Minutes of Patient Participation Group Meeting held on 29th February 2024 at 2.00 pm

Present: Cecil Taitz (Chair), Leslie Sher, Susan Grossman, Sandra Pirolo, Victor Ryde, Jacqueline Ryde, Angella Leung, Janet Hollis, Dr D Ruben, Sandra Handerek (Practice Manager).

Purpose of the Meeting

Cecil Taitz, the PPG Chair, opened the meeting by explaining what the PPG's purpose is ie. to provide an opportunity for discussion between the surgery and its users and how this might be improved and to help patients understand the problems being faced by the surgery.

CQC Inspection Report

Dr Ruben provided a summary and explanation of the results of the latest CQC report and the implications of their impact going forward.

He explained how some of the results are arrived at, and the time-line given to the surgery to improve.

This resulted in some questions about whether the CQC inspectors consult any of the patients on their opinions of the service provided by the surgery.

It was explained that the CQC do usually speak to the PPG Chair and to any patients in the surgery on the day of the visit and also use the results of the GP Patient Survey and NHS Choices comments and Google reviews.

Additionally, the CQC will look at results such as cervical smear uptake and child immunisation figures. The targets for these are 90% and although below these target levels, the surgery's achievement rates are higher than half of all practices in Barnet and North London generally, but despite this, the CQC always cite this as a failure to improve as the target is not met, even though no other practices have improved in the time-frame either.

Another issue cited as a failing by the CQC was that although we had dates for other things to be done in the diary, because we could not prove how this had been arranged and therefore that we had been proactive in setting these things up, as this had been done by phone rather than on email, they also cited this as a failing. The firms involved had their own backlogs and sickness issues which had resulted in them being late to come out to us to provide the services, but this was still cited as a failing on our part.

One example is the Legionella Risk Assessment. There is no requirement to do this annually, but as the last report had recommended that this be done annually, the CQC insisted that it must be. A date was in the diary for this, but the CQC waited until this had been submitted to them before they would draft their own inspection report.

Inspections take a lot of time to prepare for, so this does not help patients, as takes staff away from providing the service and instead forces them to focus on inspection

preparations. It also means we have to hire locums, which is very costly, to enable Dr Ruben to have time to devote to this, so the surgery budget is also impacted.

Things that the CQC had found acceptable at one inspection were no longer found acceptable at the next.

The CQC inspection reports having been at 'Requires Improvement' several times. This then resulted in NHS remedial actions being imposed. This is a list of requests for data and information, which was requested in so much detail that we sought LMC advice. The LMC confirmed that the level of detail required was greater than they had seen for any other surgery, concluding that this was intrusive and excessive and, in some cases, impossible to collate.

The NHS took 12 months to respond to the information submitted, but then stated that they did not understand the data that they had requested and we had submitted and so failed us on those points and instead of asking for an explanation, simply requested further detailed information.

These are some of the difficulties being faced by the surgery.

The CQC's next step is to either get the surgery to improve or to close the surgery.

The next inspection is due in June or July. There would be another inspection 6 months after that.

We are looking at employing a CQC inspector who also works as a consultant to come in and help us with this process and to share advice from other practices. This consultant had already been in once some time ago and felt that the surgery was basically providing a good service.

Patients' view of the Service

The patients present stated that they had no complaints about the service received from Dr Ruben, although found the process of booking difficult.

Future of the Surgery

They noted also that Dr Tang has now retired and so understood that all the responsibility for the surgery now falls on Dr Ruben and wondered about the future of the surgery, going forward.

- Dr Ruben explained that whereas the expectation in the past was that salaried doctors would perhaps take on a partnership role after some time had passed has now all changed and salaried doctors are often not looking at joining as partners anymore. They now value a better work/life balance instead and do not want the stress of being a partner. Indeed, it has become difficult even to find a salaried doctor, so have had to use locums for a long time.
- Finding suitable available candidates for most roles has become more difficult in recent years. We had been looking for a partner for one and half years with very little interest from potential candidates, when we began to consider merger as an alternative.

