Meeting of Reading Patient Voice Group

Getting To Grips with BOB Draft Primary Care Strategy

29th January 2024 - Room 4A Civic Offices and online

1 Present

- Catherine Mustill
- Jill Lake
- Libby Stroud
- James Penn
- Paul Williams
- David Cooper
- Francis Brown
- Tom Lake
- Kevin Boyle
- Brian Morley
- Mark Drukker
- Paul Myerscough
- Douglas Findlay
- Tony Lloyd
- Alice Kunjappy-Clifton
- Sunila Lobo

2 Discussion

2.1 Introduction to the Draft Strategy

Tom Lake showed a few pages from the strategy to give a quick introduction to what is proposed.

page 1 Title Showing that Primary Care consists of General Practice, Dentistry, Community Pharmacy and Optometry.

page 6 Why we need a Primary Care Strategy Showing basic stats for the Integrated Care Board Area and noting the national direction to integrate General Practice better with the rest of the NHS.

page 10 Primary Care Supports Our Communities More stats about the population and its health needs and inequalities.

page 11 Primary Care is at the Heart of our System noting the segmentation of the population into 73% generally well, 19% with moderate need and 2.4% with higher need (and a few per cent fell through the cracks). Also noting numbers of GPs (about 1100), GP nurses (430) and additional GP clinicians (over 900).

Page 13 Challenges within General Practice Difficulties in obtaining a GP appointment, registering with an NHS dentist, hiring pharmacists.

Page 14 Growing mismatch between demand and capacity As the results of lower mortality feed through, over 65s will increase by 20% and over 85s by 45% in a decade resulting in a 55% increase in demand for appointments.

Page 17 Learning from the Israeli Clalit System Brief discussion about whether the Israeli-Palestinian situation had any bearing on this. The Israeli health system had managed to shift from most expenditure in hospitals to most expenditure in the community over about 30 years. Noted that a fast transition is impossible as many careers have to be different.

Page 33 Our Priorities For Delivery Three priorites:

1. Non-complex same-day care - for patients with low complexity better manage these needs without so much involvement of GPs.
2. Integrated Neighbourhood Teams (including voluntary and charitable organisations) to provide proactive personalised care for specific segments of the population, eg frail elderly people.
3. Cardiovascular disease - a major cause of mortality and health inequality

2.2 Priority 1 - Non-complex Same-day Care

Here the intention is to use segmentation of the population and selection of presented conditions to ensure fewer patients see the GP and instead see other clinicians - pharmacists, nurses, phsyiotherapists, social prescribers, mental health workers, physician associates who are qualified to treat it, reserving GPs to work towards the top of their licence with complex cases with multiple conditions - giving longer appointments to manage these cases.

Francis Brown ran through some comments on this part of the strategy.

Page 39 - Redirect need

- Douglas Findlay: What clinical assurance will there be on the new clinical processes? Training? Audit?

- Does BOB have enough control of GP decision making?
- Have practices and PCNs got enough IT system expertise or support?
- Are Health and Wellbeing Boards really well enough connected to communities?
- At one surgery a doctor does most telephone triage after initial request by patient to the receptionist. It is brisk but effective. Isn't that the best way?
- At an outstanding practice the receptionists do the initial triage and allocation. They are confident, respectful, trained, experienced. At the busiest time they are joined by paramedics. At poorer practices staff are defensive, touchy and often need to refer.
- Melrose practice at least uses remote receptionists.
- Is Healthwatch well enough connected to communities? In Reading and Wokingham perhaps still immature after changes.
- Need metrics to check that the complexity of signing up to and using the triage software is not driving patients to A&E or Urgent Care Centre or away altogether.
- Quality of products - comment that Anima is unfit for use - set up help and other patient information is inadequate and misleading, the Windows implementation is poor, wording and sequencing are poor, consistency with EMIS Patient Access is poor - view based on 30-49 hours in surgery helping patients and about 20 hours docuenting faults or writing user set up guides. But evidence is that the use of triage software has significantly reduced the waiting time for non-urgent appointments.
- Need for practices and PCNs to exchange experience as new tranches of practices prepare for the introduction of triage software.
- Ordering repeat prescrptions is harder through the triage software than with the NHS App or with EMIS Patient Access.

Page 40 - Example of same-day access

- In practice, surgeries are refusing to accept walk-in or phone requests from the majority of patients for whom they have a mobile phone number or an email address. This could may well not really correspond to need.
- Is rebranding receptionists as "care coordinators" credible? What training will they have?
- Is there an algorithmic or machine learning aspect to the allocation of action to follow triage or is the decision entirely made by a clinician/assistant?
- Unless the receptionists has automated fill-in of some fields the use of the triage software by the receptionist for a phone call will take about the 10 minutes that it takes a patient.

- Can the care coordinator redirect a phone call back to the home practice if the patient feels that need to speak to the local staff? Can information gathered in the call be passed forward?
- What information on the capacity of VCSE organisations will the care co-ordinators have? Will the JOY app be involved?
- the use of a triage hub is a big change for patients who may expect to be known to the receptionist - this needs to be made clear in the patient presentation of the strategy. It is a big change on top of the big change of moving to triage software.
- Could we please have dummy websites available for the public to experiment with before they have to use the software for real. And video walk-through.

Page 41 - designed locally but with common features

- Need to clarify from the start that triage is handled through a central hub for the PCN or other unit as local knowledge may be lost -cf London Ambulance Service.
- Box 1 experience at Balmore Park shows that a heavy hand is needed to get patients with internet access but limited skills to register with the Anima system - this is not exactly patient choice.
- Box 2 Is triage software adquately integrated with other GP software?
- Box 6 "ideally with accompanying clinicl communication" - needs protocols to establish adequacy of onward clinical information.

