Review of the Engagement Exercise by Danebridge Medical Practice April 2021

Prepared by The Save Our Surgery Residents Action Group and Cuddington Parish Council

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Contents

Executive Summary

Following the CCG PCCC meeting at which Danebridge Medical Practice (DMP) request to close the Sandiway surgery was considered, CCG instructed DMP by letter dated 15 November 2020 to undertake a range of actions. These included 'a more detailed explanation of how additional capacity will be subsumed into the operations of Kingsmead and Danebridge, including appointment increases at both sites from the loss of Sandiway.' The action requested 'a description of expected future delivery model (post Covid) and projected impact on 'Sandiway activity' including the following areas:

- face to face urgent appointments (on the day) – for patients who can't easily plan to travel in advance
- face to face routine appointments (who have some time to plan travel)
- video/ telephone appointments
- appointments no longer delivered by GP as would transfer to AHP e.g. pharmacist, counsellor including if any of this 'non medical/ nursing activity could still take place locally e.g. community room location.'

The letter states 'This modelling of future delivery should be developed through a recommencement of the conversation and engagement with local residents and patients. This should be done initially with your PPG and then further consideration of the wider community (such as the Save our Surgery group) with key stakeholders and partners including Healthwatch Cheshire also being involved.'

CCG- PCCC asked for this because the original consultation exercise to support the closure request was considered inadequate by CWaC OSC. This new engagement exercise was only publicised on the DMP website, so only a few patients were aware of it. 4 meetings were set up covering Medications and Repeat Prescriptions, Sample Handling, Appointment Booking and New Models of Care. No meeting was offered which addressed the key issue for patients namely, alternatives to closure of the surgery.

CCG accepted that consultation would have to use virtual and online platforms. The consultation was undertaken using Microsoft Teams, which constrains the number of potential attendees to those who have the skills and equipment to handle this tricky internet software. No other internet platform was offered e.g. Zoom that has been widely used during the pandemic lockdowns and is both more familiar and easier to use for the target audience. Since confidential matters were not being discussed there was no bar to its use.

No effort appears to have been made to include a representative sample of the patient list e.g. a representative age profile, or those with physical constraints and/or mental disabilities; no support was offered to those without the equipment and skills to handle Teams and no alternative media platform was offered. Based on the attendees' feedback, it is believed that about 0.1% of the total patient list and less than 1% of the village patients attended the sessions. This highly constrained approach, coupled with the lack of public promotion of the exercise and the limited number of people actually involved, call into question DMP's compliance with the Equality Act 2010 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (see Annex to this report for details). It should be noted that since some of the patients were already members of the PPG, the number of 'new' patients involved i.e. those not consulted directly previously, was trivial.

The meetings did not address all the issues raised above, for example the participants supporting this review cannot remember 'face to face' urgent or routine appointments being discussed. There is no reference to the issues, either in the 'points raised' or the 'we will' actions in the published outcomes from the meetings. It should be noted that the SOS Group was not approached in the planning of the exercise, or to participate in this exercise although some members did attend as individuals.

The outcomes of the meetings were developed and published without any further involvement of attendees, so do not necessarily represent the views that the attendees wished to communicate. There is a significant disconnect between the points recorded by DMP in the meetings and the actions that they say they will undertake as a result. The majority of points raised by attendees are suggestions on how the closure can be alleviated by some form of replacement service or re-location of the service in the village, or the requirement not to close the surgery at all; all such points are ignored by DMP. It would appear the majority of those actions accepted by DMP deal with updating/upgrading its website, something no doubt very necessary, but that will do little or nothing to alleviate the impact of closure of the surgery on the village patients.

It is clear from the above that the engagement exercise as undertaken by DMP is in no way an extension of, an improvement to, or a substitute for the original inadequate consultation to support the closure application. The majority of the views of the very limited number of patients involved have simply been ignored

Introduction

Danebridge Medical Practice (DMP) was instructed by the CCG to undertake the engagement exercise to support its application to close Sandiway surgery. This was necessary because the original consultation undertaken by DMP was considered inadequate. The idea of focus groups was mentioned during DMP's public 'close out' consultation meeting in February 2020 but only made known to a very small number of participants - in part because of the chaotic nature of that meeting. The Save Our Surgery Group (SOS) expectation was that DMP would further publicise/promote the exercise, seeking a representative cross section of those affected to become involved. This did not happen. DMP appeared to consider that notification via its website was all that was required; note that access to the working surgeries was constrained by the impact of the pandemic. All patients who do not use the internet regularly or are unable to access it at all were therefore excluded. There is one public location for internet access in the village, the library, which was closed during most of the pandemic.

