

**Responses to Monitor's
call for evidence on the
general practice services
sector in England
(GP services):
patient representative
groups**



This document contains non-confidential patient representative groups' written responses to our [call for evidence on GP services in England](#). We have published these responses with permission, in full and unedited, except for limited circumstances where text has been removed as it was identified as being confidential, or identified individual GPs or GP practices.

Alongside this document we have published responses from patients, providers, clinical commissioning groups, local medical committees, representative bodies and other respondents [here](#).

These published submissions form part of the information considered in our [discussion document](#) following Monitor's call for evidence on GP services, which sets out what we have heard and proposed further work.

Patient representative groups

Please click on the items in the list below to jump to the submission you require.

- [Chatsworth Road Medical Centre Patient Participation Group](#)
- [Healthwatch Barnet](#)
- [Healthwatch Derbyshire](#)
- [Healthwatch Hertfordshire](#)
- [Healthwatch York](#)
- [Lambeth PPG Network, Healthwatch Lambeth and Healthwatch Southwark](#)
- [Shropshire Parent and Carer Council](#)
- [Sleights and Sandsend Medical Practice Patient Participation Group](#)
- [Responses from individuals \(x2\)](#)

Chatsworth Road Medical Centre Patient Participation Group

The Chatsworth Road Medical Centre PPG assigned 3 members to study the Monitor document asking for evidence on General Practice Services in England and to send their findings to yourselves.

This PPG has started surveying patients using relevant elements of The National Standards of Quality and Safety referred to in Regulations 9 to 24 (part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as a base.

In response to your questions 9 through 11 our experience and findings are that this practice of approximately 8500 patients has positive responses on all significant services from its patients.

You raise a number of points in your question 12 that arose in the Fair Playing Field Review and while the contractual terms and new practice rules are beyond our immediate scope we can report that the practice has positive responses from its patients on all significant services.

With regard to the latter points listed in question 12 we would like to point at that as well as providing the current GP services the Practice and its PPG is working with other Chesterfield Practices and Social Care providers within the Locality Group to develop new, more integrated services for the Elderly.

If you require any more input or further discussions please email the cc'd members of the PPG so that we can respond quickly to your questions.

The GP Appointment System The Way Forward



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Introduction

In 2012 Barnet Link published a Research Report on "Patient Access to Appointments and Use of Telephone Systems in London Borough of Barnet GP Practices". The work leading to the report was undertaken in response to issues raised by members of the community.

The Report was presented in late 2012 at a public meeting hosted by Barnet LINK and the Barnet Clinical Commissioning Group (CCG). It raised a number of issues about difficulties with the GP appointment booking process and made a number of recommendations (please see Appendix A).

This earlier study was undertaken solely from the patient perspective. In order to clarify and understand the presenting problems and to investigate the issues from the GP practice point of view, it was decided to meet a limited number of Practice Managers. This enabled us to explore the issues from their perspective and to understand the management perspective. From our previous research the major problems that we identified in the appointment process were both getting through to the receptionist and the allocation of the appointment. Having pinpointed the major symptoms we wanted to identify their underlying causes.

This report has, of necessity, focused only on access to GPs and the general appointment-making process. The issue of access to GPs and the appointment-making process applies to all groups in the community and we acknowledge that that further work needs to be undertaken to support some minorities who meet problems on a daily basis when contacting their GP.

This work, undertaken in Dec 2012 – March 2013, was done under the aegis of Barnet Link and at the time it was not known into which organisation the Healthwatch contract would be awarded. It has now been confirmed that this work will be continued under Healthwatch Barnet as the successor to Barnet LINK. Owing to this there were very severe time restraints which the group were working to, and it was only possible to plan and visit seven practices. Many of our suggestions could possibly be implemented at low cost or no cost.

Methodology

Using the National GP Survey for year 2011/2012 we looked at Question 18 which reads 'Overall, how would you describe your experience of making an appointment?' and best covers the area that we wished to investigate. We extracted the responses for this question for all Barnet GP practices in order to look at the data, selecting the responses of "Good and Very Good", and "Very Good" alone. We found the ranking of practices was very similar using these two categories so we chose to use the "Very Good" category alone. This is supported by 'Overall experience of making an appointment' from the PMS Contract review presentation by NCL NHS (NCLondon NHS "PMS Contract Review Patient & Public Representatives Meeting", March 2013.)

It was apparent from this ranking that there were a significant number of single-handed practices in both the top and bottom cohorts. We decided to discount this group as they may have issues unique to their structure as opposed to a multi-partner practice which is more representative of the GP services provided to the majority of the population in the London Borough of Barnet. We acknowledge that the next phase should include some single-handed practices.

From this ranking we then picked a limited number of practices which had two or more partners. These were 3 from the practices scoring highly; 3 from the lower end and one midpoint practice from this list.

The Practice Managers from these selected practices were then contacted by telephone and the background to the research was given. In this first phase all 7 practices that we approached were willing to take part. A meeting was then arranged and practices were asked to provide some basic statistics regarding appointments in advance of the meeting (please see Appendix B). The meetings were arranged at the Practice Managers' convenience, generally over a short working lunch at each practice, with a small team of volunteers from Barnet LINK asking a series of structured questions along the lines set out in Appendix B. For consistency, the same core team of volunteers participated in all seven visits, with additional volunteers from the GP Group as available.

The purpose of these meetings was to gather information and to hear the Managers' views on the issues around 'making appointments'. This included list size, clinical and non-clinical staff resources, number of telephone lines and patient non-attendances (DNAs).

This data was captured on a spreadsheet and subject to ratio analysis. This is shown below in Table 1 on an anonymised basis.

As a result of meeting the Practice Managers we realised that the appointment-making process is very complex and, to help understand this and the management issues involved, we produced a flow diagram (Appendix C). This highlights the complexity of the task that the Practice and the Practice Manager face on a daily basis. Please note that the flow chart is a draft and is subject to review.

Summary of Findings

Table 1 Data Analysis from GP Visits

1	2	3	4	5	6	7	8	9
Practice	List Size	Patient Satisfaction % Score	Ratio of Patients/WTE Doctor	Annual Number of Doctor + Nurse appts per Patient	Patients/Phone Line	DNAs as % Appts	Deprivation Index	Long-standing Health Problems %
A	<5000	55-59	2200	3.45	2168	2.1	13.7	41.3
B	6,000-10,000	50-54	1700	5.66	2257	0.6	14.3	34.5
C	<5000	45-49	1500	Not available	2150	N/A	14.6	48.7
D	6,000-10,000	20-24	2300	6.19	1984	13	31.9	46.0
E	15,000 +	15-19	2000	5.62	2833	8.8	13.3	44.7
F	6,000-10,000	15-19	1800	6.64	2150	1.8	14.6	45.7
G	11,000-15,000	10-14	1900	Not available	1775	N/A	14.4	50.4
Barnet Range							9.93-31.9	31.1-59.6

Data Analysis and Explanation

Column 1 - Practice identification.

Column 2 - List Size - this is the list size for each practice, banded for anonymity, provided by the Practice Manager.

Column 3 – This relates to the “Very Good” % score from the National GP Survey 2011/2012 Question 18. To avoid practices being individually identified we have presented the analysis banded by increments of 5% points.

Column 4 - The Ratio of Patients per Whole Time Equivalent (WTE) Doctor – this is the number of patients per whole time doctor. To preserve anonymity the figures in this column, “Ratio of Patients/WTE Doctor” have been rounded to the nearest 100. Analysis was based on the unrounded figures.

Column 5 – Annual Number of Doctor + Nurse Appts – this is the number of doctor and nurse appointments available per patient per year. In some practices patients are seen by a Nurse Practitioner rather than a GP. Similarly patients may be seen by a Healthcare Assistant for appropriate treatments, and these are included in this figure. This figure therefore gives a better picture of the availability of medical care. This data was provided by the Practice Managers.

Column 6 - This is the number of Patients per Telephone Line.

Column 7 - DNAs as % Appts -this is the number of patients who did not attend their booked appointment as a % of the total number of appointments.

Column 8 - Deprivation Index (from NCLondon NHS “PMS Contract Review Patient & Public Representatives Meeting”, March 2013.) The higher the deprivation score, the higher the level of deprivation recorded amongst the practices’ patients.

Column 9 - Long Standing Health Problem Score (from NCLondon NHS “PMS Contract Review Patient & Public Representatives Meeting”, March 2013.) The higher the percentage recorded, shows the greater the number of patients with a long-standing health problem.

Observations

These observations are based on inspection rather than statistical analysis.

- Looking at these figures there appears to be no direct correlation between the number of patients per doctor (Column 4) and the patient satisfaction rating score (Column 3).

- Apart from Practice A, it would appear that there is little correlation between the annual number of doctor and nurse appointments per patient (Column 5) and patient satisfaction.
- The number of patients per telephone line (Column 6) does not appear to affect ranking. Analysis of these figures seems to suggest that adding telephone lines is not the simple answer to improving access to GPs. It must be remembered that patients also use the telephone for many other reasons than just making appointments (e.g. test results, information requests) and also make appointments by non-telephone means (walk-in, online).
- DNAs as % of appointments. The wide range merits further investigation
- Ranking does not correlate with "Deprivation Index". However Practice D illustrates that implementation of new policies and procedures can improve service to patients despite a high deprivation index.
- The number of patients with Chronic Health Problems (Column 9) may have some bearing on ranking, but this is not entirely borne out by cross-referencing the annual number of patient appointments per GP and nurse. Further analysis and feedback is required.

Having eliminated all of the above and based on our discussions with practices, we concluded that some of the essential elements contributing to high patient satisfaction are:

- Good management with a strong and engaged Practice Manager
- The Doctors, Practice Manager and the Reception staff working as a co-ordinated team
- On-going patient education and managing patient expectation
- Patients confident that they will be seen when they need an appointment. This is the key to eliminating the 8am pressures on the telephone lines.

We enlarge on these findings below:

Best Practice Findings and Suggestions

From the information that we gathered at our meetings with Practice Managers at the seven surgeries we visited we drew a number of conclusions and identified some excellent good practice. We have therefore documented here the trends and conclusions that we found and have identified some of the good practice that we feel may be of interest to other practices that we have not visited.

These issues may be grouped under a number of broad headings.

Issues, of course, may fall under more than one heading and are inter-related:

- A - Managing patient expectations
- B - Information to patients
- C - Feedback & teamwork
- D - Making an appointment

A. Managing Patient Expectations

- i. Several Practices are attempting to 'educate' their patients on how to access and use the appointment system. For example, patients at one practice are asked only to phone at opening time for appointments required on that day. In one practice the guidelines for making appointments are set out in the practice leaflet. This sort of guidance seems to be helpful and instils confidence in patients that they will be able to get an appointment when really needed.
- ii. One Practice we visited is trialling the NHS Minor Ailments Scheme. Patients are offered the opportunity to use this, when appropriate, for direct access to local pharmacies who can now directly prescribe medicine to patients who have a Minor Ailment and are eligible for free prescriptions . Those who are offered this scheme sign-up and are entitled to up to 10 prescriptions for minor illnesses which are dispensed directly from the pharmacist, without having to see a GP. Please see Appendix D, where examples of Minor Ailments can be seen.
- iii. Some practices show a clear list of ailments /conditions that will be seen by the practice nurse so that it is clear which sort of appointment needs to be booked.

B. Information to Patients

- i. Practice Leaflets and Patient Newsletters are becoming more popular and seem to be effective ways of informing and updating patients about the most effective ways of using the GP surgery, and keeping them up to date when changes occur.
- ii. Some practices have developed clear, structured websites giving practical and useful information and links as well as the facility to book appointments online. These could be developed further, and patients encouraged to access these for information and guidance prior to making an appointment, and for general information. NHS England will be providing non-recurring annual rewards to GP practices for the successful preparation, establishment and adoption of electronic services to deliver online patient access during the period 2013/14 to at least 2014/15.
- iii. Public health initiatives and advice need to be channelled more carefully to patients. Often these campaigns lead to the GPs being inundated with the worried well. Focused campaigns with further guidance would be more helpful.

C. Feedback and Teamwork

- i. Several surgeries give feedback to their patients if they feel their request for an urgent appointment is not appropriate, and the matter could have been dealt with less urgently. This is fed back to the patient by the doctor they have seen, and information is passed back to the receptionist for monitoring.
- ii. Patient Participation Groups (PPGs) are an effective way of engaging with patients and enabling them to have a voice in the practice. Two of the seven practices we visited have regular contact via their PPGs and both felt they benefited from good suggestions and constructive support through the groups.
- iii. Practice Managers value the Practice Manager Network meetings, but often only the current administrative problems are discussed with no time for "best practice" ideas to be developed. Many also struggle to prioritise attending the meetings under the pressure of work.
- iv. One practice was part of a small Hub Group who meet bi-monthly to discuss practical issues/solutions and give peer support and joint working wherever

possible. This has helped support Practice Managers, and alleviated the feeling of isolation.

