

GP Access Action Group Meeting Notes
Beverley Minster Parish Rooms
2nd October 2009

Present:

Mavis Austin
Ruth Marsden
Joan Fletcher
Stuart Carr
Cea Vulliamy (note taker)

Apologies:

Jean Wormwell
Jean Turner
Pat Simmons

Joan requested a small amendment to Susan's notes from the group's last meeting
Ruth made a further small amendment.

Ruth requested that all our correspondence contains a note somewhere along the lines of 'due to statutory guidance, we request a reply no later than/within 20 days'

Action: Cea to include the update on the 0845 numbers with the minutes

Discussion around 0845 numbers and concern about the cost of calling such numbers from mobile phones (often used by the young and the worse off). Ruth agreed that this must remain part of the agenda but felt it is not worth tackling at a local level, rather we must add our voice to any national campaign.

Action: Ruth will find out appropriate department in Whitehall for ERYLINK raise concerns

Discussion around GP issues arising from bus tour – mostly generic rather than specific issues. Cea mentioned that Roland had met with Hessle Practice Manager (Hessle being a practice that received quite a bit of negative feedback).

Action: Cea to ask Roland if he has – or can produce –some kind of brief report of his meeting

Action: Cea to write to practices with poor feedback and let them know that patients have expressed some vague concerns and we feel obliged to let them know. Include information on GP Patient Participation Groups and funding available for these, as well as flagging up 'Improving Access, Responding to Patients' document.

Discussed Mavis's report on access issues in Pocklington

Action: Cea to distribute Mavis's report with meeting notes

Ruth informed Mavis that the National Association of LINKs Members has a dedicated interest group for people with an interest in health and social care issues for the deaf and hard of hearing.

Mavis told the group that she has suggested to Pocklington surgery that they establish a patient participation group, but they are not interested.

Ruth pointed out that the surgery stock in the East Riding is conspicuously old (though there are exceptions), and there is increasingly a push towards the big polyclinics etc. It raises the question of what the annual budget is for Disability Discrimination Act work – where does the money for such work come from?

Action: Cea to write to PCT to ask if there is a specific budget for DDA implementation, is there a separate funding stream, is it ringfenced, does it come out of the health budget or is it a separate endowment – from where?

Re 'formula' for GPs – Ruth has done some digging and found some things out:

There are essentially 3 types of GP practices, funded differently-

GP-Led Health Centres (also known as polyclinics, supercentres etc) – receive vastly higher levels of funding because the government wants to have them and wants to incentivise them, also because they are nwq and so don't have registered patients (and GP income is tied to registered patients, so they need a top-up). It is about 3 times, or as much as 7 times as much funding. The average per patient is £180 per annum, but there are huge variations, with up to £560 per patient/per annum. East Riding PCT pays £381.47 per patient per annum.

Year on year it reduces as the practice builds and can fund itself. In the final (5th) year, East Riding will give £102 per patient.

General Medical Services (GMS) – GPs who are on the PCT list – might be a single handed practitioner, or several in partnership. The average spend is £130 per patient, per year (lowest £107, highest £157). Enhanced services attract an average of £14 per patient per year (lowest £6, highest £26). Enhanced services include e.g. smoking cessation clinics, obesity clinics, phlebotomy, infection control, booking patient transport.

Personal Medical Services (PMS) – GPs other than those on the PCT list. Any private provider can offer GP services. Can offer services to the PCT if capacity is lacking locally.e.g. DR Thom – web-based GP – purely independent initiative.

Issue of contract management – how PCTs audit contracts – do PCTs have a proper handle on what they're actually paying for. PCTs are not apparently doing a lot of monitoring of GP contracts, but GPs are gatekeepers to hospitals. Concern about getting best value.

Action: Cea to include printout of funding for East Yorkshire with notes of meeting.

Figures do exist for adjustments to contracting, so if we want to dig, we can.

Joan asked where the salary comes from for salaried GPs

Ruth explained that it is out of the practice income. In areas where there are shortages the Department of Health does sometimes incentivise. Strategic Health Authority is doing some work on this, but it is not yet complete – will be published once it is.

Other Issues (from previous notes)

Drug issues: Ruth shared some information with the meeting

Action: Cea to distribute info with the minutes

Action: Info on Yellow Card System to be distributed with minutes

Joan will attend the NHS East Riding Patient Experience Group Meeting and give a short presentation on the work of this Action Group.

Patient Participation Groups: Ruth has been asked to establish one at her own GP surgery.

Ruth said that she would like to visit some of the practices and promote the patient participation group idea

Ruth and Joan decided to visit Brough surgery first and offered 2 possible dates.

