

## Report Summary Sheet

<b>DETAILS</b>	Part 1 (Open)		Part 2 (Closed)		<b>Agenda Item</b>	<b>3.2</b>
<b>Meeting</b>	<b>Joint Primary Care Co-commissioning Committee</b>					
<b>Date</b>	<b>28 July 2016</b>					
<b>Title of Paper</b>	<b>Engagement Report on Statement of Intent</b>					
<b>Executive Lead / Clinical Lead</b>	Suzannah Power Lay Member for Patient and Public Involvement					
<b>Author</b>	Barry Grimes, Communications Manager					
<b>Appendices</b>	N/A					

<b>Request</b>	Approval		Discussion	<b>X</b>	Information		Assurance	
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<b>EXECUTIVE SUMMARY</b>	
<b>Purpose</b>	<p>This report provides a summary of feedback on the CCG's draft statement of intent for general practice collected from the following engagement activities between March and July 2016:</p> <p><b>Patients and the general public</b></p> <ul style="list-style-type: none"> <li>• PPG network meeting on 9 June</li> <li>• 5 x area forum meetings in late June/early July</li> <li>• GP patient survey results published on 2 July</li> <li>• Chew Valley village agents event on 13 July</li> </ul> <p><b>General practice workforce</b></p> <ul style="list-style-type: none"> <li>• Feedback from cluster meetings on 10 March</li> <li>• Online survey of general practice workforce in May/June</li> <li>• Feedback from Practice Nurse Forum on 5 July</li> </ul>
<b>Recommendation</b>	The committee is asked to note the feedback summarised in the report and to take it into account when making decisions about the future of primary care in Bath and North East Somerset.
<b>Risk</b>	<b>High</b> <b>Medium</b> <b>X</b> <b>Low</b>
<b>Impact on Quality</b>	Taking positive action in response to this feedback will lead to improvements in patient experience and the quality of local primary care services.
<b>Impact on Finance</b>	The report does not make requests for any additional funding but any actions taken in response to the report could lead to cost savings or result in additional expenditure.

# Engagement Report on Statement of Intent

## 1. Executive Summary

Overall, there is general support from patients and the workforce for practices to work together more collaboratively to deliver a wider range of services in the community at appropriate times and locations. However, there is some concern that patients may get confused or frustrated if they are required to visit multiple locations for their care.

Both patients and the workforce were keen to ensure that working at scale does not impact on continuity of care as building trusting relationships between doctors and patients is a key factor in the quality of general practice and particularly important for the elderly population.

There is little demand for primary care services on Sundays except for emergencies. Drop in sessions and management of long term conditions on Saturdays would be popular. Many people requiring help at the weekend simply require some reassurance from a trusted professional to reduce anxiety. This could be via phone or online.

Discussions about seven day services should clearly explain the difference between urgent GP appointments delivered by the out-of-hour service and routine appointments with a named GP being available on evenings and weekends.

The following locations are underutilised: St Martin's Hospital, Keynsham Health Centre, Chew Valley Children's Centre, Paulton Hospital and supermarket pharmacies which often stay open on evenings and weekends.

The latest results from the GP Patient Survey show that 94% of respondents described their overall experience of their GP surgery as good or very good; the highest percentage of all CCGs in England. Only 5% are dissatisfied with their GP surgery's opening hours but awareness and take up of online services is still low.

A multispecialty community provider (MCP) is a way of working and shouldn't be confused with a physical building. Practices should work collaboratively with the RUH rather than duplicating services. Some practices are also concerned that the transfer of services into community hubs could affect their financial viability.

The workforce is supportive of exploring alternatives to QOF but doesn't want to end up with something worse which creates even more work and administrative burden.

Practice nurses are supportive of more joint working as there is not enough expertise to go round for all 26 practices in BaNES. They play a vital role in delivering QOF and the management of long term conditions.

## 2. Patients and the general public

### 2.1 PPG Network Meeting

The second PPG network meeting was held on 9 June. There were 10 practices represented in total with 13 patients and 7 staff in attendance as well as observers from Healthwatch and Sirona care & health.

A presentation was given to explain the current pressures on general practice and the CCG's vision for services in 2020. The PPGs agreed to take the information back to their practices for further discussion. The network will reconvene in September for the PPG reps to report back from these discussions.