- v. One of the key aspects that we noticed across the practices we visited was the need for good doctor/manager/staff communication. The practices that appeared to be most successful were those with good communication and strong engaged practice managers. A long-standing, stable reception team is good for patients and for the practice.
- vi. All of the practices we visited train their reception staff in-house. This varied from 2 to 3 weeks' shadowing a senior member of the reception team, to a more structured induction and trial period lasting three months – involving IT training, knowledge of protocols and procedures and signing off competencies as they are achieved. One practice had developed a training booklet for new staff. Having been involved in a Mystery Shopping project and heard how intensively the reception staff in Community Healthcare Reception desks are trained in all aspects of customer care, we were surprised that this seemed to be absent for GP reception staff who appeared to be largely trained on the job with little formal external training undertaken. We felt that reception staff would benefit from bespoke training looking at attitudinal aspects and conflict resolution techniques as well as the technical aspects covered in house.
- vii. Two practices undertake their own Patient Surveys (in addition to the National one) each year which is found to be a very useful monitoring tool, enabling the practices to promptly respond to particular local issues.
- viii. Where regular locums are used or surgery time is covered by other doctors from the practice during doctor absences, then the patient satisfaction rate is noted to be higher than where a range of different locums are used. Not all practices have cover for absent doctors.
- ix. One practice noticed that the absence of Health Visitors attached to their practice had increased the workload as they used to advise families with young children.

D. Managing the Appointment Process

- i. Telephone appointments with the doctor were perceived by the Practice Managers to be popular with patients where a given time was allocated for this form of consultation. This was a very useful facility for patients, saving a visit to the practice where reassurance may be all that is needed.

- ii. Some practices have installed systems where appointments are confirmed by text to mobile phones and appointments can be cancelled if no longer required. This has cut DNAs in some practices, but not eliminated them. It is important that practices take advantage of modern communication channels within the context of a Communication Plan.
- iii. DNAs are actively monitored and acted on in some practices, which helps to reduce the waste of resources. This is done by telephone calls and letters to the patients and, *in extremis*, removal from the list. Some practices displayed the numbers of DNAs during the previous month to raise awareness of the problem.
- iv. Only one practice that we visited had an 0844 telephone number which generated a lot of complaints and was unpopular with the patients. The practice recognised this as an issue.
- v. It has become clear during our visits that where patients are confident that they will be able to access an appointment urgently when required, the '8am scrum' disappears.
- vi. The interpreter service was reported as good but needs to be booked in advance. This saves members of the family attending and performing this function, and maintains confidentiality and the dignity of the patient. Interpreters can also help convey medical terms and information, which family members may not be aware of. However some practices are able to use their ethnically diverse staff for this function.
- vii. The practices varied considerably with the time over which advance appointment bookings could be made varying from one week to twelve months. Taking the ratings from the national Patients Satisfaction Survey, those practices with the long advanced booking period received more positive responses on the survey.
- viii. Good use is being made by receptionists of screens which flash up patients' information when an appointment is being made – thus helping to ensure that appropriate priority is being given to vulnerable and terminally ill patients. Some surgeries use cards which are issued to patients to highlight where priority is needed. This was being used as an "Aide Memoire" for the receptionists when booking appointments at the desk.
- ix. One surgery said demand for appointments had trebled in the last year. Another said patient attendances had gone up from 3 to 6 per year. Our

figures ranged from 3.45 to 6.64 available appointments per patient per annum.

- x. Over half of the practices reported that patients valued having blood testing facilities at the surgeries. This is usually done by Healthcare Assistants.

Next Steps

Recognising the small sample size of this study, we are keen to visit more surgeries, gathering further data and information on good practice.

We will consider academic involvement in our further work.

NHS England leads on primary care commissioning. We are in discussion with the CCG, which has been able to provide the GP Group with guidance on how these findings and best practice can be disseminated to GP surgeries and PPGs.

This report has been circulated to the Practice Managers so that they can check factual accuracy and make any comments.

Other Areas of Research

During this project a number of issues arose which we were not able to investigate further due to constraints both of our brief and of time.

However, we would like to note that further phases of this work will consider:

- Support for people with Learning Disabilities. Barnet LINK gave a presentation on this GP Project to the Barnet Council Learning Disability Partnership Board. Participants made a number of recommendations which will be included in future work. Molly Rayment, Primary Care Learning Disabilities Health Facilitator Nurse, is in contact with the Healthwatch Barnet GP group and hopes to work with them on issues at GP practices in order to improve outcomes for people with learning disabilities. Mencap has also been updated on this area and we will liaise with staff and members on taking this aspect forward.
- Support for people with physical and sensory impairments. In October 2011 Middlesex Association for the Blind, in partnership with other organisations presented a report to the Physical and Sensory Impairment (PSI) Partnership Board, 'Access Project for Deaf and Hard of Hearing People in Barnet' that covered key recommendations for Health Services in Barnet. We are working with the PSI Partnership Board, Barnet Vision Strategy Group on this, and it is hoped that Alison Asafu-Adjaye from Sense, will be working with the GP Group regarding accessing GP services.
- Different methods of patient triage when they first contact the surgery.

- Helping practices to be supportive for people with Mental Health conditions. Healthwatch will talk to the Mental Health Partnership Board and Mental Health Network to follow this up. The GP Group will also link with Healthwatch Barnet's work with the Gypsy, Roma, Traveller community and Lesbian, Gay, Bisexual and Transgender community to be aware of and support any projects they carry out in on primary care.

References

'PMSContract Review Patient and Public Representatives Meeting' NHS North Central London 2013-05-09

'A Research Report on Patient Access to Appointments and Use of Telephone Systems in GP Practices within the London Borough of Barnet' Barnet LINK. November 2012

National GP Patient Survey (www.gp-patient.co.uk)

Acknowledgements

Thank you to the volunteers of the Barnet LINK/Healthwatch Barnet GP Group for their hard work and support in the compiling of this report. In particular to Melvin Gamp and Ranil Jayasinghe for their assistance in completing the Practice Managers meetings.

Thank you to the 7 Practice Managers who very generously and constructively gave their time and expertise enabling us to complete this piece of work. They were a very dedicated and inspiring group of managers and we thank them very much for their contributions.

Our grateful thanks are also due to John Morton, Chief Officer NHS Barnet CCG, and Becky Kingsnorth, Head of Primary Care Strategy, Barnet CCG, who have reviewed the report and supported the Healthwatch GP Group in taking the work forward.

Finally, we would like to thank Selina Rodrigues, Head of Healthwatch Barnet, and to say how much we appreciated her support and advice during the researching and writing of this report.

Appendix A: Previous Report Recommendations

Recommendations taken from 'A Research Report on Patient Access to Appointments and Use of Telephone Systems in GP Practices within the London Borough of Barnet'. 2012 Barnet LINK

- I. GP access systems need to be revised to ensure the system is patient-centered, logical, friendly and helpful. From the evidence gathered we have learned that a significant number of the patients taking part in this research felt that the booking system in their surgery was not patient-friendly.
- II. The quality of communication between patients and their surgeries should be improved, through Patient Participation Groups. We recommend practices to talk to their patients about adjusting their systems to make it easier for them to access GP services when needed.
- III. Regarding booking by phone specifically, GP practices are strongly encouraged to look at creative ways to increase patient satisfaction in this area, for example allowing patients to ring in the day before for the next day's appointments.
- IV. Standardisation of telephone numbers across Barnet's GP practices is needed. We are concerned to see that around 10% of GP surgeries are using 0844 numbers, or other premium numbers, which create barriers to the service for those who cannot afford the charges incurred.
- V. Clearer information about appropriate use of NHS services is needed to raise patient awareness about when to go to GPs, Chemists, Walk-In-Clinics and A&E.
- VI. A cost effective balance between demand and capacity is important and we recommend identification and circulation of "best practice" and current demand/capacity analysis and local bench marking.
- VII. Serious consideration should be given to technology-based systems to ease the pressure on the telephone booking system. Alternatives would be needed for those that are unable to use the internet or other technology.
- VIII. Overall patients disliked divulging their symptoms to a receptionist as it was perceived to be breach of confidentiality. Decisions about whether an appointment is an emergency matter or not should be made by a clinical member of the team (i.e. a nurse or a doctor).
- IX. GP appointment systems should be patient-oriented based on the evidence gathered so that those who are vulnerable, disadvantaged, too ill or in need of special support are more sympathetically looked after. Perhaps an alternative telephone line or protected calling times could be considered.

- X. From the survey responses, there is the possibility that some surgeries may not have an adequate number of telephone lines or staff to serve all the patients on their lists and we recommend that “mystery shoppers” test the surgery telephone systems and report their findings.
- XI. Best-practice procedures should be shared across GP practices in Barnet, so that those rated highly by patients can serve as models to encourage change and improved patient satisfaction.
- XII. We are concerned to see Edgware having consistently higher negative feedback than East Finchley. We recommend future exploration by CQC is focused on this geographical area to improve quality of services.
- XIII. We would like to see patients being able to see a named doctor as far as the appointments allow, and similarly for emergency appointments.
- XIV. Dignity and respect of patients should be observed at all times, in particular regarding requests to see a male or female doctor.
- XV. Regarding test results, we strongly recommend that each practice has a clear and consistent policy regarding test results.

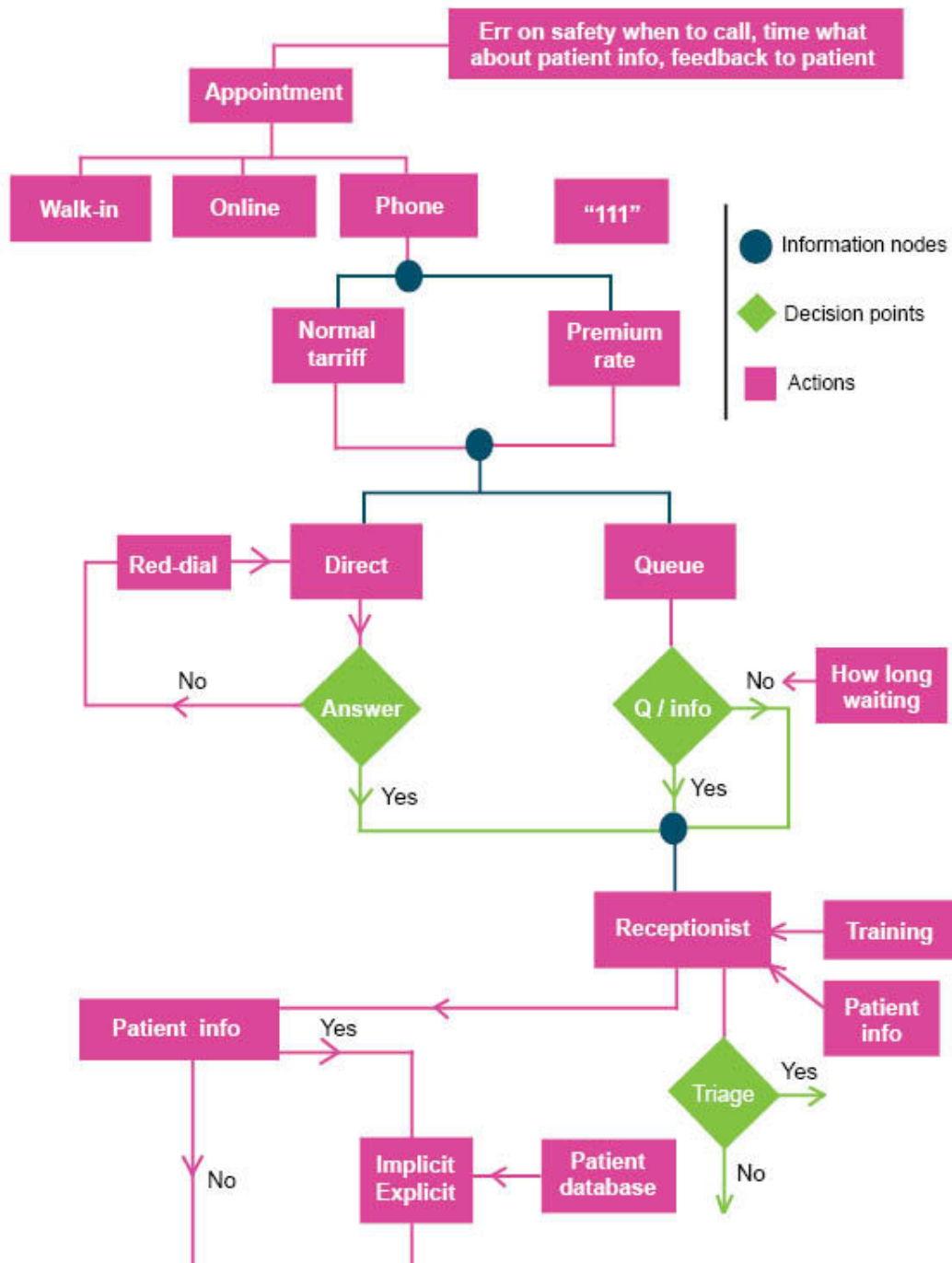
Appendix B: Questions and Data Gathered for GP Visits