Action: Cea to contact Brough practice manager to try and arrange a visit for Ruth and Joan with an emphasis on collaborative working, information-seeking and seeking their assistance in rolling-out of good practice.

Ruth would like to see the work of this group properly braided into the commissioning of ERYNHS – professional executive committee of the PCT should have a GP member – can we find out who this is and ask for a meeting with him or her?

Action: Cea to find out the name/contact details and see if she can arrange a meeting.

Action: Cea to distribute the list of dispensing GPs with the notes

Stuart gave an update on the Hull Hospitals AGM which he attended. He noted that it seems that E Riding is doing better than much of the country at the moment.

Next Meeting: 5th November 2009

10am to 12 noon

Parish Centre Meeting Room

Please find below the various e mails/reports received in response to questions raised at the GP Access meetings:

What is the Yellow Card Scheme?

The Yellow Card Scheme is vital in helping the MHRA monitor the safety of the medicines that are on the market.

Before a medicine is granted a license so that it can be made available in the United Kingdom, it must pass strict tests and checks to ensure that it is acceptably safe and effective. All effective medicines, however, can cause side effects (also known as adverse drug reactions), which can range from being minor to being very serious. For a medicine to be granted a licence, the expected benefits of the medicine must outweigh the possible risks of the medicine causing adverse effects in patients. Sometimes, it is difficult to tell whether a possible side effect is due to a medicine, or something else. Even if it is only a suspicion that a medicine or combination of medicines has caused a side effect, we ask **patients** and health professionals to send us a Yellow Card.

Yellow Card reports that we receive on suspected side effects are evaluated, together with additional sources of information such as clinical trial data, medical literature or data from international medicines regulators, in order to identify previously unidentified safety issues or side effects.

Information gathered from Yellow Card reports made by patients and health professionals is continually assessed at the MHRA by a team of medicine safety experts made up of doctors, pharmacists and scientists who study the benefits and risks of medicines. If a new side effect is identified, information is carefully considered in the context of the overall side effect profile for the medicine, and how the side effect profile compares with other medicines used to treat the same condition. The MHRA takes action, whenever necessary, to ensure that medicines are used in a way that minimizes risk, while maximizing patient benefit.

In assessing the safety of medicines, the MHRA is advised by the Commission on Human Medicines (CHM), which is the Government's independent scientific advisory body on medicines safety. The CHM is made up of experts from a range of health professionals and includes lay representatives.

Issue of TTO medication

I contacted my PCT rep colleague from Drugs and Therapeutics Committee and he replied as below:

*There are agreements between the hospital and the PCT. It is the responsibility of the **hospital** to supply 28 days of medication on discharge. For some items like (a large vial of) insulin this can be less, but then extra effort must be made by the hospital to inform GP of any changes. In all cases a discharge sheet with all medications on it should be given by hospital (this is a blue sheet) on **discharge**.*

Furthermore the standard is to supply the GP with a proper discharge letter within 28 days. Hospital doesn't always do these things and occasionally it can take much

longer to be informed of medication changes (one patient recently was discharged in May and I only just received a letter). Recently there have also been a few cases where patients received only a week medication. This is usually not enough. By the time the patient has handed in the blue medication discharge sheet, the Surgery has altered the prescription, the GP checked and signed it, the patient taken the prescription to the Pharmacy and the Pharmacy ordered, received and dispensed the medication.....

In short the system usually works but not always.

*The psychiatric services have their own rules and they usually only supply 7 days. They are however very efficient in supplying information on medication changes (often a fax to the Surgery **before** discharge).*

Patient Participation Groups

Patient Participation Group (PPPG) Campaign

A national campaign was launched on 2 June, encouraging GPs to set up PPGs to help their practices remain responsive to patient needs. The campaign is being run jointly by the National Association for Patient Participation, Royal College of General Practitioners, NHS Alliance and British Medical Association, with support from the D of H. It includes resources to help GPs set up a PPG and promote quality and responsiveness. The groups are already having a positive impact at GP practices across the country, from introducing information and education services to helping to run health promotion events.

From GP and Practice Team Bulletin, Issue 85, June 2009, Produced by the D of H.

Further to PPGs in GPs, I have established that 40% of GPs nationally have such a group but can only find Hedon in Humberside for our area. (Ruth)

NHS to ban premium rate numbers

14 September, 2009

Premium rate telephone numbers will be banned for all lines used by patients and the public to contact the NHS, Health Minister Mike O'Brien has announced.

A public consultation was carried out and almost 3,000 members of the public responded, demonstrating the level of feeling on the subject.