### 2.2 Area Forums

Bath & North East Somerset Council organises regular Area Forums in Bathavon, Bath City, Chew Valley, Keynsham and Somer Valley.

Ian Orpen and Barry Grimes (supported by Corinne Edwards) attended all five forums in late June and early July to present the CCG's draft statement of intent, collect feedback about primary care services in those five communities and seek views on seven day services. The feedback is summarised below:

#### **Seven Day Services**

There needs to be clarity between urgent GP appointments delivered by the OOH service and routine, bookable appointments with a named GP being available on evenings and weekends.

#### *Saturdays*

- Appointments should be available on Saturdays for those who work during the week. Saturday mornings should be the bare minimum.
- Saturday appointments should be drop-in sessions or only bookable a few days before to prevent slots getting booked up by people who could have attended during the week. This would also reduce the number of people who may not turn up if the weather is good and they decide to do something else instead.
- People will go to A&E on Saturdays if they can't see a GP on Friday and don't want to wait until Monday.

### *Sundays*

- GP appointments on a Sunday are not required unless it's an emergency. There are a limited number of GPs so if they have to work at weekends there will be fewer appointments available in the week.
- Public transport on a Sunday is limited which makes it difficult for people to get to appointments. If you need a prescription then the majority of local pharmacies are not open either.

### *Weekdays*

- More early appointments before work would be good e.g. 7:30am onwards.
- Some people are concerned about seeing a GP in the evening who has been working since 7:30am but others noted that nurses and midwives work 12 hour shifts.
- If you are ill enough to see a GP then you shouldn't be at work anyway. Many people get better in time without needing an appointment so we shouldn't make access to GPs too easy.
- Mondays (or Tuesdays after a Bank Holiday) are often the hardest time to get an appointment because everyone has been waiting over the weekend for the surgery to reopen.
- Pharmacies in supermarkets are often open until late at night. Why don't you offer appointments there? Services don't have to be in GP surgeries. Look at where the public go and deliver services from there.

### *Emergencies*

- Patients don't choose when they get ill. If they have an urgent concern, they want to be treated in their own community rather than travelling elsewhere or going through a call centre.
- Someone who wants a doctor on a Sunday or late at night is generally an emergency or someone who just needs some reassurance over the phone from an appropriate person.

- The GP out-of-hours service already exists for emergencies but they should have access to the full patient record. They can also prescribe and dispense medication if required.

## **Bathavon**

Freshford Surgery lies within the BaNES council area but is part of Beckington Family Practice which comes under Somerset CCG. This leads to confusion about which services are available to patients.

St Martin's Hospital is an underused resource. It could be an important location for supporting the population growth at Foxhill (Mulberry Park).

The automated phone systems have too many options, especially if you get put through to reception whichever option you choose. Booking an appointment online also needs to be made easier.

Patients often need to provide their records for pension companies or medicals. If you could do this yourself online then you wouldn't need to bother the GP about it.

People are happy to talk to any healthcare professional that can help them. This could be done on the phone or online rather than face to face.

Experience of 111 has been very good. It's a good way to get reassurance without burdening the GP practice.

The older generation are reluctant to bother their GP and wait until they're really ill to book an appointment. The younger generation expect appointments straight away but could often get the advice they need online.

## **Keynsham**

It's important for people to see a doctor who knows them to ensure continuity of care. Need to build a trusting relationship.

Phone appointments save time and means people don't have to travel to the practice but many people are not aware they are available.

Why are practices advertising for more patients when you have to wait a week for an appointment?

One patient explained he had to travel all the way to the BRI for a five minute diagnostic test on a machine. This test should be available in the community.

The Keynsham Health Centre has not been utilised in the way it was envisaged. More services could be delivered from there e.g. minor surgery, diagnostic tests.

Patient records across all three practices in Keynsham need to be joined up so the practices can rotate evening and weekend appointments between them.

The Paulton Minor Injuries Unit was advertised in the Council Connect magazine. It provides a very good service but not many people know about it.

The quality of nurse-led services needs to be highlighted too. Trainee nurses should be encouraged to come and work in general practice.

### **Bath City Conference**

An MCP should be like a GP practice that provides a hub for community services, mental health services and the voluntary sector.

Practices need to make more use of community assets. There is a lot of knowledge and energy within communities but they need to share information and collaborate. The GP is not always the best person for someone to see.

