WOKINGHAM AREA PPG FORUM

Minutes of the meeting held at Parkside Family practice
Headley Road, Woodley at 7.30 pm Wednesday May 1st 2019

Chaired by Tony Lloyd	Wargrave PPG

Those in attendance

Barry Harris	Brookside
Pat Evans (PE)	Finchampstead
Clare Odds (CO)	Finchampstead
Julie May (JM)	Loddon Vale
Sylvia Caston (SC)	Loddon Vale
Andy Wells-King (AW)	New Wokingham Road
Brian O'Regan (BO'R)	New Wokingham Road
Helen Edwards (HE)	Parkside Family practice – Practice Manager
Marion Naylor (MN)	Parkside
Angela King (AK)	Swallowfield
Roberta Stewart (RS)	Swallowfield
Tony Lloyd (Chair - TL)	Wargrave
Dr Debbie Milligan (DM)	Berks West CCG
Dr James Kennedy (JK)	Berks West GP Alliance
Wendy Bower (WB)	Berks West CCG
Rhian Warner (RW)	Wokingham Borough Council

Apologies for absence

Peter Odds (PO)	Finchampstead
Peter Davis (PD)	Parkside
Tom Berman (TB)	Wargrave
Gary Edwards - GE	Woodley Centre Surgery – Practice Manager
Clive Spires	Woodley Centre Surgery
Marjorie McDonald (MM)	Woosehill
Jane Bingham (JB)	Woosehill
Jim Stockley (JS)	Chair - Wokingham Healthwatch

7 out of the 13 Wokingham Borough practices were represented at this meeting. (Absentees: Burma Hills, Twyford, Wokingham Medical Centre, Woodley Centre, Woosehill, Wilderness Road).

1) Apologies for Absence.

Noted as above

2) Minutes of the last Forum meeting - **Oct 26th 2018** were approved subject to a correction submitted by Shirley Pearce (Twyford)

3) Matters arising

There were no matters arising

4) CCG / ICS update

a) **Connected Care**

The Royal Berkshire Hospital is now connected up and can access primary care records. GP practices using EMIS can access Connected Care while those using Vision cannot.
In response to a question about whether Connected Care is having the desired effect, **DM** noted that when she was doing out of hours work, it was very helpful to be able to access patients notes. A colleague working in A&E accessed patients care plans using Connected Care because they were more up-to-date.
At the Royal Berkshire Hospital (RBH) , although A & E data is quite comprehensive (because they were on the system first), other forms of patient data are still being put into digital format and are by no means comprehensive.
Although there is an opt out system, patients are always asked for permission to access their records.
In response to a question about the future potential benefits of Connected Care **DM** advised that it had significant patient safety benefits, particularly for the those patients that had poor or non-existent communication capabilities.
It was noted that practices have been able to access x-rays and blood test results for some time.
Patients should benefit by not having to repeat their history on multiple occasions as they will all be accessible on Connected Care

b) **Integrated Care System (ICS) communications**
TL noted that there was an ICS website(http://www.berkshirewestics.org/) and an ICS newsletter that you can subscribe to at http://www.berkshirewestics.org/get-involved/ **DM** cautioned that the current STP (Berks West Bucks and Oxon) was likely to morph into an ICS with Berks West becoming a “Place” and the 4 current districts (Wokingham, West Berkshire etc.) becoming “localities” and PCNs becoming “neighbourhoods”.

c) **ICS Projects**
in response to a question about the key projects that the ICS was undertaking **DM** advised that, in addition to connected care and A&E, there was a major project on outpatient redesign. At the RBH some clinics are doing an increasing amount of patient consultation either by telephone or Skype. Other clinics are being moved out into the community
“DAWN” is an electronic system that automatically monitors the blood tests of all patients on the special medications that are used to treat your type of arthritis. Other conditions could be monitored in a similar way and another project is looking at identifying and implementing automatic monitoring.
The ICS is also looking at rationalising back-office functions to make them more cost efficient. ICS finances are going to be a struggle this year.

d) **Patient Portal**

TL asked about the development of the patient portal. **DM**s view was that it was unlikely to progress until clinicians had full access. It was pointed out that, at many surgeries, patients already had potential online access to a lot of information such as blood results requested by GPs at the practice (but not those requested by hospital consultants or conducted outside the area).

e) **Healthwatch survey on the NHS Long Term Plan**

TL reminded the meeting to do what they could to increase the number of responses to this survey.

