NHS
Portsmouth
Clinical Commissioning Group

NHS Portsmouth Clinical Commissioning Group
Patient Participation Group Forum
Wednesday 29 May 2013

Questions from the Forum

Q. Does Portsmouth have to join a national out of hours GP scheme or can we do our own thing?

A. Out of hours GP services are locally commissioned, there is not a national out of hours service (NHS 111 is a national service).

Q. Can people contact an out of hours GP directly?

A. Patients need to go via the NHS 111 service and, if appropriate, NHS 111 call handlers will request that the local GP out of hours service calls the patient back and should advise the timeframe for this call back, which will depend on how busy the service is and clinical priority of the call.

Q. Where are NHS 111 calls answered?

A. Locally, the Portsmouth NHS 111 service is provided by the South Central Ambulance Service, with staff based at the ambulance service call handling centre in Otterbourne, near Winchester.

Q. Are GP practices obliged to use NHS 111 or can they provide a separate out of hours service themselves?

A. NHS 111 is a national service so covers patients at all practices. GP out of hours provision by individual practices changed with the 2004 GP contract.

Q. Not having used NHS 111 before, how does it work - is there always somebody there?

A. Telephone call handlers are available 24 hours a day, 7 days a week.

Q. If you call 111, what is the average time for calling a patient back?

A. During GP hours, callers are referred to their regular GP. Out of hours, the out of hours GP will prioritise and there could be delays at pressure times such as busy weekends. We are working with the out of hours GP service to address this, as it is still not acceptable if patients identified as a low priority experience long delays.

Q. Would it be possible for the out of hours GP, or QA Hospital, to have access to patients' records electronically?

A. There is work underway to try and improve access to patient records, for example, for patients in their last few months of life, to ensure their wishes are made clear to all services

that may be involved in their care including the Accident & Emergency department, ambulance crews and so on.

Patients should be asked by their GP if they are happy for their records to be shared.

Q. How does the Treatment Centre fit in?

A. There is currently a review of all urgent care provision taking place, and this includes the Treatment Centre.

Q. Can patients from Southampton use St. Mary's Treatment Centre too? For example, an arteries check-up was set up by Southampton.

A. Yes – and patients from Portsmouth may use the Southampton Treatment Centre. National screening programmes are commissioned by NHS England and have designated centres across the UK to make best use of resources. For example, Southampton is the local designated centre for aortic aneurysm, and Portsmouth is the local designated centre for colon screening.

Q. How are you differentiating yourself from the Primary Care Trust?

A. The principles have remained the same, but the CCG is now more clinically led. In relationships with providers such as acute hospital trusts we are trying to be bolder. In terms of membership there is now definitely more engagement with GP practices and colleagues. There is recognition of the importance of GP services and the need to develop these further.

Q. How do you avoid potential conflicts of interest for GPs – their national contract versus local services?

A. There are opportunities for the CCG to locally develop 'enhanced' services outside of the national GP contract and we are also working with member practices on how they can work together and bid to provide local services.

There are clear standards regarding conflicts of interest for GPs as both commissioners and providers of services and individual GPs must declare any potential conflict of interest if their own practice is involved. All meetings include such declarations and a register of interests is maintained so this process is transparent.

Q. How are you going to engage the younger generation?

A. We are exploring different ways to communicate, such as Twitter, and perhaps having a similar session for the under 25s.

Q. With all the doctors involved in the CCG, are you concerned that this will take away front-line time with patients, and if so, how are you addressing this?

A. We recognise that whilst we would like all member practices to be involved, not all want to become involved to the same degree. For example, some GPs will get involved in small pieces of work or projects, or attend meetings to give their viewpoint. There is a good pool of GPs in Portsmouth, part-time and full-time, and we want to keep them here so we always consider engagement and succession planning.

Q. Do CCG doctors get a salary and if so, where does the money come from?

A. All CCG staff are paid out of the allocated budget for running costs. There is an agreed level of payment set nationally, a local remuneration committee to oversee this and accounts are published annually.

Q. Does the CCG have any role in GP professional development?

A. TARGET is an educational programme for GPs in Portsmouth that is supported and funded – there are ten events each year (five at individual practices, five involving all practices). In addition, we hold evening sessions looking at commissioning, service re-redesign and so on. We also work with the Deanery for GP training and appraisals.