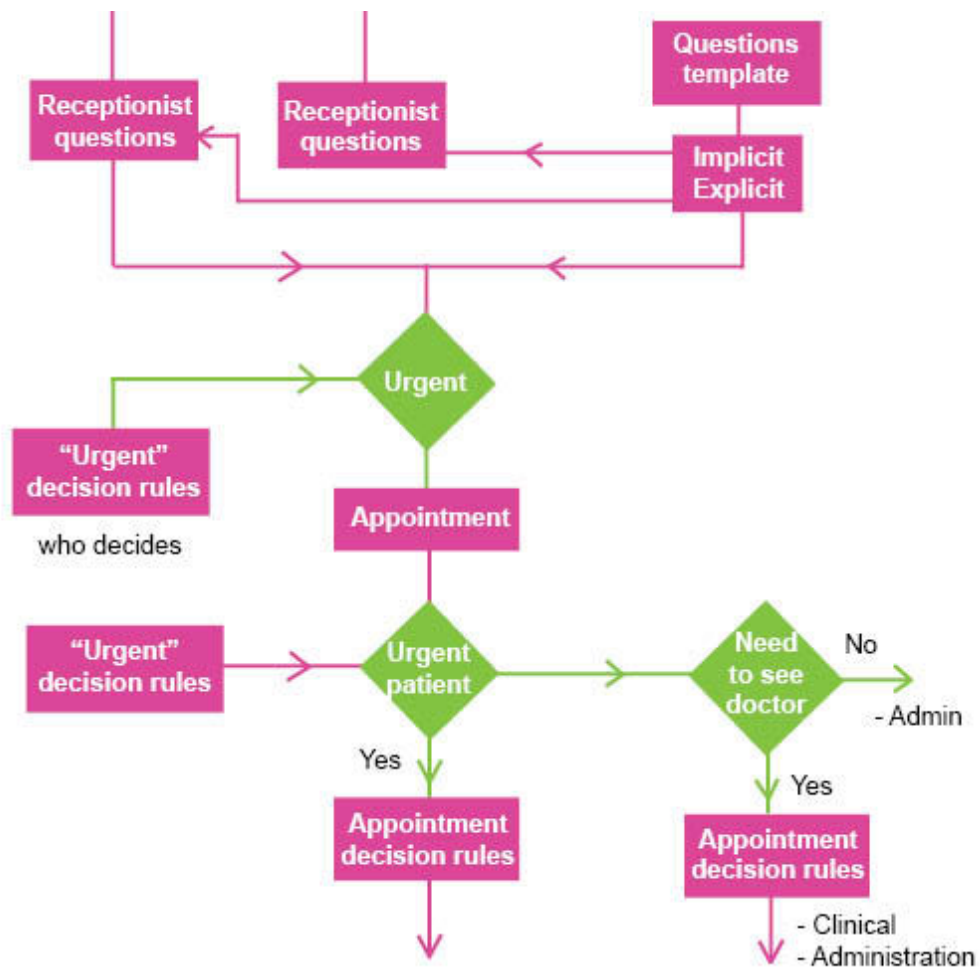
Name of Surgery:	
Address:	
Tel:	
Date:	
Time:	
Practice Manager:	
List size of Practice:	
WTE for Partners:	
WTE for Assistant Doctors:	
WTE for Nurses:	
WTE for HCA:	
Total number of appointments per week with Doctors:	No. Pre-bookable:
Total number of appointments per week with Nurses:	No. Pre-bookable:
Total number of appointments per week with Healthcare Assistants:	
Total number of telephone consultations with doctors per day:	
Number of phone lines operating at the same time:	
Number of receptionists answering phones:	
Number of receptionists for face to face contacts (or do they do both?):	
Is there on-line booking:	
Is there computerised check-in at the surgery:	
DNAs:	

Appendix C: Draft Flow Chart showing GP Appointments System

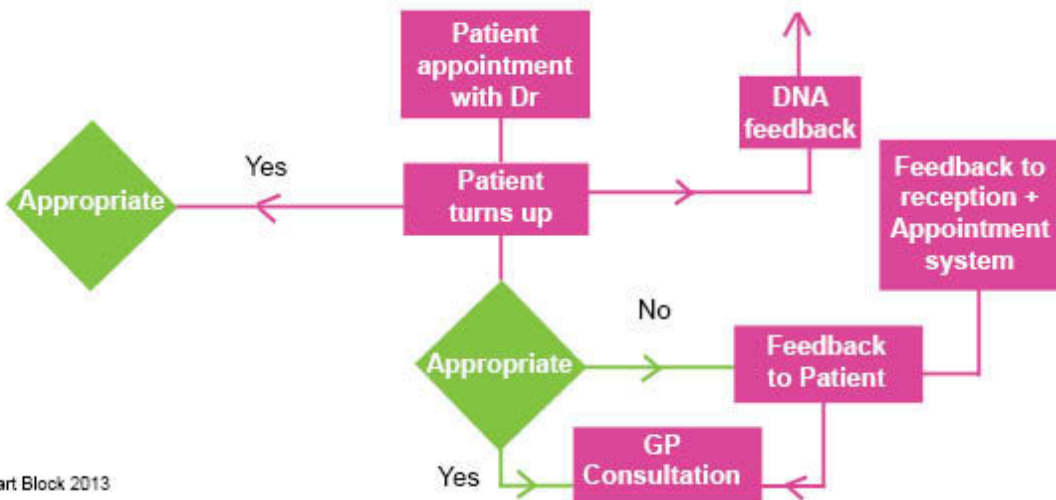


GP Appointments System Process Chart DRAFT - Subject to Review





-
- "now"
 - hospital, 999, 111
 - "urgent" slots
 - Routine
 - Non-routine
 - Future bookings how far ahead
 - Reminder system
-



Appendix D: An Introduction to Barnet Community Pharmacy Minor Ailments Scheme

How do I join the scheme?

If you have any of the minor ailments listed in this leaflet and are registered with a participating Barnet GP practice, you are eligible to join this scheme.

Please follow the steps below to obtain your Minor Ailments passport, which you can use up to 10 times.

- 1) Take this leaflet to your GP receptionist and ask for a Minor Ailments passport (one per patient). The receptionist can give you more information about how the scheme works and which pharmacies are taking part.
- 2) Take the passport to your chosen pharmacist.
- 3) The pharmacist will ask you a few questions and give you the appropriate advice and treatment.



What minor ailments can be treated under this scheme?

- Athletes Foot
- Constipation
- Cough
- Cystitis
- Diarrhoea
- Earache
- Fever
- Hay Fever/allergic rhinitis/allergies
- Head lice
- Indigestion
- Insect bites/stings
- Mouth ulcers
- Sore throat
- Sprains/strains
- Teething
- Threadworm
- Vaginal Thrush
- Verrucas
- Upper Respiratory Tract Infection
- Warts

IMPORTANT INFORMATION

Do not share your medication with others even if they have similar symptoms.

Advice may also be obtained from
NHS Direct on 0845 4647 or nhsdirect.nhs.uk



Barnet Clinical Commissioning Group



Minor Ailment Scheme

A new service for patients to obtain free treatment (if eligible) direct from your Pharmacy



What is the Minor Ailment Scheme?

Everyone can go to their pharmacist for free advice or to buy a medicine for a minor illness or ailment. The scheme allows you to use a passport, given by your GP, to get medication (free, if eligible) straight from your pharmacy for conditions listed in this leaflet.

The Minor Ailment Scheme allows you easier access to the same advice, treatment and medicines from your pharmacist as you would get from your GP, without having to wait for a GP appointment.

Who can use the service?

People who are registered with a GP practice in Barnet that is taking part in the scheme. Currently the scheme is only available in certain GP practices and pharmacies.

Why visit the pharmacy?

- Pharmacists are trained to treat minor ailments such as head lice or sore throat.
- You will not have to visit your GP for a prescription or wait for an appointment.
- Your GP will be able to spend more time treating patients with more serious illnesses.
- This is a confidential and high quality service, designed to meet the needs of patients.

Will I pay for my prescription?

The normal exemptions apply; medication will be free to NHS exempt patients. The price of the medication or a normal prescription levy will be charged per item to non-exempt patients.

What will the pharmacist ask me?

The pharmacist will ask you a range of questions about:

- your symptoms
- how long you have had symptoms
- your current medication
- history of ailment
- any other illness you have.

The answers will help the pharmacist to make a diagnosis and offer you advice.

Will I always get treatment for my ailment?

You will definitely be given advice and treatment if necessary. The pharmacist may decide that you need to see a GP and refer you back without giving you any medicine.

Will I still be able to see a GP?

Yes, if you want to you can still have an appointment to see the GP or nurse. This is just another way that you can get advice and treatment without waiting for an appointment with your GP.

Which pharmacy can I go to?

Please ask your GP practice for a list of participating pharmacies.

Please be aware that the service may only operate when the named pharmacist taking part in the scheme is on duty.

IMPORTANT INFORMATION

Your pharmacist is providing treatment and/or advice under the minor ailment scheme in line with the symptoms you have described.

healthwatch Barnet



Contact Healthwatch Barnet:

Tel: 020 8364 8400 ext 218

Email: info@healthwatchbarnet.co.uk

www.healthwatchbarnet.co.uk

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1st August 2013

GP Services Call for Evidence
Monitor
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Dear Monitor

CALL FOR EVIDENCE ON GENERAL PRACTICE SERVICES SECTOR IN ENGLAND

We welcome Monitor issuing a call for evidence to determine the extent to which commissioning and provision of general practice services is operating in the best interest of patients.

Initially, I would like to take this opportunity to advise that Healthwatch is an independent consumer champion that was set up in April 2013, as a result of the Health and Social Care Act 2012.

Healthwatch exists in two distinct forms, the national body which is Healthwatch England, and locally, of which there are 152 local Healthwatch organisations across the country.

Healthwatch Derbyshire gives the Derbyshire public a strong, independent and **collective** voice. We provide a platform for local voices to have an impact on local services, not just for the people who use them, but anyone who might need to in the future.

We focus on gathering the views of people of all ages from children and young people to adults and seek to reflect the diversity of the communities of Derbyshire.

Information shared with Healthwatch is fed directly to those responsible for the design and delivery of services, letting them know what they are doing well and where there is room for improvement.

In future if/when you require patient feedback/experiences to inform your work, Healthwatch organisations can be contacted to assist.



Following concerns regarding access to GP Services a piece of work was undertaken by Healthwatch Derbyshire to look into this further. What we found was that although overall most people were happy with the service they received, there seemed to be concerns around the process of obtaining a GP appointment.

Comments such as:-

- *Poor GP Access.*
- *GP appointment times slip too much.*
- *Some GPs don't keep to their mission statements.*
- *Dr First has worked well but some drawbacks especially for people who work.*
- *Getting to see a GP is difficult and can take weeks.*
- *Not easy to get an appointment. Have to call at 8am. Not easy unless an emergency, can take up to two weeks. Lines are constantly engaged and by the time you get through, all appointments have gone.*
- *Can take up to 3 weeks to get an appointment.*

Other comments gathered:-

- *In [named] Medical Centre, there is a moving electronic display which says that appointment with GP should be for ONE problem only. This seems to be against proper medical practice. GP should know all the problems a patient is having as some could be related problems. Also it would cost the NHS more to have another appointment for a second problem.*
- *Called today (29th July 2013) for a GP appointment. The earliest available was 7th August 2013 to see a GP. To get an earlier appointment, have to call at 8.30am tomorrow morning. By the time patient gets through, the appointments will all be gone. Was also advised there are GP appointments blocked for Thursday which will be released on Tuesday morning. Which then means if called on Tuesday morning, the practice is showing they offer appointments within the 48 hour timeframe. Previously same thing happened, so ended up calling the OOHs with partner being admitted to hospital for a long stay.*
- *A patient was told that [surgery] does not have a GP there on a Monday, and that there is only one doctor at [surgery]. This patient is likely to make a formal complaint to the Area Team.*

Patient Story - March 2013:-

- *Call made to practice around 9.00am, operator asked what the problem was, my wife said she had a very painful foot and happened to mention she thought it might be a bunion.*



The next comments were quite alarming to me. My wife was told, and I quote, "I don't think we deal with bunions, I'll ask."