5) GP Alliance update

a) **Background**

JK outlined the background to Primary Care Networks (PCNs)
NHS England and NHSI had started to realise how much pressure primary care was under. Not only were practices struggling with the current workload but the new models of care being proposed would add additional burdens. This led to the announcement at the end of March of a new GP contract. This new contract, included a funding stream for five years rather than the normal one year. The plan recognises the need to introduce new clinical professionals into primary care. These include social prescribers, clinical pharmacists, physician associates, paramedics and physiotherapists. They would not be employed by individual practices but would be shared across areas.
What wasn't covered as well in the new contract was any recognition of the risk posed to primary care by the age profile of practice managers.
Practices are therefore being encouraged to grow themselves into networks in order to deliver new models of care. Hence PCNs
Within each PCN, a clinical director needs to be appointed. Some funding has been provided for one day per week of his time together with some admin support. However, the job description for this role will make it very challenging to fulfil in just one day per week.
Practices in the north of Wokingham have been working together for a number of years but what PCNs will permit is the extension of the primary care offer as additional services gradually migrate to the networks, including some that are currently in the acute sector. Partnership organisations such as local authorities and voluntary organisations will also be providing services.

b) **Implementation**

Across the population of Berks West (ca 550,000), it looks as if there might be 15 or 16 PCNs. They range in size from the North Wokingham cluster (62,000) down to about 35,000. Brookside is forming a PCN with the Wilderness road practice. Finchampstead and Swallowfield are forming a PCN and Woosehill, Wokingham medical centre, New Wokingham road and Burma Hills are forming another. There will therefore be four PCNs serving Wokingham Borough.
Within the ICS, it would be impractical to have 15 or 16 voices representing PCNs and discussions are taking place to determine which issues should be dealt with at ICS level, at Wokingham Borough level and at PCN level and how

that should be achieved..
JK stated that it was really important for patients to have a say and that PPG's were going to be a key factor in delivering successful primary care networks.
BH asked when the benefits might start to be felt by patients. **JK** noted that clinicians could currently feel a bit isolated and PCNs will hopefully provide more support and thus improve the service to patients.
HE added that the proposed influx of physician associates and other clinicians should go some way towards resolving the difficulty that some patients have in obtaining appointments. You may not get to see a GP , but you will be dealt with more quickly by another qualified clinician.
Regarding specialist clinics it may be the case, for example, that one practice hosts specialist diabetes clinics and another does rheumatology. Similarly, one practice may do blood tests on certain days of the week whilst another might do them on the other days.
JK noted that these changes might help practices to retain staff by spreading the workload and avoiding burnout.
RS asked whether all of these additional staff were likely to be available. In relation to paramedics, **DM** advised that the south-central ambulance services (SCAS) were revising their recruitment policies to take into account the likely demand for paramedics across the area and not just for the ambulance service.
JK noted that when the personal circumstances of paramedics change, some of the older ones are attracted to jobs which have a predictable pattern of work so that they can fit in their work responsibilities with their family and other responsibilities. Before these opportunities existed some paramedics left the NHS completely and thus it may be possible to retain paramedics who might otherwise have left the service. There may however be problems in recruiting enough physiotherapists. There is currently a shortage and thus this aspect of workforce planning is likely to be implemented towards the end of the five years.
PE sounded a note of caution. Sharing of staff has been tried before but failed because of bureaucracy. **HE** advised that it is already working and quoted an example of the two physician associates that she is now employing.
JK noted the HR challenges associated with any changes and the associated financial risks that practices might face. The Alliance is looking at alternative employment arrangements to facilitate seamless sharing of staff and to reduce the financial risk to practices.

