PATIENT OPPORTUNITY PANEL MEETING

MINUTES OF THE MEETING HELD THURSDAY 15 JUNE 2017
Beacon Centre, Wolverhampton Road, WV4 6AZ
4.30pm – 7.00pm

Present:

Dr Richard Gee	GP Engagement Lead, Dudley CCG
Helen Codd	Engagement Manager, Dudley CCG
Maria Prosser	Communications and Public Insight Support Officer, Dudley CCG
Jason Evans	Clinical Commissioning Manager for Urgent Care, Dudley CCG
Dr Duncan Jenkins	Pharmaceutical Public Health Team, Dudley CCG
Joanne Taylor	Primary Care Commissioning Manager, Dudley CCG

Representatives from the following PPGs:

Pat Lamb	Lapal
Sue Bicknell	Lapal
Stuart Steele	AW Surgery
Victoria Evans	Practice Manager - Kingswinford Medical Practice
Bryan Caldicott	Moss Grove
Irene Arrowsmith	Three Villages
Audrey Heer	Friends of Ridgeway Surgery
Stuart Rudge	Feldon Lane
Stephen Schwartz	Castle Meadows
David Stenson	Moss Grove
Margaret Roberts	Stourside
Tim Jeavons	Northway
Harry Bloomer	Wychbury
Bill Beardow	Wychbury
Jack Bates	Castle Meadows
Chris Bate	Lower Gornal
David Gill	Lower Gornal
Sue Hatton	Moss Grove

1. Welcome, Introductions & Apologies

Richard Gee welcomed all to the POPs meeting and thanked all for attending. Richard chaired this meeting on behalf of Julie Jasper who was unable to attend. Introductions took place.

Apologies were received from:

Julie Jasper	CCG Lay Member, Dudley CCG
Laura Broster	Director of Communications & Public Insight, Dudley CCG
Keren Hodgson	Engagement Officer, Dudley CCG
Jayne Emery	Chief Officer, Healthwatch Dudley
Geoff Lawley	AW Surgeries PPG
Cicely Thomas	Friends of Ridgeway Surgery
David Taylor	Feldon Lane PPG
Bob Parker	KMP PPG
Dawn Fazey	Gornal PPG
David Orme	KMP
Allan Hughes	Woodsetton
Tony Durrell	St Margarets Well PPG
Rachael Meredith	Quincy Rise PPG
Carole Evans	The Limes PPG

2. Presentation by Jason Evans – Commissioning Manager for Urgent Care

Jason Evans introduced himself as the Commissioning Manager for Urgent and Emergency Care. Jason manages the Urgent & Emergency Care budget of £100m which covers: Emergency Ambulances, NHS 111, A&E at Dudley Group NHS Foundation Trust (DGFT) plus a £3m contract with the Urgent Care Centre.

The Urgent Care Centre (UCC) opened in April 2015 offering 24/7 service, but at that time the CCG was unable to secure funding for a new build and the UCC were housed in interim premises. The location and size of the UCC did not meet public expectation and compromised full service delivery eg the emergency department reception was never designed for primary care streaming; there were no rooms available 'hands on' triage; poor line of sight to patients waiting to be seen; privacy issues and the UCC were unable to stream ambulance patients.

It was noted that with limited space, the UCC provides a very successful pathway and has one of the best 4 hour wait targets across in England.

Jason displayed an aerial view of the current UCC and Emergency Department, which clearly identifies the layout concerns etc. In 2016 a working group was established and 3 options were identified and progressed through to a feasibility study. Jason advised members that the CCG had been successful in securing £2.6m funding to build the new Urgent Care Centre. Architects have provided designs for an extension and redesign of the UCC. It is anticipated that the new UCC which will be of modular design will open in November 2017. The UCC will have a new entrance, treatment rooms and the reception will commence streaming of walk-in and ambulance patients.

As work commences, the A&E department will have a temporary entrance (to the right of the current ambulance bays).

A steering group is held on a monthly basis and includes clinicians, chief executives of Dudley CCG and DGFT and Healthwatch Dudley. Their remit is to consider all aspects of the build and appoint a contractor. In July an advertisement will be circulated for contractors. Jason agreed to share all future plans and welcomes feedback from members.

