PATIENT PARTICIPATION GROUP

MAY LANE SURGERY

Notes of a Meeting held on the 8th October 2015 at 11.00 hrs

1. **Members Present:** George Way (Chmn), Chris Osgood (Secretary), Joan Gummer, Helen Boxall, Ron Manuel, Maureen Hebron , Leslie Cross, Rosalind Cameron-Mowat, John Hobson (Vice Chmn), David Thould.

2. **In Attendance** Wendy Hunter (Surgery Manager), Dr Simon Opher.

3. **Apologies** Mike Baker, Sally Hayward, Fiona Madden
Harry Atkinson, Hayley Bewick, Marcia Heaven

4. Minutes of the Last Meeting

The minutes of the last meeting were accepted.

5. Matters Arising

a) Hernia and Cardiac Waiting Lists

SO reported that cardiology was an issue in Gloucester but not in Cheltenham. In Gloucester the maximum waiting time of 18 weeks was regularly being exceeded. Hernia too is a significant problem and plans were being made to reduce the waiting lists, which are currently up to about 12 months. Both these are worse in Gloucester than Cheltenham and it isn't clear why. Efforts have been made via the commissioning process to bring the suppliers into line by using penalties for breaking their contracts but SO felt that with the current financial crisis in the health service these efforts may not be very successful.

GW asked if Urology services had the same problems. SO replied that there had been 15% increase in the number of urology referrals, probably caused by a new diagnosis technique for prostate cancer; this was less worrying because the cause was known and could be expected to reduce again after this initial rush.

b) Moving the "Signing – In" Book

WH confirmed that she had moved signing in book and briefed the receptionists

6. NAPP Report

LC said there was nothing to report this time.

5. HealthWatch

a) Sophie Ayre - a Quick Overview

GW welcomed SA to the meeting and she began to gave us an overview of the functions of HealthWatch. SA noted that she was from HealthWatch Gloucestershire, one of148 local HealthWatch organisations whose function is to report on the operation of the NHS as seen by its users. Users'experiences are gathered by a variety of methods such as public outreach events, visits to organisations such as PPG's and so on. Last year they gathered about 3000 items in this way, which they then combine to produce reports which can be used for the guidance of commissioning agencies and also by suppliers to improve their operations. SO questioned whether or not we could pass on to HealthWatch problems with services such as hospital transport. SA agreed that HealthWatch would certainly take up such problems and RM provided an example whereby pacemaker programming equipment could not deal with a pacemaker which had been installed a different hospital. A complaint passed via HealthWatch caused the provision of new equipment within a week. Because they gather information county wide HealthWatch are in a position to spot trends currently this is leading them to two investigations the first concerning hospital discharges and the second looking at problems in podiatry provision. For the first of these MH felt that we should bring back convalescent homes to look after those who require nursing care rather than hospital interventions.

SA was anxious not to give the impression that they were only looking for criticisms - about one third of the comments from the public were positive and complimentary. Additionally HealthWatch have a team of information advisers whose role is to make people aware of services both in county and more widely. Their database contains services ranging from lunch clubs to organisations designed to assist with particular illnesses and conditions. SA went on to explain that to ensure that HealthWatch gets the best information and can disseminate it effectively it maintains a wide range of contacts with large number of health related committees and organisations ranging from PPGs through the CCG, Hospital Trusts, various councils' Health and Well-Being departments and the Care Quality Commission.

CO asked how HealthWatch is funded. SA said that the major part of the funding came from the central NHS coffers together with a contribution from the county council. GW thanked SA for her contribution.

b) HealthWatch/PPGFramework – June 2015

This document provides a template for the operation PPG's and contains within it an example Confidentiality Agreement which it suggests all members of PPG's should sign. There ensued some discussion of confidentiality and what it meant. SO used the example of CO's hernia operation. CO expressly permitted discussion of the delays in getting the operation in the hope that that might produce resource which might reduce the current 12 month waiting times for himself and the many others who must also be waiting. The problem arises when the subject of discussion is not present or expresses a wish to remain anonymous. In this case the topic can be discussed but nothing should be said, appear in the minutes, or in any record, of the meeting which could be used to identify the person involved. CO agreed to check the minutes on the web see if a further redaction is required. ACTION CO

It was also agreed that future minutes would be circulated to those present meeting and only when positive acceptances had been received from all members present would the minutes be circulated to a wider PPG. ACTION CO

The confidentiality agreement template was discussed as were the penalties for breaking the agreement. SA pointed out that it was only a template and within limits we could make our own choices. Several typographical errors were noted and passed to SA for onward transmission to the authors.

6. Comments on the Stroud & Berkeley Vale Locality Development Plan 2015-17

a) Mental Health – Questions from DT

1. Ref 3.1 On Target Programme

DT had a question related to the "On Target" weight management program. He asked whether or not the account had been taken of the problems with some drugs, used to improve mental health, which had the effect of sedating patients leading to weight gain and movement problems.