Will practice mergers actually deliver significant cost savings if they don't relocate to one big building? Is it worth the aggravation?

Patients could get confused or frustrated if they're required to travel to different practices to see specialists for different long term conditions.

Community midwives should be included in MDT meetings. They are primary referrers.

### **Somer Valley**

People are often willing to travel to see 'the best' for specialist care e.g. heart specialists in Bristol. Services should only be moved out of hospitals and into the community if the quality and clinical outcomes can be maintained.

The White Horse Medical Centre in Westbury is run by a group of three GP practices and offers a wide range of services including minor operations.

The NHS has limited resources. There is a five month wait for physio services so maybe more resources should be focussed there.

The local community supports the relocation of Hope House Surgery. The practice is struggling for space but it is still accepting new patients. They plan to increase their

capacity by 4,000 by moving to a new location in Radstock but few people are aware this would include co-location with the library and other council services.

Local people (and the local GP practices) are very concerned about the number of new homes being planned in the area. They want to see more infrastructure built to support the increase in population, particularly health services and transport.

There is concern about the differences in life expectancy for a child born in Radstock compared to a child born in Midsomer Norton.

The CCG were encouraged to use parish and town magazines like Midsomer Norton Life to raise awareness of health issues with the local community.

## **Chew Valley**

The Children's Centre is not being utilised to its full potential. It is on the school site but owned by the council. It could be used for elderly care.

Chew doesn't have a critical mass of population so services are thin on the ground. If multiple agencies can group together then it will become easier to provide services to people holistically.

How will mental health services be delivered in primary care? A lot of the long term management of mental health conditions is now the responsibility of GPs but do they have the skill set to manage this effectively?

## **2.3 GP Patient Survey**

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people across the UK. The results show how people feel about their GP practice.

In BaNES, the latest results are based on 3,185 responses from fieldwork carried out between January and March 2016.

### **General feedback**

*94% of respondents described their overall experience of their GP surgery as good or very good; the highest percentage of all CCGs in England. The range between the 26 practices in BaNES was 86% to 97%.*

- 86% found it easy to get through to someone at their GP surgery on the phone
- 94% found the receptionists helpful

- 90% were able to get an appointment when they needed to
- 95% found their appointment convenient
- 86% had a good experience of making an appointment
- 26% felt they had to wait too long to be seen
- 98% had trust in the GP or nurse they saw or spoke to

### Feedback on out-of-hours services

- Only 5% are dissatisfied with their GP surgery’s opening hours
- 28% felt it took too long to receive care or advice from the OOH service
- 89% had confidence in the person they saw or spoke to from the OOH service
- 71% said their overall experience of OOH services was good

### Online services

	Awareness	Used (last six months)
Booking appointments online	37%	9%
Ordering repeat prescriptions online	40%	14%
Accessing medical records	6%	1%

## 2.4 Chew Valley Village Agents

*The Village Agents in the Chew Valley held an event on 13 July to obtain feedback about primary care services from elderly patients. Their findings are shown below:*

Working people need access to early morning and evening appointments. A drop in session on a Saturday for more urgent situations is the bare minimum required.

The 111 service is not generally well received locally because of conflicting advice. They don’t know people or understand their history. Some people have tried and get very confused.

There needs to be a better definition of “urgent” i.e. when someone really should see a medical professional rather than self-medicating or mismanaging their condition.

It’s better to get an elderly patient in front of a GP quickly rather than letting them get worse. How can “early interventions” happen if there are no urgent appointments?

Telephone access to a GP or local medical professional at the weekend would be helpful. Just having someone trusted to talk to would reduce the panic and anxiety.

Waiting 2-3 weeks for an appointment is too long. It would be nice to get an appointment within a week.

There needs to be better follow up by GPs when people are discharged from hospital as there is so much to take in and new regimes to follow.

Getting ill at the end of the week is very scary if you know that getting an appointment is going to be difficult. Urine infections that need immediate attention could be resolved quickly if you can get to see someone at the weekend.

If I need to get to the GP at the weekend, transport might be difficult but I don't want to spend the whole weekend worrying.

Bishop Sutton and Chew Stoke subsidise a minibus every Wednesday to take people to the local surgery. A block booking is made by the practice so that everyone can be seen without having to book ahead. Can that happen for other areas?

We can't expect a seven day service for the same budget but if the available times do not reflect the needs of the patients something must change.