c) **Population health management**

JK noted that there were sectors of the population who are not presenting to primary care but should be. The ICS is looking at potential ways of accessing these groups so that the impact of primary care is more effectively spread across the entire population.

d) **Continuity of care**

TL asked whether ICS or PCN strategy gave any consideration to continuity of care. **JK** commenced by stating that there was a great deal of evidence that continuity of care not only improved clinician/patient relationships but also led to better outcomes. However, the reality is that this is currently not always possible to deliver. PCNs will need to consider strategies for providing continuity of

implementation of the care plan for complex patients, continuity of the story of patients so that they do not have to repeat their stories on multiple occasions etc. Inevitable handovers to other clinicians will need to be done as seamlessly as possible.

e) **Timetable**
The PCN proposals need to be in by May 15th They should be approved or amended by the end of the month and implemented from July 1st

6) Rhian Warner – Wokingham Borough Council.

Rhian works for Berkshire West CCG as well as Wokingham Borough Council and her main focus is the integration of health and social care. Rhian has been working in Berks West for the last 18 years and is a physiotherapist by profession. She has worked at the CCG, the RBH, Berkshire Healthcare trust, Wexham Park, two private hospitals and has also done a stint in London.

The latest drive for integration has come from the Better Care fund. This was a government led initiative funded by the Department of Health, the Ministry of Housing, NHS England and the Local Government Association. That was announced in 2013/14.

In Scotland, health and social care started to be integrated in 2012 under a single directorate, but even so, they still have much more to do. In Wokingham a partnership between commissioners and providers has been created. This is somewhat unusual in England. There are eight partners; the CCG , the local authority, the GP Alliance, Berkshire Healthcare Trust, the Royal Berkshire Hospital, Optalis, HealthWatch and Involve. The primary objective was to build trust between the participants so that change can be delivered for the benefit of local residents.

There are already some significant successes

a) **Reduction of emergency admissions**
Although the absolute numbers have now plateaued, the population of elderly people is increasing by 3% pa which indicates continuing improvement of at least that amount.
Non-elective admissions are still going up, however, but surprisingly in the 20 to 50 age group. The causes are currently being researched

b) **Delayed transfers of care (DTOCs).**
Being in an acute hospital is very dangerous. For every day that you spend in hospital your muscles age by one year. In the last year DTOCs have been reduced by another 12½ %. In England, Wokingham are in the top 40 performers among 150 local authorities. A reduction in the waiting time in hospital for those requiring social care has been achieved.

c) **Keeping people at home safely for longer**
There has also been a reduction in the number of people permanently admitted to care homes. The Borough was expecting 132 but actually managed to reduce the number to 80. This has been very financially advantageous to the local authority and has allowed reinvestment in service provision. It is also impossible

to ensure that people returned home stay there longer with the number remaining at home for more than 91 days continuing to increase.

d) **Community multidisciplinary team meetings**
The community multidisciplinary team (MDT) meetings have been reformed and now have a very strong "core" group of professionals. For those with multiple long-term conditions this has resulted in a reduction in emergency admissions of 30%, a reduction in A&E attendances of 25% and a reduction in calls to the out of hours GP service of 27%. Please have a look at Guys story to understand the impact that the MDT approach can have. https://www.youtube.com/watch?v=9ZwFpgPQTG8&feature=youtu.be

e) **Cost savings**
Better care has resulted in cost savings. Last year, the objective was to save £2.5 million and this target was only missed by just £76,000

f) **Community navigator service**
This service is growing year by year. Users report that they feel much more self-reliant and confident. The service has been recognised nationally.