Additional Nurses?
One patient commented that she had found the recent review she had had with the nurse very useful and asked if we could hire additional nurses.

- Dr Ruben explained that there is currently not sufficient money available for this.

Dressing Changes?
Another question was raised in regard to the changing of dressings and why this is not provided as a service at this surgery whereas it sometimes is at others.

- It was explained that the funding for this is given to the hospitals, not to GP surgeries and that hospitals simply tend to have an expectation that surgeries will oblige. However, without the funding not all can. The larger surgeries with more staff and so also with more time, might simply do this because they can afford to do this, but smaller surgeries will find this more difficult.

Blood Pressure Monitoring
There was a question about Blood Pressure monitoring. Patients stated that they may take their blood pressure themselves, but do not necessarily understand the results and were concerned that their machines do not get calibrated, so the results may not be correct.

- Dr Ruben explained that consistent results would not suggest a problem, but equally that patients could book for our HCA to do this for patients, if they wished.

Regular Blood Pressure Visits
A further request was made as to whether a nurse could be sent over to check blood pressures once a month, which as Farthing Court and Francis Dick James Court are so close to the surgery, might be a possibility.

- Dr Ruben will consider the feasibility of this request.

Phlebotomy
Phlebotomists were funded to take blood samples at the surgery for a time, but this ceased, despite the expectation that surgeries would continue to provide the service without funding. Primary Care Network (PCN) staff provide this service also, so to some extent, phlebotomy has been re-introduced. Some Health Care Assistants (HCA) are trained to be able to do Phlebotomy also, but not all and our HCA is not.

Test Efficiency
A patient mentioned that a text was sent to them to get a blood test or blood pressure check, but wondered whether any other tests due could have been done at the same time to help avoid multiple trips to the hospital, as for many this entails a costly cab ride.

- It was explained that we do try to get as many things done at the same time for this reason as possible and that Reception staff should be checking to see

what else might be due to be able to request those when a blood test form is collected.

Receipt Acknowledgement

Mr Sher explained that his wife's blood test results were not evaluated after he sent them in and then he received another request for them instead, so wondered if patients could be sent an acknowledgement when they supply information to the surgery?

- Dr Ruben said this could probably be done, although with as much information coming in as we have, it might not be feasible.

Results Processing

The patients would like results to be processed more quickly.

- Dr Ruben explained that historically, the surgery has not notified patients if results received were normal and that the usual procedure has been that patients ring to obtain results.
- However, the Patient Access App now shows results so they can also be accessed this way now. You would need a smartphone for this however and the patients pointed out that older people don't always use these.

Appointments

The patients do not feel that the appointments system works well and that it is difficult to get an appointment.

- Dr Ruben explained that so many appointments were going to waste due to lack of attendance and failure to cancel appointments no longer wanted, that the surgery moved to a telephone triage system as this helps to avoid wasted appointments and allows greater through-put. The surgery had been planning to move to this new system in Autumn 2019 and put up signs about this in the surgery, but due to issues with our then phone system and the cyber attack which was not resolved until February 2020 this was delayed and then subsequently introduced for the entire NHS overnight when the pandemic struck.
- Telephone triage allows the surgery to be able both to see more patients in the same amount of time, to prioritise those with urgent problems sooner and provide test results more quickly.
- The problem with lack of appointments is mainly due to level of demand and capacity. The volume of requests made on-line is so large that the system has to be switched off within minutes of being turned on, as more requests than there are appointments available to accommodate them have already received by then. On-line requests are the most useful way for patients to contact the surgery as the clinician then has some details about the problem the patient is contacting us about and they free up the phone lines for those who do not have access to request an appointment on-line to be able to call the surgery more easily instead, because fewer people are ringing in at the same time.

