PPG Meeting Minutes

Thursday 7 March 2019

Attendees

(AC)	Practice Manager
(DS)	Patient Representative
(EG)	Patient Representative
(JM)	GP Partner
(MJ)	Patient Representative
(MC)	Patient Representative
(PP)	Patient Representative
(RD)	Patient Representative
(PR)	Patient Representative
(TM)	Patient Representative

Apologies
JN

Minutes
The meeting was held in addition to the scheduled meetings to allow time for a presentation by JM on the changes to CCG's (Clinical Care Commissioning Groups).
AC circulated a handout of the email sent to members about Deer Park's Appointment system. She reiterated that the number of appointments available to book online would always, necessarily be affected the need to 'keep back' slots for emergency appointments.

Presentation: CCGs; STPs & PCNs etc.
JM thanked members for their responses to the draft information for patients on the appointment system at Deer Park. He explained that the presentation was not exhaustive but should cover the main changes that had happened in the last 30 years.

Historical perspective (slide 2)
In the mid-1990s there was an 'internal market' – money followed patients. Initially, there were Fund Holding Practices with a budget to spend on total patient care, however, this worked best for large practices. In smaller units such as Deer Park, large chunks of the budget could be used up if a single patient had multiple and complex medical needs requiring the attention of several types of service. Government then introduced Primary Care Groups (PCGs) which quickly became PCTs (Primary Care Trusts). These groups of

practices were given a nominal budget: if savings were made, the practice had freedom to choose where it was spent.

By 2013 the CCGs had been introduced. Clinicians lead the groups because they were best placed to understand what patients needed. JM served as a member/chair for ten years in Nottingham and became disillusioned by the lack of opportunity to implement or effect changes. RD asked for clarification about the provision of services for a patient who lived in the county but attended a city practice. JM responded that Deer Park had been given the choice whether to become part of the Broxtowe or Nottingham City CCG. They chose the latter as, in comparison to the county, the city is 'under-privileged'. Overall the decision has been advantageous to the practice.

Clinical Care Commissioning Group (slide 3)
Basically, a group that 'commissions' services, that is if a patient needs an X-Ray the CCG will commission a provider. The Secondary Care Services (SCS) (QMC and City Hospital) command 80% of the area budget. The Primary Care providers (GP practices) receive the smallest amount, as funding for Mental Health Services and City Care take precedence. Primary Care services need to make savings wherever possible. It can be difficult for GPs to request funding: there is a conflict of interest when they ask for funding for a service and then say, 'we can deliver that'. A GP practice can, in theory, 'shop around' for a service but there are problems:

(i) patients may not want/be able to travel to another area
(ii) the chosen provider may not have the capacity to help
(iii) it could destabilise the SCS by reducing their funding. Government protects hospital spending, if the hospitals overspend the 'bale out' comes from other services. This obviously has an adverse effect on those services for example, a patient having a psychotic episode responds very well to immediate treatment but when funds are short, they may have to wait six months for follow up care. This is counter-productive not only for the patient's health but also in terms of cost.

City Care is frequently reorganised simply because its services, Physiotherapy, Podiatry etc. are easy to change. DS asked to what extent hospitals used their in-house departments. JM said that in theory a patient having hip replacement surgery should get at least two hospital-based physio sessions; in practice however, GPs are often required to organise the sessions. TM commented that nowadays patients have much shorter stays in hospital giving less time for in-house after care. NH asked whether 'the rest' subsidised hospital over-spend, JM said that government could not let a major acute hospital fail, so basically Secondary Care Services would always be baled out at the expense of other care providers. AC commented that GPs were generally fed up with the system as it could lead to their practices failing. MC commented that, in the past there was less bureaucracy as a GP could make a direct referral. PP is a member of various committees at QMC and stated that they were continually bringing such matters to the attention of the Board and gradually progress was being made. MJ raised the issue of readmissions saying that they were costly in time and money as well as detrimental to patient health.