3. Questions

Q1 November 2017 is a remarkably quick turnaround. How will this date be met?

In advance of the bid, planning permission was requested and this to be agreed imminently. The extension will be of modular design and contractors have been informed of the build and the deadline. We expect the UCC to be operational before mid-winter therefore November was selected.

Q2 Where will the UCC be located?

The UCC entrance and overall site will be to the left of the current A&E entrance.

Q3 It feels like capacity and performance has dipped at the UCC lately, are we redesigning a build for now or for example 5 years time? Will members of POPs be represented at the monthly steering group?

The UCC is demonstrating exemplary work but did agree that they were very busy over the winter period. Jason confirmed the designs are modelled for the future and the group should be assured of resilience.

Jason welcomed POPs representation at the monthly Steering Groups and agreed to attend POPs again hopefully August to share the refined layout plans with the group. Stuart said he and Geoff Lawley would be happy to represent the group.

Q4 Have you incorporated a Pharmacy into the design?

No not within the UCC. DGFT have explored this and state that it will not be financially viable as there wouldn't be enough primary care prescriptions to reimburse all the various expenditures ie licences, staff etc...

Duncan Jenkins joined the conversation and stated he is keen to find a model that would work onsite at UCC/DGFT; however financial costs are making this difficult. Duncan explained that a CCG commissioned pharmacy located on the Priory Estate are interested and wish to be involved. It may be necessary to look at technology ie community pharmacies.

Q5 Are there any contractors in the running?

Jason confirmed that DGFT had held discussions with a small number of companies. Once the plan is finally agreed, contractors will then commence enabling. The A&E entrance will temporarily move into a modular building to the right of the ambulance bays, to allow access and commence building.

Q6 Are you improving onsite car parking?

No additional improvements will be made; the former staff car park by the Maternity building has been made available to members of the public. We accept that parking is an issue but this is a nationwide problem.

Q7 How will ambulance patients access the emergency department for triage?

When the new building is up and running, all ambulances will go via the UCC entrance for streaming of patients.

A purpose built ambulance handover suite (will house 15 trolleys) will be built and will assist the compromised ambulance crews.

Richard Gee thanked Jason for his update presentation and for all his efforts in establishing a UCC and securing funding for the new build.

4. Decommissioning Policy – Dr Duncan Jenkins

Duncan introduced himself as the Pharmaceutical Public Health Team lead.

Duncan advised the group that the PPHT are collaborating with Dudley CCG colleagues and have launched a consultation on the Draft Decommissioning Policy. The details of the consultation are available on the CCG website. Duncan provided an overview:

The NHS and Dudley CCG is financially challenged and the 'decommissioning policy' may be able to assist in saving £100m across the UK and £14m in Dudley. £14m equates to 3% of the whole £470m CCG budget. There has been an increase of 3.4% outpatient appointments; 2% emergency admissions to hospitals' 2% A&E visits and more funds are needed to be spent on Continuing Healthcare as the UK has an ever increasing aging population.

What is the Decommissioning Policy?

'Decommissioning' refers to the process of withdrawing funding for a particular service or intervention. It does not refer to redesigning pathways, appointing new providers, retendering, revision of contracts, or review of reimbursement mechanisms.

The policy will allow the CCG to make decisions in a considered and fair way, supports redirection of spend from low priority to higher priority items – try to maintain financial balance (demonstrate how the CCG can and will save money) and protects the CCG from legal challenge (as there are robust systems in place).

The way in which the CCG will approach this is to ensure overarching principles ie stay in budget which is a legal requirement; understand that the CCG cannot provide everything – not legally expected to provide all that patients need; have a consistent process ie decision making; prioritise, consider all options available; engage with the public and professionals and consider the impact this will have.

The CCG will utilise a prioritisation tool (what is the need – essential or a luxury; evaluate the service and does it provide value for money; if a cost saving is identified how best could we utilise these funds; how many patients will it affect; would it be fair to stop providing a service or item; should the NHS be spending money in this area; does it meet a national priority and does it address health inequalities ie close the gap of services between deprived and affluent areas) which will work in-conjunction with an impact assessment and identify a defined process for the decommissioning to take place.

