Marazion Surgery
Patient Participation Group

Minutes of the PPG Meeting on 3rd December 2024

Presentation by Dr Tinkler, GP Partner

Collaborative Collection Action – Presentation by Dr D Tinkler:

Dr David Tinkler introduced himself both as a GP Partner at Marazion Surgery and also as the Vice-Chair of the Local Medical Committee (LMC). The LMC were a body that acted on behalf of GPs and linked in with national contract negotiations. LMC's worked with the British Medical Association (BMA), and General Practice Committee (GPC) who were part of the BMA. The BMA were a union for all doctors in the UK.

General Practice was not run by the NHS in the same way as secondary care and hospitals but held a contract to offer general medical services to the NHS. There had been two imposed contracts in the last two years. Given the rate of inflation the contracts did not cover the increased costs involved with offering the general medical services outlined in the contract. Most general practices worked on a partnership model and could not therefore go into debt like hospitals, so were therefore forced to run efficiently. A salaried GP worked a standard eight hours and twenty minutes a day, whereas GP Partners worked much longer hours as they also had to run their practices on top of providing general medical services.

The way that practices were funded through the contract was very complex. The figures were historically based on patients attending on average for a small number of times, DT thought this was six times a year. The PPG agreed that the majority of patients attended far more frequently. Funding however was less than an annual TV licence and less than the cost of an apple a day. Despite this, primary care offered the bulk of NHS consultations though they were paid far less than the NHS hospital budget.

Some services were contracted separately to the main contract, ideally to suit the needs of the local patient population. However, the funding for these had not been reviewed for some years. Indeed, many of the services offered by the practice were not funded at all, often because there was a gap in the service with the hospitals.

The government say that they want to offer more services in practices, closer to patients' homes than hospitals. However, they had not mentioned any funding or increase in resources being made available to practices. Currently the practice offered a clinic with Dr Battle, Consultant Geriatrician, at the practice.

General Practice were contractually required to become more digital. There was a push towards practices using a total triage system, which some practices locally had adopted. This would mean everyone having to complete a form to request an appointment; this may not be the right approach for all patients and not suit the way the doctors felt worked best for patients. There were lots of new technology that could help manage patients, such as proactive systems to review prescribing trends and look for potential issues.

As a result of the pressures on general practice and to address the work that was being done but not funded by the NHS, the BMA and doctors began what is known as collective, collaborative action. By acting as a nationwide group, rather than as individual practices, it is hoped to affect local and national change to being properly funded for work being done. Over the years additional services have crept into daily workload, without an increase in staff or resources.

'Be there for you whenever you need us, to deliver continuity of care and bring back a time when patients knew their doctors.'

We follow the BMA advice to offer patients fifteen-minute consultations, rather than five or ten minutes historically. This allows clinicians to identify acute illnesses, social issues, notice other factors, provide preventative treatment and screening. This prevents the need for patients to make multiple appointments and the doctor may pick up on a medical condition that they would otherwise not have mentioned.

In order to spare patients the anxiety of long waits for appointments, General Practice needs more people, more space and consulting rooms, and more funding. Any NHS funding for premises tends to be spent on hospitals.

Patients can choose to contact us by phone, online consultations, email and simply walk-in to speak to patient advisors.

Why do many patients find it so hard to access their GP? General Practice is being broken.

In Cornwall General Practice sees more patient appointments that the national average. Most are still face-to-face. Patients who are in the area temporarily and use our services frequently compliment us on the ease of getting in touch and the quality of our service.

However, GP's and their teams are exhausted and losing morale. No matter how many hours we work, we still cannot see all the patients who need our care; we are over-worked and under-valued. The phrase 'moral injury' refers to Clinicians being unable to provide the standard of care they morally feel is needed due to limited resources this leads to the risk of being 'burnt out' and off sick with stress. There is a national feeling of General Practice having unsafe working conditions. People who work in General Practice need to look after themselves, in order to be able to look after others.

Nationally figures indication that approximately 1,000 practices have closed, and 10,000 GP's have left the NHS. The government previously promised 6,000 new GP's, but the full-time equivalent numbers are still going down. Access for patients is getting worse.

General Practice funding had been cut by over £66billion since 2019. There is no funding for additional services and no funding for more GP's or Practice Nurses.

The BMA have therefore led the ballot of doctors for collective, collaborative action; something needs to change.

There had been coverage of the action being taken by General Practice in the press and media; however some was misleading or mis portrayed. Dr Tinkler was keen to communicate what the practice was doing, as part of this national action. The PPG were a group representing the patient population of the practice and he hoped that his presentation would be helpful in sharing information. He was keen that the PPG shared their experiences and concerns with the practice.

What does General Practice need? More GP's. More Practice Nurses. More staff. Modern buildings with plenty of consulting rooms. More appointments for patients.

As discussed, the doctors offer 15-minuite consultations. They offer 25 consultations per day, some prebooked and some on the day. The BMA considers this to be the maximum safe workload for a GP and also follows European guidance. However, this does not include all the other work that happens in the background, with prescribing, medication reviews, looking at correspondence, dealing

with test results and internal tasks, messages and queries. GP Partners also have the operations demands of running the practice, reviewing changes in NHS policy and working procedures.