Medical centres should offer small operations (for appropriate conditions) so people don't have to travel to the bigger hospitals in Bristol and Bath.

The Village Agents are constantly trying to encourage people to attend regular reviews for their long term conditions. These appointments should be "ring fenced". Only a few require full GP input.

Many people who can't get to the practice easily don't understand the criteria for getting a home visit so they wait until they're really ill in order to get a home visit.

### **3 General Practice Workforce**

#### **3.1 Feedback from Cluster Meetings**

*The CCG's cluster meetings on 10 March brought together representatives from practices across Bath and North East Somerset to discuss new ways of working for general practice. Some of the key points from this session are below:*

Don't create competition between practices which could destabilise relationships.

How will working at scale impact on the brand and reputation of individual practices?

The vision needs to be achieved through evolution; not forced on practices.

The new generation of GPs don't want to be partners or own estate.

The biggest barriers to change are money, time and capacity.

GPs need PA support to reduce the time they spend on admin and paperwork.

What will the role of BEMS+ be if practices start to work at scale in their clusters?  
Could they provide project management support to clusters or could practice managers perform this role?

Allied health professionals and pharmacists need to be involved in decision making.

It's important to have separate approaches for Keynsham and the Chew Valley.

More complex, specialist services could be delivered at Paulton Hospital as it's not financially viable to deliver these services from every practice in the cluster.

More services and funding should be transferred from secondary care into the community but transferring services from practices into community hubs could affect the financial viability of the practice.

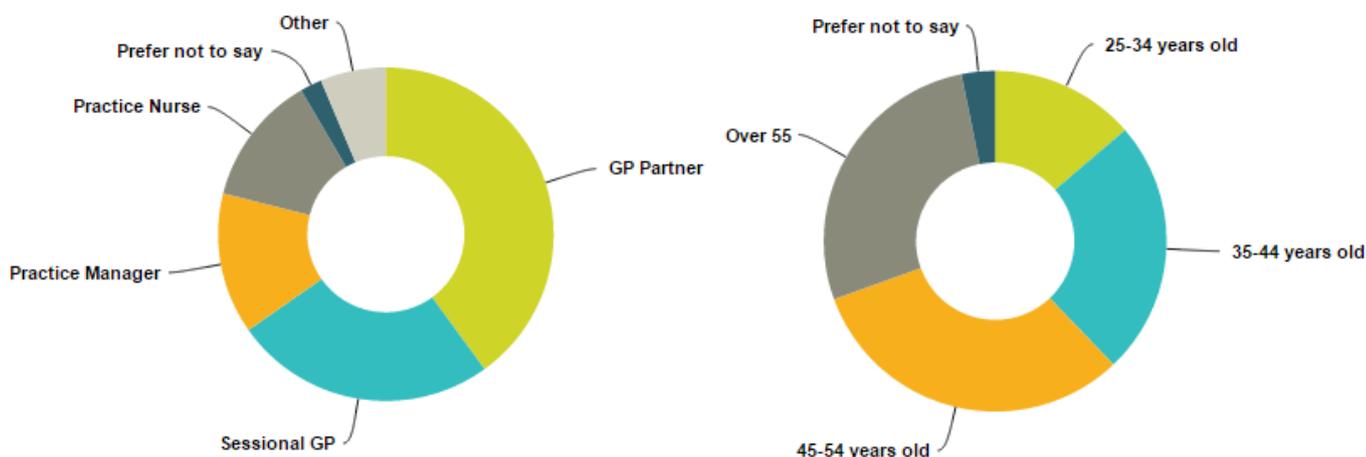
Multispeciality Community Providers (MCPs) could provide:

- Rooms for GPSIs and other healthcare professionals
- Management of long term conditions
- Peer support groups and patient education e.g. memory cafes
- Diagnostic services
- Minor injuries units
- Minor procedures
- Day centre
- MSK
- Intermediate care
- Gastroenterology
- Cardiology
- Joint injections
- Dermatology
- Geriatricians