The Impact Assessment will look at how this will impact on patients ie will it cause emotional distress, required to travel further for treatment; the wider system ie unintended consequences or will a 'pop up' service appear elsewhere; provider – the CCG must ensure their financial viability and local community ie will jobs be lost?

The CCG recognises that demand could outstrip the budget so they will need to look at relative priorities to ensure increased priority for residents of Dudley. One example was should we prescribe silk underwear on prescription for patients with skin conditions. Is this an essential item or a luxury – what other options are available to patients with skin conditions?

There are three consultation questions:

1. Is the overall approach reasonable?
2. Does the prioritisation tool include the right things?
3. Does the impact assessment include the right things?

The consultation can be accessed via
http://www.dudleyccg.nhs.uk/engagement-and-consultations/

Feedback is encouraged and welcomed.

Questions & Answer Session

Q1 What is the timescale for the consultation and implementation of this policy?

5 weeks – the link & policy will be circulated to POPs members and all were encouraged to feedback, all input is considered and is a valuable asset to the CCG.

Duncan stressed that there is no current list of items to withdrawn but this would be considered at the next stage.

Q2 Do you have a current Prioritisation Tool?

No, the CCG intends to access the general tools available.

Q3 Will the areas considered have a weighting and balancing system applied?

The CCG has thought long and hard about this and a previous scoring system was problematic. It has therefore been agreed to adopt a qualitative approach and compare one on one.

Q4 Given the impact on social care, will funding feature in this model?

The CCG will look at this for inclusion in the model.

Social care alongside healthcare will be considered particularly with the proposed Multi-Specialty Consultation Process (MCP). In April 2018 the MCP will commence and the MCP and CCG will have a collaborative approach in this area but it is anticipated that the CCG will hold responsibility.

Q5 When does the Consultation close?

Helen Codd confirmed the consultation will end on the 14 July 2017.

Q6 If a judicial review was held would the decommissioning policy discriminate against ethnic backgrounds, patients of different needs? Should this be NICE guidance (national requirement)?

Simon Stevens is encouraging a judicial review of NHS Clinical Commissioners. Unfortunately GP are stuck in the middle due to ethical and contractual issues.

There is a drug tariff 'Black List' and work is ongoing nationally to add items to this list for example paracetamol could be added as it has little or limited clinical value and is easily accessible at a fraction of the cost if supplied on prescription.

Richard Gee thanked Duncan for a clear and informative presentation and encouraged all group members to provide feedback.

5. Draft minutes from last meeting & outstanding actions

The minutes from the meeting held on 6 April 2017 were agreed as a true and accurate record.

Notes

Page 3 – Atlantic House should state it is an adult service.

Page 4 – Needs assessment – should this include young people? It was agreed that this should be noted; however at this time Trish Taylor had stated that the adults' mental health needs assessment was ongoing.

A discussion took place with regards to DNA's (Did Not Attend) and the associate costs to the practice and the NHS as a whole. It was reported that a patient from Lapal Practice

received a hospital appointment and it stated that if the patient were to DNA the cost to the NHS was X amount. Is this something that the GP practices could also advertise? It was noted that Feldon Lane PPG had previously advised patients of the costs to the practice and how failing to attend also affects other patients.

The discussion also looked at attendance at A&E or UCC when it wasn't necessary. What are the costs involved? Richard Gee agreed to identify the GP and the A&E/UCC costs and circulate to POPs members.

Action: Helen Codd to find costs.

- Approximately £30 to £40 per DNA to a practice
- An attendance at A&E costs on average £130; it costs on average £1,500 per emergency admission
- An Ambulance call out on average costs £200

No outstanding actions were reported.

Matters Arising:

David Gill stated he would like to ask a question with regards to MDTs for mental health and how they currently run in 9 GP practices. His practice wasn't aware of the 9 GPs with this facility and the GP was questioning what is the difference between the MDT operated at their practice where they do review patients, some who have mental health problems as well as other health problems. What is the difference to what they are doing now and what is being proposed for the future?

The proposal that we discussed last time is for a specific MDT which is entirely dedicated to patients with mental health problems, so there are mental health clinicians, consultant psychiatrists and CPNs on the MDT. This is a pilot and is therefore being monitored. There will be a report issued once the pilot is over, so we can see if this is worthwhile. For the smaller practices may wish to combine these two MDTs but as for larger practices (ie over 10,000 patients) may find it more beneficial to run parallel MDTs. Each practice can design the way in which their MDT operates.