RD asked whether waiting lists were a result of too few consultants or lack of money. JM said 'both': but even with more money it takes ten years to train doctors so the insufficiency

cannot be reversed overnight. The 'bottom line' would be 'if' the Government or CCGs *told* Primary Care givers to *not overspend* and to cut referrals then the response from Deer Park would be 'no' and do what they believe to be right for the patient. In the next two years however, practices will be under increasing pressure to limit referrals.

Sustainability & Transformation Partnership (STP) (slide 5)
There began to be more joined up thinking, Secondary Care should not dominate Social Care. Progress has stalled and the STP is now merely a 'wish list'. TM commented on the service that convalescent homes used to offer saying how it bridged the gap between hospital and general practice – a halfway house. MJ remembered the Home Help service run by local authorities. There was a general feeling that STP was about something that had once prevailed. NH said he had assumed that STP was another service, a body of people, but now realised it was a concept. JM said the STP had good ideas but no concrete plans: some plans had even been contradictory. EG commented that without an increase in taxation it was difficult to see where money could come from to make improvements.

Primary Care Networks Opportunities (slides 7 & 8)
Deer Park will be in partnership with Harrow Road and Cripps Medical Centre: it does not have a lot in common with the latter in terms of client group. By 1 April 2019 they will join to appoint providers for primary care initiatives such as walking groups, which will be 100% funded. The PCN will receive 70% of the funding needed to appoint a pharmacist. The idea is to create practices of 20 to 30 GPs who will share nurses, admin teams etc. JM said that it could be very positive if say, the PCN could provide its own X Ray service but initiatives such as 24-7 appointments are mainly a political move. This may cater better for younger people than older ones who tend to favour continuity of care.

JM said that it was not all negatives; as a member of a PCG you could grab opportunities. Members understood funding and how to get the best available for their patients at the earliest opportunity. He feels that the appointment of a pharmacist (to source medicines etc) will happen because it will save GP time feeing them for patient care. JM would also like to see the reintroduction of an acute visiting service where a GP can send a trained paramedic to visit a patient. The paramedic, being 'inside' secondary care could treat or refer as necessary. It would be very efficient as patients might be seen by hospitals early in the day, resulting in earlier treatment and maybe even preventing an admission/overnight stay.

Why are the CCGs reorganising? (slide 6)
JM returned to the slide which had been overlooked. He said GPs would not be concerned if the reorganisation was in the interests of improved health care, but it was primarily about saving money. The second factor was government initiatives: originally GPs were supposed to be able to drive what was considered best for patients, whereas now it is government who decides. Ideas such as 24-7 GP appointments are the main agenda. The third issue was 'demand pressures': average life expectancy has increased by 10 years, but people may expect only one year of that is likely to be in good health. For GPs this means an increase in the complexity of health problems that they must address. Whilst a sore throat may be diagnosed and treated in a 10-minute appointment, the complications arising from diabetes etc. cannot. AC was concerned of the very short time that practices had: the changes were

due to be implemented 1 April 2019 and they had still not received plans from Nottingham CCG. There will be no time for proper consultation.

EG asked whether the amalgamation of CCGs was a national initiative; JM said it was not. The joining of county and city CCG was about saving money: basically, the underspend by the Nottingham CCG was being used to bale out the county CCG who had overspent. The City CCG was granted £497 million and 'saved' £40 million compared to a similar overspend by the county.

Referrals for podiatry and physiotherapy etc. will now be vetted by a clerk, not a clinician. The GP will still be accountable for clinical risk. PPG members raised concerns about the potential for increased costs when people had to have a second appointment and eventual referral – a waste both of time and resources. It is the CCG themselves who have decided to make the changes, not clinicians. The people running the CCGs are required to make savings and these will necessarily lead to a reduction in services.

Finally, AC told the group that a member of the LMC (Local Medical Council) was coming to set up a social media account for Deer Park Practice.

There was general concern that many people, including AC and JM, would be unavailable for a meeting 18 April. Members decided it would be better to rearrange the date to be outside Easter holidays. EG will circulate alternative dates.

Meeting closed at: 14.20

Next meeting: TBA

Any items for the agenda to EG by Thursday 28 March.
Please note that Kate Horton from the local CCG will attend the next meeting.