SO agreed that it was an issue and that patients with poor mental health often have poor physical health as well. However they are very useful drugs from the point of view mental health and a balance has to be struck. This is taken into account in the On Target programme.

2. Ref 5.4 all Public Health Identified Indicators

The last entry in the box headed "All Public Health Identified Indicators"(self-harm/suicide) which appears to suggest that self-harm and suicide were somehow equivalent.

SO agreed that this gave a false impression since the self-harm related primarily to children and suicide group were mainly men aged from 20 to 55 so they should be separated. SO agreed to feed back the need to separate these items. ACTION SO

b) Questions from CO

1. Forward by Hein le Roux

CO questioned whether the type of health service we would get if the attitude, demonstrated by Hein le Roux in the statement below were to become the norm, would be the health service would want **"This is quite a contrast from how I used to work focusing only on the needs of the patient in front of me and not thinking much about the wider population need or about the cost of my interventions"**.

SO commented that although Dr Le Roux's statement seemed a bit strong there are areas where it is good for clinicians to think about cost, particularly in drug prescriptions where buying a named drug rather than using the generic could easily waste large sums of money. However when clinicians are paid to reduce referrals to hospital(and there have been attempts to do this within the health service) SO feels this is an area which he would wish to avoid completely. Equally he feels that it is worth reviewing referrals to help clinicians improve their skills and avoid wasteful, unnecessary referrals. He then went on to say that just seeing patients doesn't do much for their health. Often what they really require is assistance in stopping smoking or perhaps losing weight, that is preventive medicine so perhaps clinicians should be spending more time devising such preventive programs.

2. Sec 2.1 The Structure Diagram

How many of the posts shown in the structure diagram are paid posts and what is the cost of commissioning our healthcare now as compared with the previous system?

SO admitted that he didn't know.

3. Sec 2.3 "Our Ambitions"

CO quoted from the document. **"When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way".** CO questioned their ability to deliver this because there were no monitoring tools in place; hospital waiting lists are not published and the only information sent back to the practice comes as a letter once treatment is completed. SO pointed out that this wasn't quite

true because patients would come back and complain and that practices now had in place a system to collate this kind of information. CO suggested that perhaps we could push hospitals into publishing their waiting lists so that there would be a bit more information which might then permit practices to manage the hospitals more closely.

SA agreed to take back and pass on the suggestion that waiting lists might be published so that Practices can properly manage the hospitals from whom they are purchasing services. ACTION SA

4. Information Officer

CO asked if the surgery had an Information Support Officer. SO confirmed that they had and that,currently, his task was to look at variability. At the moment this is showing that Walnut Tree is over referring on dermatology and under referring on eyes, when compared with the average. This highlights areas where clinicians may look and consider whether their decision-making could be better.

5. Sec 5.2 - "Please Translate"

This section reflects the number of errors in the document as a whole, the first paragraph of Section 5.2 being totally unreadable. SO pointed out that the information here was valuable since it was talking of the work of the JSNA (Joint Strategic Needs Assessment) which attempts to identify the requirements that the health service must satisfy as well as identifying variability between practices. To assist the document's authors other errors found are listed below:

- two items in the list labelled 2.6 were duplicated

- in section 5.2 pie charts for Gloucestershire and the Stroud and Berkeley Vale locality had different colour schemes for the segments making comparisons difficult.

- the section numbering was incorrect in the document – it reads "2.1, 2.4, 2.2, 2.3, 2.4".

7. A.O.B

a) JH noted that hospital transport is now provided by Arriva and it's up to the patient to book direct with them. Anyone wanting to use them would have to justify why they needed Arriva's specialised services and it is not clear how one would do that.

b) GW asked when the online services were likely to become available to Acorn. SO said that was to be discussed at a meeting next week.

c) MH raised the question of patient with macular degeneration who was advised take three months off from treatment and then to go back to another clinic. After three months she rang to discover what was happening was told that she was on a list but could get no more information and didn't know what to do? SO advised that she should contact the hospital again and if she had no success and then see her GP, the GP effectively being her agent in her dealings with the National Health Service.

d) JG raised a problem getting prescriptions via the Pathfinder. From requested prescription to delivery took about eight days. SO and WH agreed to investigate but suspected that it had been lost en route and then reissued. SA commented that HealthWatch had received a lot of issues concerning pharmacies and would be glad to hear about any problems that might happen here.

e) Finally, a PLAUDIT - JG also wanted to praise one of the registrars, Dr Timmus, who had been "just what a GP should be!".

Date of Next Meeting

Friday 11th December 2015

There being no further business the meeting closed at 12.10.