6. Networking

Members took time to share ideas and information.

7. Discussion about Long-Term Conditions and Patient Engagement – Joanne Taylor

Joanne introduced herself as the Commissioning Manager for Primary Care.

Joanne provided an update on long-term condition, patient engagement, access and patient online. The CCG has commissioned a local framework which is called the Dudley Quality Outcomes for Health It was noted that 42/45 GP practices have agreed and chosen to move away from the national contract which is called the Quality Outcomes Framework (QOF) to the local contract which is commissioning the New Model of Care. There are three themes in the New Model of Care

- Access for people, at a time that is convenient for them.
- Continuity of care for example a patient suffers with a long-term condition and you wish to see the same GP or nurse

- For the frail/elderly we have co-ordinated care – for example multi-disciplinary teams (MDTs) from different providers working together to co-ordinate the patients care

As part of the process the CCG has had an independent evaluation team visit the practices evaluating these areas. The team will revisit practices in the summer in order to see how to engage better with patients in practices and to follow up patients following a consultation with a medical/nursing professional.

Joanne asked if any members of the group had any thoughts on how to engage better with patients and if the PPGs wish to become involved.

Joanne provided an example of how national contracts commission services for diabetic patients: there are local schemes for GPs who go above and beyond and national schemes but these overlap. Dudley CCG wishes to develop a single framework which encompasses all and develop an alert system and templates so that all practices work to the same standards.

Access indicators should ensure that all practices are open 'core' hours and same day access is granted to under 5's and over 75's and MDTs are held on a monthly basis.

The CCG now has a standard set of generic core indicators which include:

- Named Care Co-ordinator
- Provide screening for various healthcare issues ie Alcohol status, BMI, Depression, Diabetes, COPD etc (preventative methods and evidence-based targets)
- Evidence-based targets (this will be refined and tighter target area to reach)

It is the aim of the CCG to have all GPs on the same framework in readiness for the commencement of the MCP in April 2018.

A member of the group expressed a concern as they are currently experiencing difficulties in booking appointments with the GP and are often seen by one of the trainees, hence the lack of continuity of care. If a patient has a medical emergency they are usually able to book a same day appointment but for routine or long-term care condition appointments you have to wait 2-3 weeks and it is never with the same person. Richard Gee explained that the increase in demand in acute emergency is causing problems for long-term care/conditions and continuity. There are limited GP resources and often the workload is spread across the team such as an Advanced Nurse Practitioner (ANP) or a Healthcare Assistant (HCA). Training staff to support the GP is helpful as it allows patient demands to be met. For example a HCA can be trained to take clinical measurements such as blood pressure measurements and the ANP can review a patient care plan.

Joanne explained that Diabetic Consultants now also work in the primary care setting and work closely with GPs which is beneficial to both the patients and the medical professionals. The CCG is exploring patient centred goals which allows patients to set their own goals ie smoking cessation, losing weight etc which means they are more likely to achieve. There is a need to explore how we converse and encourage patients to make the right health choices.

There is a need to separate acute illness appointments from long-term condition appointments. Practices operating within the framework will arrange annual review appointments for approximately 30-45 minutes in length.

Standardised Screening Tests – How is it different?

By monitoring blood pressure, BMI, smoking, exercise, diet, alcohol early intervention can extend and improve an individuals' life expectancy. Having holistic assessments now manage the individual and their conditions all at once – this then saves time, money and ultimately helps the patient.

An issue was raised by Bill Beardow around standardised testing. He has a test every 6 months and has asked to have this with his annual health check but has been told this is not possible.

A debate followed around PSA tests for prostate cancer, whereby Richard Gee advised evidence had showed it was not a good screening test and that a better test was needed.

Joanne asked how the PPG could support a positive change in patient engagement.

A few members of the group stated that they had not been contacted by their practice to attend an annual review. However, it was reported that AW Surgery allows 60 minutes for a diabetic review. A group member advised that she had attended the initial pre-diabetic group and it had 8 attendees, at the meeting last week there were only 3 attendees. Members questions whose responsibility is it to inform patients of annual reviews. Joanne agreed to look into the annual review calls.

