PPG Minutes, 12th September 2024

Charnwood Community Medical Group – Dr Hanlon and Partners Patient Participation Group (PPG)

1) **Chairman's welcome –** A huge turnout, thank you – had to open the doors! Helen welcomed us as Acting Chair. Mick introduced a new prospective member, Ian Overton. Ian has extensive knowledge working in mental health. Welcome to the group Ian.

2) **Those present** – Mick Gregory (Chair) Helen Davison (Vice Chair), Bhasker Khatri (Management Team), Carole Jefferson (Secretary), Anne Lockley, David Jefferson, David Meredith, Elizabethan Sharpe, Emilene Zitkus, Peter Lewis, Shirley Siriwardena, Paul Hanlon (Business Partner and SIRO - Charnwood Community Medical Group - Practice). Visiting speaker – Paul Moorhouse

3) **Apologies received**, Ian Farnfield, Mellissa Hadfield, Sandra Mould

1. Visiting Speaker – Paul Moorhouse 'The role of Occupational Therapy / Physiotherapy on a Renal ward in an acute hospital setting'.
    a. This was a very interesting and insightful presentation.
    b. Explained the difference between Occupational and physiotherapy
    c. Paul sees a mixture of people who have suffered kidney failure for a variety of reasons
    d. He explained the various treatments offered - Dialysis,
    e. Patients suffer decrease in physical condition after periods of time in bed. There is a judgement to be made between keeping patients mobile while maintaining safety
    f. Paul is a physiotherapist based at Glenfield Hospital, part of a clinical team which supports patients back to health and subsequently being fit enough to be discharged. Patients may be physically fit but not fit to be able to return home. A judgement has to be made based on the circumstances of the individual patient about whether or not they would be safe and thrive at home. All kinds of aids are trialled and employed with the patient and training given.
    g. Home alone may not be the best place for a patient to be discharged to and there are alternatives to 'living' in an acute ward, such as a hospital for rehabilitation, a care home or their own home with a care package.
    h. Paul is very aware that he has the luxury of being able to work with patients for longer than other clinicians, to get to know them and to design a care plan that is tailored for them.
    i. Paul answered questions, thank you Paul.
    j. Helen thanked Paul on our behalf.

2. <u>Q&A</u>
    a. Q -I do remember feeling very very weak and you encouraged me. It was so tiring
    b. A – You were determined and that will have helped your recovery. Patients mindset is very important – you are a great advert
    c. Q - The kidney specialism is it all transferred to Glenfield now?

d. A – It's a mixture. doctors working on kidneys, then the urology, Ureter, bladder, urethra etc are at the General. We moved to Glenfield a couple of years ago to align to vascular, diabetes and cardiac specialists. It's easier to work with them there. There is a plan for Urology to move to Glenfield
e. Q – what do you do about an uncooperative patient who tries to avoid physio?
f. A – there's only so much that we can do. We can't force people. We can advise them of the benefits. We hear every excuse. If people don't want to be helped we can't. They are then affecting their own recovery and their families
g. Bhasker asked a question which I couldn't pick up on the recording but it was something about discharging patients when they are medically fit but not able to cope at home
h. A – it's a dilemma. We have to come up with a plan to get the patient home, or find a way to create a bit more time to work with them, e.g. options on the presentation
i. Q – our next meeting we have someone from adult social care. Yu have highlighted the issues about discharging patients but someone has to pick up social care. They will be telling us about the support they give to patients at the point of discharge
j. A – I feel so sorry for our colleagues in Social services who are under immense pressure. E.g. all the equipment – someone has to teach patients how to use it. Delivering the level of care in a short period of time is difficult. There are issues about funding, - who pays for the care. It costs an enormous amount. We are passing a huge pressure onto Social care
k. Comment – I wish I had brought my granddaughter she is about to start a university course on physiotherapy
l. A – fantastic.
Some people call us physical terrorists – we call it tough love!

Please refer to Pauls very detailed PowerPoint presentation attached to these minutes.

