West Mid Beds Locality
Patient Participation Group

Thursday 11 May 2017
Boardroom, Houghton Close Surgery, Ampthill

Attendees:

Gill Hiscox – Practice Manager, Barton & Chair	GH	Doreen Stoddart - Houghton Close	DSt
Allan Elliott - Flitwick	AE	Mandy Regan – Houghton Close	MR
Ted Marchant - Greensand	TM	Dr Michelle Saint – Houghton Close	MS
Ann Nevinson - Greensand	AN	Graham Youngman - Asplands	GY
Roland Browne – Oliver Street	RB	Sian Pither – PDM, BCCG & Notes	SP

In attendance:

Dr Kay Elliott KE

Item No	Item	Action
1	**Welcome and Apologies**	
1.1	Apologies were received from Paul Titchener – Oliver Street, Dave Simpson – Flitwick, Richard Browne – Barton	
1.2	The group welcomed Dr Kay Elliott, Macmillan GP and Cancer Lead for BCCG.	
2	**Minutes from the Previous meeting 26 January 2017:**	
2.1	The minutes were approved as correct	
3	**Actions from the Previous Meeting:**	
3.1	All actions were agreed as completed with the exception of:	
3.1.1	6.4.1 – PPEF ToR had not been shared.	
3.1.2	6.4.2 – PPEF minutes had been shared to PPEF members but not to the LPPG members.	
3.1.3	6.4.3 – First newsletter went to PPEF members not to WMB LPPG as promised.	
3.1.4	SP noted that she had attended a meeting with Comms and all the LPPG organisers in the CCG to discuss PPEF and it had been agreed that PPEF agendas and newsletters would be circulated. Meeting dates would also be aligned to enable improved feedback routes between PPEF and LPPGs.	
3.1.5	GH noted her disappointment that the Director of Communications and Engagement had not followed through on the actions and it was agreed that she would write to her to express this and ask for genuine engagement.	
3.1.6	**Action – GH to write to JM to express disappointment that actions had not been completed and ask for genuine engagement**	**GH**
3.1.7	8.1.1 – SP had not completed the LPPG ToR as the PPEF ToR were required first.	
3.1.8	**Action – SP to rewrite the LPPG ToR in line with the new governance structure and PPEF**	**SP**

4	**Cancer – Improving Clinical Outcomes**	
4.1	Dr Kay Elliott introduced herself explaining that she had been a GP for more than 30 years and a Macmillan GP for 7 years. She was also now the Cancer Clinical Lead for BCCG which is an educational role with GP Practices regarding quality improvements and cancer pathways.	
4.2	KE talked through the attached presentation.  Cancer the CCG and you.pptx	
4.3	KE explained there is no separate cancer department in hospital but that it carries through all areas.	
4.4	**Key Relationships**	
4.4.1	KE noted all the different groups that she works with including:	
4.4.2	• *Network Cancer Group* - made up of Consultants and Nurses in hospitals trying to improve outcomes and pathways	
4.4.3	• Strategic Clinical Network – covers the whole of East of England	
4.4.4	• *Cancer Alliance* – just started and may be difficult as covers the STP footprint. Cancer Networks face specialist providers i.e. Dunstable patients go to L&D, Leighton Buzzard patients go to Stoke Mandeville and Milton Keynes Patients go to MKH. Therefore they are all facing different directions.	
4.4.5	• *Specialist Commissioning*- NHSE Department which pays for the rarer, more expensive treatment and scanners.	
4.4.6	• *NAEDI* (National Awareness and Early Diagnosis Initiative) – ensuring awareness and focusing on taking away the stigma of talking about cancer. Previously they have done the bowel screening 'poo in the post' programmes. They will shortly be starting a respiratory cancer screening programme focusing on breathlessness, highlighting lung cancer and heart problems.	
4.4.7	**Action – all PPG members to check if there is a 'Be Clear on Cancer' poster in the Practice Waiting Rooms**	**All**
4.5	**Who does what in Cancer Commissioning?**	
4.5.1	KE explained that the CCG commissions all diagnostics steps i.e. if you are going to the toilet a lot, the GP refers you for tests to find out what is wrong.	
4.6	**'Time targets':**	
4.6.1	• 'Two Week Waits' – this is the time from the GP urgently referring you to the consultant, to your first outpatient appointment	
4.6.2	• '62 days' – this is the time form when the GP first refers you to the time you have your treatment i.e. a patient attend the GP Practice with a lump in her breast, 62 days later she should be having chemo/radiotherapy/mastectomy. However if the patient has another long term condition such as diabetes, the anaesthetist may not be happy to anaesthetise the patient due to their condition – this makes it more difficult to fit in with the 62 days target.	
4.6.3	Some cancers require more tests than others i.e. prostate cancer has many different treatments from do nothing and monitor all the way to a large operation with robotic assistance. Also many men wish to take a few weeks to think about their options which also makes it difficult to achieve the 62 day target.	
4.6.4	Only L&D Hospital has achieved the 62 day target. Bedford Hospital missed and received a fine (which is paid to NHS England who use it to offset the debt) but have achieved it in 3 of the last 4 months. However, Bedford treats fewer people so just one patient can make all the difference.	

