University Practice Patient Participation Group - Extraordinary Meeting

Tuesday 1st September 2015 6pm

Attendees

CL, SL, LG, TW, Janet Hallam, Dr Nicky Mounsey, Rita Taylor.

Apologies for absence were received from SB, JA and VQ.

We have had one resignation from AH and we have expressed our gratitude to him via email for his contribution to the group.

Practice Funding

Dr Mounsey spoke to the group regarding the financial pressure the practice is under from the new Funding Streams.

This practice is a PMS practice rather than GMS. Briefly this means that we receive a lump sum to run the practice rather than doing the work, submitting invoices to be paid piecemeal for the work done.

We receive core money from NHS England which amounts to £'s per patient. This amount is weighted. Because of the way that this calculation is made our practice is weighted at 0.7 of the total due to the unique practice profile.

In the past we have been able to add bolt on monies for extra services, some of which are being taken from us.

MSK Services (physiotherapy, acupuncture, ultrasound, sports injuries).

This may be taken over by "Care Closer to Home" – Locala (a social enterprise).

Sexual Health Services

We won the business case for this service but Locala have contested this and have taken it to the high court. We can carry on with our services until this is sorted out.

Tuberculosis Screening

This has been taken over by Public Health and will be a blood test instead of the Mantoux test we used to do. The criteria for being screened has changed and this means less tests being done.

Hearing Tests

There is no longer any funding for this so the patient will have to attend the hospital.

Patch testing for allergies

There is no longer any funding for this so the patient will have to attend the hospital.

Minor Injuries

We are currently putting together a business case to keep this service. If the service is not kept then these patients will be sent to A&E putting enormous pressure on them.

Psychotherapy

This service is currently safe as there is no comparable provider.

We receive monies from National Enhanced Services such as working with over 75s. We obviously do not have many >75 patients and therefore there is no earning potential here.

QOF (Quality Outcome Framework) targets include heart disease or strokes for instance and again we do not have a prevalence in this area. I.e. other practices have greater earning potential.

The Primary Care Trust (PCT) is now disbanded and has been replaced by the CCG (Clinical Commissioning Group). This group is made up of Doctors, Nurses, lay people and the general public. They commission local services namely secondary care (hospital). Currently the CCG have partial delegation of the money provided for our area by NHS England. We expect that the CCG will be applying for full delegation within the next year. Currently they do not hold the contracts for General Practice.

As a PMS practice we receive a lump sum which is weighted to reflect the differences in age, sex, disease, rurality and turnover. These calculations are compounded. The first calculation is made on age which means we are seriously disadvantaged right from the start. We turnover around 3000 in (and 3000 out) patients every year (being a University Practice) but the turnover is the last calculation so this is only calculated on an already disadvantaged figure.

We are losing services and earning potential because of our type of patient. For instance we are losing the potential to earn per patient for Alcohol services. Clearly this amounts to more work for us than for instance a practice with low patient turnover as it is a screening tool carried out on newly registered patients. The monies are being spread more evenly even though we have more work on this area than the other practices and then to compound the hit our monies then get the 0.7 weighting attributed too.

This amounts to our funding potential being virtually halved but still having to provide the same services. We will have the same overheads as a “normal” practice, or in fact more overheads because of the turnover of patients annually. Our front end costs are the same.

The “average” patient consults approximately 5.2-5.4 times per year and our weightings are because NHS England believe that the over 75’s consult more and the 18-25s consult less. We did a mini audit which showed our patients consulting at 5.2 on average! Students were classed in the “deprived” group of patients but this is not applied now. Our list size is growing but our monies only grow for 700 out of every 1000 new patients, because of the weighting.

Of the Practices in our area 8 or 9 will lose nothing. 4 or 5 will lose in the region of £20k to £30k. We will be losing £300K over the next three years. We can earn back 75% of this in the first year by doing extra work. 50% in the second year and 25% in the third year.

We are still contesting this with NHS England and the CCG. All practices nationally and locally are feeling this pinch however because of the way we are set up and the cohort of patients we serve we will be losing hundreds of thousands rather than thousands.

We tried to approach the University but they were a bit bewildered as to why we needed their input. We have approached other Universities via a forum but they have not been affected to the same extent as ourselves. We are an innovative practice and are always moving forward. We are currently bidding on a business case to provide Psychotherapy services to other practices as a pilot programme.

Our PRG members suggested widening our services to the local area for the elderly. In order to bring in the same monies for instance for hypertension we would have to recruit in the region of 50,000 "normal" patients to dilute the low prevalence. If we were to stop seeing patients to become a "normal" practice our patients could be absorbed into the nearby practices without too much impact on them so this would not be an incentive to help us. They have also suggested that we contact our local councillors (most of the university accommodation is in their area) and the National Students Union who would be interested in the quality of services provided to students.

It was felt that at the very least the practice should take legal advice. This of course can be very costly very quickly.

Dr Mounsey outlined how our services will change. All our free services will be stopped. Blood tests which were previously undertaken by us will be stopped and our patients will have one clinic per week provided at the surgery by the hospital and any other tests will have to be undertaken at the hospital. Hearing tests and patch testing will all have to be referred to the hospital. The practice will have to streamline the services and make efficiencies for example there will be work that the doctors do that the nurses can take over or nurse work that the health care assistants can do. Dr JL has retired now and will probably be replaced with a Nurse Practitioner rather than a GP. Dr Mounsey is currently mentoring a nurse doing minor illness and this may be taken further. We are making a case for a CPN to join the practice to cover some of our Mental Health regular reviews. One PRG member (SL) offered her services for befriending students.

We do a lot of medical certificates for the students and sometimes letters. We will be charging for this and will speak to the University regarding giving access to hardship fund for students who cannot afford to pay for this. PRG members agreed that the charges we are proposing are reasonable. That is, £10-20 for certificates and £40 for full letters. The NUS may also be able to help students to pay for this and should certainly be contacted to put them in the picture. The NUS is funded by the government.

We are expecting the CQC to visit us and the work needed to get us ready for the visit has been put on hold due to all this going on.

PRG members suggested looking into whether ex–students who were barristers could help us. We could possibly put something into the next Alumni publication or ask them to send something out to ex-students. We should also let other services know of the impact their services if we do stop delivery of the services.

It was suggested that we should go to the media and to our local MP and to let the students know about the services they will be losing. – JH pointed out that we do not wish to rock the boat too much as we are still hoping for an amicable resolution of some of these issues.

Friends and Family Test responses

Due to the time spent on the previous topic this item will be delayed to another meeting. It was suggested that we display some of the nice comments on the walls to improve morale and for patients to see.

Any Other Business

Online access to medical records was discussed. We need to check records in order to offer retrospective access of medical records. This would be unmanageable if all patients wanted access. We could just offer prospective access without retrospective access. This would be very easy to implement. PRG members voted unanimously to offer prospective access to online records. If anyone particularly wants retrospective access they can apply for it. This would make the process far more manageable.

The next meeting will be arranged at a later date.