4) Approval of minutes of July 12th 2024

a) Minutes were agreed and signed
b) Matters arising – The Corkill Award. The deadline for submissions is 16th October. Mick will work on a submission and will invite us to meet to work on it. The focus this year is around patient engagement and patient experience

5) <u>Project Groups</u>

a) Standard letters and text messages
   i) Two Davids, Bhasker, and Helen have met. Results sent to Paul
   ii) The amendments have been accepted and are now in use.

b) The Practice website group (Emilene, Melissa, Carole, Mick) haven't met, but Mick has sent out individual tasks for us to get on with.
   i) Ian and Helen - The Patient Information items page. Helen and Ian have met
   ii) Carole -The PPG page. Carole has sent comments to Mick.
   iii) Melissa and Emiline -The Practice Information page.
   iv) Mick - The home page and Contact us page. Mick has worked through.
   v) So all aspects delegated are in progress

(1) If anyone else spots anything such as an incorrect word or spelling that needs changing, please contact Mick. mick.gregory242@gmail.com or carole@djassoc.f9.co.uk

(2) Hoping to report back to the group at the November meeting

6) Practice and Federation Updates

a) David M was unable to join the meeting on TEAMs so he raced down to the surgery. Paul will set up a practice session with David M and Carole to see if we can find any issues.

b) Great attendance today, the big meeting room was needed! Thanks everyone. Paul will set up the full meeting room next time.

c) Lord Darzi's independent investigation of the NHS in England. Report published today 12th September.

i) Some key details

(1) It is estimated that it will take eight years to get back on track

(2) The health of the nation has deteriorated
Factors affecting health, such as poor-quality housing, low income and insecure employment, "have moved in the wrong direction over the past 15 years". Lord Darzi points out that there has been an increase in multiple long-term conditions. This includes mental health issues, particularly among young people.

(3) Spending is poorly distributed
recommends that more be spent in the community, and less in hospitals

(4) Waiting times have become unsustainable
Waiting times targets are being missed across the board, including for surgery, cancer care, A&E and mental health services.

(5) Cancer care has declined
Cancer care still lags behind other countries and cancer death rates are higher than in other countries.
There is much more, please see
https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=14650806_NEWSL_HMP_Library%202024-09-13&dm_i=21A8,8Q0MU,6MRUL9,108NED,1

d) The Practice Plans to write to all patients explaining how the Practice is delivering our care . A letter is in preparation and will come to us for comment before publication.

e) BMA Collective action

i) We have a plan as a Practice to explain to patients. To write out to explain what the collective actions are and how they will affect patients. The letter will come to the PPG for comment before sending it out. So far, no questions or comments from patients.

ii) Collective action from General Practice is *not* a strike. None of the actions which are suggested *might* be carried out, are contractual for us so we can stop doing them at any time without breaching our contract. A strike is 'not performing an action that you are mandated to do'. Any action that we take will have an impact on patients so decisions have to be carefully worked out.

iii) There are ten items that Practices have been *asked to consider* by the BMA. If any one action is carried out, then that is part of the Collective Action.

(1) Working to recommended safe limits in terms of patient contacts. That is twenty-five per day. *Our Practice has been working towards safe limits for a number of years, therefore this is nothing new for us. One patient contact might then result in letters being written, pathology results examined. We can't stick to that in 'on call' or on-line consulting. There isn't an internationally agreed number. We offer 15-minute appointments as opposed to ten.*

(2) Stop engaging with e-referral advice and guidance pathways unless it is timely and clinically helpful. *There are situations where we would always seek advice and guidance. We don't do it for the sake of it. So we are already working this way.*

(3) Serve notice on any voluntary services undertaken that plug local commissioning gaps at the expense of the business and staff. *Our ICB have been very proactive. E.g. we do blood tests for hospitals. We probably make a financial loss but we wouldn't propose to stop doing them because we're resourced to do them luckily. We don't think that there are a lot of voluntary services carried out here that we aren't contracted to carry out. It's a funding argument – different.*

Comment – it's easy to get a blood test at Loughborough Hospital and its quicker. It might be better to direct patients to Loughborough Hospital as they are quicker

(4) Stop rationing referrals investigations and admissions refer…. to specialist care when it is clinically appropriate to do so. Use a referral proforma. *Using local proformas isn't a contractual duty. When we make a referral often we are required to use a referral system that asks for a series of tests, which, if they haven't been completed the referral may be sent back to us. We spend hours arguing about rejected referrals. We think that if a GP thinks that a referral is needed, we will send a letter. So we support this action, because the to and fro with the referral, we think, makes it more difficult for a patient to be seen.*