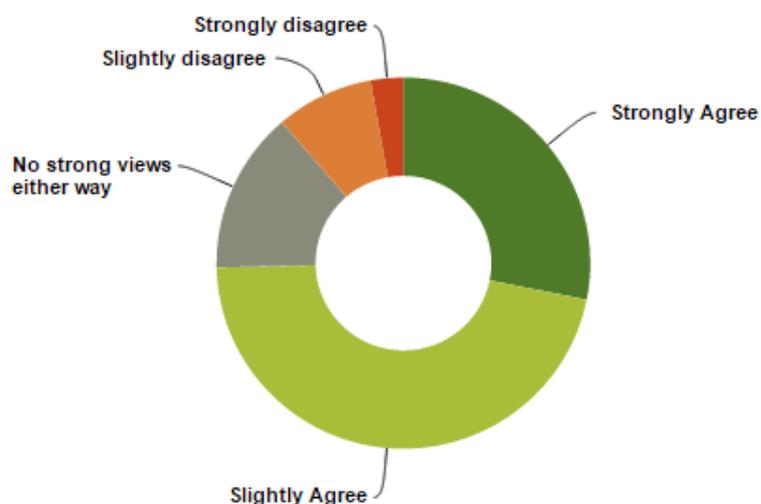
### **3.2 Online Survey of General Practice Workforce**

The CCG carried out an online survey in May/June 2016 to seek feedback on the draft statement of intent from the general practice workforce.

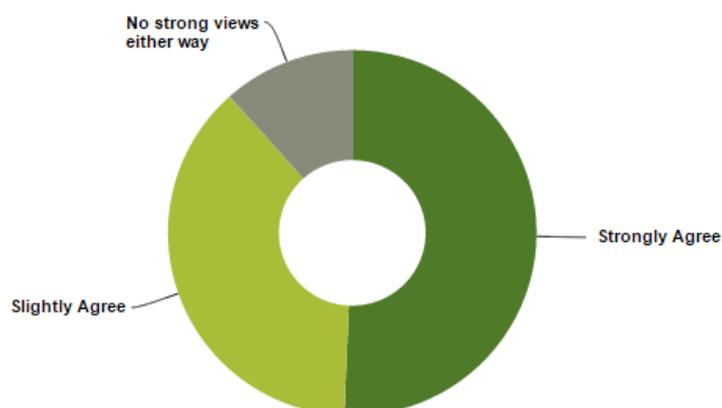
95 responses were received from practice staff from across all four cluster areas. These have been broken down by job role and age below:



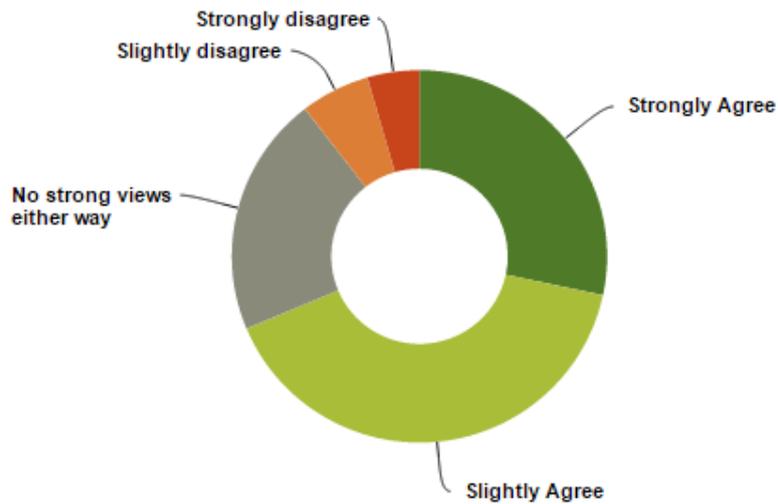
**Overall, do you agree with the vision for general practice in B&NES set out in the Statement of Intent?**



**Does the Statement of Intent have major implications for you or your practice?**



**Would you be happy to explore a proposal to scrap QOF and replace it with a Dudley-type outcomes model?**



**Do you agree with the following aspects in the Statement of Intent?**

	Strongly Disagree	Slightly Disagree	No strong views	Slightly agree	Strongly agree	Average (out of 5)
Building multi-disciplinary team approaches	4%	0%	4%	27%	64%	4.47
Maximising the role of technology	2%	4%	5%	24%	62%	4.40
Supporting practice collaboration	4%	5%	4%	30%	55%	4.26
Developing new roles in the primary care workforce	5%	7%	7%	34%	44%	4.06
Securing high quality services through quality monitoring and peer review	4%	4%	13%	46%	31%	3.97
Developing a number of locations as MCPs to deliver out of hospital services	7%	8%	10%	46%	27%	3.78
Groups or merged practices that serve larger populations	7%	25%	10%	37%	20%	3.37
Enhanced offer on evenings and weekends	18%	17%	15%	34%	13%	3.06