- Patients were reassured that those requesting an appointment on-line have no advantage over those calling by phone instead, as we reserve a third of available appointments for those calling by phone. Not all appointments are supplied to on-line patient requests. There are also after 1.00 pm appointments which are not released until 1.00 pm by phone only for those who have not been able to call or go on-line earlier.

111 Service

One patient enquired whether the surgery receives reports from the 111 service about patients who have used this.

- It was confirmed that these are sent to the surgery, but that information provided can be sparce and rather limited, partly due to the fact that the service is operated by non-clinical staff following protocols. This can lead responses to be over-cautious as they are designed to be risk-averse.
- Also, 111 staff have the ability to book patients directly into one of the three daily slots reserved for them to use, but sometimes, they simply ask patients to come to the surgery, which can be a problem, as there will not be an available appointment for them to be seen straight-away and they may have to come back, which is annoying and inconvenient for the patient, but is usually due to the 111 staff not following the procedure provided for them.

Additional doctors?

Patients wondered whether the surgery could employ more doctors to try to increase capacity.

- It was explained that we had tried to do so over a long period, but that we only had a couple of applicants who had not worked out.
- Our solution was to employ two Physician Associates instead. This is a new role with qualified candidates only recently becoming available for hire. They will become better regulated over time, but already have to have done a dedicated course to acquire qualification after having already done a bio-medical degree.
- Physician Associates are not doctors. They can take a history of the patient's problem, but are supervised by a duty doctor, who can examine and prescribe if needed.
- This represents a different way of working. Doctors may become specialists in one field and nurses have diversified into more complex roles such as Advanced Care Practitioners and may have taken a course to be able to prescribe independently; Health Care Assistants can take courses to allow them to do different things, such as give vaccinations or take blood samples, but they cannot perform nursing tasks.
- There is investment in expanding such roles, so that now, via our Primary Care Networks, we have social prescribers, physiotherapists, a first contact health mental health worker and well-being coaches. All of these are provided through primary care now, whereas most might only have been available via secondary care previously or not via the NHS at all.
- The funding model has changed with money now coming mostly via the PCNs to surgeries rather than direct or going direct to social care. There is no specific funding to provide key services such as doctors and nurses.

Self-help information for the Surgery Website
A request to place more self-help information on the surgery website was made.

- We will look into how we can do this.

Phones
A query was raised about how long it takes for the phones to be answered.

- It was explained that receptionists have to both take calls and help people coming to the desk and that some issues can take longer to deal with than others, which all impact on their ability to answer calls more quickly.
- However, with more people making on-line queries, this reduces the number of phone calls coming in and the number of people visiting the surgery in person.
- Patient triaging also enables us to direct patients to the person best equipped to help them.

Funding
- All of these measures help to squeeze a bit more out of the system.
- This is reflected in in the creation of urgent treatment centres, which may be fewer in number and further away than local surgeries might have been in days gone by and mean that surgeries are left to deal with patients with chronic conditions.
- Funding is therefore now differently distributed and the sum given to surgeries has been changed and reduced substantially.
- The surgery has recently moved to being funded under the General Medical Services model as the Private Medical Services model no longer provides opportunities to earn additional sums for completing extra services, so there is no advantage to using this anymore.
- GP Surgeries have lost 20% of their funding since the days of David Cameron. Surgeries were recently instructed to pay a 6% increase to salaried doctors, but given no additional funds to increase pay for any other surgery staff.
- The funding increase awarded to surgeries for the next financial year is only 2% which does not afford the ability to take on additional staff.
- Surgeries have been instructed to begin offering a new programme of care management for existing long-term conditions under the Long-Term Conditions LCS. This means that patients should have multiple problems dealt with at one appointment and may not need to have as many tests done as tests should cater for more problems at once than previously, but we have already approached these issues this way at this surgery with our own system Auto-Q, which operated in this way long before the LTC LCS was thought of and rolled out in Primary Care, so it will not make much difference to how we have already been working for many years.

Next Meeting
The next meeting will likely take place in about two months' time, but the date has yet to be agreed.