Operator returned to the phone and said, "I've spoken to the doctor (forget the name) and we don't deal with bunions. You will have to go and see a podiatrist." At this stage the diagnosis wasn't even known.

My wife duly made an appointment with a podiatrist for 28/3/13 and was told she would probably need a referral as her foot was really bad. In order to do this she would have to see a GP.

The first question is what service are patients supposed to expect when they are told to go and see a private provider?

Also to my wife's and my consternation, the podiatrist my wife saw informed her that he had only, the week before, delivered a QUEST session about foot care to the practice (named surgery).

What followed next is what I have tried to defend on behalf of the practice i.e. access to get an appointment.

Week commencing 8th April 2013:

Called Monday 9.00am took quite a time to get through. Told no appointments, my wife enquired what to do next. She was told to ring back at 8.00am tomorrow. My wife asked about advanced appointments and was told these were booked up until May.

Tuesday, rang again. No appointments, again. When asked, "why can't I get an appointment for another day," was told by the practice that they don't do that you'll have to ring at 8.00am tomorrow.

Wednesday, rang 8.00am took 20 minutes to get through, only to be told no appointments. At this point my wife who is usually very placid began to get quite annoyed. She explained she had been trying to get an appointment for 3 days and asked as to why at 8.20am had all the appointments gone. The practice told her that they only have one GP here. After further dialogue the operator said she would speak to her supervisor. She returned and offered my wife an appointment for the following Tuesday 16/4/13.

You may ask how I can report this detail when the experience concerned my wife. It is because we had the phone on speaker in order that I could monitor the situation.



Not a very satisfactory experience and I now understand why so much is made of the situation at PPG meetings. Despite all promises that the situation is being improved, there is a long way to go if patient satisfaction is to be improved.

Look forward to your reply, I would question the calibre of clinicians if they are telling patients the practice doesn't consult on certain conditions.

We are able to provide more evidence (patient stories/intelligence etc) relating to this particular subject area.

This can be obtained by contacting Mrs Jas Dosanjh, Community Involvement Worker, on the above telephone number or emailing her at jas@healthwatchderbyshire.co.uk. Jas is the Healthwatch Derbyshire lead on GP Access.

Healthwatch Derbyshire trusts you find the above informative and useful.

Finally, it would also be extremely helpful, when responding, if you could please address correspondence direct to Mrs J Dosanjh.

Yours faithfully



Darren Bailey
Healthwatch Derbyshire Chair



Accessing GP services

In June 2013, Healthwatch Hertfordshire asked its members about their experience of accessing GP services. 44 people gave us their comments. We are planning some further work to find out more about the nature of the issues and to support local surgeries to improve practice. The following is a summary of feedback received.

Issues reported with making an appointment to see a GP

Continuity of care

- It is difficult to get an appointment with a specific GP. Sometimes it's important to see the same GP, for example, long term conditions and parents/carers of disabled children.

Timeliness of appointment availability

- Comments that it can take 3-4 weeks to get a non-urgent appointment with a GP.
- Other comments from patients who have experienced being unable to get an appointment even when calling at the specified time.
- This is compared with some comments that it is never a problem: *"I can get to see any doctor within a week"*.
- Although the sample size is small, appointment availability is reported to be better in smaller practices.
- There is a view that it has become more difficult to get routine appointments in the last 6 months - 2 years.
- Comments that appointments are only available a week in advance so these get booked up quickly.
- Tactical misuse of the system. Reports of patients being driven to making 'insurance appointments' in anticipation of being unable to get an appointment at the appropriate time. Also inflating symptoms to attend sit and wait clinics.

Patient experience of the booking system

- Comments that systems for allocating appointments are excessively rigid: *"surgeries should be prepared to make an exception (to appointment rules) without the patient resorting to begging"*
- The experience of requesting an appointment is frustrating and there were reports of unsatisfactory customer service. *"Do you really need an emergency appointment?"*
- Comments from carers that their needs are not recognised. While there are some reports of surgeries 'flagging' carers on the system, it was not clear that there is any policy to prioritise appointments for carers or make special provision.

People told us about systems in place at their surgeries to manage appointment booking, and alternatives to seeing a GP

On-line booking

In some surgeries there are reportedly few appointments available online, whereas others make appointments available up to 6 weeks ahead.

Telephone appointments

- Acknowledged to be a useful alternative to waiting for an appointment in person, but comments that it can be difficult to explain a problem over the phone and that appointments are sometimes triaged inappropriately.
- Arrange a call back from a duty doctor

Telephone Triage

- Speak to a duty GP before you can book an appointment for a new issue. Comments that it can take a while to speak to a GP but that once this has happened an appointment can be arranged quickly.
- Triage of all appointments by a practice nurse, which was seen to be a good alternative to triage by a receptionist.

Out of hours appointments

- Same day appointments reserved for after surgery hours so that most appointments are available to be booked in advance.
- Appointments available on Saturday morning and early morning / evening

Use of other surgeries in a group

When an appointment is required quickly, this is considered to be helpful practice, but only for those patients who are able to travel to another surgery.

Practice nurse appointments instead of seeing a GP, if appropriate. Comments that this relies on appropriate triage.

'Sit and wait' clinics

The patient attends in person without an appointment and waits to see a doctor.

People suggested the following to improve the availability of appointments

- Facility for GPs to make appointments on the system themselves when they are with the patient, for example, if they want to see the patient in 2 weeks.
- Skype appointments as an alternative to speaking over the phone.
- Could surgeries be open on Sunday and Bank Holidays?

Healthwatch York

The major issue which has been brought to Healthwatch York with regard to GP services is the access to GPs for the deaf community. It appears that there is no longer funding for BSL interpreters. Surgeries are refusing requests for interpreters and telling patients that it is too expensive. Deaf people are using a variety of strategies to cope. The following are examples of the kind of issues people are facing in York:

Some people have been offered the services of an interpreter via the internet, but have found this to be unsatisfactory – both because the technology was not good enough, and because they have no choice of interpreter (such as a female patient requesting a female interpreter). One patient also found that because the interpreter was from another region the BSL used was not what they understood.

One patient was accompanied to the surgery by her young daughter. The GP used the daughter to interpret.

One person reported that she has to ask for time off work to go to the doctors to interpret for her husband, who is deaf.

Patients have reported being left in the waiting room because they were unable to hear their name called when it was their turn to see the doctor. There were no visual indicators.

One couple, who are both deaf, reported that a GP was rude and became angry when he realised they were both deaf.

Young mothers who are deaf are worried about accessing GP services when their babies are ill. They worry about waiting times if they need an interpreter (2-3 weeks) and can't get in touch with the GP by text so they have to go to the surgery.

One patient who is deaf, and whose first language is not English, was not able to understand how many tablets he should be taking. He resorted to looking it up on the Internet.

We do have further details about all of the above examples, if required.

Lambeth PPG Network, Healthwatch Lambeth and Healthwatch Southwark

Response to Monitor's call for evidence on general practice services sector in England on:

- Patients' ability to access GP services, including their ability to switch practices
- The ability for new or existing providers of GP services to develop the scope of the NHS services they offer, including in new locations
- New models of primary care that local health communities are planning or considering and the potential barriers to these being implemented.

Dear Monitor

Unfortunately we only heard of your call for evidence recently, so we can only send you brief responses and recommendations from the Lambeth PPG Network and from Healthwatch Lambeth. Contribution has also been gauged from Healthwatch Southwark on the issue of Access further along in this letter.

Investment in Patient Participation Groups (PPGs)

We would like to work with you, and invite you to hear more about our work, if you wish. We have recently completed a joint project with NHS Lambeth Clinical Commissioning Group (CCG), which sought to develop PPGs run by patients, for patients, and we believe that to produce good primary care, it is vital that you invest in the Patient Voice.

We believe that the DES system, while helpful in nudging primary care towards establishing and maintaining Patient Reference Groups, has not brought about the changes that should have resulted from this level of investment. We recommend that there is an evaluation of the money spent on the DES, which we recommend is spent differently to enhance primary care.

We think that changes must be made to enhance primary care resourcing, and to encourage the use of patients and the public, as **assets in the community**. We believe that skilling up local people, would add value to local communities particularly those in areas of deprivation, where there is often high use of A & E services, because of a lack of information about services available that could assist.

We also believe that in areas of deprivation there has been a sharp increase in demand in primary care, caused through the increase in financial poverty and cuts in social care and voluntary services.

We think you should research the work carried out in Lambeth to develop Community Healthy Living Champions alongside Pharmacy Healthy Living

Champions, which together have been working with primary care to develop signposting and support services to promote health and wellbeing.

Recommendations

1. Invest in PPGs as people-powered assets to enhance health and wellbeing and add value to primary care.
2. Evaluate how best to use the DES money to support the development of PPGs which will act as partners to primary care, to add value and hold services to account.

Shift funding to Primary and Community Provision

Healthwatch Lambeth recently met with Lambeth CCG in their Big Health Debate to set their next 5 year strategy. We believe strongly that there should be greater investment in preventative services that are community based and work with primary care and voluntary and community groups, rather than ever increasing investment in Foundation Trusts.

We would like to see local people involved in the commissioning process to ensure that the specifications meet their needs. The voluntary and community sector has strong connection and reach to a wide and diverse population of people and could provide valuable evidence on health and social care services.

Recommendations

1. Empower residents to become commissioning partners in primary care.
2. Ensure voluntary and community sector are able to shape the commissioning process.
3. Work with councils and Health and Wellbeing Boards to bring about greater neighbourhood-based information centres for health and wellbeing in areas of deprivation.

Access standards and equality analysis to ensure appropriate provision

We have been concerned that there are no clear standards for primary care access. We feel that these must be developed locally to take account of the health literacy and deprivation profile of each community.

Online access may increase health inequalities in many areas, and should not be used without deep analysis to ensure equity.

Telephone systems are extremely variable, and some still use 0844 numbers which is unacceptable.

Guidance is urgently needed on suitable methods of introducing telephone triage, and access through online booking as if done badly, this will sharply increase health inequalities and A and E presentations.

One local example is a family with learning disabilities who sought to change practices to get a good GP who works well with LD families. They were told that if they changed they would not be able to receive home visits, so decided not to change. Another example is of a person who needed to access primary care whilst away from their home county and being signposted to several facilities which could not provide the care he needed. This returns to the issue of the appropriate information provision to the patient.

Recommendations

1. Ensure any standards on access are drawn up with patients and the public locally and use Equality Impact assessments to review their impact.
2. Ensure guidance is given on telephony and telephone triage and online booking so there is a uniform quality applied.
3. Introduce equalities frameworks to allow for GP to specialise in equality groups with equal access.

Further recommendations

1. Allow patients to hold their own care records and be in control of allowing others to access their records
 2. Develop a uniform approach across all GPs about allowing access to records
 3. Develop integration across all those involved in an individual's care including GP, voluntary sector, peer supporters, and access to be decided by the individual.
 4. Hospitals should start to address letters to patients and copy them to GPs.
 5. Discharge letters should be given directly to patients so that they hold details of medication.
-

Shropshire Parent and Carer Council

we have been made aware of your current interest in feedback from parents on their experience of local GP Services. The Shropshire Parent and Carer Council (PACC) is a member of the National Network of Parent Carer Forums and our main aim is to support the participation of parent carers of children and young people with disabilities or additional needs in decision making across all service areas.

Parent carers and young people with disabilities or additional needs are often multiple services users and have a unique view on service provision. PACC on a number of occasions have discussed parent carers views on the service offered by GP's to their families. We have attached two documents that include feedback on this topic; our response in 2012 to the Children's Health Outcomes Forum and a write up of part of a discussion in July 2013, when we were considering the priorities for Shropshire CCG.

We hope that these are of interest to you. If you would like to know more about our work please do visit our website or feel free to get in touch.

[Two attachments were included with this submission; they appear below]



Face 2 Face
Parents supporting parents
of disabled children

Shropshire Parent and Carer Council

PO Box 4774,
Shrewsbury,
SY1 9EX

Tel: 0845 601 2205

E-mail: enquiries@paccshropshire.org.uk

Web: www.paccshropshire.org.uk

Feedback on access to GP's for families of children with disabilities or additional needs in Shropshire – July 2013

During the workshop Parent carers often mentioned how challenging ordinary life can become when you have a child with a disability or additional need. Things that other families take for granted such as visiting your GP or Dentist can become impossible because these services are delivered in a way that makes no adjustment for those with disabilities or additional needs.

Many of the parent carers who came to the workshops no longer take their children to the local GP or to the dentist unless it is absolutely essential or until crisis point has been reached.. Parent carers felt that this was an inequality that was overlooked and needs to be addressed. The barriers to accessing these services included;

- The physical environment not being accessible to those with mobility difficulties
- Having to enter anxiety producing environments to access services e.g. busy / noisy waiting rooms
- Set time limits for consultations that means that the health professional can't establish a relationship with the young person that would enable an examination or treatment to be carried out
- In the case of GP's an unwillingness to visit young people with sensory or anxiety issues in their home. This service is often offered for those with mobility problems but not those with other challenges.