Q. Is the GP appraisal system compulsory?

A. Yes – all GPs must have an annual appraisal.

Q. Do you get income from other CCGs?

A. We share functions with neighbouring CCGs. In Portsmouth, we host and run Medicines Management, and Finance, Performance & Planning teams on behalf of Portsmouth, Fareham and Gosport, and South Eastern Hampshire CCGs. South Eastern Hampshire CCG runs the Commissioning function on behalf of the three local CCGs.

Q. How can we help get people home from hospital sooner and into community care? For example, if care packages are already in place or if there have been problems with lack of communication between the hospital and the GP.

A. Communication is key and there are systems in place – each patient should have an assessment before being discharged so if, for example, district nursing support is needed in the community, this should be in place and arranged before discharge. If people are "stuck" in hospital, this is something we need to work out.

Q. Who is driving the push for electronic prescribing? A pharmacist has been encouraging sign-up but what happens if people don't have the facilities or don't want electronic prescriptions?

A. Electronic prescriptions are a national plan and most of the UK has started to implement them, including Portsmouth. However, electronic prescriptions are voluntary, not compulsory, so people should not feel pressurised into signing up to electronic prescriptions. Manual prescriptions remain an option and a back-up.

Q. Is there a system to capture CCG best practice across the country?

A. Yes information is shared in a variety of ways including publications and national conferences.

Q. If a non-emergency operation is needed and your GP refers this to a panel, is this within the CCG's remit? Are there budgets dedicated to particular things? For example, knee operations and waiting lists for cataracts.

A. All GPs follow referral criteria and there may be exclusions, for example, patients above a certain Body Mass Index (BMI) may not be eligible for knee operations, which has been quite controversial.

There is an Independent Funding Review process and the panel, comprised of clinicians, considers all requests from GPs outside of the referral criteria on a case by case basis.

It is up to individual hospitals to prioritise their waiting lists.

Q. If you need an operation, can you choose which hospital to go to?

A. Yes, providing the hospital is registered and offers the procedure, a patient can elect a hospital of their choice.

Q. Why have GP practices stopped toenail cutting services? They only do this for diabetics now.

A. There is a national debate as to whether a toenail cutting service is for health or social care.

Q. If a foreign national, from outside the EEC, needs hospital treatment here in the UK, do we claim back the cost?

A. The NHS has a duty to provide emergency care to anybody that needs it, regardless of their country of origin. However, the NHS will not provide on-going care. Due to the checks that take place, such as patient NHS number checks, it is very rare that foreign nationals receive on-going care if they are not eligible.

Q. Could you pay extra to have more hospital staff available at weekends?

A. This is the subject of regular discussion with all hospital providers. Even if extra clinics are put on, the hospital may struggle to provide staff as they are not encouraged to routinely use bank staff. Whilst we are aiming for more 24/7 care, the reality is that there is not enough funding available for this.

Q. Of the members of the governing board, who is responsible for the budget? What happens at the end of the financial year if you overspend? Or even worse if you underspend?

A. Ultimately, Dr Jim Hogan is responsible as Accountable Officer. He works closely with Jo Gooch, Chief Finance Officer. If there is an overspend, essentially the overspend will come out of the following years budget. If there is an underspend, this may be either a planned underspend or a chance underspend, which would be investigated and understood, which might allow investment in different services the following year. The money would not be lost.

Q. To whom are hospital consultants accountable and who can patients approach if dissatisfied with the treatment by a particular consultant?

A. Consultants are accountable to their employing NHS Trust. If dissatisfied with their treatment, you should write to the Chief Executive of the NHS Trust concerned.

Q. Generic drugs seem to be replacing proprietary ones to a large extent. How can it be shown that the cheaper ones are as good?

A. The majority of medicines prescribed by GPs have been through a licensing process to ensure their quality before they can be marketed. There is little clinical evidence to suggest that interchanging proprietary branded and generic medicines causes any adverse clinical

effects. A generic medicine contains the same quantity of active substance(s) as the proprietary branded medicine that originally received marketing authorisation (i.e. the reference medicine). If a generic medicine is granted a licence, the regulatory authority has considered it equally safe and clinically equivalent to the reference branded medicine when used at the same dose to treat the same condition.