Rutland PPG Meeting

06/12/21 – Rutland County Council Chambers

Attendees:

- Hilary Fox (HF)
- Nicola Turnbull (NT)
- Tracey Allen-Jones (TAJ)
- John Lesley (JL)
- Andrew Nebel (AN)
- Mike Fryer (MF)
- Peter Packer (PP)
- Flic Brewster (FB)
- James Burden (JB)

Minutes:

The aim of today is to go through the 6 priorities of the Place Based Plan and give feedback on the delivery plan to reflect the patient group voices.

MF – group discussed last week. A bit cynical about it, says we've seen it all before, what is different now? Goes round and round in circles. We're not setting any targets or time frames or finances to see that it actually is achieved. It needs doing.

HF – Yes. We need to delivery plan to have SMART objectives. As Rutland we need to know the details and how the gaps will be filled and make the delivery plan meaningful.

MF – We need baseline data too

PP – I feel that filling in the holes is the most critical thing. Because without the services we have nothing to pull together. If the components are missing it will fall apart. The emphasis should be upfront on getting the services working effectively.

HF – we need to know what that looks like and translate into an action that we can measure.

AN – on page 14 there is more detail, but even those high level actions listed are lacking in tangibility to see something identifiable. EG priority 1 – develop a plan for Rutland. Surprised that there isn't a plan for Rutland already. Who will do it, by when, what will be in it? Need to populate the actions with detail. The next steps are still vague. Need a next step to give more detail.

JL – as we have said, these are "apple pie". But where is the resource coming from to do this work?

HF – it depends on what it is, and it will be a group of different sources. We can measure other funded plans against this

JL – but where it says develop a plan, who will do that, and where will the resource come from?

AN – we will be looking to the ICS

HF – it will be Place level, and that's why this forum is important, as we are Place level

AN – so ultimately they will find the scope and funding of what is decided on as a plan at Place level

TAJ – there is also community and voluntary sector and funding in there so we need to be looking there too.

HF – there is a lot of funding available if you can place bids and support pilots, it's not usually the funding that is the blocker. If we look at section 6 – these are still high level. What do we want to see in there? Looking at priority 1 – I would want to see an improvement in childhood immunisation as providing the best start in life. It is easy to measure and freely available, and we know looking at health inequalities that we have patients who are likely to have lower immunisation rates. It then becomes the responsibility of the system rather than just the GP. We don't have access to military families but as a Place we can ask others to take responsibility.

JB – the good thing about imms is that it means you have contact with the hidden families and children who are not seen. If you target those patients they are probably the ones who need the most support.

PP – if we are looking at imms. You have to start by having a reliable means of measuring what is happening. What about the military who we cannot oversee? We need to set a target

HF – we have fingertips data and public data available, Public Health will have numbers and rates. Making it a plan that we all own then each bit does what it can to reach its target. The people that the council are responsible for, military, GP, then we will all get our numbers up. We want to see an improvement. And we need to understand the numbers of those not being seen. We need to build into the plan a recognition of the minorities who are not being seen. Our deprived families miss out more because they live in an affluent area that is assumed to have no problems.

FB – need to consider the numbers, as opposed to just percentages, because 8% means something different in Leicester than it would here

JB – Corby families vs Rutland families and support available

PP – why is it lacking in Rutland? (The support for low income families as opposed to Corby)

JB – until you drill down on the detail then higher lever organisations make assumptions that you will align to the area around you. But the reality is that you become less visible. It is good to look at it from a numbers perspective as opposed to the percentages as it makes it more real.

AN – this also comes back to other resources, e/g/ schools, how do we engage those in the actions and what we want to define, because we need those expertise. So does there need to be a process of how we include those groups?

TAJ – they are engaging in stakeholders and their opinions. That is going on in tandem with the consultation and workshops are happening.

AN – how are we mobilising them to work in an integrated way with what we are doing? This is a very patient centric group but if we're trying to define the totality of the plan then we are not the correct people. We need to know what the other experts in the system are planning and thinking. What are the other key issues?

HF – waiting times for community paediatrics, worse in Rutland than other areas. Dental and Eye checks in schools – again, that is Public Health and what the council is choosing to spend its budget on or not. Mental health and maternal health. We have lots of community resources that could be used better, such as Pepper's. There are resources that we don't know about.

JB – there is a 2 month wait for childhood psychiatrists privately, let alone the NHS patients, so they tend to go out of county. If we were setting a target on that, it would be difficult, because you either raise your referral criteria or increase staff which takes time. It's difficult to reduce queues.

HF – if we say that our target is to reduce waiting time for children's mental health, then what are we doing about it in GP, what is the council doing, what are community services doing? That's where the place-based plan comes in and joint ownership of it.