Suggestions for addressing these issues included;

- Providing quiet areas for young people to wait or recognise the need for them to wait elsewhere (e.g outside in the car) and reception staff going to them to tell them when they can go in for their appointment
- Parent carers being able to request appointments at the end or beginning of the day when waiting rooms might be quieter
- The offer of home visits
- Longer appointments being offered for young people with disabilities or additional needs
- Local GP's and Dentist's going into local school's to get to know the children and young people before they need to see them professionally. The Dentist service did at one time visit children at Severdale School which was valued by parent carers but that service was withdrawn and now many of those children see a dentist less frequently.
- Training for GP's and Dentist on working with children and young people with disabilities or additional needs



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Response to the Children's Health Outcome Forum Consultation

The Shropshire Parent and Carers Council is a local parent carer forum and part of the National Network of Parent Carer Forums. The issues raised by the Children's Health Outcomes Forum were considered by Shropshire parent carers of children with disabilities or additional needs and their responses are summarised below.

- **What are the main challenges for families of disabled children and young people getting into the health system**

Difficulty in getting referrals to services such as CAMHS or developmental paediatricians. GP's and sometimes Health Visitors, 'gatekeep' the access to specialist services and many lack the required experience or knowledge about paediatric conditions to do this effectively.

Parent carers concerns are too readily dismissed. Parent carer report having the following comments made by their GP when they made an appointment to discuss their concerns – "he's just showing off" (child later diagnosed with Autistic Spectrum Disorder); "he is really well behaved he can't have Aspergers"; "she will just grow out of it" (child later diagnosed with rare medical condition).

Parents report that there is a lack of proactivity in the system, both in the initial response to concerns and in the planning for the future. There is a sense that in many cases situations need to reach a crisis point before action is taken.

Lack of services working together to get the bigger picture, no system to collect feedback from different settings to inform decision making when concerns are raised.

Long waiting times following referrals or the need to go back to the beginning of the queue if issues re occur or new issues arise.

- **What are the main changes that would improve access to the health system?**

Improved awareness of the value of working in partnership with parent carers – GP's, Health Visitors, School Nurses etc to undertake professional development relating to working positively with families.

Improved knowledge of GP's, Health Visitors, School Nurses etc about paediatric conditions. Possible creation of a specialist paediatric role to be based in each local surgery / health centre to be considered.

Extension of the Child Development Centre model where agencies are co-located to carry out multi disciplinary assessments in response to GP referrals.

Improved contact between GP's, Health Visitors, School Nurses etc and specialist paediatric services – team building!!

Improved data on local need so that resources can be targeted and used more efficiently.

- **What are the main challenges for families of disabled children and young people getting a quality health assessment?**

Parent carers report experiencing a reluctance to do investigative tests on behalf of health professionals. This often is translated into a sense of their concerns not being heard or of being abandoned to cope with whatever situation they find themselves in without any prospect of improvement.

Long waiting times for tests following referrals especially if having to be referred to regional hospitals

A lack of consistency in the skills of paediatric professional's ability to understand or engage with children and parents to facilitate the gathering of information.

Getting health professionals to look at the bigger picture

Some parents may not be able to communicate the required information effectively. There needs to be a robustness in the assessment system to allow for this, so that all children receive a quality assessment service regardless of their parents communication skills or understanding.

- **What are the main changes that would improve health assessments?**

More diagnostic tests available locally – reduce waiting times and distance travelled by families.

A system that requests input from other services that support the child or young person e.g. school to ensure that any consistencies or inconsistencies provided by the bigger picture are noted.

A move away from the 'let's wait and see' approach which often leaves families struggling with a challenging situation that they are finding difficult to manage. Set time line for completion of assessments and system for recording outcome of assessment.

Improved information sharing between different specialist areas in the health service, e.g physiotherapists, S&L and paediatric consultants.

Improved record keeping or availability of case files, including the implementation of a summary record that is maintained at the front of the file so that any health assessment is based on the most up to date information about a child or young

person. This is especially important for young people with complex needs who may develop new health conditions.

- **What are the main challenges for families of disabled children and young people accessing a quality health service?**

Many services do not understand the needs of young people with disabilities or additional needs and how a disability can impact on another condition. For example one parent reported that taking a blood sample from her diabetic son was almost impossible because of his Aspergers and that health professional who were trying to take blood had no understanding of why this was or how to deal with the situation.

Post code lottery re access to certain specialists

Having to travel long distances to regional hospital centres and poor communication between specialist centres and regional hospitals.

Poor facilities in health care settings for disabled children with physical disabilities.

Lack of communication between health services and with other service area such as social care and education.

- **What are the main changes that would improve access to a quality health services?**

Better planning of health premises to ensure they meet the needs of all patients. E.g. ceiling track hoists in outpatients clinics at each hospital so that those with severe physical disabilities can be properly examined.

Regional specialists doing more 'outreach' clinics at local hospitals

An exchange programme between specialist centres and regional hospitals as part of a professional development programme.

Improve disability awareness training for health care professionals

The creation of a key worker role that would provide co-ordination of the care received by the young person and their family and act as a link between services. Many children with disabilities or additional needs often access multiple services and the positive management of the interaction between service is a key requirement for achieving good outcomes for families.

- **What are the main challenges for families of disabled children and young people accessing a quality health transition experience?**

Grey areas re hand over points for transition from Paediatrics to Adult ward if child has Learning disability and is under Community Paediatrician who will oversee care of young person until they leave school (possibly at 19)

Often no like-for-like services between children's and adult services eg physiotherapy for young adults with long term conditions. This is used as an excuse not to provide a service even though it is still needed.

Lack of overnight residential respite provision for young adults with complex health needs. Adult hospice system does not operate under same guidelines as children's hospice system.

GP's often have had minimal input for children with disabilities or additional needs up to 18 years but then the 'adult' the patient care is transferred back to them to oversee/facilitate.

The lack of understanding of the role of parent carers as advocates for young people with disabilities, especially with regard to young people with learning disabilities. This often results in the exclusion of parent carers from decision making and the loss of their expertise relating to the young person.

- **What are the main changes that would improve access to a quality health transition experience?**

Clearer guidelines re health transition to be given in writing so that proper hand overs can be planned. Health services to be involved in transition planning from age 14 in line with education and social care. There needs to be a real commitment from health to the 'single plan'.

Services provided in children's services should continue to be provided in adult services if the need is still there. Being told there is no equivalent service is not an acceptable defence.

As more young people with complex health needs survive into adulthood and have grown up receiving excellent care and support from the children's hospice movement, the health system must acknowledge that they need to provide appropriate quality follow on provision for young adults.

Better transition planning in handing back care of young adults to GP's who may have had very little involvement in the last 18 years of that person's health care needs.

The recognition of parent carers as partners in delivering care and establishing a transition plan that is person centred and based on shared decision making with the young person and their family.

Many of the existing outcomes identified in the NHS and Public Health Frameworks are applicable to children and young people as long as there is **clear guidance** about what these outcomes actually mean for this group. One of the key differences when considering outcomes for children and young people is the role of parent carers and the need to support the whole family. This is particularly important for children and young people with long term conditions or who may need support into adulthood.

Sleights and Sandsend Medical Practice Patient Participation Group

As I am unable to attend the consultation meeting in Leeds, I should like to pass on the views of patients from Sleights and Sandsend Medical Practice, gathered from responses to 2 questionnaires devised and evaluated by our Patient Participation Group.

1. How important is it to see the same GP every time -

It is important to see the same GP if you have an ongoing or chronic condition, but otherwise all our GPs are well respected.

2. Are patients able to access a GP in a reasonable amount of time when they need to? -

As long as you are willing to see any GP and don't mind waiting at the end of surgery, you can usually see one on the same day.

3. Are patients able to access a GP or register at a GP Surgery in a place which is convenient for them? -

As we are in a rural area, some patients have to travel up to 7 miles to attend the surgery, since the one in Goathland closed down. However, some patients choose to travel from further afield because they have moved, but prefer to continue with a Practice where they know and trust the GPs.

4. Are Patients able to switch GP or GP Practice when they want to? -

We are able to see any GP in the Practice, but haven't asked about changing GP practice.

5. How responsive are GPs to issues raised by PPGs?

The GPs have responded positively to issues raised and have changed some areas of the Practice to address them.

John Kapp

I have been secretary of my GP practice for 2 years, and a patient representative for 13. I have recently written a report for my Health and Wellbeing Board (9 pages) attached. The essence of my experience is that patient and public involvement (PPI) has been token only, due to the paternalistic attitude of doctors on a pedestal, telling patients on their knees to keep taking the pills. PPI is a role reversal of that, which few doctors (and few patients) can stomach, as both are out of their habitual comfort zone. However, this attitude is maiming and killing both.

As I say in this report, prescription drugs are massively over-prescribed, for the lack of commissioning of talking therapies. At this massive dose, drugs do more harm than good, but everyone feels powerless to change the system. The result is loss of morale in staff, and loss of confidence in patients.

The remedy is to mass-commission talking therapies, (particularly the Mindfulness Based Cognitive Therapy (MBCT) course, so that the waiting time can be reduced to a few weeks. funded out of the reduced drug budget. This will reduce side effects, improve outcomes, improve morale and confidence, and reduce costs.

[The attachment sent with this submission follows]

By John Kapp, [✂]

CURING THE NHS AND DEPRESSED PATIENTS BY MASS-COMMISSIONING THE MINDFULNESS COURSE

1 Summary of conclusions

The crisis in the NHS is caused by the following factors, which can be solved locally by councillors initiating culture changes:

- a) The overprescribing of drugs, which generally do more harm than good with side effects.
- b) The failure of the old Primary Care Trust (PCT) to commission sufficient effective drug-free treatments, so that patients go untreated, even though GPs want to prescribe them, and patients want them.
- c) The fear of whistle blowers that will they will lose their jobs if they say things that are politically incorrect (such as the above)
- d) The prevalent culture among public sector staff of ignoring representations from members of the public (like me)

The commonest conventional treatment for depression is antidepressant drugs. Talking therapies are commissioned, such as Cognitive Behaviour Therapy (CBT) but it is only effective in only a small minority of patients, and the waiting time is up to a year. Mindfulness courses are much more cost effective, but have such long waiting times as to be unavailable unless patients are suicidal.

To show the disparity between drugs and drug-free treatments, last year in England there were 50 million monthly prescriptions written for antidepressant drugs. Pro rata 1.25 m prescriptions were written in Sussex, and 250,000 written in the city of Brighton and Hove. The latter presumably went to 21,000 out of the 30,000 depressed patients in the city. They may have helped by masking their symptoms, but drugs do not even *claim* to cure depression.

To prevent, heal and cure depression, patients and sick staff need 16 hours of tuition in mindfulness courses teaching self help tools to cope with it's cause, which is stress. However, the number of these provided in Sussex last year were less than 8,000 for 160,000 depressed patients, so the waiting time was 20 years. To create a mental health service worthy of the name 'service', GPs have to be able to prescribe these courses ***as easily as Prozac.***

My deputation proposes that the Council and NHS jointly plan to commission and provide at least 10,000 patients places annually in the city. This would require 500 courses pa, which could be run by 20 full time facilitators running 25 courses pa, for 20 patients per course. That would cost the NHS about £1.25 mpa, which is only

about 2% of the mental health budget of £55 mpa and £200 per patient treated. This is a more cost-effective treatment than the drugs replaced, so should be paid for from the drugs budget. This will also improve staff morale and patient confidence, so help cure the crisis in the NHS.

This scale of provision cannot be achieved by the present public sector tendering process, which is too bureaucratic, (100 page tender documents) long-winded (taking a year) and un-necessary. It was the PCT's provider-centred way of excluding non-drug treatments, and has no place in a new patient-centred NHS. A scheme should be set up whereby GPs prescribe vouchers which patients can exchange for courses with existing facilitators who are presently running them in the private sector, and are retrospectively paid, as pharmacists are for drugs. I hope that the HWBB will accept and implement this proposal.

2 Recommendation

That the policy of the PCT, as stated on 18.3.13: 'We have no plans to procure additional complementary therapy services at this stage,' be changed to: 'The CCG are considering Mr Kapp's proposal to mass-commission the mindfulness course to enable GPs to prescribe it as easily as Prozac, and will report back to the next meeting of the HWBB on 27.11.13.'