(5) Switch off the ability for third parties to input data into the GP record. *For example if a pharmacist does a blood pressure reading, we want them to write to us, not just fly in it to the record. We support that action. We want the information but in a way that we can process it.*

(6) Withdraw permission for data sharing agreements that exclusively use data for secondary purposes i.e. not for patient care. *This covers data sharing anonymously for NHS research. We agreed to review. We believe that some data sharing anonymously for research can be so important that we wouldn't want to prohibit that.*

(7) Freeze sign ups to new data sharing agreements unless we are mandated to do so. *We would consider them on a case by case basis*

(8) Switch off medicines optimisation software for the purposes of making financial savings or for rationing. *We do have software and it pops up to tell us if we can get something cheaper. But it also pops up to tell us that we are prescribing something which we shouldn't be such as a clash of medication. We would not make a decision based on cost that means that a patient would have a less effective medication currently. We wouldn't switch off anything that is keeping patients safe. So we are already doing this.*

(9) Defer signing up for digital telephony until GP guidance is available. *This is so that NHS England can look at phone data, number of calls, how long they take to answer. This has now been contractually mandated.*

(10) Defer making decisions to enter a pilot programme until advice has been sought. *We would never enter any pilot without considering it carefully first*

iv) Where these actions are sensible we are doing them already, so we can argue that we are part of the collective action but hopefully patients won't notice a huge difference.

v) We would like to try and explain to patients why the BMA action is happening, why the quality of your general practice has deteriorated. So the Partners will write a letter for patients and send it to the group for comment within the next 2 -3 weeks.

vi) Comment - Invest in general practice.

vii) Peter suggested that we send it to our new MP.

viii) We don't think that there will be a central Federation response as every Practice is different.

f) <u>RSV Vaccine</u> (Respiratory Syncytial Virus)

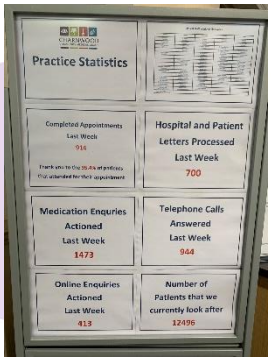
RSV vaccine protects against a winter virus. Relevant Patients are currently being invited. There will be a Saturday clinic on 28th September. We want to complete the RSV before we start our winter flu vaccinations as there has to be a minimum space between RSV and Winter flu vaccine.

g) Winter flu vaccine

Two clinics will be run, 5th October and 12th October, 08.30 - 12.30. Invitations will be sent out. Practice staff should be able to run the clinics, but if we are able to support, that is very welcome. Helping with the general flow. Good opportunity to talk to patients. There will be lots of clinics during the weeks. Vaccinations will continue until no one wants one *Carole to ping the group to ask for volunteers.*

We won't be providing CoVid jabs.

h) The Notice Board. This suggestion from the PPG (July 11th 2024 item 7) has been enacted, giving details of which members of staff are in the building and what they are currently engaged in. This information has received positive responses. It is updated every Monday morning. Even the Practice was amazed at the numbers.



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i) Artificial Intelligence

A huge amount of AI software is coming in. No plans to start using that yet, we need a forum to discuss it.

7) The Practice Patient surveys

As agreed in June, surveys are now being sent out to patients who have had appointments over the past week, using the sorts of questions on the Friend and Family test. Responses will be tracked over a few weeks to get a flavour of patients' feelings. Should give us a 'real time' view. We have had some really nice comments. Paul showed us recent stats, which will need some analysis. Paul will bring data to our meetings. Very encouraging although we all know that General Practice isn't as good as it used to be.

8) Meetings attended

a) A few of us attended a focus group in July investigating the patient/doctor conversations. We have been invited to a follow up meeting in October to explain their findings.

9) Visiting Speakers

November 14th – Tracy Ward. Adult social care

10) Date of next meeting

October 10th 2024 – business meeting. Paul will bring survey data

11) **The meeting closed at 18.45**

Thank you, Paul for your input, very carefully explained.

Minutes agreed and signed as correct…… (Chair) Date……

Encs – Paul Moorhouse Power Point presentation