JB – It is also about how those other services are introduced to people and highlighted. Often it is a rejection letter that lists other services. Would it be better done by a phone call. Is there capacity in the third party that patients can be sent on to in the voluntary sector?

HF – we do now have our social prescribing team, so we don't need to know everything. If we need more access to mental health support, then how can we achieve that? What we might need is a care coordinator to make that happen.

PP – the magic word it triage, deciding the route.

HF – yes and bridging the gaps because often the triage is go on a 2 year waiting list, or nothing.

AN – maybe there are certain areas where as opposed to a percentage increase, you might set an absolute minimum, for example, when a referral is made for MH then the patient should be seen within 3 months. Dental care – not one Stamford dentist takes NHS patients. If you are a single mum with children, you can't attend and can't take children. So every child in Rutland should have access to dental care without question. Many children in areas of deprivation have poor dental care.

PP – it's the same as the school dental examinations which no longer happen.

JB – that also links to those missed children who don't have immunisations etc as they can't travel elsewhere and don't attend.

TAJ – the idea of getting leverage in certain age groups to then identify families under the radar. Is it important in this plan to have the whole family approach? We assume we will start with children and move out, but it doesn't have to be about that. There's no wrong age to start to identify families and children who need support.

PP – looking at the 1001 days. Is it impossible to set targets on that? For example, saying every child needs to be seen so many times in those 1001 days?

JB – that is where the plan needs to come into place because there are plans in place that support those, but the issue is the children who then don't attend. 1000 days is roughly where new synapses and brain development occurs, which is why that is the focus of the plan. Their ability to learn and socialise is set in those days.

PP – so the target is ensuring that those percent who are slipping through

AN – I wonder if we could just to priority 4 as we won't have time to read through the whole plan, as we know in Rutland that we don't have the breadth of services available in the rest of LLR, and patients struggle with access. Yes we are affluent, but we are elderly affluent in remote places with limited access to transport. Can we bid for a diagnostic centre to be in RMH and improve diagnostic capabilities in Rutland?

HF – it's likely that due to the speciality that the diagnostic hubs will be provided that our diagnostic hub will be in Melton to cover the East and Rutland. But what is important is what they are calling

"spokes". So it may mean that MRI and endoscopy is only available in Rutland but the "spokes" such as 24hr ECG and ultrasound etc we should be able to access in Rutland as opposed to the current travel to Glenfield etc. As far as we are concerned Melton would be good enough.

AN and MF – agree that would be a good outcome

AN – that is great but another challenge is that there is an MRI in Stamford Hospital and for many patients just going to Stamford is better than Melton. So are the diagnostic pathways allow you to make that referral across boarder in a Lincolnshire CCG. As it should be

HF – we can order scans at Peterborough and Stamford if our system is configured to do that. Empingham and MOSS are, but Uppingham and Oakham aren't. We need to look to ensure that all practices are configured to all local hospitals. What doesn't exist is consultant pathways. If you see a consultant in Oakham and need a scan, there is not a pathway for a scan in Stamford.

PP – is it correct that as a patient who needs some treatment, I can elect to go anywhere?

HF – Yes

JB – the system, ICE, doesn't always join up. So sometimes you get better joined up care by sticking to Leicester because the consultant cannot see results for someone who had bloods taken in another locality.

AN – and I think what Hilary said about the consultants having more issues is true. The other issue is reimbursement to travel costs and where your postcode is. There are examples where simple measures can make a difference to patients

JL – this is not patient centric, this is System centric, and it can be changed

AN – it's not even GP centric, it is system centric.

PP – I would love that to be an objective, to solve the cross-border problems.

HF – I think we have this as a priority but there are things we don't know are an issue and therefore they don't get addressed. In this plan there is something about engaging across borders. What it doesn't mean is two CCG bosses talking, it means that a patient can go for their bloods somewhere and they consultant can access them etc.

JL – there is also the issue of man power to run the resources etc.

JB – part of the issue is how long it takes to man the resources

HF – and that is why in Rutland we don't have that kind of equipment

TAJ – we also need to look at this from a children's perspective, and phlebotomy is a big one

HF – so we need this to be an action where diagnostics are available to anyone anywhere, including children

JB – the collections for bloods are early afternoon, so there are lots of areas that could be improved to make a difference. What you need is a centralised, expert place where people are doing it often enough and it is done well.

PP – we have RMH so we could have someone there one day a week

HF – for children, one day a week at RMH would be great.

AN – there are some services we know are deficient, e.g. community nursing. All I hear from patients is that community nurses are scarcely available.

HF – they are not the most skilled and they are spread very thinly across Melton and Rutland and are task specific as opposed to a continued care of a patient.