3 Mr Kapp's deputation as minuted, (reproduced from the draft minutes of the Council meeting on 18.7.13).

18.2 Mr. Kapp thanked the Mayor and stated that; "15 years ago I was a Councillor like you. For the last 13 years I've been a patient representative and a critical friend of the NHS campaigning like Julia Bailey. For the last 3 years I have been facilitating the 8 week Mindfulness Course which teaches people self help tools by which to manage their conditions. This course was featured last week on the Horizon program which showed that it can produce spectacular results in reducing intrusive negative thoughts as demonstrated by the presenter Doctor Michael Mosley.

There are 30,000 depressed people in the City who could benefit from this course. My proposal is to mass commission this course and mass provide it so that less people would need to go to A+E. Implementing it would meet some of the recommendations of the Francis report and the report published last Tuesday by Sir Bruce Keogh. It's only fair to say that the NHS already do commission this course so that they can check the box 'complies with nice guidelines' however so few facilitators are commissioned to provide it that the waiting time for the 160,000 people in Sussex is more than 20 years unless you are suicidal. This is tantamount to non provision and it risks commissioners being taken to judicial review without a legal to stand on.

I'm one of more than 25 facilitators in the City who provide this course for clients who pay the going rate of a few hundred pounds. The poor patients can't afford this sort money so do without and suffer the consequences. This is a cause of health inequalities. To reduce health inequalities for the last 5 years, I have been

campaigning for commissioners in the NHS and the Council to reduce this excessive waiting time by opening up the market to facilitators in the 3rd sector like me.

To be ready to contract with the NHS and the Council, 3 years ago I created a company called SECTCo for short, this stands for Social Enterprise Complementary Therapy Company. SECTCo's slogan is: 'medication to meditation.' SECTCo's mission statement is: 'Give a man a pill, and you mask his symptoms for a day. Teach him mindfulness, and he can heal his life.'

I sent hundreds of e mails, documents, to commissioners but no one would engage with me and all seemed to have decision paralysis. I know that the law changed only 4 months ago on the 1st of April. Since then, you Councillors have the responsibility for Public Health, so I am calling on you to play doctor to these commissioners and cure their decision paralysis. Please jointly set up with the NHS, a voucher system which would empower GP's to prescribe this mindfulness course as easily as they could Prozac. This would enable patients to access the course from existing 3rd sector providers within a few weeks. This is not privatisation by the backdoor but simply reducing waiting times for effective treatment which Labour did when they were in power and which has all party support."

18.3 Councillor Jarrett replied, "Improving mental health and wellbeing has been a priority for the City Council and the Clinical Commissioning Group and there's considerable joint work in pursuing the same. The 2013 Mental Health Commissioning Prospectus was, as you know, a joint initiative between the Clinical Commissioning Group and the City Council. You will also know that there is now a Brighton and Hove Wellbeing Service which aims to improve access to psychological and support services for people with common mental health conditions such as anxiety and depression. This contract was awarded following a competitive tendering process and includes as part of the specification a range of evidence-based treatments including Mindfulness Cognitive Behavioural Therapy. General practitioners across the city are referring patients to this new service.

The city council and Clinical Commissioning Group will be retendering mental health promotion contracts next summer following approval of the Public Health Commissioning paper at P&R committee on 11th July 2013. The defined outcomes will reflect the mental wellbeing strategy that is being developed through the Health and Wellbeing Board and is likely to follow the Five Ways route: Connect, Be Active, Take Notice, Keep Learning, Give and the Public Health, NHS and Adult Social Care outcomes frameworks. Many other locally commissioned programmes across the City Council and Clinical Commissioning Group deliver on Five Ways. These include joint work of Public Health with the Sports Development Team, Be Active, considerable City Council and Clinical Commissioning Group community development and equalities work, Connect, Adult Learning Schools, Keep Learning, Volunteer training and coordination, Give, and a large arts and culture programme, Take Notice, including a proposal for specific arts and culture work for World Mental Health day this year.

Mindfulness courses are also delivered independently by several local voluntary organisations such as Mind and MindOut, and you will be aware that there are several local independent practitioners of mindfulness. The City Council and Clinical Commissioning Group will continue to work together on the mental health and wellbeing agenda, and promote mindfulness where there is evidence for its effectiveness. Mental wellbeing will remain a priority on the current Health and Wellbeing Strategy. I should emphasise that Health and Wellbeing Board is a

Council committee. It cannot instruct the Clinical Commissioning Group to do anything nor would it wish to. We work in partnership.”

18.4 The Mayor thanked Mr. Kapp for attending the meeting and speaking on behalf of the deputation. She explained that the points had been noted and the deputation would be referred to the Health & Wellbeing Board for consideration. The persons forming the deputation would be invited to attend the meeting and would be informed subsequently of any action to be taken or proposed in relation to the matter set out in the deputation.

4 Mr Kapp’s deputation as printed on the supplemental agenda paper, including 2 pages of references.

Deputation concerning the Curing the NHS’ Dementia by Mass Commissioning the MBCT Course

(Spokesperson) – Mr Kapp

I am a complementary therapist, and a facilitator of the Mindfulness Based Cognitive Therapy (MBCT) 8 week course (1) which is NICE-recommended (2) to improve mental health by teaching people self-help tools by which to better manage their emotions, so they don’t need to go to A&E. There are more than 20 facilitators in the third sector of the city (3) providing this course for clients who pay the going rate (£150-370). This course is provided free on the NHS, but the waiting time is 20 years unless you are suicidal. (4) causing health inequalities as the poor can’t afford it.

3 years ago, to reduce the waiting time, I created the Social Enterprise Complementary Therapy Company (SECTCo) (5) whose slogan is: ‘medication to meditation’, and whose mission statement is: ‘Give a man a pill, and you mask his symptoms for a day. Teach him mindfulness, and he can heal his life’. To get public sector contracts I sent hundreds of e mails, documents, phone calls, to commissioners. These were not answered, because there was no-one at home who could make a decision, even to say: ‘no’. The NHS did turn 65 last week, and decision paralysis is a symptom of dementia. Even Jeremy Hunt says it is sick. My experience proves that **it has dementia**. For the sake of both doctors and patients, we need to cure it. I am the Julia Bailey of Brighton, and pleading for your help now, The government has done it’s part by filling the democratic deficit in health. You are now responsible for public health, and for directing the strategy of the new Clinical Commissioning Group, (CCG). I am therefore calling on you councillors **to play doctor to the CCG** and cure it’s demented paralysis by banging heads together. Please set up a ‘chemist shop’ voucher system by which GPs can prescribe the MBCT course as easily as Prozac. This would boost their morale by restoring their original function as teachers, (6) Then patients could access the course free within a few weeks from the third sector, so wouldn’t need to go to A&E. This will fill the disconnect (7) between drugs and talking therapies, and restore patients’ trust. Please do not dismiss this proposal automatically as ‘privatisation by the back door’. It is just a way of reducing waiting times for effective treatment, which has had all party

support nationally for more than 7 years. (8). Opening up the market to local complementary therapists would create local jobs and keep the money in the local economy, benefitting our citizens, rather than swelling the profits of drug companies. It will also improve health, reduce inequalities (9) and save taxpayers’ money.

First recommendation. The Council authorises the CCG to engage with SECTCo to do 2 pilot trials of the MBCT course for £5,000 (10) and to engage a researcher to evaluate them, and report back to Council in November.

Trial 1. Up to 12 patients referred from a GP surgery in Hove.

Trial 2. Up to 12 sick council staff.

Second recommendation. The Council instructs the CCG to consider this proposal to set up a voucher system for the MBCT course in the city, and report back to the Health and Wellbeing Board (HWB) at its next meeting on 11.9.13.

Supporting Information:

References

1 Author. I took this MBCT course myself 5 years ago in the voluntary sector in Brighton, paying £185

for it. It transformed my health, so I took the teacher training and have run 7 courses to date, for a total

of about 70 students. A researcher conducted a trial last year in which 22 students took part. They increased their positivity score by 20% on average, and the best half of 11 students improved by 30%.

2 The evidence base for the MBCT course

a) **NICE Clinical Guidelines** CG 23, (Dec 2004) and CG 123 (May 2011) for patients who had suffered previous bouts of depression. Other trial results are given below:

b) The trials in 2002 (Teasedale et al) halved the 5 year relapse rate for patients who had suffered 3 previous bouts of depression.

c) It has a 30 years evidence base from more than 500 clinical trials, showing it to be effective in improving mental health for almost anybody, including drug and alcohol addicts, see Breathworks, Manchester (Gary Hennessey) www.breathworks.org.uk

d) It is used by Transport for London, with 20,000 staff, where it has reduced staff absence by 73%.

e) It is being taught in schools, where it improves performance in all areas, and there are moves to get it included in the core curriculum. www.mindfulnessinschools.org

f) A Survey by the Mental Health Foundation showed that 3 out of 4 doctors think that all patients would benefit from mindfulness. www.bemindful.co.uk/mbsr/evidence

g) A recent trial of 15,000 patients shows that talking therapies are better than drugs.

(Source: PLOS Medicine, 2013; 10: e1001454)

h) Polls show that 3 out of 4 patients want free complementary therapy on the NHS.

(Foundation for Integrated Health, 2009).

3 Third sector provision of the MBCT course

There are 30,000 depressed patients in the city, and potentially they all have the statutory right to a MBCT course under the NHS constitution if their doctor says it is clinically appropriate, as it is a treatment which is NICE-recommended. If all those patients asked their GP for a prescription for this course, and if 20 patients were to be treated together in a class, to deliver their statutory obligation the CCG would need to commission 1,500 courses over say 3 years, say 500 courses pa.

A full time MBCT facilitator can provide up to 25 courses pa, (one course on each day of the week, - 5 per week – on a cycle repeating 5 times per year) so to provide 500 courses pa the CCG would need to commission 20 facilitators.

There are more than 20 MBCT facilitators already teaching this course in the city's third sector, so they

could be mobilised to treat patients on GP referral if contracted by public sector commissioners, as proposed. These courses could be provided for £2,500 per course, (10) and £125 per patient treated, which is far cheaper than drugs. The total cost would be £1.25 mpa, which is about 2% of the city's mental health budget of £55 mpa.

4 Waiting times for the MBCT course are given in my paper: 'Co-creating a patient centred NHS'

11 pages, 19.6.13 and www.reginaldkapp.org, section 9.56, and other papers there and on

www.sectco.org.uk,

5 Social Enterprise Complementary Therapy Company, (SECTCo) was founded by the author on

4.5.10. It's website is www.sectco.org.uk. Its business plan (written 3 years ago) can be seen on

www.reginaldkapp.org, section 9.39, including a list of its 143 complementary therapist founding members in section 5.

6 The word 'doctor' comes from Latin 'doctare, to teach,' so prescribing courses would improve their morale. 60% of GPs are in imminent danger of burnout. (Pulse magazine)

7 The disconnect between drug and talking therapies

The cause of the NHS's sickness is a disconnect between

- the needs of patients for which they go to the doctor, namely treatments to prevent, heal and cure their sicknesses, and
- the only mass treatments on offer, namely drugs which do not even *claim* to meet those needs, but only mask the symptoms.

Everyone knows that street drugs (like fags and booze) are dangerous and harmful, but to get them you have to spend your own money. Prescription drugs are no less dangerous and harmful, but the commissioning system gives doctors no alternative but to massively overprescribe drugs, giving them away like sweets at a childrens' party, breaking their Hippocratic oath: 'do no harm', as all drugs have harmful side effects.

Last year they wrote a billion monthly prescriptions to about half the population, which means that on average 30 million of us are taking 3 prescription drugs, which are slowly poisoning us with side effects.

An inverse care law applies, which shows that the more prescription drugs we collectively take, the worse public health becomes.

To add insult to injury, last year drugs cost us as taxpayers £15 bn, which lined the pockets of private multinational drug companies who have been convicted and fined billions of dollars for putting profits before patients.

This disconnect is the reason why:

- NHS staff morale is at an all time low, as they work for a monstrous system which gives doctors no alternative but to prescribe harmful drugs on demand.
- Patients have lost faith and trust in this monstrous system, which serves no-one but the drugs companies.

Clinical commissioning means that GP commissioners (who see 40 patients per day) have taken the place of PCT managers (who never saw any patients, so never knew whether the treatments worked that they were buying). Patients can ask for MBCT courses, but GPs can only prescribe them if the CCG sets up a system (such as this proposal) to mass-provide them.

8 Privatisation by the back door?

No, it just reduces waiting times, as the Labour government did in 2006 for talking therapy. They opened up the market by recruiting 10,000 therapists from the private sector for Cognitive Behaviour Therapy (CBT) under the Improving Access to Psychological Therapies (IAPT) programme. Two years

later they opened up the market for hip and knee replacements to Independent Treatment Centres. These policies were successful and popular, and so would this proposal to open up the market to MBCT facilitators.