SOS as a group was not approached to participate in this exercise, although some members applied and were accepted to join the groups. It was agreed within SOS that they would present their personal views; presumably in the same way as those members of the PPG who applied and were accepted to attend also presented their personal view rather than the PPG opinion. However, the SOS group has noted that DMP would already know PPG members' views since they would have been expressed in PPG meetings.

This SOS review is based on feedback from these individuals who attended the meetings.

Engagement Session Format

DMP decided to hold the focus groups on the internet using Microsoft Teams. The meetings were stated to be a maximum of one hour, and15 was suggested as the maximum number of people to be involved. No prior information was provided so that a part of each meeting was taken up with setting the scene. No support was offered or available for those without the necessary skills or equipment to handle Microsoft Teams; or to those who were hard of hearing, partially sighted or blind; or to those with other disabilities or long-term conditions that make handling Teams difficult. If the internet had to be used, Zoom would have been preferable as it has been used by families for communication during the pandemic and people in general have been learning how to use it. It is simpler to use than Teams and, since confidential information is not involved, would have allowed a wider range of people to participate – assuming they could make the times chosen for the meetings during the day. It should be noted that the age profile in the villages has a higher proportion of the elderly than the national average; the elderly are most likely to be affected by the closure and are least likely to be able to handle the internet and its interactions.

While it is recognised that disability is not always obvious to casual inspection, the attendees who supplied this information saw no evidence that DMP had made any attempt to involve a representative cross section of its patient list, for example those with mobility or mental health issues. The constraints imposed on those to be consulted by holding the consultation on line is so discriminatory that it is considered contrary to the Equality Act 2010 in that it discriminated, inter alia, against patients in respect of age and disability. It can also be considered to call into question the compliance of DMP with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – specifically Regulation 17 sub section 1, sections 2(a) and 2(e) This legislation requires the Practice to undertake 'effective' consultation. (See Annex)

Engagement Session Content and Attendance

4 meetings were offered dealing with Medications and Repeat Prescriptions, Sample Handling, Appointment Booking and New Models of Care. Only the last of these might have addressed the key question of those being consulted – what options were available for keeping the surgery open? The other 3 meetings dealt with the Practice's desire to find nominal solutions to the problems that the closure of its surgery will cause for the patients in the villages. Meeting 4 " New Models of Care" was so generic (dealing in part with Integrated Care Partnership issues) that it was considered by SOS group attendees to be irrelevant to the proposed imminent closure of the surgery.

Note that participants contributing to this review cannot recall key issues like 'face to face' appointments being discussed – and they and most of the other issues identified by CCG in its letter (see Executive Summary) do not appear to be reported or actioned in the published outcomes from the meetings (see analysis below).

Attendance at the meetings was sparse. In most meetings the number of people involved in managing or monitoring the meeting matched the number of patients. DMP initially suggested that patient numbers be limited to 15 per session, suggesting 60 patients maximum. This represents ~0.3% of the total practice list and ~1.7% of the village patients. They actually achieved less than this, 0.1% of the total patient list and less than 1% of the village patients are believed to have been involved. Since some of the patients were already members of the PPG, the number of 'new' patients involved i.e. those not consulted directly previously, was trivial.

There is no way that this exercise can be considered an 'effective' engagement exercise which extends, improves or substitutes for the previous inadequate consultation.

Engagement Session Outputs

The meeting outputs are discussed briefly below. It is assumed that the issues recorded by the Practice in its output documents are at least representative of the issues raised.

However, it should be noted that the outputs were generated and published without any consultation with those who contributed to the meetings. DMP has no way of knowing whether the conclusions drawn from the information it received agreed with the views expressed by the consultees. Without this cross check the Practice could well have written its conclusions without the meetings taking place. Indeed DMP appears to have done just that when the lessons it claims to be implementing are compared with the issues it says were raised in the meetings (e.g. see session 4 below).

