Reading Patient Voice Group

Questions and Comments on the BOB Draft Primary Care

Strategy 3rd February 2024

1. **Background**  
   The BOB ICB has issued a draft primary care strategy for consultation. The consultation lasts until 29th February. This follows the the NHS national long-term plan, the national Fuller Stocktake of primary care and workshops and discussions organised by the BOB Integrated Care Board and the preparation of the Board’s Forward Plan for healthcare in the BOB area.

Reading Patient Voice Group held a 2-hour meeting on 29th January at which the strategy document was discussed in detail. Minutes of the meeting have been circulated , in a form aligned to the pages of the strategy. The questions and comments following have been distilled from those minutes.

The BOB Integrated Care Board has arranged a 1-hour online consultation at 7.30pm on Tuesday 6th February. As this is quite a short time we have sought to draw out key questions in the different areas as well as documenting other comments and questions for written communication.

1. **Overview**

This is a serious effort to improve staff and patient experience under straitened circumstances. But the presentation, engaging as it is, is not suitable for the wider public. Many questions remain and the document does not justify those straitened circumstances from a wider strategy.

This strategy doesn’t appear to tackle the wide variation in GP practice standing with patients. Some practices are clearly striuggling to satisfy their patients. If they could be brought up to the standard of the average, health inequalities might be reduced.

**Q1: Why is there no priority to improving the less-well performing practices?**

1. **The Documents**

The strategy is issued as a 55 slide presentation and a 17-page summary presentation. The pages are well laid out and presented. But as patients have remarked, “There is too much NHS and [business] consultant speak”. Clearly the main strategy document has many audiences and must contain a lot of detail. But there should have been a simple patient oriented summary focusing on: “Why Change”, “What Changes Will Patients See”, “Which Groups of Patients Will Be Affected”. There is still time to produce and circulate this.

**Q2: Why is there no patient-oriented presentation?**

1. **Funding**

We have learned that real-terms, per-patient funding of GP practices fell by 11.2% from FY2018-19 to FY2022-23 despite NHS funding increasing. The way in which the ICB can influence GP practice funding is not at all clear. Rachael de Caux (BOB Chief Medical Officer) has said recently that there is no money for estates [meaning primary care premises]. Yet the strategy expresses an intention to move resources from acute care to primary care.

**Q3: What discretionary means does the ICB have to influence GP funding?**

**Q4: Why is there no quantitative commitment to move funding to primary care?**

1. **Social Determinants of Health**

Collaboration is now a key duty of the NHS. Yet the strategy does not recognise the central role of social determinants of health, and the consequent need to collaborate with local authorities and their public health departments to improve health.

**Q5: Could there be more collaboration with local authorities and public health on the social determinants of health?**

1. **Workforce**

It is noticeable that there is no reference to the NHS national workforce plan. In considering retention of GPs, working arrangements are addressed, but aspects like estates are not. The option of offering a fully salaried primary care service is also not considered.

**Q6. Have the factors influencing the retention and attraction of staff been fully considered?**

**Q7. Why is physiotherapy not more prominent?**

1. **Priority 1 – Non-complex Same-day Care**

We have many detailed issues which we hope are summarised in the emphasised questions.

* 1. What clinical assurance will there be on the new clinical processes? Audit? Training?
  2. How will children, infants, people with learning difficulties, be viewed by+ the systems?
  3. Could there be a drop in diagnoses of e.g. sepsis or cancers etc? What countermeasures could be put in place?
  4. How will care coordinators be trained? Retained?
  5. Will there be enough consistency between practices and PCNs? In software? In practice?
  6. Is triage software adequately integrated with other GP software?
  7. Does the triage software allow for the repeated visits that may be needed for a differential diagnosis?
  8. Do practices and PCNs have enough IT expertise to choose well and to maintain the services effectively?
  9. Will some patients be put off or diverted to A&E by the difficulties of signing up to online triage software? Have we considered - language barriers? Mental health? Metrics?
  10. Will voluntary organisations be involved in helping patients who find difficulty with the change? Consistently across place/PCN?
  11. Will ordering prescriptions via the triage software be consistent with using the NHS App? And no harder?
  12. Are practices limited to a choice of high-quality products? We have criticisms of Anima but no knowledge of others.
  13. Will patients be able to choose phone or in-person application for appointments? We have been told of patients being refused these if they have an email address – and this could be inappropriate.
  14. Will those who use phone or in-person access lose out or be left behind?
  15. Will patients lose out because the care coordinators don’t have local knowledge?
  16. What happens when practices are present in more than one neighbourhood?
  17. Is there evidence that this approach will improve patient experience?
  18. Will this approach improve continuuty of care for more complex patients?
  19. You describe GPs spending more time with complex patients, but they will probably also have to spend more time supporting pharmacists, physician associates and other clinicians. Can you describe the GP’s time allocation more closely?

**Q8. Will there be a measurable improvement in clinical outcomes?**

**Q9. Will patients experience improve for all groups of patients?**

1. **Priority 2 - Integrated Neighbourhood Teams**

We already have integrated neighbourhood teams, with District and Community Nurses, Community Matrons, Health Visitors, ARRS staff in practices. Patients sometimes complain of confusion and disagreement about who does what. Again we give some detailed questions and try to sum up in emphasised questions.

* 1. How will the present situation change?
  2. What change does this mean for staff?
  3. How will present confusions and responsibilities be clarified?
  4. Will patients have access to prompt help when things go wrong?
  5. What specialisms will be included in the teams?
  6. Where will INTs be based?
  7. What geographical area will an INT cover?
  8. How will an INT relate to GPs?
  9. Will this overstretch the District and Community Nursing Services.
  10. Is there evidence that this approach will reduce health inequalities and hospital admissions?

**Q10: How will Integrated Neighbourhood Teams be managed to give a good, seamless patient experience?**

**Q11: How will Integrated Neighbourhood Teams relate to the rest of the NHS?**

**Q12: Will this be a cost-effective approach?**

1. **Priority 3 – Cardiovascular Disease**

**Q13: Are outreach and community-based consultants cost-effective?**

**Q14: Is there evidence that this approach will reduce health inequalities?**

**Q15: Shouldn’t the targets be more ambitious?**

1. **Dentistry**

**Q16: Have you considered a salaried community dental service as provided by Berkshire Healthcare?**

1. **Delivery**

**Q17: What are “sites”?**

**Q18: What arrangements will there be for sharing and learning as we go along?**

**Q19: Will the GP patient relationship suffer?**