“For people on low incomes, and for those who need to contact their local doctor or hospital regularly, these costs can soon build up. We want to reassure the public that when they contact their local GP or hospital, the cost of their call will be no more expensive than if they had dialled a normal landline number,” said Health Minister Mike O’Brien.

The British Medical Association’s GP Committee and the Department of Health will co-operate over the next few months to bring in the legislative changes to the GP contracts.

Deputy Chairman of the BMA’s GPs Committee Dr Richard Vautrey said: “Patients who call their surgery because they’re ill shouldn’t be penalised because they have to call an 084 number, so we’re pleased that the phone companies who supply these lines to practices have agreed to ensure that their tariffs are in line with local charges.”

PCT guidance reveals plan for GP investment of £50m

**Tom Ireland, GP newspaper,
01 October 2009, 12:10pm**

Practices are to be encouraged to bid for a share of £50 million to be spent on helping them improve access, according to PCT guidance.

Practices that are performing poorly in the patient experience survey will be invited to submit business cases to PCTs, explaining how they would use extra resources to improve access and patient satisfaction.

Practices already scoring highly could apply for cash to develop 'more innovative approaches to reach people who do not normally access primary care', says the document, from Primary Care Commissioning, a network of PCT advisers.

It was agreed in the 2008/9 contract settlement that £50 million would be added to PCT allocations to boost 'access and responsiveness', but the GPC warned in May that there was no way of finding out how, or even if, PCTs were spending it.

GPC negotiator Dr Chaand Nagpaul welcomed the guidance, but he was not confident that PCTs would translate it into cash for practices.

'The crux is whether PCTs have the resources and make them available, or whether this becomes an aspiration that gathers dust,' he said.

Dr Nagpaul also warned that the process of submitting business cases must not be 'disproportionately bureaucratic' to the funding available.

Areas suggested for practices to improve include making sure premises comply with the Disability Discrimination Act and agreeing to make a higher number of GP or nurse appointments available (see below).

The guidance states there will be no fixed price for the services and once investment is agreed, regular monitoring visits and extra patient surveys would track practices' performance.

Dr Nigel Watson, chief executive of Wessex LMCs, said many practices will be inexperienced at pricing the services they provide and developing a business case.

'I'd prefer to see an enhanced service so you could see it all laid out first,' he said.

'But it's something I would welcome if the funding is recurrent - too often the funding is one-off and then it stops.'

Dr Watson questioned the logic of penalising practices financially with the patient survey then deciding to fund them.

'But it could be a good mechanism for helping under-funded practices improve their services,' he said.

Access funds

How practices can earn a share of £50 million:

- Reach an agreed standard on 48-hour access
- Ensure a certain number of GP/nurse appointments per week
- Record and act upon feedback from a patient participation group
- Undertake extra patient surveys
- Target hard-to-reach groups
- Premises comply with the Disability Discrimination Act

Issues Regarding Access To Pocklington GPs Group Practice

1. Access

There is a short ramp with handrails on both sides – the slope is fairly steep but adequate for most users.

Once up the slope there are two sets of double swing doors. These are very difficult to open and hold open for people who have to walk with aids such as rolators (frame on wheels), wheelchair users, mothers with pushchairs – especially if they also have a toddler as well as a baby in a pram – and also difficult for any person who has an Assistant Dog. The doors can easily bash into you and little children can catch their fingers in the door frame. I have ruined my brake wire to my rolator when it got caught on the handle of one of the doors. I have seen young mothers telling their toddlers to go out first which I consider is a huge safety risk for the child. Toddlers are very unpredictable and could easily run out into the road as the surgery is located at a very busy junction.

2. Reception Desk

There is no lowered section of the reception desk which means the receptionists have to lean over the top of the desk to speak to a wheelchair user. The receptionists also suffer as they have to stand all the time although there is apparently a stool if they feel they need to sit. (no good if a receptionist is short in stature.)

3. Loop System and Computer Software designed for Deaf Patients

The RNID wrote to me back in 2004 advising that all GP Surgeries were given money by Central Government to purchase software for their computer so that a deaf person can use it to explain their

medical problems. I understand to date Pocklington Surgery does not have this software installed.

Disability Discrimination Act 1995

I have been on line to find about the Law which covers GP surgeries and public buildings. Unfortunately I am not authorised to go into certain parts which shows dates etc when alterations should have been made by. However, I have contacted the RNID who are going to send me a Leaflet on Surgeries (as to-date hasn't arrived) and I have also written an email to the Disability Rights Commission asking for specific information. Directly I have this I will notify you.

If it comes before our next meeting on Monday, 7th September I will bring it to the Meeting.

Mavis Austin