9 Reducing health inequalities

The cause of health inequalities is the rich get the health benefit from complementary therapies which the poor can't afford. This proposal would reduce them by GPs giving patients free vouchers for courses, which they can cash near them. To walk their talk, 'physician heal thyself,' doctors too should

access the MBCT course that they prescribe. This new system would produce 3 benefits to public health: reduction of harmful side effects from drugs, effective treatments, less cost to the taxpayer. (4) Our e petition on the council website from Nov 2009 got 445 signatures, and there is another up now from 4.7-10.9.13.

10 Cost implications of these 2 trials SECTCo provides 2.5 hours per week, for 10 days and pay facilitators £1,250 at £50 per hour, and assistants £750 at £30 per hour. Room hire is £500, so our tariff price is £2,500 per course, negotiable.

The following material which has come up since the deputation was written on 10.7.13.

5 Mr Kapp's response to Cllr Jarrett's response to his deputation

Thank you for your response to my deputation to Council on 18.7.13. I am pleased that it was referred to the Health and Wellbeing Board, that mental wellbeing will remain a priority in the current Health and Wellbeing Strategy, and that you recognise the value of mindfulness courses as a treatment for mental sickness.

The policy of the PCT in regard to mindfulness courses was clearly stated on 18.3.13 by Anne Foster in answer to my Freedom of Information question, as follows: 'We have no plans to procure additional complementary therapy services at this stage.' The purpose of my deputation was to change that policy to a massive expansion in the provision of mindfulness courses. It is not clear from your response whether you support this expansion, or not, and you did not answer my recommendations.

You mention the retendering for the mental health promotion contracts next summer (2014) as if it would result in more mindfulness courses being available for patients. The tendering process for the Community Mental Health Support programme, (for which SECTCo bid unsuccessfully in July 2012) did result in new mindfulness courses being provided under the Wellbeing service.

I welcome this service as an excellent initiative, but only 2 extra facilitators were commissioned to run them, which will only reduce the waiting time from it's present 20 years by about 3 weeks. I am calling for a hundred-fold increase, and a radical change in the way that facilitators are contracted, by means of a voucher system.

You mentioned the minutes of the Policy and Resources committee of 11.7.13. I have looked at these, and concluded that they formerly record the handing over of Public Health from the PCT to the Council together with it's budget of about £18 mpa. However, they did not imply the policy changes that I am seeking.

Your response does not address the crisis in the NHS, (as described by the LSE, Francis and Keogh reports) and in our local A&E department, which has the worst waiting times in the country. Neither did it address my deputation's calls to set up a voucher system by which GPs could prescribe the mindfulness course as easily as Prozac. I hope that you and the CCG officers will now address these issues, and also consider the following additional material which has arisen since I wrote my deputation on 10.7.13.

6 The Council's One Planet strategy for health and happiness is furthered by SECTCo's proposal

We congratulate the Council for becoming in April a ***One Planet Council***, the first in the world. The aims are set out in the Sustainability Action Plan (April 2013). The Health & Happiness section on p64-68 of that plan sets out 44 policies, of which 36 would be promoted if the Council adopts our proposal for mass-commissioning the mindfulness course. We have annotated these below. It can be seen that 25 out of 44 paragraphs have 5 stars, and a further 9 paragraphs have 3 or 4 stars, so our proposal would have a positive effect on 36/44 policies.

One Planet Council - Health & Happiness

'The philosophy underpinning One Planet living is to create a sustainable future, in which happy and healthy people thrive and contribute to the overall aim of maintaining the earth's resources for future generations.

This principle focuses on the values, beliefs, factors and actions to promoting health and happiness in both our workforce and city wide employed communities.

Within the council, this work is led by its Human Resources and Organisational Development team (HROD), in partnership with internal teams and partners within the local and national community to create a sustainable and happy workforce.

High level objectives – where we want to get to

One Planet Council:

▪
1*****Identifying and reducing localised health inequalities through partnership working, improving access to affordable resources

▪
2*****Creating an environment where employees are able to take personal responsibility for improving their own health and wellbeing

▪
3*****Improving access to work and retention of employees with health related condition

▪
4*****Reducing sickness absence through proactive, preventive measures

▪
5Targeting and addressing specific issues within the work environment

▪
6*****Respect' being an organisational value and council colleagues show respect to each other and their perceptions confirm this

Where we are now

••The council recognises that its employees are its most valuable resource.

••
The People Strategy 2011-15 outlines senior leadership commitment to; providing clarity on organisational purpose and ambition, a description of expected workforce behaviours, a revised individual performance management system that measures the 'what' and the 'how' of delivery and a supportive learning & development programme.

••
7*****For the organisation, wellbeing is not just about quality of life, but also about the organisation's culture, its leadership and its resources.

••

8 Feedback from the most recent staff survey demonstrated that the council has flexible working arrangements that are recognised and appreciated by the workforce.

..

9*****We have selected a new occupational health provider and since 2012 have supported colleagues to manage their own physical and mental health and wellbeing.

..

10 The council monitors employee wellbeing and satisfaction and can provide evidence of work-based improvements.

..

11*****The council recognises that (nationally) despite improvements to working conditions, sickness absence is still increasing. New and innovative approaches to addressing this are under review.

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..

12*****A review on our approach to the highest cause of absence (stress) is currently underway

..

13****Colleague involvement and engagement is important to us and we see engagement as both an 'outcome' and a 'process'.

..

14 We continue to develop our employment policies to retain skills and experience and meet the needs of all generations in the workforce and working patterns and styles.

..

15*****Our involvement in the Healthy Cities Partnership means we work with key partners to target health inequalities through access to current resources and initiates rethinking our traditional approach to health and engaging employees.

..

16***Recognition of the detrimental impact of worklessness on populations and the positive impact that work has on health and that work is good for health.

What We're Going to Do:

Action	Dates	Led by	Financial Implications
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17 Describe the behaviours we expect from all colleagues and staff can evidence how they put them into practice	April 2013 Behaviours launched end April 2013 Staff Survey results – Nov/Dec 2013 Investors In People Reviews – ongoing	HR&OD working in partnership with senior officer leaders.	Within existing budgets
18*****Providing access to wellbeing interventions that are designed in response to need and accessibility and in response to National initiatives i.e. Non Smoking Day, Flu campaign, Cancer awareness interventions.	Ongoing Support awareness campaigns for minimum of 4 well-being awareness topics annually.	HR&OD working in partnership with local managers	Within existing budgets
19 Protect the health of our employees by increasing the uptake of occupational immunisations and health surveillance as identified by risk assessment Develop an awareness campaign on blood borne viruses that can be used city wide both in and outside of BHCC.	Establish a database of health surveillance roles by June 13. Increase uptake of occupational immunisations by 10% in 2013-14. 2013 -2014	HR & OD	Within existing budgets
20 Maintain our solid commitment to dignity at work though the introduction of organisational	Behaviours launched end April 2013	HR&OD	Within existing budgets

choice.

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Health and Happiness – One Planet City

One Planet Living is defined as a future where it is easy, attractive and affordable for people to lead happy and healthy lives within a fair share of the earth's resources. This section focuses on initiatives which promote health and happiness.

21*****This section includes areas of work overseen by the newly established Health and Wellbeing Board, as well as the Healthy City Partnership.

22****From April 2013 local authorities take the lead for improving the health of their local communities. Therefore there is a currently transitional period around funding and this action plan will need to be updated.

High level objectives – where we want to get to

- 23***The One Planet vision is to make it easy, attractive and affordable for people to lead happy, healthy lives within their fair share of the earth's resources.

- 24*****The Council, partner organisations, communities, residents work together to support people to achieve and maintain a healthy life and to reduce health inequalities across the City.

- 25*****Brighton and Hove will make the most of community assets in order to improve health and wellbeing.

- 26*****Local services will be designed with physical and mental wellbeing in mind and local people will be involved in shaping wellbeing.

27*****The aspiration is a reduction in the difference in healthy life expectancy between communities through greater improvements in more disadvantaged communities. This is a high level outcome in the new national Public Health Outcomes Framework. However currently this requires Census data to construct at Local Authority, and thus it will only be reported every 10 years. Differences in overall life expectancy are now available annually for local authority areas. Other outcome indicators that are relevant include:

- 28*****Emotional wellbeing: Improved self reported wellbeing

- 29*****Promote active living:

0
30***A greater proportion of physically active adults and fewer physically inactive adults

0
31The proportion of children and young people using active travel as their main method of travelling to and from school.

- 32*****Age Friendly City: indicator to be defined as part of Stage 1 of this initiative which is to ensure our physical and social environment promotes healthy and active ageing and a good quality of life for older residents.

- 33*****Alcohol and substance misuse services: Successful completion of drug treatment

- 34***Improving sexual health: Reduced repeat sexually transmitted infections

- 35****Improve health and wellbeing through the workplace: Number of workplaces who are engaged in supporting employee's in improving their health & wellbeing.

Where we are now

- 36*****Brighton and Hove residents are happier, more satisfied & feel their life is more worthwhile compared with the UK average (Office for National Statistics 2012). However, the local Joint Strategic Needs Assessment 2012 highlights that the City has higher than average mental ill health needs and persistent health inequalities.i

- 37The local City Tracker survey shows a high level of satisfaction with Brighton and Hove as a place to live.

- 38*****The newly established shadow Health and Wellbeing Board has developed a Health and Wellbeing Strategy for Brighton and Hove. This will be published in 2013. The strategy has five key priorities including Emotional Health and Wellbeing (including Mental Health), dementia, smoking, healthy weight and nutrition, and cancer & cancer screening. A mental health promotion strategy for the City is being written to support the Emotional Health and Wellbeing action plan.

- 39****Brighton and Hove is a member of the World Health Organisation (WHO) Healthy City programme. The Healthy City Partnership has overseen action to promote active living, healthy workplaces and healthy urban environments.

- 40*****Programme Boards for alcohol, substance misuse and obesity have recently been established to coordinate tackling these challenging areas. A programme board for sexual health will be established during 2013.

- Membership of WHO Global Network of Age Friendly Cities has been agreed by the council as part of plan to achieve Age Friendly City Status.

What we're going to do

Action	Dates	Led by	Financial Implications
<i>41*****Develop and deliver an emotional wellbeing promotion strategy</i>			
42*****Engage local people about happiness and wellbeing, to inform development of the strategy action plan, focusing on the 'five ways to wellbeing': connect; be active; take notice; keep learning; give.	2013	BHCC and partners	Within existing budgets
43*****Measure local progress against <i>No Health Without Mental Health</i> implementation plan (the national strategy – will include determinants of mental wellbeing such as parenting, green spaces, older people at risk of isolation).	2013	As above	Within existing budgets
44***Launch and delivery of strategy action plan.	2014-19	As above	Within existing

7 Public sector staff absence rates could be massively reduced with mindfulness courses

Much of the above mentioned Council's health and happiness strategy addresses the welfare of their staff. The Council employs 12,000 staff, who have an average staff absence rate of 4% (implying that 480 staff are off sick at any time). The local NHS including primary care probably employs another 8,000, totalling 20,000. This is the number for whom the HWBB is now responsible, and about 800 are off sick.

This makes the HWBB an employer comparable in size to Transport for London (also with 20,000 staff) As mentioned in my deputation, they provide mindfulness courses for sick staff, and have reduced their absence by 73%. I believe that the city could achieve similar beneficial reductions in staff absence if the HWBB adopts my proposal, and provides a mindfulness course service for all their sick public sector staff.

SECTCo is willing to negotiate a contract to run these courses in public sector offices, and private sector venues, such as Revitalise (86, Church Rd Hove BN3 2EB (opposite Hove town hall) To minimise disruption to working hours, they could be offered 3 times per day, before work (say 730-830am, in the lunch break (say 1230-130pm) and after work (say 530-630pm)

The MBCT syllabus is normally 2 hours per week for 8 weeks. This could be compressed to 1 hour per week, as the mindfulness in schools course has done. This is called 'b' and presents the same material more speedily, using video clips. I have done the teacher training for this course, and have the teaching aids, which I would make available.

8 Dr Michael Moseley's Horizon programme on mindfulness, shown on BBC2 on 10.7.13.

This 1 hour TV programme shows the effectiveness of the mindfulness course as experienced by a sceptical doctor, who admitted that he had been suffering from chronic insomnia for over 20 years. Dr Moseley was wired up to brain scanning machines before starting this 8 week course, and after completing it 7 weeks later. His machine scores improved by a factor of 3, and there was a noticeable improvement in his posture, attitude and positivity, which was remarked on by his wife.

I had the same experience when I did the course 5 years ago, and have observed it in most of the 70 students I have taught. This was confirmed by the questionnaire results of the 22 who took part in a research trial last year. I recommend councillors and commissioners to watch this programme, and take the course themselves.

