Morden Hall Medical Centre

Patient Representation Group – initial meeting 10th January 2012

Chaired by Steve Hartley.

Item	Subject	Action
1.	Present: Dr Paul Alford, Dr Ravi Patel, Dr Amir Akhtar, Hyacinth Bell, Zoe Marezana, John O'Brien, Maureen O'Brien, Elspeth Clarke, David John, Jayanthani Hettiaratchi, Fiona Doyle, Harshita Patel, Subramaniam Sritharan, Steve Hartley Apologies: Angela Kilkenny, Derek Heaton, Mary Gell	
2.	The meeting began with introductions and a welcome to the practice. Steve Hartley passed around agendas to those present and explained the background to the idea of having a patient group, highlighting the fact that this was a government initiative to put patient involvement at the heart of their plans to reform healthcare as well as being something that the practice had aspired to do. The criteria for running a patient group include that the practice should seek to recruit a representative sample of its patient list for the patient group. However with our diverse population this has been difficult to achieve and we are still trying to recruit from some groups. The agenda wasn't followed precisely and there were questions from the floor during the discussions which were answered by the doctors. Due to the fact that members were not identified at the time that questions were put these minutes will use the indicator Q to identify when a question was put by a member of the group.	
3.	Background: Paul Alford began by speaking about the introduction of commissioning of health services and how practices and affiliations of practices had come together to commission, or buy services. He explained that under new proposals which had been widely publicised it had been necessary for practices to come together in larger groups called consortia and MHMC intended to be part of a Merton group of practices. Q – Will the changes mean that patients won't have access to choice any more? Amir Akhtar answered, saying that there will be no planned increase in NHS spending above inflation over the next 5 years and this effectively meant that there would be a 20 billion shortfall in that time. Paul explained that he would have responsibility locally under the BSBV scheme (Better Services Better Value) for children's services, and said that 25% savings were required over the next 4 years. He added that this saving would be generated partially by a more efficient service generally, and partially by more treatment being carried out at primary level. He said that he was a believer in this format, feeling that it would mean that when hospital care was required in the future it would be of a better standard for those who really needed it as a result of these changes. To illustrate this point Paul described the situation at St George's currently, where he said that they had been swamped by demand for some types of elective surgery, and it was likely that some types of electives would have to be moved elsewhere. Paul encouraged any patients who wished to take part in work on the BSBV scheme to make themselves known to him. Q – Who pays when patients are sent abroad for treatment? Paul answered that the commissioning group pays Q - What are the priorities now? Are they financial? Information is cheap to provide so can communication be improved? Could we make more use of email to help people who aren't keen to speak in public? Particularly about medical information? Amir replied that some practices were using virtual patient groups where feedback and communication from the group was by e-mails rather than face to face meetings. He added that actual medical information by e-mail was not yet established in the practice mainly due to concerns about confidentiality and organisation and safety issues but might possibly be used in the future Paul went on to say that the practice's expenditure currently stands at approximately £16m	