Session 1: Medications and repeat prescriptions

The reported points raised have been reviewed to see how many relate to the 'we will' actions identified.

The total number of points/ issues raised by attendees in this session is 26.

Action (We Will)	Number of Points made by participants relevant to the action recorded by DMP	% of total number of points raised by attendees
Update Our website with clear information	4	~15%
Make it simple to understand how to get through the right person when you need to	5	~19%
Include details of charities and other organisations who can help the community	1	~4%
Review what phrases we use on our systems	1	~4%
Total	11	42%

It is apparent that feedback from ~42% of the responses has been used to generate the actions - all of which are focussed on improving consultation through the website.

A further 46% of responses can be summarised as seeking some form of local solution to the problems that will occur if the surgery closes. Updating the website will not alleviate these problems. The output does not even acknowledge the category containing the largest number of points raised i.e. changes to alleviate or preclude closure of the surgery.
None of the above actions address the issues raised in the CCG letter and do not alleviate the real problems caused by closure of the surgery.

Session 2: Dropping off samples

The total number of points/ issues raised by attendees in this session is 24.

Action (We Will)	Number of Points made by participants relevant to the action recorded by DMP	% of total number of points raised by attendees
1. Work with our community pharmacy to ensure they have a stock (of red topped sample bottles)	6	25%
2. Make it simple to understand how to get through to the right person when you need it and it works	1	~4%
3. Review our algorithm and triage process, supporting our reception staff to be responsive to the needs of our patients	1	~4%
Total	8	33%

It is apparent that feedback from ~33% of the responses has been used to generate the actions - all of which are focussed on improving consultation through the website.

A further 42% of responses can be summarised as seeking some form of local solution to the problems that will occur if the surgery closes.

Assuming the community pharmacy is Rowlands in the village, action 1 above represents some assistance to overcome the problems and partially addresses one of the issues identified in the CCG letter. Quite how filled bottles are to be identified and returned is not addressed. The other two actions are updating the communication and triage algorithm that may be helpful in the long run but does nothing to address the problems of returning filled sample containers.

Session 3: Appointment Booking

The total number of points/ issues raised by attendees in this session is 37.

Action (We Will)	Number of Points made by participants relevant to the action recorded by DMP	% of total number of points raised by attendees
1. Review and update our website with clear information	4	~11%
2. Encourage our patient participation group (PPG) to support patients in their communities. Also approach Healthwatch and Save our Surgery	1	~3%
3. Confirm that in 2020/21 no (zero) complaints were received by the practice about the application to close the branch surgery at Sandiway	0	0
Total	5	14%

It is apparent that feedback from ~14% of the responses has been used to generate the actions - all of which are focussed on improving consultation through the website.

A further 54% of points raised by patients deal with the difficulties of accessing the central facilities if the surgery is closed. These are ignored.

The participants who attended the session and who provided feedback to the SOS group have no recollection of the issues in the CCG letter being discussed, for example with regard to 'face to face' urgent and routine appointments, or the provision of a local primary care facility in the village.

The second of the "We Will" actions appears to encourage any group other than DMP to provide support for patients in their communities, something that the NHS has as one of its primary objectives. Seemingly DMP does not see this as part of its role.

The final action does not appear in the points raised and does not even address the question which DMP has recorded. The question DMP raised is 'You would like to know how many complaints Danebridge has had about the closure of Sandiway surgery?' The response focuses on 2020/21 only. It would not be surprising if no complaints were received in 20/21 since the country was (and still is) in the grip of a pandemic. Sandiway surgery was closed temporarily by DMP because of the pandemic and patients were aware of this so would not have complained. The government had asked people not to bother the NHS unnecessarily. It has subsequently been established that there were complaints in 2019/20 and the decision to use 'selected' data does give rise to speculation about the Practice's motives in so doing.

Session 4 New Models of Care

There were 27 points raised by attendees in total, under 3 different headings.

However, it is not possible to undertake a simple review as has been done with the other sessions, because there does not appear to be any relationship between the points raised by attendees and the "We Will" actions written by the Practice. Points raised by attendees are recorded but totally ignored.