Page 42 Action plan for Non-complex same-day care

- re "support clear outcome metrics" have we cleaned up practice lists for ghost patients, unseen patients etc
- Can we improve correlation between practices and geographical neighbourhoods - in Reading this can be confusing.
- We know of one practice that has chosen its triage system without agreement from other practices in its neighbourhood. Consistency aids patients supporting one another.
- What area does a "Local Action Team" cover?

Rurality How will this differ from widespread rural practices to overlapping urban practices?

Reporting How will the hub calls and sortware use be monitored, audited?

SMART? Is Priority 1 SMART (Specific, Measurable, Attainable, Realistic, Timely)?

2.3 Priority 2 Integrated Neightbourhood Teams

Catherine Mustill explained that this was building on services that already existed. There are district and community nursing, community matrons, home visits, 2 hour rapid rehabition service and many specialised nursing services - heart failure, COPD etc, community mental health teams and other community mental health workers.

Page 44 Integrated Neighbourhood Teams

- It is unclear what are these teams will cover.
- Where will the teams be based?
- Will this put further strain on the already overstretched district nursing and community nursing services?
- How will teams get together to share and compare?
- What specialisms will be included in the teams?
- Experience shows that there can be confusion and disagreement over who does what - who takes bloods etc, with patients left frustrated, long delays, difficult travel etc. Will there be a place where patients can phone in/mail their problems and with the authority to get things sorted out?

2.4 Priority 3 CardioVascular Disease

Francis Brown had reviewd this section. The novel aspect is perhaps the emphasis on tacking health inequalities in this condition and using outreach.

Voluntary and Charitable organisations How will they participate. What investment might they receive? According to the NHS long-term plan they must be involved.

2.5 Comments on the overall approach

Experiencing change Change only works if the staff take ownership.
The Document

- Document has few numbers, unconvincing, no additional investment in prevention.

- Clearly this is a single document targeted at many audiences. Well presented but with few concessions for the general public. There is a real need for a more detailed - what will this mean for me - presentation for the public.

Overall

- This follows a period when BOB had 3rd highest reduction in GP practice funding per patient in real terms FY2018-19 to FY2022-23 at 11.2%. What is the mechanism of such reduction? What discretionary spend was involved? Will it be reversed?
- No targets for number of patients per full-time equivalent GP. No link to the national workforce plan.
- No discussion of the factors that lead to retention of GPs - even apart from salaries - working environment - workload - administration - autonomy.
- No apparent investment in GP premises. Where will the hubs come from? Expectation is for local authorities to provide.

Patient experience

- No discussion of clinical risk - could there be an increase in undiagnosed or late diagnosed disease - sepsis, cancers.
- No discussion of whether online triage could drive some patients to A&E or Urgent Care Centre or even to stay away.
- The quality of service is being reduced.
- The GP patient relationship will suffer.
- In new estates there may be no GP surgery nearby.

Page 32 - Our approach to delivery

Tab 1 Create Focus What are the high impact actions - are they the three priorities?

Tab 2 Delivery Programme Approach What data will be used to drive decision-making?

Tabs 4&5 ICB and System Partner Support Isn't the system already overstretched without having to support these changes? Returns will lag the funding needed for innovative actions.

Page 33 Three Priorities

- It states, "we will focus on working with communities that experience the most inequalities", but are we talking about geographic communities, ethnic/culturual background communities or other groups of circumstance (e.g.

homeless) or specific cohorts or segments? Note that the NHS alone cannot change the social determinants of health and even local authorities have limited powers and means.

- Physiotherapy is not mentioned.

Page 34 Other Improvements

- The term "locality" has been dropped - do we just have places and PCNs (associated to neighbourhoods in theory) - and what about sites? Where do Local Action teams fit?
- Where is accountability? For budgets? plans? defining deliverables? assessing deliverables? It states,"Place based Partnerships **are accountable for delivery of the priorities**" but also "The BOB ICB Primary Care and Community Care Strategic Transformation Coordination Group is **accountable for delivery of priorities**".

Page 36 - Phased approach This is specified by sites, 18 in all across BOB - but what are they - there are 156 GP practices and 51 PCNs - what will sites be?

Page 53 - Developing a scorecard

- FFT must be more consistently entered on time by all practices. Only 10% submit on time. We need timely data in public especially from the poorer performing practices.
- GP Patient Survey is taken only annually and comes out with a 6 month delay. Then the answers need rescaling to be able to interpret them. We could ask the standard questions of patients locally every month at the poorer performing practices to get timely data on patient experience.
- QOF data in available internally every month.

2.6 Views elicited by Paul Williams

These views were from older people who were asked their views on the draft strategy document.

- Can't decide on priorities from the information given
- Too much NHS and consultant speak
- Want all surgeries to deliver same level of services - how to achieve it?
- Public want to pick up phone and have appt in 24 hours if urgent or get a reasonable future appt
- Improved patient experience
- Reduce health inequalities!

- PPGs involved in monitoring the changes and reporting patient concerns
- Senior citizens with complex health issues want to see a doctor who knows them
- Transport is important for any new hubs, with parking and good bus access
- Those who are not comfortable with internet access must see they are not left behind
- Need for public reporting on proportions of different kinds of appts, and primary treatments
- Since Covid there is a perception that the service is diminished with little investment
- Use a common approach to common technology

3 Actions Proposed

- Produce minutes before consultation on 6th Feb.
- Derive a response to the strategy from the minutes.