AN – a discussion of services as opposed to the high-level discussion is conducive to defining where improvement is necessary.

FB – it's the patients' perception of the services that are available. They are more concerned with what is happening to them and now as opposed to the high-level priorities.

MF – unfortunately the perception is that GP services are falling. If you look at ratings of local GPs, the perception is that the service has dropped because of the Covid vaccination programme, but on a whole, it hasn't changed that much.

AN – another area is elderly care and where primary and social care come together, and this is another aspect where it would be interesting to know what the service is and what the plans are. Elderly care must be high on the agenda for many patients.

MF – for example there is a queue now on 999 calls

JL – that is a process issue too

AN – another example is the Stamford Minor Injuries which is supposed to be an Urgent Treatment Centre and open longer than it is and many patients don't know about it.

NT – how do we best communicate this information to patients too? Because we can share on Facebook but we miss so many patients.

PP – the practices are relying on PPGs to disseminate the information, there is no real professional body to share information and disseminate to the population. Information can also be relayed incorrectly.

FB – The MIU information could be put on the practice websites. If you hit more patients that way then it is improved compared to before. We can ask the local paper etc. You're never going to reach everyone but you can increase it.

HF – what we really need is for lots of people to respond to this plan individually and lots of engagement that says the same message, e.g. we need children's phlebotomy in Rutland. Being too vague, such as we need more services, is still easy to ignore as opposed to specifics.

FB – I still think that somewhere in this there needs to be a way to access the families who do not tend to engage.

AN – and landing the paper on someone's desk doesn't enable you to put your finger on the exact things that need changing. It doesn't open the dialogue and the detail of what matters. Empingham have identified our patients by ward and sent the parishes copies of the draft plan to disseminate and gain feedback. The worry is that it is easy to sit and look at the plan and say yes it is good. We need to open conversation about services and how we can make the patients' lives better.

JL – looking at the priorities is probable 2 or 3 days of discussion. There is a vast amount of work to be done.

HF – the plan is there will probably be meetings on each priority.

AN – it's a good start, this plan, but there are many more steps to go. There are specialists that need to come together and task and finish groups to define the tangible elements and it's a big piece of work.

PP – is this from Rutland County Council

HF – no, it is the Health and Wellbeing Board - CCG, Rutland County Council and one of the Councillors – it was Alan Walters but is now Oliver Hemsley as interim, LPT, Hilary.

PP – so could this not go out as a paper to all residents? Or these questions be asked?

HF – they have done that with the Future Rutland, and some of that feedback is in here. We as a PPG for Rutland, have a strong voice. It may be that we can't get 1000 voices, but if we have a consensus from this group, it is difficult for them not to listen to that.

AN – that's why this represents a valuable additional layer to our practice level work

JL – where do we go from here? To progess this

HF – we need to produce a Rutland PPG response to this plan. We need to put that forward

JL – as an action from our perspective, what can we do? I have in mind our virtual PPG we have in Uppingham. We can cut this down, because its too big, and send it out to many of those people. How are you going to analyse it? The other thing at the surgery is a survey monkey questionnaire, as a pilot, but the work is in the summarising of the data

HF – the consultation is open on the Council, but the specifics is about what happens to patients that make their lives difficult? We need specific patient stories and examples to bring this down from high level to things that matter. It doesn't need to be a generalised story, what we need is as many people as possible to fill in the consultation with as much detail as possible.

JB – we also need to ensure it is specific issues that are solvable to help a patient's journey. For example, not being able to get a blood test done is specific and solvable and makes a difference to the patient journey. But saying I couldn't see a GP on a day of my choice because I want to, is hard to fix and measure. What we need are the specific gremlins in the system that impact on patient care. It's not about access to GP's, it's about the pathways being better.

AN – I would also like to tap into the CCG (what will be the ICS) but there will be a number of people who will be employed to look at health care within Rutland who look at these issues. So can we tap into some of them?

HF – that is what I think will be at the meetings, it is the CCG who has written this.

AN – so can we sit down with the people who wrote this to look at the delivery plan and shape it?

HF – the delivery plan isn't there because they don't know.

PP – if we have a mandate and put it together to present them with a set number of points that we as Rutland patients believe in

AN – as PPGs lets try and flesh these points out to spot these gremlins in the system to feed into the plan. Using the plan to shape those and what the plan means to those patients.

HF – we need to be almost writing the delivery plan ourselves. We are the only PCN to bring together our PPGs and are the only Place that has bought together a Place Led group. We need to ensure we use it. The consultation is until the 7th January. So we need to exchange ideas by email.

AN – ACTION – draft a questionnaire to send to other PPG leads.

ACTION – feedback by the 20th December