This is not surprising since they are focussed on potential alternatives or alleviations to the impact of closure. DMP has expressed no interest in keeping the surgery open and has also stated publicly that it has no responsibility for how patients access its facilities.

DMP simply do not accept any responsibility for these problems even though it is its intention to close the surgery that precipitates all of these problems. Such an attitude is more in keeping with a profit centred commercial monopoly; it was not to be expected by the patients of a caring and responsible medical practice.

Conclusions

The following points arise from this review: -

1. The engagement exercise reached a tiny proportion of the DMP practice list and appeared (to those who did participate) to reach only a very limited selection of patients on the list.

2. The use of Microsoft Teams effectively precluded participation of a large proportion of those who were to be consulted. This is considered to put the Practice in breach of the Equality Act 2010 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Reg 17).

3. The outcomes of the consultation sessions were developed and published without any further involvement of the attendees. DMP does not have any evidence that the lessons it took from the sessions are those the attendees were trying to get across.

4. There is a significant disconnect between the recorded points of discussion and the "We Will" actions produced by the Practice. Indeed, in some sessions it looks as though the actions were developed independently of the session input.

5. The vast majority of points that raised issues or made suggestions to alleviate the impact of closure have been ignored.

6. DMP were given a very specific remit by the CCG PCCC and it appears from the output of the Engagement Sessions, that patients are being steered to use remote and online communication through the DMP website. This totally disregards the further requirement by the PCCC for consideration of in-person, face to face consultation and for some form of local primary care provision e.g. use of a community building.

Annex - Legislation

Equality Act 2010

Chapter 1 of the Equality Act 2010 lists the Protected Characteristics to which the Act applies. Age and Disability are the first two on the list.

Chapter 2 deals with Prohibited Conduct under direct discrimination. Para 13 states:
'A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A would treat others.'

In **Part 3** Provision of Services Para 29(1) states 'A person (a service provider) concerned with the provision of a service to the public or a section of the public (for payment or not) must not discriminate against a person requiring the service by not providing the person with service.'

There can be no doubt that DMP is a provider of medical services to a section of the public – its patient list. During the engagement exercise DMP was providing the opportunity for patients to comment on its intended actions. In constraining the method of consultation to those who can handle Microsoft Teams on the internet, it effectively precluded the involvement of those patients who cannot handle Teams; it did not offer the consultation 'service' to which they are entitled. No other alternative was offered – for example the more easy to use Zoom platform. Thus DMP treated those who cannot handle Teams, or do not have the equipment to handle Teams, less favourably than those who do. Publishing the process on the website further disadvantaged those who are not regular internet users, and by offering only 4 time limited sessions at specific times of day it discriminated against those who are working or have duties which prevented them attending.

The villages have a higher proportion of elderly people than the UK average. It is these people who are most likely to be adversely affected by the decision to close the surgery. This group of patients is least likely to have the equipment, the competence and/ or the confidence to use the software needed to participate in the consultations.

DMP did not appear to make any provision for those who were precluded from using Teams by physical or mental disability – thus treating this group less favourably than those who could.

In view of the above, it is argued that (whatever its intention) DMP has discriminated against a proportion of its patients on the grounds of age and disability – which would appear to put DMP in breach of the Equality Act.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – specifically Regulation 17 specifically sub section 1, sections 2(a) and 2(e).

Sub section 1 states 'Systems or processes must be established and operated effectively to ensure compliance with the requirements of this part'. Sub section 2 requires the registered person to have systems and processes to (2(a)) 'assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)'. Sub section 2(e) states 'Seek and act on feedback from the relevant persons and other persons on the services provided in the carrying on of the regulated activity for the purpose of continually evaluating and improving such services.'

While the engagement exercise can be argued to be in line with subsection 2 (a) and (e), it is argued that the consultation was not carried out effectively because: -

(a) using a net-based medium limits the access of the target audience,

(b) the public promotion of the exercise was extremely restricted,

(c) a very small number of people actually participated i.e. less than 0.3% of the total patient list.

Lack of effective consultation appears to put the Practice in breach of subsection 1 of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.