The QOF and the outcomes need to be understood by patients on how it will help them to live longer and healthier. If the public understand then they can be motivated to lifestyle changes and benefits. The three-yearly NHS health checks for patients aged between 40-70 years) have a poor uptake and this varies across the practices. The reason for this is poor communication and retaining good staff members. It was suggested that the CCG should include patients in developing and writing letters which are then used and sent to patients. Richard Gee stated that he visits every locality and practice at least once a year and is keen to help in the better engagement between practices and patients.

Harry Bloomer stated that MDTs cross over and share the workload. Richard Gee agreed that rationalising services is common place but if the patients were informed of the reasons why then they would understand.

It was noted that some surgeries still close 2 x 0.5 days per week ie Chapel Street Health Surgery (Wychbury) which is seen to have a gap in service. The CCG is looking at these surgeries and considering early development of services. In order to make changes, there is a need to illustrate the benefits.

Footnote: can the CCG assure the public that plain English is used and the removal of acronyms is enforced.

8. Questions to Board

Richard Gee asked those present if there were any questions they would like raised at the DCCG Board Meetings.

David Stenson stated that he had submitted a question for Board which relates to a 'Hub in Kingswinford' – is there any additional information available? Helen Codd acknowledged that this question had been received and will be raised at the Board meeting.

Board July 2017
Question asked:
When will information be available for the proposed hub in Kingswinford? Which practices are likely to be involved and how will consultation with staff take place? What is the time frame for this?
Response provided by: Matt Hartland
We are in conversation about primary care developments in Kingswinford with local practices. We are however not at a point where we are able to share any further information at the moment as any proposal or suggestion has to be viable for all involved. Once we know whether a proposal is viable, we would undertake a full consultation with all affected patients, staff and local communities to ensure that views are sought on the options and that there is an opportunity to influence the future of primary care in Kingswinford. There is no time frame for this at present and any communication will be led by the practices themselves in the first instance.

Is it correct that the practice at Colleygate is being considered by the CCG for closure and the land will be used for new build? Richard Gee recommended that an Estates Strategy presentation is arranged for POPs. Helen Codd acknowledged this request and confirmed that Matthew Hartland and his team had been approached and were trying to agree a date to attend POPs.

9. Updates

9.1 Healthwatch Dudley

Jayne Emery was unable to attend this meeting; however she has provided a written update to be included in the notes.

- Healthwatch Dudley has continued to attend many events to listen to people's experiences of health and social care.
- The Annual Report for 2016/17 will be available the beginning of July and this will be circulated to POPs members.
- The quarterly report for April to June 2017 will also be circulate mid-July.
- Information Point Training is being offered to all GP practices.
- Upcoming Projects:
  - Healthwatch will be starting a piece of work shortly, talking to people who have experience of homelessness, alcohol and drug misuse and mental health problems about how they use health and social care services. We want to find out which ones work well and which ones could do better.
  - We will be supporting Dudley Office for Public Health and Dudley CCG with the development of a new pharmaceutical needs assessment. We will be gathering peoples views and experiences of accessing and using community pharmacy services.
  - We will be assessing how parents and carers of infants and young children get access (or not) to medical advice or help. This may be through contacting NHS 111 services, doctor's surgery, travelling to Russells Hall Hospital and being seen at the Urgent Care Centre or Emergency Department and the Paediatric Assessment Unit.
- If any PPG members would like to support any of the above projects, please do get in touch and we are always happy to come and give an update/talk at any PPG meetings.

9.2 RHH Building

This was covered by Jason Evans presentation.

9.3 MCP Update

Richard Gee advised the group that Purdah ended on 8 June and that the CCG has issued the Pre-Qualifying Questions (PQQ) document on the 9 June 2017 to launch the procurement. Expressions of interest are to be submitted within the next four week period.

9.4 Mental Health Acquisition Update

The Black Country Healthcare Partnership Trust and Dudley & Walsall Mental Health Partnership Trust are considering a business case for the Birmingham Community Healthcare Trust to amalgamate the three Trusts. The proposed date for this amalgamation is 1 October 2017.

10. Date, Time & Venue of next POPs meeting

Thursday 10 August 2017
10.30am – 1.00pm
Zion Centre, Halesowen, B63 3DA.