Much of the work done in General Practice is not funded but provided in order to plug commissioning gaps with secondary care and other NHS services. As part of the action being taken, notice has been given that Primary Care will stop offering these unfunded services; the intention being to promote them to be properly allocated and funded moving forward.

Physical health monitoring for adults with eating disorders:

This should be an integral part of their management by the specialist eating disorders service. Physical and psychological monitoring should be undertaken by someone who specialises in this area of medicine, as these are highly vulnerable patients.

Practices gave three months' notice of our intention to stop offering this as an unfunded service by General Practice. They have very quickly commissioned this with the specialist team who have taken over this work.

Complex wound management:

Some patients attend the practice up to three times a week, for appointments lasting up to an hour on each occasion. In other areas there are dressings services commissioned outside of primary care; indeed, there used to be a dressings service in Ludgvan that closed during the pandemic and never reopened. The time spend doing this complex wound management directly impacts on the ability of the nursing team to offer preventative medicine and chronic disease management.

Since we gave notice, the commissioners have arranged for a service to be properly funded from April onwards.

Practices in Cornwall have been praised by the commissioning team for working with them to find solutions to problems and ensure that patients are managed effectively.

Working collaboratively:

One of the PPG members present was keen to make the information about West Cornwall Hospital Urgent Care Centre clearer on the surgery website; she was encouraged to liaise with Juliette at the practice with her suggestions.

It was noted that vulnerable patients, such as those with learning disability, required more support to access NHS Services. Having more services available locally in their usual GP Practice was often helpful. This was an area that the PCN (Primary Care Network – General Practice working together) were involved with. As mentioned previously practices already hosted Dr Battle, Consultant Geriatrician. There were community settings for Mental Health and Wellbeing Practitioners.

Transport was often difficult for patients, and it was agreed that a volunteer service would be hugely helpful to many people. Anyone interested in this should contact the PCN to be included in their discussions. It was noted that GP visits took a doctor away from being able to offer consultations to multiple patients in the same length of time.

Practices in the Penwith PCN had data sharing agreements to allow collaborative working.

Referrals:

GPs often asked for a specialist opinion from secondary care, however as hospitals had been struggling with demand, they had put restrictions and blocks in place.

It was almost impossible to have a conversation with a consultant, as used to happen historically. There was an electronic system that could be used to seek 'Advice & Guidance' which the doctors were using when they felt appropriate.

However, as part of collaborate collective action, GPs were refusing to complete forms and arrange tests that were not necessary as part of the decision to refer the patient. A consultant may reject a referral suggesting further tests, but if a GP felt a specialist needed to review a patient, they were challenging this decision so that the consultant arranged tests and follow up under their specialist care.

GP Connect:

This system allowed third parties to enter information directly into patient's GP notes. The practice has turned off the write-back function in this system, as per the BMA guidance. There was a concern that information would 'flood' the notes and make them less coherent and clear. There was also the risk that someone would enter information but not take responsibility for ensuring that it was adequately followed up.

Medicines Optimisation:

The Practice has kept these on (analysRx and optimise Rx as we feel they provide information that is helpful for us to deliver patient care) There was a system that would automatically prompt a clinician when issuing a medication, about a safety alert, or to use an alternative medication, though sometimes the prompt was only for financial reasons. These system prompts were sometimes helpful, but not always acted upon.

The practice often liaised with the Clinical Pharmacist about medication audits, safety alerts and appropriate changes to alternative medications.

Online Consultations:

General Practice contractually had to offer online consultations. These were turned off at weekends and at night, due to safety concerns. If a 'red flag' severe symptom or concern was identified from the information provided by the patient, it automatically prompted them to call 999. However there had been instances where the patient had ignored that advice and then put in the free text that they were having chest pains!

The BMA collective collaborative action suggested that the number of online consultations received by a practice should be limited in number each day. The practice had not currently done this.

Questions:

Dr Tinkler thanked everyone for attending and hoped that they had found the presentation helpful. The PPG members present commented that he had presented well and made the difficulties and actions being taken understandable. One commented that one of the biggest challenge must be to keep patients / members of the public informed and therefore positively supportive. It was hoped that the PPG would help in this task.

One member of the PPG commented that she had heard positive feedback about staff being referred to as patient advisors, as this more clearly represented their role in the practice and their training in being able to signpost patients to the most appropriate clinician.

There was a short discussion over the future AI digital technology that may become available in the future.

When new houses were built, one member of the PPG was under the impression that money was contributed towards education and health infrastructure. Dr Tinkler confirmed that in his experience, in his roles with the LMC and PCN, he was never aware of any funding being received for health from housing developments. But there were some funds that could be used for project developments to

help the community. If this PPG member was aware of what they were the practice and the PCN would value this information.

On enquiry it was suggested that anyone with an interest in applying for grants and working to develop health services locally should contact the PCN who he was sure would be keen to hear from them with any ideas or interest.

On enquiry it was confirmed that there were no GP Practices run by hospital trusts in Cornwall. But there were some nationally and some of these had failed and were handing back contracts. All were run as GP partnerships under an NHS contract.

Dr Tinker thanked everyone for attending, and for their positive comments about the practice. The practice, and all General Practices nationally, appreciated the support of the public. The aim was to ensure the future of General Practice.

Date of Next Meeting:

A meeting would be arranged in early 2025.

Action List:

Date of next meeting to be confirmed	Juliette