**What are the unique selling points that make general practice in BaNES different from anywhere else?**

High quality general practice	★★★★★
Collaborative working	★★★★★
<i>your care, your way</i>	★★★★★
Mix of urban and rural areas	★★★★★
Population growth	★★★★★
<b>Other Suggestions:</b>	
Wide gap between affluent and deprived areas	
Strong relationship with RUH	
High numbers of visitors	
Two universities	
Low level of local industry	

**General Comments**

Practices working at scale must not impact on continuity of care. Building trusting relationships between doctors and patients is a key factor in the quality of general practice and particularly important for the elderly population.

An MCP is a way of working. It shouldn't be confused with a physical building. We must work collaboratively with the RUH rather than duplicating services in MCPs.

Groups of merged practices need to be aligned within a tight geographical area to avoid time and money being wasted on travel for home visits, MDT meetings and peripatetic specialist roles.

The CCG needs to recognise the goals and timetables of individual practices and discuss this with them on a 1:1 basis. Some face to face consultation with those practices not yet signed up to a merged model would be helpful.

If people are our greatest asset then there needs to be a transformation plan for the workforce, particularly those who may transfer from secondary care to deliver services in the community.

Will all of the existing primary care workforce be utilised? Will staff have to work across various locations? Will there be enhanced pay and conditions for working late nights and weekends?

Fragmented community services and lack of care in the community are a real concern.

The CCG needs to set out clear benefits for partners e.g. central admin for CQC, scrap QOF to focus on patients as per Dudley and gradual rationalisation of buildings with the CCG purchasing those that are willing, with slow relocation to the hubs.

GPs should have the option of a "salary plus" model; the plus being bonuses for performance/shares in the buildings. Shares in the buildings also offered to all other primary care staff.

What is the strategy for addressing the impending GP recruitment crisis? Suggesting that a system that is failing to cope with current demand should offer additional extra weekend and evening surgeries is misguided and will add to the exodus of GPs from primary care.

There is no explanation of how the panacea of 'federating' will actually resolve the major problems of primary care. More explanation of how the GP Forward View fits locally is required.

Do not like the feeling of being pushed towards something that may not be the correct way forward. Once again it is a political incentive, not what may be required to make a more efficient NHS.

### ***What are the implications for you or your practice?***

#### *Working together*

- Merging or working collaboratively with other practices.
- Without a plan to work together, we will not cope.
- Either forced merger or practice closure.
- Some practices may break away in search of gains, threatening the cohesiveness of the patch.
- A significant percentage of practice income is derived from enhanced and 'non-core' services. Limiting these to individual practices could lead to inequity of funding and of access to services for patients.

- Because of the geography of the Norton Radstock area I feel a spoke and hub model with practice federation rather than full merger being better suited to our area. Individuals acting as spokes to a central hub (e.g. Paulton) where more centralised services (e.g. diabetes, dressing clinics, INR clinics) could be potentially run.

### *Seven day working*

- We are jumping to provide care to patients who can largely wait until Monday. How much ill health will be prevented by seven day working?
- Seven day working will affect the practice dynamic and impose different stresses on the practice team.

### *Continuity of care*

- Potential for knowing your patients less well.
- Continuity and patient relationship diluted.
- More consultations with unfamiliar patients and reduced continuity/familiarity.
- A particular issue for the elderly and people with long term conditions.
- Some more vulnerable patients may not engage if there is only one central place for chronic disease management.
- I am concerned that larger practices will mean less knowledge of our patients and their families, less personal care and more of a production line.

### *Managing change*

- Change in working role and management structure.
- Reinventing the wheel and throwing away what has evolved over decades.
- Time implications of bidding /invoking changes
- Whatever happens I expect a radical shakeup of the way our practice currently works. Whilst some of those changes will be beneficial, some will undoubtedly be to the detriment of our staff, our practice and our patients. I am not optimistic.
- "Provide more and better for less resource" seems to be a common thread through every change.
- There needs to be much better communication at all levels to limit rumour and lack of trust.
- It is not a "one size fits all" strategy. Patients in rural areas do not have ease of access to larger centres.
- How much support can the CCG provide to bring about transformation?