7) What does Integration mean?

a) **Leadership team**

A really strong leadership team has been developed in Wokingham Borough. Dr Amit Sharma from the GP alliance has been working very closely with the team and funding was found to support the paramedic pilot in the area. **RW** stressed that this is a very complicated system. They have to work with multiple partners at both a Wokingham level and a Berks West level and remain aligned to the priorities at both levels as well as the Health and Wellbeing board.
(list of priorities appended.)

b) **One team ethos**

There is no appetite to create a single organisation but just to develop and improve team working within the partnership. **RW** has a 5 year plan to develop the partnership.(see appended) which incorporates learning from exemplars such as devolution project in Manchester.

c) **Feedback**

Rhian is very keen to get feedback from PPGs and the public on the visions and outcomes. Do they resonate with you?. What should be changed. What is being missed out?. Please call or e-mail Rhian.(see appended slide pack)

d) **Integrated care network**

There is now an integrated network that can slot round the primary care network. It was aligned to three localities and will now be readjusted to four. That shouldn't be a problem. However, when the network was set up, they delineated between urgent on the day services and those services requiring ongoing support. This

created barriers and those barriers are now being removed to create a single network to make it easier for service users
Key priorities for next year include culture change to help accommodate new ways of working for staff and to persuade staff that they are working for the Wokingham Integrated Partnership rather than Wokingham Borough Council Berkshire healthcare trust etc. This means gradually building trust between staff. There is still a lot of work to do on processes and pathways.
In West Berkshire, for example, they have a very good joint care pathway which helps people get out of hospital and back into the community. It works very well and people are able to get back to the community or reablement very smoothly.
In Wokingham, it is recognised that the local pathway is not as smooth and they have been working with West Berkshire to implement their system in Wokingham.
In West Berkshire, under the joint care pathway, there is a single point to which referrals are made irrespective of health or social care needs unlike Wokingham where calls have to be directed to either health or social care teams. Removing this barrier eliminates delays associated with incorrectly directed referrals.
Because providers work with different computer software Rhian proposed that e-mail communications are all done using an NHS.net e-mail account. This has now been implemented and works satisfactorily.
The network is looking at ways of empowering residents. In particular it is looking at ways of improving navigation to the health and care system. The excellent Wokingham Information Network has now morphed into the community services directory
http://www.wokingham.gov.uk/care-and-support-for-adults/search-the-community-directory/ where you can find over 2000 voluntary service organisations.
Next year the partnership will be looking at how to how they prioritise funding for these organisations to make them more sustainable
It is recognised that the partnership is not very good at community engagement and Rhian would like to come to PPG meetings as well as this forum meeting in order to improve understanding and receive feedback from local residents.

e) **Responses from the Group**

MN observed that in her experience people could be discharged from hospital but received no care for days from social services. **RW** pointed out that the RBH operate a home from hospital service in conjunction with the Red Cross for people that are living alone.
MN then raised the issue of access to physiotherapy services and whether the RBH would provide the necessary patient transport for recently discharge patients so that they could practically access such services.**RW** pointed out that there was a huge project going on at the moment looking at community re-enablement services. In Wokingham in the last financial year the number of re-enablement hours was increased by 50 to 250. This year they will increase to 400. An additional physiotherapist has been recruited this year for the intermediate care team as the lack of resource was inhibiting efforts to discharge people from hospital more quickly.
RS mentioned the lack of district nurses. **DM** agreed that there was a shortage of them but asserted that district nurses were still at the core of community patient

care. **RS** noted the lack of continuity. **DM** advised that Berkshire healthcare trust were in a position where they didn't have enough senior nurses to provide supervision and support at each practice. For patient safety reasons, they therefore forced to reorganise the district nursing service into localities in order to ensure adequate supervision.
JK noted that there was evidence that the maximum size of teams that could work together effectively without e-mails etc. is about 120 to 150. District nurses working in such teams in primary care networks should therefore know who to go to for advice even if a senior nurse was unavailable.
The MDT meetings are really effective and really do make a difference.

AK described her experience as a headteacher and the value of the district nursing service at a time. **JK** reiterated that this was what they hoped primary care networks would develop into because they make the difference between good care and really good care. **JK** expressed the hope that the message from this meeting will be that continuity of care, sharing information, having a cohesive plan, good communications, knowing the family, knowing the context are really important and that Wokingham has gone a lot further than most. The outcomes, so far, have convinced everybody that they need to go even further. The challenge for the future is to answer the question “How do we know if I'm making a difference?” **JK** reiterated that by developing team working, staff job satisfaction significantly increased which then led to improved retention rates.

Date of next meeting
TBA

Appended

1) Rhian’s slide pack