	Q – How is the practice budget broken down? Is there for instance an amount for knee care, or any other specialist area? Paul answered that a total is set both at borough and at practice level. He added that this was based on practice list size, and on other factors such as levels of deprivation. Ravi Patel pointed out that this was not real money being paid to partners, but effectively a paper budget. Amir added that there are nationally-set tariffs for NHS services. Q – What happens if you go over budget? Ravi explained that with the new contracts which practices would get from April onward there was a threat that a practice could potentially lose its contract. He explained that patients would still have access to NHS cover, but the opportunity would exist for another organisation to take over the practice population should that happen. Paul added that it was important for prescribers within the practice to be responsible and stay within budgets, and that was why patients may sometimes find that repeat prescribed drugs that they received may sometimes be changed, where doctors felt able to prescribe less costly medicines without reducing effectiveness. Q – Is it a concern that GPs' time will increasingly be spent on administrative work justifying demands made by health authorities, and what percentage of the budget is spent on administration by GPs? Paul explained that this differed for each doctor. He said that he himself was involved with various external health organisations and therefore spent around 3/8 of his working week on admin-type work. The other doctors gave an explanation of their average working day, with much admin done in their own time or evenings. Amir pointed out that the within the Commissioning groups(CCGS) the majority of the work would be undertaken by certain GPs and the majority will not be involved day to day in the running of the CCGS	
4.	Steve explained that part of the remit set by the health authorities in order for the practice's patient group to be compliant with their format was that we should carry out a survey of our patients. He produced a draft survey with questions on various aspects of performance relating to the practice and asked those present to assess it to see if they felt questions should be changed or added to. Q - The waiting room has become smaller in recent times. Amir explained that the practice had developed the first floor area and this had been taken over by a private health provider offering NHS services. He explained that the waiting room was smaller due to the need to move the reception desk behind the fire door to comply with fire regulations. Paul added that there was a commitment to improve conditions in the waiting area and also a desire to reduce waiting times so that the reduction in space would become less noticeable. It was proposed that the survey should include questions about: • Referrals, asking if the patients felt they were e.g. effective, appropriate and timely • Identification of whether the person answering was doing so on behalf of themselves, or as a parent or carer • Frequency of visits (again for themselves, or as a parent or carer) • Whether the patient's preference is to visit the practice or A&E initially Q – It seems unfair that the practice are charged for hospital stays Amir answered that from April patients visiting A&E inappropriately would be asked to see their GP Q – Does the practice have closer ties with any particular hospital? Paul answered that this is not really the case, adding that if anything doctors refer most often to St Helier, but the ability of patients to choose will persist. He explained that choice wasn't necessarily available for tertiary care, but it always was for secondary care, and technically patients could elect to be seen in the Hebrides if they wished. Qs – Can the practice publicise its website. Many people are unaware that it exists. Shouldn't the practice also ask new patients for email addresses? What is on the website currently? Should the practice try to collect email addresses from existing patients? Should there be a noticeboard with current issues? Steve spoke on this and accepted that the website was currently underused. Steve and Amir pointed out the difficulties with emails as there was a potential that patients might want to email about medical issues whereas it wasn't possible for security reasons for the practice to do this. Steve added that there was a possibility of 'information overload' and indeed there was already a lot	

	of information available already available in the form of posters etc that people didn't notice. There were further questions: Q - Can doctors inform patients about their routine absences – regular days off etc? The doctors accepted this in principal, but added that there were occasions when they would come in on their days off and didn't want to give patients the impression they were misleading them. Q – Are there any plans to do anything about the difficulties patients experience in getting appointments? Steve answered that the partners had discussed this again quite recently after numerous initiatives in the past. This time a partner had undertaken to research the various options and report back to the partnership. It was expected that the partnership would be looking at options such as telephone triaging amongst others, to try to reduce the burden. Paul added that each year the partnership offered over 50,000 appointments and fulfilled its obligations with regard to the number of patient contacts per number of patients that it was required to undertake. It was suggested that this would be a useful fact to add to the website. Q - Does the practice find opening on Saturdays beneficial? Amir explained that this had been an initiative set up by the previous government but the practice weren't allowed to restrict it to enable those who worked during the week to see a doctor, therefore it wasn't particularly helpful in that respect at least. Q - Is there a practice policy on when patients should see a doctor or a nurse? Would increased nurse usage help provide more appointments? Paul said that there is a sign up in reception which points out that services such as contraception and smoking cessation can be dealt with by nurses	
5.	In summary Steve thanked everyone for attending and apologised for the fact that the agenda hadn't been rigidly adhered to. He said that it had perhaps been necessary on this occasion for it to follow a less structured format so that participants could get a feel for each other and ask questions that would probably not need to be asked on future occasions. He added that it had been decided not to send out agendas in advance on this occasion due to the fact that not everyone had email access, but in future it would be likely that members would want to submit their own agenda items for discussion. He asked participants to look through the survey at their earliest convenience and contact him with any additional questions that they thought it should contain, as there was a time constraint on this and it would probably have to go out prior to the next meeting.	
6.	AOB: • None	
7.	Next meeting – First week in February	