and that he is only able to give a personal, biased opinion based on the information he has. He expressed concern that patients are not aware of the changes being brought into the NHS.

Dr Davies quoted from an editorial in the British Medical Journal by Kieran Walsh which commented, despite the government' publicised intention to make the NHS less complicated, it has in fact become more complex in recent years.

Alan Taylor commented that the NHS now employs considerably more managers than it does consultants. He suggested that the various managers of the different areas of the NHS will be 'pulling in different directions'. He suggested that while there might be a need to reduce the number of managers but that this decision will have to be taken by the managers themselves effectively deciding that their own role is not necessary – clearly this is unlikely to happen.

It was suggested that doctors should take on some of the management role however Dr Davies pointed out that doctors don't have the time to do management as well as their clinical roles. Additionally doctors don't have the necessary management skills to take on the huge budget and complicated structure of the NHS. Clinical Commissioning Groups were marketed as a way to hand control of the NHS to doctors however this control is, in reality, still in the hands of the managers who ran the Primary Care Trusts until April of this year. The intention was to put control of the NHS in the hands of doctors who would be able to tailor the service to address local needs. This wasn't practical so the government created NHS England, a government body which took over commissioning and created the Commissioning Support Agency – a centralised body of managers.

Managers and centralisation have increased and no-one knows what is happening at a local level. A huge amount of work has been generated to allow managers to manage by providing them will statistical information. While GPs try to keep the practice local and relevant to local needs this is becoming increasingly difficult to achieve whilst still collecting and analysing sufficient statistical information to provide to centralised managers.

The effect that huge amounts of time and money are being wasted. The problem is that a large number of small practices (there are, for example, 76 GP Practices in Somerset) doesn't work as a management model. There is pressure to streamline the service by merging practices to create a small number of "super practices" serving a huge number of patients over a wide geographical area.

With 7,500 patients, Cheddar Medical Centre is considered a medium sized practice but is actually considered very small by a management model. Somerset CCG serves approximately 544,000 patients across the county but this may still be considered too small to be efficient (according to the management model mentioned above).

Services provided by surgeries are provided under contract. Small bodies have very little ability to influence the contracts on a national stage. Some of contracted services include immunisation programmes, child health checks, learning disability checks, smoking cessation, contraception, and pre and post operative care. In the future practices may be asked to bid to continue carrying out the service. This could lead to wide-spread privatisation of these services as it would be more cost effective to give the contract to a private provider who could manage the service for all patients in Somerset than it would be to manage 76 individual contracts with the GP practices. Privatisation on this level could be seen within the next twelve months.

Pauline Drummond clarified that it is not yet clear how the tendering of these services will work but it seems likely that there will be an expectation that the bids will cover most or the entire county. At the moment each practice is paid to care for their patients. However support to primary care has been slashed. Practices would need to be organised to offer a county-wide service. Patients may need to travel further afield for certain services.

Dr Davies: It is difficult for doctors to do anything about this direction of travel. The BMA is meant to be arguing on behalf of doctors but is not being listened to. The only people who can realistically influence the government are voters. It is up to voters to decide what is important – whether they would rather have a very local service or a centralised complex which may be further afield but might have more facilities such as x-ray. The compromise would be on

personal care as it is unlikely that a patient in this scenario would be able to see the same doctor each time they visited the surgery. The surgery cannot tell patients which model would be better for them personally. Patients must look at the information available and make a decision for themselves.

It is a concern that patients don't know what is going on and how their experience of the NHS might be changing.

As an example of how low morale is in the GP community, three local surgeries recently advertised for GP partners. In the past these positions would have had upwards of 75 applications each however between the three vacant positions there were only two applications. Junior doctors don't want to become GP partners. They are doing locum work instead which is better paid and doesn't involve the stress and long hours experienced by a GP partner. Again, this will lead to a breakdown of the continuity of care currently offered by GPs. It is important to be aware that the thousands of new doctors mentioned in the media are not choosing general practice. There is major crisis looming as there will not be enough GPs interested in partnership to sustain individual surgeries.

Doctors are being required to spend an increasing amount of time doing paperwork and collecting data which is putting new doctors off. If the practice didn't do this work then it wouldn't be paid and would be considered a low quality, failing practice. This information would be publicised and patients would make decisions about the practice accordingly.

The intention was that doctors would act as advisors and in theory this is a very good idea however they are not being given time to do the work properly or being trained to fill a management role. There are a few individuals within the CCG who do work like this however they are a small proportion.

Pauline drew attention to a document which has been created by NHS England titled A Call to Action. It is available in three parts by following the link below. The first part is the briefing document which is very long. The second is a collection of slides which give a good overview and the third is an evidence document. **The link also contains a survey which patients may like to complete.**

http://www.england.nhs.uk/ourwork/com-dev/igp-cta/

Practice Survey

The results of the mini poll, which are attached, show that the three areas which have been identified as most important to examine by way of the main patient survey are:

1. Choice of hospital – what is the patient experience of the Choose and Book system and can this be improved by the practice?
2. Accident and Emergency – how do patients decide which service to visit and how can the practice help with this decision?
3. National changes to the NHS – what aspects of Primary Care do patients value the most and how can the practice protect them?

The group agreed that these were the most important areas to consider and did not think that any other areas should be included in the survey.

The group split into three groups to consider the different areas and to begin to create questions for the main survey. These have been collected and the survey will be based on this information.

The survey will be sent to the PPG in draft form for comment. When agreed it will then be released to the practice population. We aim to release the survey in time for the first flu clinic on 12th October as this is a time when patients who do not visit the surgery very often will be available to complete the survey.

As in previous years, the survey will be available for completion in electronic form via our webpage and in hardcopy in the surgery. It will be advertised on the website, in our newsletter and in the surgery.

Care Quality Commission (CQC)

CQC are now in the area, carrying out inspections of local surgeries. As such it is likely that they will contact Cheddar Medical Surgery soon. They have asked that two people from the PPG be available for them to speak to. Ideally these will be a chairperson and secretary. Additionally there will be a CQC inspector in the waiting room talking to patients about their experiences of the practice during their visit.

The role of the CQC is to ensure that the practice is complying with its obligations to patients and staff in a range of areas such as health and safety, patients consent and safeguarding. A copy of the document for PPGs was attached to the previous email.

If the surgery is found to be compliant it is likely that they will carry out inspections every three years.

Stasia Taylor and Kokila Lane kindly agreed to be nominated to the CQC as contacts for the PPG.

Health and Social Care Information Centre (HSCIC)

This is a government scheme involving a huge database of information obtained from surgeries. The practice is being asked to send **non-patient identifiable** information from the clinical system. There is currently no information about what will be done with the information.

It is very simple for patients to opt out of the scheme by notifying reception.

This information has been communicated to the patient population via our website, in the surgery and in our most recent newsletter.

Proposal to combine the PPG and vPPG

For the past two years the surgery has run an 'in-person' PPG and a virtual PPG. Recently we have been issuing invitations to PPG meetings to the PPG and vPPG in order to ensure that we have as much patient input as possible.

It is therefore proposed that we combine the two groups into a PPG. This does not imply any sort of obligation to come to the meetings and we will continue to communicate with PPG members by email or post as we have always done.

There were no objections raised to this plan and it was therefore implemented effective immediately.

Any other business

There was no other business to consider.

Next meeting

The draft survey will be sent out by email for comment and then released to the practice population.

It is intended that the next PPG meeting be held in late November or early December when the results of the survey have been collected. The date will be announced in due course.