9 Sir Bruce Keogh's report, published on 11.7.13

As a result of this damning report, the government took the unprecedented step of placing 11 hospitals under emergency measures. It shows that the whole NHS has a serious crisis in staff morale. It is our NHS, and we all have a responsibility to do what we can to heal it. For example, I have previously taken part in the peer review of hospitals as a patient representative, so am on the list. On 31.7.13 I was requested to volunteer again, which I gladly did.

My theory about the cause of the catastrophic loss of morale in NHS staff, and loss of confidence in patients, (mentioned in my deputation) is a general lack of faith in the effectiveness of drug treatments. Drug-free treatments exist, but are insufficiently commissioned to be readily available within short waiting times. This results in drugs being so massively over-prescribed (a billion monthly prescriptions in 2012) as to generally do more harm than good. My proposed solution is to mass-commission and mass-provide the mindfulness course for staff and patients, and de-commission over-prescribing drugs. This will be funded from the drugs saved, at reduced cost overall, as drug free treatments are more cost-effective than drugs.

10 Is Nick Clegg backing my campaign by joining dementia friends?

Dementia has been top of the health agenda for a year, following publication in June 2012 of the London School of Economics report showing that 750,000 depressed

patients were not receiving proper treatment. This campaign got a boost on 1.8.13, when Nick Clegg sent an e mail that he had become a *dementia friend*, together with 10,000 others, including me. He gave a link to NHS Direct sites giving the gory details about dementia, written by the Alzheimer's Society. The message from this site is that anyone concerned about memory loss should get checked out for a dementia diagnosis from their GP. People fear going mad even more than they fear death, so this message could result in many people taking this up on behalf of aging parents. It is difficult to get appointments with GPs, so is this causing excessive waits at A&E?

The site says that there are already 800,000 cases of dementia in England, and forecasts this to rise by 200,000 (25%) by 2020. Locally in the city we have 1/200 of the national population, so this statistic means that 4,000 patients have dementia, and this will rise by 1,000 to 5,000 in 2020.

There is no conventional cure for dementia, so GPs cannot offer patients losing their memory anything but doom and gloom of increasing dependency. Having to tell patients this (and other) gloomy prognosis is soul destroying, and may account for why surveys show 60% of GPs are on the point of burn out. (as reported in Pulse magazine)

The mindfulness course can prevent dementia, and if taken early, can reverse it, as I say in my paper: 'Can mental sickness be prevented, healed and cured? Medication to meditation,' dated 20.2.13. I circulated this paper in February to councillors and staff on the HWBB both by e mail, and in hard copy. It's summary can be seen on www.sectco.org.uk.

If the HWBB adopts my proposal, GPs would only have to deliver this doom and gloom scenario to those whose dementia was far advanced. Early onset cases could be offered a mindfulness course, which would teach them what they can do for themselves. Instead of accepting the prognosis that the number of dementia patients has to *rise* by 25%, we in the city could confidently target the number of dementia cases to *fall* by 1,000, to 3,000 by 2020.

Cases from my family give evidence that this is possible. my mother (who was a psychiatrist) was diagnosed with Parkinsons disease when aged 57. She was an invalid, and died a bad death of cancer aged 67, in 1966. Meditation courses were not available then. In 2000, I lost my first wife (Janet) to cancer, (when I was 64) after 37 years of marriage, which plunged me into depression. A year later I met my second wife, who introduced me to meditation, which I have practiced regularly. My memory and general health have dramatically improved, and I feel better than I did 20 years ago. Given the support that I was rich enough to be able to pay for, I believe that many or even most old people could do the same.

11 NHS constitution – waiting times

On 24.7.13, I received from DoH an online survey about the following proposed new clause of patients' rights under the NHS constitution:

6. You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution

To be of use to patients, these waiting times have to be a few *weeks* not *years*. For example, for hip replacements, this is 18 weeks (4 months) The present 20 year waits for the mindfulness course is 100 times too long. As mentioned, the purpose of my deputation is to change the old PCT's stated policy on 18.3.13 to: ***'have no plans to reduce them'***. The CCG and HWBB took over from the PCT on 1.4.13, but do not have to adopt all the PCT's policies. In this case, if they do, they will be vulnerable to being taken to judicial review by dis-affected patients. The chairman of NICE, Sir Michael Rawlin, publicly said a year ago (Today programme 2.4.12) that commissioners who fail to commission NICE-recommended treatments are breaking the law, and could be put in the hot seat without a legal leg to stand on. I have warned the PCT about this, as I don't want this to happen.

12 NHS constitution – public involvement

On 24.7.13, I received from DoH an online survey about the following proposed new clause of patients' rights under the NHS constitution:

23. You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

I have been trying to be involved directly in the planning of healthcare services since I became a patient representative, 13 years ago. Most of my letters and e mails were not even acknowledged, let alone answered. When they *had* to be answered (as with my freedom of information questions) the attitude was grudging, as if my suggestions were unwelcome intrusions to their more important work, and I was frequently fobbed off.

This silo attitude (a 'glass wall') between staff and patients is harmful to both alike, because it isolates them from their common humanity, and the reason why staff sought a caring career. This isolationism contributes to the crisis in staff morale and patients' lack of confidence.

This is just a habit, which can be broken with good leadership. The government is right to emphasise the need for a culture change, (as John Major did 20 years ago when he created the citizens' charter) but actual change can only come from local leaders, such as councillors.

My experience after a decade of campaigning is that the unwritten rule throughout the public sector is to **ignore** all communications from the public as if they had never been made. E mails are not acknowledged, nor answered. Phone calls do not get through to the staff concerned. If answered by a colleague, they cover up, saying that the person wanted is not there, or busy. Requested messages to phone back are ignored. Requests for meetings face to face receive the same treatment.

This attitude has some benefit to staff, which is why it has continued and become the norm. They cannot be held to account for not answering communications because they can pretend that they were never received. Although I have never worked for the public service, from what I have seen in the media, staff that blow the whistle are hounded out, and lose their jobs.

However, the long term effect of this is bad for everyone. It results in imprisoning both staff and public into separate silos, in a monster system which both feel powerless to change. The service which the public pay for in their taxes deteriorates, until it reaches crisis point, as has happened to the NHS.

I ask the members of the HWBB to initiate a culture change in the Council and NHS's 20,000 staff, as private sector leaders do for customer care. They simply need to change the present rule of automatically **rejecting** the communications from the public to **welcoming** them, and consider them carefully, and referring them up as appropriate. This will result in better services, better outcomes, improved staff morale, and meet some of the recommendations of the Francis and Keogh reports.

13 Joint Strategic Needs Assessment for the mindfulness course

According to the local public health statistics, there are 30,000 depressed patients in the city, and 160,000 in Sussex. The MBCT course is NICE-recommended, so patients have the statutory **right** to it if their GP says it is clinically appropriate for them. GPs therefore have an implied statutory **duty** to consider prescribing the course to **all** those patients for whom it is clinically appropriate, which is presumably **all** of them, numbering 30,000 in the city and 160,000 in Sussex. To discharge that implied duty, GPs would have to offer a course to **all** these patients. This they cannot do at present, because the old PCT commissioners did not give them the corresponding statutory **right** to prescribe it.

This does not apply to drugs. The PCT have contracts with the 37 pharmacies in the city to honour the delivery of all drugs prescribed within a few days at most. Some

250,000 monthly prescriptions for antidepressants were delivered to patients in the city last year, which was enough for 21,000 depressed patients to take them continuously. (However, it has widely been reported in the media that they don't work, and cause harmful side effects)

However, the PCT commissioners have only commissioned enough contracts with mindfulness facilitators to provide for at most 8,000 patient places pa, out of 160,00 depressed patients in need, hence a 20 year wait. This is why only about 1 in 100 (those who are suicidal) get offered a course at present.

This disparity can be illustrated by imagining the scenario that there were no pharmacies in the city, because the PCT had never commissioned contracts with them. (I believe that this was the situation in the Soviet Union, which is why advanced non-drug treatments like Scenar were developed) Every prescription for drugs given you by your GP had to be taken to Lanchester House, and you simply had to wait until you were called to come and collect your drugs, which sometimes took years. In the meantime you either got better, or worse. That is the situation for patients who want drug-free treatments, like CBT and MBCT courses, free on the NHS. However, they are plentifully available in the private sector at a few weeks notice, if you are rich enough to pay the going rate for them.

14 How many mindfulness course interventions were provided last year?

The above figures are guesstimates, as I have not been able to find out accurate figures, because of the secrecy mentioned in paragraph 12 above. Until July 2012, Sussex Partnership Foundation Trust (SPFT) had the sole contract for mental health services throughout Sussex. My figure of 20 years for the waiting time in Sussex was guesstimated from figures given me 2 years ago by Robert Marx, who is in charge of facilitator training for SPFT. He said that he had trained about 20 new facilitators in 2010/11, but he would not tell me how many courses they were contracted to run. I just assumed that they provide 20 facilitators to run 20 courses per year with 20 patients per course, so treat 8,000 patients pa. One fifth of these 8,000 patient places, namely 1,600 places pa, can be attributed to the city.

To update these figures, on 29.7.13 I rang Robert Marx, who said that they are now running courses back to back (ie continuously without breaks) but he again refused to give me any figures. My assumption of 20 courses pa per facilitator assumes that they are run back to back, so I believe that this 8,000 figure is historically an over estimate, and the actual waiting time was longer than 20 years. It could be 40 or 60, or longer.

The new contract with Brighton Integrated Care Service (BICS) includes mindfulness courses, which is greatly to be welcomed. I was told by BICS (Helen Curr) last January that 2 mindfulness facilitators had been engaged, and were to start running

MBCT courses from last Feb. I have left many messages asking her to tell me how many courses and patients they have run courses for to date, but she has not responded. This is typical of the unco-operative attitude mentioned in paragraph 12.

All I can do is guesstimate. Assuming BICS have already run 6 courses, for 10 patients per course, about 60 patients would have been treated to date. This could be projected to treat 100 in a whole year. This will only reduce the 20 year waiting time for 30,000 depressed patients by 3 weeks.

The planning of future services should not be based on adversarial guesstimating. I recommend the HWBB to collect and publish reliable statistics about the true present provision of the mindfulness courses service. GPs need to know how many patient places are annually contracted for these courses, so that they know how many patients they can refer.

Jack Saltman

[X]

We have an excellent General Practice [X], here in [X] Surrey. But over the past few years, I have seen it put under more and more pressure. The doctors are finding it increasingly difficult to provide the excellent service of the past. These are some of the reasons:

Over the past five years its budgets have been cut by £120,000. This has meant that the funding received for each patient has fallen from £9 to £6.

The QOF targets seem to change all the time. The changes have introduced more difficult targets with higher thresholds before payment is made. This has made life for the doctors much more difficult with the added salt to the wound in that the potential amount of money to be made has fallen by £12,000. They (the doctors) tell me they work a lot harder for less money. Hardly an incentive to excel in their work!

The £10,000 annual allocation for the non-clinical side to QOF, the Practice received for things like annual life support training, audits to check tests are carried out correctly, all clinicians were correctly vaccinated etc. has gone. This money paid for the admin of all this....it has now disappeared completely. In its place we now have the CQC which makes this non-clinical side mandatory.....so the work still has to be done.....for nothing!

CQC has created a whole raft of alterations to the fabric of practices. [X] We are having had to make structural alterations to mention nothing of new floor coverings and replacement of waiting room chairs etc., all with little help from the old PCT now the CCG. Again to add to the misery, the Practice has to pay an annual membership fee to the CQC!

As a result of the pension changes for doctors, we have just lost one of our very experienced senior partner. He tells me he had no choice but to retire before his pension took a real hit. He will be sorely missed.

From a patient's point of view, this is what I see:

- 1: Our GPs are working longer and harder - often putting in a 12 hour day.
- 2: Patients suffer because the Practice can no longer hire locums to cover leave - afternoon emergency clinics have had to be held to cope.
- 3: Staff pay has taken a real hit. There has been no substantial pay increase given to staff for the last four years.
- 4: Partner/ Doctors took no pay for three months....just to keep the 'business' afloat

5: Services that the doctors used to be paid to provide have dried up as the money dried up. Emphasis is now on extra-activities which are being introduced or expanded that do carry a price tag.

In fact the deterioration of what, even a first class surgery like ours can provide, is heavily marked.

We have doctors, nurses and staff who take the service they provide us the patients, very seriously. The uphill struggle they face daily is having a profound effect upon not only their morale but on their determined effort to continue to provide the services for which they are justifiably proud. This is now a major talking point in our area.

As an addition, I find it amazing to hear this week from the Sec. of State for Health that old people (and that includes me!) is now saying the each old person will have a dedicated doctor to monitor them. This just as Practices are trying to convince patients that they no longer have a dedicated doctor and that you are now a patient of The Practice.

One of the very best things about the NHS, the family doctor who knows and cares for you. is rapidly disappearing!



Making the health sector
work for patients

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