### *Workforce*

- Workload. Already struggling with what we have. Unable to recruit GPs. Long term sick. Difficulties with getting regular locum cover. Everyone is overworked as it stands.
- Longer appointments and collaborative working should make general practice a more attractive option for incoming partners.
- I am concerned about yet more new 'jobs' being created to 'solve ' the GP (and shortly nurse) recruitment issues. Would prefer better investment in training more nurses and doctors and retaining them.
- If done properly, could lighten workload and stress across many disciplines.

### *Sessional GPs*

- As a locum, I can envisage possible new roles which may be interesting.
- I have concerns about how the sessional GP workforce will fit into this new vision and what voice they truly have. I know the CCG and BEMS+ are keen to have reps but without financial investment what true weight do we carry?

### ***Comments on scrapping QOF***

It depends on the detail. A lot more information on the proposed model is required.

Anything which leads to increased and meaningful improvements in service delivery should be welcomed.

We don't want to end up with something worse which creates even more work and administrative burden.

We have a high functioning, high quality primary care in BaNES. We can afford to cherry pick only the ideas that have proven, evidenced-based value, and dismiss pie-in-the-sky DoH initiatives that will add nothing to our patient's experience.

How would it happen and who is going to do that? Mustn't lose what is good about QOF in terms of education/good practice. New measures must be achievable and resourced and not break stretched minds/capabilities.

QOF is out dated but some aspects do serve a purpose. Management of long term conditions has improved in the time QOF has been present.

I would support working with a very reduced and clinically appropriate QOF. Clinically appropriate management of frail elderly should be incorporated.

Interested in a similar scheme being proposed by a group of practices in Bedminster/Bishopsworth called Primary Care Home which has a more clearly defined structure.

Have nowhere near enough idea what Dudley really involves from a few slides. Need to see it running.

QOF has a lot of good points not just bad, be wary of change without good reason and sufficient resource.

We need better community care and service for our patients. You can have all the MDT meetings you like but it's no use to patients if the answer from reablement and social care is no resource available.

QOF is routine and practices are used to it. A new outcomes model will increase the work for practices in the short-term. It is also likely to be subject to indicator creep (addition of new ones).

Practices are still likely to do the QOF work as most of it is just good chronic disease management. Therefore an outcomes model is likely to represent additional work which should be remunerated appropriately.

Provided this is not a means to syphon money away from practices.

Not enough evidence on the longer term success of this. I would be cautious that it will cost us and patients in the longer term.

Some QOF work is valuable and we would be doing it anyway. Need to ensure new model is research-based and is appropriate for both urban and rural communities.

QOF consumes a vast amount of GP time with little demonstrable benefit.

Most of QOF evidence based and is part of normal care. If we went to another model we would still have to do this work but also do new work to get money. I thought the aim was to reduce workload?

Quantitative metrics/thresholds for activity risks unscrupulous practices gaming and values quantity over quality at a time we should be moving to longer single visits.

### 3.3 Feedback from Practice Nurse Forum on 5 July

It is valuable to have student nurses working in practices. Many go on to full time roles in the practice.

At Chew Medical Practice, nurses limit Saturday appointments to the management of long term conditions (e.g. asthma, diabetes) which have been very popular. This service could be run from a MCP site on behalf of a number of practices but patients like to see the same nurse each time.

Saturday working could cause some nurses to quit.

If elderly patients are required to travel to different practices they will get confused about who they are seeing and where. In Bath, most patients walk to surgery but in rural areas patients will usually take the car.

St James's extended hours are Monday evening and Saturday morning every week to avoid confusion.

Many nurses are approaching retirement so there won't be enough expertise to go round for all 26 practices. That means practices have no choice but to collaborate and share expertise across communities.

Practice nurses are the 'engine room' of QOF. There was strong support for replacing QOF and having one version of the template. The IT systems need to be joined up so you only see the questions that you need to ask. Bristol has a package to do this.

Practice nurses are enthusiastic about working together and sharing best practice. They are happy to change IT systems if required.

Don't bulldozer or be dictatorial. Listen to people's needs and understand their willingness to work outside the 9-5 routine.

The nurses in each cluster should get together regularly so their representative can listen to their views and represent them at the CCG cluster meetings.

Nurses can do a lot more than management of long term conditions. They can also provide urgent care and contraception etc.