4.6.5	Specialised Commissioning are responsible for rarer tumours, cancer in the under 25s, tertiary level surgery, most chemotherapy and all radiotherapy.	
4.6.6	Tertiary level means specialist level – these operations are only carried out in specialist centres: Lister = prostate surgery Papworth = lung surgery Royal Free = liver surgery	
4.6.7	This type of surgery is also governed by the 62 day target which is a huge pressure.	
4.6.8	AN asked if the 'clock was ever put on hold'. KE Confirmed this was only done by patient choice i.e. the patient requires a specific date outside the 62days.	
4.6.9	KE noted that at the hospital, Multi-Disciplinary Teams (MDTs) consisting of Cancer Nurse Specialists, consultants, surgeons, radiologists and administrators, discuss each case and come to a shared understanding regarding the next steps and treatment.	
4.7	**What are the Challenges?**	
4.7.1	**STP** – KE noted there should not be much change for the patients but the different areas covered in the STP will share good practice. They will try to keep patients in the existing network footprints**.**	
4.7.2	**New 28 Days Target to Diagnosis –** may be hard to achieve in some cancers i.e. breast cancer is fairly easy to diagnose but lung cancer more difficult. The Cancer Networks, therefore, are pushing for this target to be 'Rule in or out' rather than diagnosis.	
4.7.3	**Improving 1year Mortality** At 42.9%, Bedfordshire CCG is just below the national average for 1 year mortality rate of 49%. BCCG should be better than it is. Lung cancer outcomes are particularly poor as Bedfordshire does not have any more cases but it is diagnosed later than other areas; patients for some reason are less likely to come forward at an early stage.	
4.7.4	AE asked if it was to do with the pollution from the brickworks. KE said no, there was no proven connection.	
4.7.5	KE discussed some cancers were on the increase especially in younger people due to the 'warts virus' (human papillomavirus, or HPV). The most common of these was Cervical Cancer but there are others too causing neck and head cancers, in the same family of viruses.	
4.7.6	Other cancers are falling such as lung cancers due to less people smoking but in Bedfordshire there is too much obesity.	
4.7.7	KE discussed Britain's improving mortality rate but that it was not improving as fast as in Europe. She noted that this was due to the different health systems in the different countries i.e. in Germany if a patient sees blood in their poo, they straight to the proctologist rather than their GP. Britain and Denmark are fairly similar in outcomes as they have a similar style of health system.	
4.7.8	**Improving Patient Experience** KE noted the need to improve patient experience. The scores are usually pretty good except for the confidence in the nurses on the ward. Bedford Hospital has difficulty recruiting nurses due to the uncertainty of its future and a high turnover with no specialist wards, therefore, although the nursing standard is high, the feeling of security is not there for the patients.	

4.8 **4.8.1**	**Good News** KE noted that there was money available from transformation funds. More Community Specialist nurses are required.	
4.8.2	Patients with other illnesses such as heart problems are now being treated for cancer whereas before this did not happen i.e. patients with lung cancer but also heart issues are being treated for the cancer and the very elderly are also being treated.	
4.8.3	KE noted that there is a specific patient group at Bedford Hospital called BCAP (Beds Action Cancer Partnership). Lots of leaflet have been rewritten to be more user friendly and helpful.	
4.8.4	TM asked about the 'poo in the post' scheme. KE noted that Bedfordshire had fully rolled out this programme. There was a new test coming out which was easier and did not require refrigeration	
4.8.5	There is a future plan for a GP based test as part of investigating symptomatic patients	
4.8.6	Over 55s will also soon be offered a one off flexible sigmoidoscopy.	
4.8.7	AN discussed raising public awareness of cancers and destigmatising it, noting that many communities will not even talk about it as they don't want to be labelled. KE recognised it was difficult to talk about even amongst professionals, noting the case of the BBC journalist who did go to the GP when he had difficulty swallowing and later died of throat cancer.	
4.8.8	DS discussed the difficulty patients experience understanding what the clinicians say. Patients need empowering to ask questions if they don't understand the lingo. KE noted that the new GP apprenticeship course does concentrate on communicating with patients but this does not happen in hospital although things are improving.	
4.9 **4.9.1**	**Kidney Cancer Support Network** DS stated that her daughter was part of the Kidney Cancer Support Network and handed out their leaflet, noting that the network was run by patients.	
4.9.2	**Action – all PPG members to take the Kidney Cancer Support Network leaflet to their practices and ask the Practice Managers to order more for their patients.**	**All**
5 **5.1**	**Previous Topics Update** SP gave the attached update regarding topics which had previously been raised at the meeting.  Previous Topics update 11.05.17.doc	
5.1.1	**Action – SP to clarify the meaning of ACS (STP update)**	**SP**
5.1.2	**Action – SP to contact Healthwatch to clarify what they are going to recruit patients with an interest for the Right Care SIG meetings. Can PPGs help?**	**SP**
5.1.3	**Action – SP to create a register of topics and updates for each meeting**	**SP**

6	**STP Update**	
6.1	GY attended the STP event in March. He noted that he had sat on a table covering a certain subject e.g. Maternity and Children etc. Each table discussed the topic and made suggestions and notes. Each table was then asked to visit the other tables and read the notes.	
6.1.1	GY noted that this was not well organised and difficult to do in the time constraints. AN noted that she and TM had also attended and said they did not think it was clear that all the topics discussed were linked to priorities other than the Acute services priority, which was frustrating.	
6.1.2	BH thought the hospitals, although taking the lead, did not want to work in an integrated fashion as it would mean losing some money so it would be hard to actual integration. MS noted that she had attended a Clinical STP meeting where 150 community clinicians were asked what the STP could do to support Primary Care so she hoped it would work.	
6.1.3	GH noted that funding was available for the STP and Primary Care improvement but it was quite challenging to obtain. MS noted that money had been given for training of Clinical Administrators who take the pressure off the GPs by carrying out the majority of their paper work for them i.e. entering blood results onto the system. MS noted that this had already made a difference to the GPs at Houghton Close.	
6.1.4	**Action – SP to feedback to the STP Comms team that patients would like feedback from the events**	**SP**
7	**Locality Development Plan**	
7.1	GH noted that work streams needed to be identified where they linked to funding streams. Al practices were involved in developing each work stream now (previously each work stream had been aligned to only one practice).	
7.2	The priorities being worked on currently were:	
7.2.1	1. <u>Locality Website</u> – Only 4 practices had signed p to the new website so far and were using it only as individuals so not achieving the same benefits. The costing of signing up to the website was £3,000, and an application for money had gone to the Resilience Fund at NHSE. The locality had been successful in its bid at first but then NHSE said there was no money	
7.2.2	2. Home Visiting Service – The locality had applied to the Transformation Fund for £52k per annum for 2 years across WMB. The bid was for 1 WTE (but two people) Advanced Nurse Practitioner to work across the locality, concentrating on patients in care homes and frail elderly (75+) in their own homes but the exact process was yet to be confirmed.	
7.2.3	The work stream aimed to:	
7.2.4	• reduce pressure on GPs having to leave the practice to carry out home visits	
7.2.5	• complete visits earlier s if a patient needed to be admitted to hospital this would be done earlier in the day preventing the afternoon pressure for the hospital	
7.2.6	• provide continuity of care from the same practitioner for those patients who are seen regularly	
7.2.7	The bid needed to be approved by the CCG first and then on to NHSE. Oliver St Surgery would likely host the nurse	

8	**Any Other Business**	
8.1	BH asked what the response times were like for ambulances in Bedfordshire as he knew of someone who was breathless that had to go to hospital after the ambulance he called for breathlessness never turned up.	
8.1.1	**Action – SP to obtain Ambulance response times for Bedfordshire**	**SP**
8.2	BH noted that the Walk in Centre at the L&D was to be closed and patients to call 111. Was this happening in Bedford too?	
8.2.1	**Action – SP to clarify the situation regarding Walk in Centre closures in Bedfordshire**	**SP**
8.3	TM noted that the Phlebotomy Service at Bedford Hospital had now move to Weller Wing and his experience was very poor. DS stated her experience had been ok.	
8.3.1	SP explained that the CCG was looking at Phlebotomy Services as a whole and would take into account patient experience and expectations. GH noted that the practices want to provide the service in the community but it would require funding for the phlebotomist.	
9	**Future Meeting Dates:**	
9.1.	**Thursday 20 July 2017**	
9.2	**Thursday 19 October 2017**	